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Mary Podmolik King

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The Dissertation Committee for Mary Podmolik King certifies that this is the approved
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**The Lived Experience of Becoming a First-Time,
Enlisted, Army, Active-duty Military Mother**

Committee:

Lorraine O. Walker, Supervisor

Donna L. Rew

Gayle M. Timmerman

Kay C. Avant

Ruth G. McRoy

Janice B. Griffin Agazio

**The Lived Experience of Becoming a First-Time,
Enlisted, Army, Active-Duty, Military Mother**

by

Mary Podmolik King, B.S.N.; M.S.N.

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Dedication

To my husband Dan, and to my children
Daniel, Jacob, Thomas, and David, with love.

Acknowledgements

My deepest gratitude goes to the amazing young, enlisted, Army, active-duty military mothers who, despite their hectic lives, made the commitment to complete all four interviews for this study over five months of their journey into motherhood—with the hope that their stories would make a difference in the lives of those to follow. They willingly shared the joys, challenges, insights, and experiences of becoming a first-time, active-duty mothers during a time of increasing operational tempo. Their narratives provided the main body of the data. They were exceptional role models in dealing with the ever-present tension between the two major competing commitments in their lives, their intense love for their infants and honoring their commitment to the military.

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**The Lived Experience of Becoming a First-Time,
Enlisted, Army, Active-Duty Military Mother**

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The purpose of this study was to explore the nature of the experience of becoming a first-time, enlisted, Army, active-duty, military (EAADM) mother and to gain an understanding of their transition to the maternal role. Using hermeneutic-phenomenological methodology, interviews were conducted at four maternal-transitional time periods: just before delivery at about 36 weeks gestation, at 4-6 weeks, 8-10 weeks, and 14-16 weeks postpartum. Interviews were audio taped and lasted 20-60 minutes. Of the 18 EAADM mothers who enrolled, only ten EAADM mothers completed all four interviews. Their 40 verbatim transcripts were used for the final analysis. Mothers ranged

from 19-27 years of age, had ranks of specialist (E4) to staff sergeant (E6), and 2-8 years of Army service. There were seven vaginal and three cesarean deliveries of four girls and six boys. A thematic analysis revealed four overarching themes in each of the four time periods: just before delivery—preparing for self as mother; home on maternity leave—gaining a new sense of self as mother; return to work—integrating self as mother into self as soldier; and just before potential deployment—self as mother competing with self as soldier. There were four themes sustained *across* the four time periods: integrating the infant into their lives, experiencing a sense of loss for the future with their infants, acknowledging their own and the infants' fathers' mortality, and demonstrating one's competence as soldiers. Findings indicated that becoming an EAADM mother was experienced as an ever-present tension between competing commitments: the mother's intense love for her infant and honoring her commitment to the military. The acceptance of the pregnancy was met with the units' questioning the mothers' competence as a soldier as a result of pregnancy. Bonding with the unborn infant was countered with anticipatory grief for the irreplaceable lost time with her developing child. The intense joy, awe, and delight the infants brought to their mothers' lives in the present were simultaneously overshadowed by these mothers' thoughts of their own and the infant's father's mortality. Directions for future research and implications for enhancing the lives of the EAADM mothers were discussed.

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Chapter 1: Introduction

Effective May 15, 1975, active-duty military women were guaranteed the right to remain on active duty and could no longer be involuntarily separated from service because of pregnancy (Holm, 1992). Although 30 years have passed, little is known about the experience of motherhood in the military context. Research on active-duty military mothers has focused primarily on pregnancy outcomes (Barfield, Wise, Rust R., Rust, K., Gould, & Gortmaker, 1986; Fox, Harris, & Brekken, 1977; Greenberg, Yoder, Clark, Butzin, & Null, 1993; Irwin, Savitz, Bowes, & St. Andre, 1996; Irwin, Savitz, Hertz-Picciotto, & St. Andre, 1994; Magnann & Nolan, 1991; Ramirez, Grimes, Annegers, Davis, & Slater, 1990; Rosen & Evans, 2000) rather than maternal well-being. This knowledge gap is inconsistent with the recent expanded visions of women's health and well-being during the reproductive years (Grason, Hutchins, & Silver, 1999; Walker & Wilging, 2000).

The limited research on the experience of the transition to motherhood within the military work environment has focused on support received from supervisors and coworkers during pregnancy. Officers reported more pregnancy support from their chain of command and their coworkers than did enlisted personnel (Correnti & Jensen, 1989; Evans & Rosen, 1997). While both officer and *enlisted Army active-duty military (EAADM) mothers* continue to have less favorable pregnancy and birth outcomes than their civilian counterparts (Fox et al., 1977; Magnan & Nolan, 1991; McNeary & Lomenick, 2000; Splonskowski & Twiss, 1995), enlisted women have more negative pregnancy outcomes than officers (Messersmith-Heroman, Moore, & Heroman, 1994;

Ramirez et al., 1990; Rosen & Evans, 2000). To date, the subjective experience of becoming an enlisted mother on active duty remains unstudied. EAADM mothers were chosen for this study because the EAADM mother is at greater risk for negative pregnancy outcomes, and higher rank also correlates with higher salary and the potential for more resources to deal with the military lifestyle (Harrell, 2000). What is it like to be a first-time, enlisted, Army military mother on active duty? How does the EAADM mother transition to the maternal role between the month before the infant's birth and the infant's 4 month birthday? The answers to these questions may be the key to providing the tools needed by EAADM mothers to successfully negotiate this role transition.

Purpose

The proposed qualitative research was undertaken to explore the nature of the experience of becoming a *first-time EAADM mother* (hereafter referred to just as *EAADM mother*) and to gain an understanding of the EAADM mothers' transition to the maternal role. How the EAADM mother copes with her transition to the maternal role is critical, not only to her health and job performance, but also to the health and well-being of her infant. A better understanding of the experience of maternal role transition within the military social and cultural context may lead to development of appropriate guidance to enhance the EAADM mothers' health and support her transition to the maternal role.

Background of Proposed Study

Becoming a mother is a complex cognitive process that begins during pregnancy as the mother formulates her expectations of herself in the maternal role. Her expectations are shaped by her life experiences, values, and attitudes (Mercer, 1995).

After confirmation of pregnancy, the mother searches her environment for the strongest maternal role model, generally, her mother or a respected peer within her own social environment. She internalizes the role model that is consistent with her own values and beliefs, and conducts mental role rehearsals of how it will be between herself and her child. She integrates the ideal image of herself as mother into her “real self,” as a result of the interactions and feedback the mother receives from her infant (Mercer, 1995; Rubin, Part I, 1967a, Part II, 1967b). The mother-infant relationship is developed within the context of her spouse and immediate family, influenced by her other roles and responsibilities, and further shaped by the greater social and cultural context of her life (Mercer, 1995).

The impact of selected maternal, infant, and spousal variables has been evaluated with regard to their influence on the development of the maternal role within the context of her spouse and immediate family. These variables have demonstrated positive and negative effects on the mothers’ transition to the maternal role, making it difficult to separate the effects of maternal, infant, or spousal variables on the process of maternal role transition (Belsky & Rovine, 1990; Belsky, Spanier, & Rovine, 1983; Gotlib, 1990; Majewski, 1986; Mercer, Hackley & Bostrom, 1982; Reece, 1995; Roberts, 1983; Youngblut, et al., 1993). While most research with civilian (non-military) mothers has focused on maternal, infant, and spousal variables that impact on maternal role transition, the effects of employment on maternal role attainment have received less attention (Mercer, 1995).

For employed mothers, it is not the work itself, but rather the conflicts between the multiple roles of parent, spouse, and worker that have the greatest impact on the mother's health and her successful transition and adaptation to the maternal role (Beck, 1995; Jimenez & Newton, 1982; Majewski, 1986; Mercer et al., 1982; Myers-Walls, 1984; Power, Parke, & Ross, 1984; Reece, 1995). The health status and health-promoting behaviors of the working mother take less priority as she seeks to integrate the role of mother into her worker and spouse roles. Mothers often sacrifice self-care in order to perform the roles and responsibilities of being a parent, spouse, and worker (Agazio, Ephriam, Flaherty, & Gurney, 2002; Verbrugge & Madans, 1985; Woods, 1985, 1987).

Military mothers represent a unique population of employed mothers since their health is protected by regulatory mandates, and they have free access to health care. In order to begin service on active duty, all military members are required to meet strict standards of medical fitness (Army Regulation [AR] 40-501, 2002). Health risk appraisals are conducted routinely for all soldiers, and health promotion activities are mandated components of soldier training. Periodic physical and dental examinations are dictated, and there is free access to medical care. Immediately on confirmation of pregnancy, the active-duty military mother is placed on a physical and work profile to protect the health of the mother and her infant. Following delivery, there is a prescribed 42-day postpartum recovery period, unless medical conditions necessitate an extension (AR 40-501, 2002).

Despite these precautions, active-duty military mothers remain at increased risk for negative pregnancy, labor, delivery, and birth outcomes. Fox et al. (1977) first

identified the *active-duty military pregnancy* (p.707) as a high-risk category and subsequent research has supported this linkage. Active-duty military mothers continue to be at greater risk than their civilian counterparts for pregnancy-induced hypertension (Magann & Nolan, 1991); preterm delivery (Greenberg et al, 1993; Irwin, et al., 1996; Irwin et al., 1994), cesarean delivery (Magann & Nolan, 1991; Rawlings & Wier, 1992; Schillac, 1999), and infants of lower birth weight (Barfield et al., 1986; Greenberg et al., 1993; Magann & Nolan, 1991; Rawlings & Wier, 1992). There is not a clear understanding of the etiology of the increased risks for EAADM mothers; however, work conditions have been cited as the reason for the increased pregnancy risk and outcomes (Fox et al., 1977; Ramirez et al., 1990).

Enlisted status further predisposes active-duty military mothers to increased risk for pregnancy and delivery complications. EAADM mothers are more likely to be single (Buttenmiller, 1984; Irwin et al., 1994), have unintended pregnancies (Clark, Holt, & Miser, 1998; Evans & Rosen, 1997), experience more medical problems during pregnancy (Irwin et al., 1994; Buttenmiller, 1984), and deliver preterm infants (Irwin et al., 1996; Rosen & Evans, 2000). The results of the EAADM mothers' risk could be due to several factors. In the military, increasing rank is generally equated with increased chronological age, education, life experience, work experience, and salary. EAADM mothers, therefore, may have less internal and external resources available for the transition to motherhood.

Recent intervention research results have demonstrated some success in improving pregnancy outcomes for military women. An exercise and education

intervention for EAADM mothers and their family members (Lombardi, Wilson, & Peniston, 1999) reduced the incidence of negative pregnancy, labor, and delivery outcomes. An interdisciplinary obstetrical clinic dedicated to low ranking junior EAADM mothers (Calhoun, Jennings, Peniston, Patience, Pulos, Hume, et al., 2000) raised junior EAADM mothers' pregnancy outcomes to the level experienced by senior enlisted and officer mothers. Low ranking junior EAADM mothers included the ranks of E1 to E4, private to specialist, while senior enlisted status included ranks E5-E7, sergeant to sergeant first class. The quantitative analysis of pregnancy outcome data does not, however, address the EAADM mothers' subjective experience of pregnancy and their transition to the maternal role within the context of the military.

Significance of the Proposed Study

Approximately 15% of the active-duty Army is women, and 38% of them are mothers. Among these EAADM mothers, 52% have at least one child (Defense Manpower Data Center [DMDC], March 31, 2001). The percent of women on active duty in the Army increased 3% from 1998 to 2001, and it is projected that this percentage will continue to rise (DMDC, 1998; DMDC, March 31, 2001). While quantitative studies have focused on pregnancy outcomes, to date, the EAADM mothers' subjective experience of pregnancy and subsequent transition to the maternal role remains unexplored.

Since relatively little is known of the subjective experience of EAADM mothers' maternal role transition, this qualitative study provided a beginning understanding of the phenomenon of the EAADM mother's maternal role experience of becoming a mother in

the military environment. This knowledge can provide a baseline for further research and guidance designed to meet the needs of the EAADM mothers' transition to the maternal role.

Statement of the Problem

The goal of this qualitative study was to gain an understanding of the meaning of the lived experience of becoming an EAADM mother. *Meaning* is to make sense of something (Jaffe & Miller, 1994); in this study, meaning was to make sense of becoming and being a first-time mother on active duty. The primary research question was: What is the nature of becoming a first-time, enlisted, Army active-duty military (EAADM) mother?

In this longitudinal study, EAADM mothers were initially interviewed when the mothers came in for a prenatal visit between 36 weeks and delivery, followed by additional visits at three points after delivery: when the infant was 4-6 weeks of age, 8-10 weeks, and 14-16 weeks. The initial questions at each of these visits were open-ended, followed by more specific questions that focused on the experience of becoming a mother on active duty. Subsequent questions were more probing, resulting in clarification or elaboration of issues brought up in prior interview(s). Also, subsequent questions were used to verify or refute the researcher's impressions, observations, or preliminary analysis of the transcripts of prior interview(s), field notes, or other field documents (See Appendix A, Interview Guide).

Sensitizing Framework

Meleis's theory of transitions (Chick & Meleis, 1986; Meleis, 1975; Meleis & Trangenstein, 1994) was used as a guide to begin to understand the EAADM mother's experience in her transition to the maternal role.

Transition is defined as “. . . as a passage or movement from one state, condition, or place to another” (Schumacher & Meleis, 1994, p. 119). In order to develop interventions to support EAADM mothers' maternal role transition, there must be an understanding of the EAADM mothers' developmental process of maternal role transition. The individual meaning of becoming a mother and the transition to the maternal role must also be known before appropriate nursing interventions can be developed to support this transition (Chick & Meleis, 1986).

There are four types of transitions relevant to nursing: developmental, situational, health-illness (Chick & Meleis, 1986), and organizational (Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994). The transition to the maternal role has been called both a developmental (Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994) and a situational transition (Chick & Meleis, 1986).

The three universal properties of transition are: (a) The process occurs over time, (b) there is a movement from one state to another, and (c) there is a change in identity, roles, relationships, abilities, and patterns of behavior, structure, function, or dynamics (Schumacher & Meleis, 1994). The boundaries of the transition exist from the first

anticipation of the transition until the new state is reached. The transition process boundaries are not fixed and are influenced by the context in which the person exists.

Transition conditions affecting the individual include the meaning, expectation, and the level of knowledge, skill, or planning required for the transition. Perception of a successful transition varies by person, community, and society. The three major indicators of a healthy transition are subjective well-being, role mastery, and well-being of relationships.

Role change is a critical aspect of any transition. Role acquisition requires new knowledge, behavior, and skills for a new definition of self. Social norms, demands, and rules determine role performance. Role norms and expectations of role performance are determined by observing others in the role, by feedback from others on one's performance, and by the individual's own capabilities (Thomas & Biddle, 1966).

Disconnectedness is part of the process of role change. There is a disruption in the orderly connection between the former roles of one's life. Familiar reference points for prior role function are replaced with new reference points. The new reference points may be derived from patterns of behavior, skills, or knowledge from other roles (Chick & Meleis, 1986; Gordon, 1966). Role clarification comes about through mastery of knowledge for role performance, based on one's own expectations and previous experiences through interactions with others and is evaluated as a result of reciprocal responses from others (Burr, 1972). Role insufficiency occurs when there is disparity or discontinuity between what one expects of oneself and one's actual performance (Gordon, 1966; Meleis, 1975). Role insufficiency may be caused by one's lack of

understanding of the role definition, lack of knowledge about the role, or misinterpretation of cues from others about role performance (Meleis, 1975).

The level of disconnectedness with acquisition of a new role is replaced by an integration of the new with the existing roles. Role integration involves an evaluation of the content of the role job description, the time span of the work in the role, and the degree of ownership of the roles. The addition of a new role is related to the form that the new role takes, how existing roles expand in size or content, and whether old role responsibilities diminish, can be delegated to others, or are lost because they are no longer relevant (Gordon, 1966; Hall, Stevens, & Meleis, 1992). Role integration has also been defined as the balance between role satisfaction and role stress within and between the key roles of worker, spouse, and mother (Douglas, Meleis, & Paul, 1997; Meleis, Norbeck, & Laffrey, 1989), and the process of satisfactory integration of multiple roles (Hall et al., 1992)

The greatest strength for use of the theory of transitions was that it formed a sensitizing framework for beginning to understand the lived experience of EAADM mothers' transition to the maternal role. Identifying the conditions that affected the transition to the maternal role and role integration provided the initial discernment for the understanding of the EAADM mothers' maternal role transition within the military environment. EAADM mothers were asked questions such as: "Are you comfortable with your decisions as a new mother?" "What helps you to be the kind of mother you want to be?" "What make it hard to be the kind of mother you want to be?" In order to gain an understanding of the subjective reports of well-being, maternal role mastery, or well-

being of relationships the transition to the maternal role, EAADM mothers were asked, “Do you feel like your old self?” “When did this happen?” “What do you think about the most (about anything)?” Answers to these questions helped the researcher understand the nature of the experience of becoming an EAADM mother on active duty and were used in Chapter 5 to describe implications for enhancing the lived experience of becoming an active-duty mother.

The theory of transitions provided an overall sensitizing framework to understand the process of EAADM mothers’ transition to the maternal role. Becoming a mother is a developmental as well as a situational transition. For the EAADM mother, the official time span of this developmental process began with confirmation of pregnancy. Confirmation of the pregnancy sets in motion mandatory reporting, counseling, and the assignment of a pregnancy profile with prescribed duty parameters, which in turn may result in a situational transition.

Applying the theory of transitions to EAADM mothers further suggests once the pregnancy profile and mandatory pregnancy counseling are completed, the following experiences may result: Depending upon the mother’s job description or military occupational specialty, the EAADM mother’s pregnancy profile alters her job and job conditions and, as a consequence, the support from supervisors, coworkers, and subordinates (Correnti & Jensen, 1989). She may experience an immediate change in identity, from that of a go-to-war soldier to one who is non-deployable. She and her fellow soldiers may question her abilities and capabilities. The structure, function, and dynamics of her work role may be altered just by the confirmation of her pregnant state.

Clarification of her work role may be evaluated as a reciprocal response from others at work and may set the stage for the process of integration of her maternal role into her spousal and worker roles.

The timetable for role integration in a sense may be forced. Immediately upon confirmation of pregnancy, her maternal role may be questioned in light of her work role (Correnti & Jensen, 1989). The environmental realities of being subject to military regulation may place limits on the EAADM mother's control and may limit or complicate the options of her personal journey of transition to the maternal role. Meleis' sensitizing framework for the theory of transitions (Chick & Meleis, 1986; Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994) was not prescriptive, and thus provided an overall framework within which to begin to understand the EAADM mother's journey to becoming a mother on active duty.

Significance of the Phenomenological Approach

The most appropriate method to gain an understanding of the lived experience is phenomenology (van Manen, 1990). Phenomenology is the study of the lived experience, of being in the world (Cohen, 1987; Merleau-Ponty, 1962; Moran, 2000). The phenomenological approach used in this study was guided by Cohen et al. (2000) and van Manen (1990). This researcher's aim was to critically examine the subjective experiences of EAADM mothers as they reflected upon the life experience of becoming an EAADM mother. A description of Husserl's (1950, 1977) philosophy of method and the research methods of the phenomenologist are presented in Chapter 3.

Because of the paucity of knowledge about the lived experience of becoming a mother on active duty, the phenomenological method was used to gain insight into the lived experience of becoming an enlisted Army mother on active duty.

Assumptions

1. EAADM mothers will want to talk about their experience of becoming a mother on active duty.
2. Motherhood is experienced differently by parity, marital status, and military rank.
3. The opportunity to share the nature of the experience of becoming a mother and being a mother, spouse, and military member in a confidential supportive environment will be beneficial to participants.
4. How the EAADM mother makes meaning of her experience will be related to how the mother thinks about her approaching motherhood and being a mother, her own experience of being mothered, her interpretation of the ideal mother, and what expectations she has for herself as a mother.
5. The meaning mothers make of the phenomena of motherhood can be discovered through analysis of interview data.
6. The language, speech, or text of the interview data must be interpreted within the context in which the speech took place.
7. The researcher is an integral part of the research process, part of the context in which the EAADM mothers reveal the meaning of the motherhood experience.

8. Meaning can be derived from both the EAADM mothers' and the researcher's perspectives.

Limitations

The findings of this study were limited to a sample of ten first-time, enlisted, Army active-duty mothers at one military location. The interview process itself may have been therapeutic for the EAADM mothers as they had the opportunity to reflect on their experiences in a confidential supportive environment. The EAADM mothers' participation in four interviews as they became new mothers may have changed the EAADM mothers' experiences of the phenomena under study.

Summary

In this chapter, the purpose, background, significance, statement of the problem and research questions, sensitizing framework, significance of the phenomenological approach, assumptions, and limitations were described. The purpose of this study was to gain an understanding of the phenomenon of the lived experience of enlisted motherhood in the military environment. In this longitudinal hermeneutic phenomenological study, EAADM mothers were interviewed one time between 36 weeks and delivery and then three times after delivery, when the infant was 4-6 weeks of age, 8-10 weeks, and 14-16 weeks of age.

The sensitizing framework for this study was Meleis' theory of transitions (Chick & Meleis, 1986; Meleis, 1975; Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994). Because relatively little was known about the EAADM mother's lived experience of becoming a first-time mother in the military environment, a hermeneutic

phenomenological approach was used to gain an understanding of this transition process (Cohen, Steeves, & Kahn., 2000; Steeves & Kahn, 1995; van Manen, 1990).

The literature review in Chapter 2 addresses research relevant to the experience of first-time motherhood and motherhood within the military environment. The third chapter presents the research methodology and the procedures used to conduct this phenomenological study. The fourth chapter presents the study findings. The discussion, conclusions, and recommendations for further study are articulated in the fifth chapter.

Chapter 2: Review of Empirical Literature

Becoming a mother for the first time has been called a developmental process (Erickson, 1968); one of life's most challenging experiences (Brazelton, 1963, 1969), and a crisis event (LeMasters, 1975). Becoming a mother is an internal cognitive process that begins in childhood during the mother's development of her feminine identity (Deutsch, 1945; Rubin, 1984; Schectman, 1980). Values, attitudes, and beliefs about maternal identity are shaped by the experience of being mothered and are evaluated against other role models within the context of the new mother's social and cultural environment (Mercer, 1995; Rubin, 1984; Schectman, 1980). Roles and relationships between the expectant mother and her mother, the expectant father, her co-workers, and significant others involved in the life of her family will be changed as a result of the transition to motherhood (Brazelton, 1963, 1974, 1981; Hrobsky, 1977; Pickens, 1982; Rossi, 1993; Rubin, Part I, 1967a; Part II, 1967b; Schectman, 1980). In order to gain a perspective on the phenomena of becoming an enlisted Army active duty military (EAADM) mother, the literature review addresses: a) the experience of becoming a first-time mother; b) the infant and spousal contributions to the motherhood experience; c) employment and motherhood; d) the military family and the military work environment, and e) the experience of military motherhood. The limitation of the research about the military experience of motherhood demonstrates the need for a qualitative hermeneutic phenomenological study.

The Experience of Becoming a First-time Mother

Rubin (1984) proposed that becoming a mother occurred on three levels: physical, cognitive, and social. Mercer (1986a, 1990) also described three levels of the process of becoming a mother: a) biological and physical, b) psychosocial, emotional, and cognitive, and c) social. The mother's physical boundaries change as the infant grows in size, and her body does not return to its pre-pregnant state after delivery (Rubin, 1968). The emotional and cognitive work of pregnancy is influenced by the constantly changing body image due to biological and psychological changes brought about by the hormonal changes of pregnancy (Mercer, 1995; Rubin, 1968, 1984). Throughout her pregnancy, the mother examines and re-examines the image of herself as the ideal mother, and how she will perform in the role based on what she already knows about herself (Rubin, Part I, 1967a; 1984; Mercer, 1981, 1995).

Each woman customizes her performance in the maternal role to fit her own internal template of what it is to be a mother (Imle, 1990). Once a baby is born, how a mother enacts, organizes or establishes herself in the maternal role is a balance between her internal template and her external relationships and resources (Rubin, Part I, 1967a, Part II, 1967b; 1984).

How a mother perceives and demonstrates her maternal role is culturally defined (LaRossa, 1986) and is a result of the interaction of her cognitive resources and affective mother-infant interaction (Walker, Crain, & Thompson 1986a, 1986b). A woman's mothering behavior is unique to each child. For subsequent children, the mother uses herself as the role model for mothering, making adjustments in her behavior as warranted

by the subsequent child (Rubin, 1984). The process of being a mother is also subject to change because of the daily life experience. For some mothers, the act of giving birth is being a mother (Sterling, 2001), while other mothers report lack of confidence in their decisions as mothers, even one year after delivery (Mercer et al., 1982; Mercer, Hackley, & Bostrum, 1984).

Maternal Tasks of Pregnancy

The developmental tasks of pregnancy are ensuring safe passage through pregnancy and childbirth, acceptance of the pregnancy by others, binding-in to the infant, and giving of self (Rubin 1975, 1977, 1984). Behaviors associated with ensuring safe passage are related to obtaining as much information and knowledge as possible about pregnancy and childbirth (Rubin 1984). During the first trimester, the first task revolves around the confirmation of pregnancy. Rubin (1970) describes the response as “Who me? Pregnant? Now?” (p. 502).

The initial response of disbelief or ambivalence even for planned pregnancies is thought to be related to the lack of outward confirmation of pregnancy. Bodily changes are not immediately visible that can confirm pregnancy, but rather there may be internal feelings of being somehow different than pre-conception (Rubin, 1970). Once the woman acknowledges her pregnancy to herself, she can begin to incorporate the reality of the fetus into her life (Leifer, 1980). Maternal feelings develop along a continuum during pregnancy and a desired pregnancy positively influences maternal role development (Robson & Moss, 1970).

The mother's task is to make a place in her life for the new baby. Significant adjustments must be made in the woman's view of herself, her role with her significant others and her place in the larger context of the outside world (Grossman, Eichler, Winicoff, Anzalone, Gofseyeff, & Sargent, 1980; Pickens, 1982). The pregnant mother's relationship with her own mother or mother figure often undergoes significant change during the course of the pregnancy. Generally there is a resolution of past conflicts and the woman's mother can often provide emotional and psychological support despite geographic distances (Martell, 1990).

When quickening occurs during the second trimester, the woman sees the infant as separate from herself and can begin the binding-in to the child (Rubin, 1975, 1977, 1984). Movement signals the reality of the infant as a separate entity from the mother, and may be the beginning of a mother's love (Rubin, 1984) for her fetus. By the end of the second trimester, the mother has begun to work through some of the psychological issues raised by the challenge of pregnancy and the acceptance of her pregnant state by others (Imle, 1990). Binding-in to the child begins with fetal movement and continues throughout the pregnancy and into the postpartum period (Rubin, Part I, 1967a; 1977)

The hallmark of the third trimester is nesting, the preparation of a physical space for the infant in the home, and the attainment of supplies to care for the infant. The woman continues to seek safe passage for herself and her infant through delivery. The third trimester is the time that parents attend birthing class. The mother continues to acquire as much knowledge as possible about the upcoming delivery (Rubin, 1984).

Knowledge may be a tool for mothers to obtain some control over the unknown of the infant and delivery (Highley & Mercer, 1978).

After the infant's birth, the mother becomes emotionally attached to her infant by a very characteristic pattern of maternal touch. The mother first touches the infant using her fingertips, progresses to using the palm of her hand, and then her arms as she enfolds the infant to her body. She begins by gently touching the infant's extremities, unwraps the infant (if the infant was bundled) and soon examines the undressed infant (Rubin, 1963; Klaus, Kennell, Plumb, Zuehlke, 1970). As the mother examines her new infant, identification of family features or traits further validates the mother's attachment to her infant (Rubin, 1961; Brazelton, 1969). The infant responds to the mother's examination, and soon a reciprocal relationship develops between infant and mother (Brazelton, 1979). The giving of oneself as a result of the pregnancy, becomes even more complicated after the delivery as the mother gets to know her infant (Mercer, 1995)

Maternal tasks of postpartum

Rubin (1977) describes the two tasks of the postpartum period as taking-in and taking-hold. Taking-in encompasses all the events that have occurred during labor and delivery, and resolving the issues of labor and delivery. The birth experience can affect the mother's ability to begin behaviors appropriate or necessary for infant care. How the mother perceived her behavior during the delivery process may in turn influence her ability to be a mother. A mother's negative perception of her performance during labor can negatively influence her ability to focus her energy on care of the infant (Bing &

Coleman, 1980), while a positive perception of her maternal role performance has been related to a positive birth experience (Entwistle & Doering, 1981).

A mother's self-evaluation of her delivery experience may be resolved if she is able to fill in the "missing pieces" (Affonso, 1977, p. 159) of her labor and delivery. Mothers who have viewed video tapes of their labor, however, demonstrated that the need to fill in the missing pieces may not always be helpful. Mothers were not aware of the sounds they made during labor or the intensity of the pain experienced. Viewing the tapes brought back a visceral response and required additional nursing support to resolve the normality of the mothers' behavior and reassure mothers of the adequacy of their performance during labor and delivery (McKay & Barrows, 1992).

In addition to a mother's self-evaluation, the type of delivery can influence a mother's satisfaction with the birth experience. Cesarean delivery can significantly lower primiparous mother's satisfaction with the birth experience (Marut & Mercer, 1979; Mercer, et al., 1982). However, a positive experience with Cesarean delivery has been associated with regional versus general anesthesia, and the presence of the father or other support person at delivery (Cranley, Hedahl, Pegg, 1983; Marut & Mercer, 1979, Mercer, et al., 1982).

Immediately after birth the infant enters a sensitive period of reactivity of 40-60 minutes duration, during which time the infant is able to see, to follow with the eyes, and to turn to sound (Brazelton, 1979). While Klaus, Kennell, and Hamilton (1983) proposed mother-infant contact during this sensitive period of reactivity was necessary and essential to the development of maternal attachment, other researchers have reported

appropriate maternal attachment behaviors despite the lack of mother infant contact during this one sensitive period (Lamb, 1982; Mercer, 1983; Seigel, Baumann, Schaefer, Saunder, & Ingram, 1980; Tulman, 1981).

Type of delivery has also been related to differences to, and more difficulty in, assuming the maternal role, particularly in the early post partum period. Mothers who have vaginal deliveries generally have less physical difficulties and emotional adjustments, at least initially, than mothers who have delivered by emergency or planned Cesarean birth (Eakes & Brown, 1998; Fishbein & Burggraf, 1998).

Taking-hold is characterized by the tasks required for taking care of the infant and oneself. Although the time required for accomplishing these two tasks varies, the developmental process for taking-hold is evident (Martell & Mitchell, 1984; Mercer, 1981; Rubin, Part I, 1967a; Rubin, Part II, 1967b). When the mother's needs are met, she can then focus on the infant. More recent research indicates while post partum nurses' teaching focused on infant needs, learning to care for their own needs had a higher priority for the mothers during the hospital stay. (Ruschala, 2000).

The taking-in and taking-hold stages that have guided nurses' care of new mothers has been brought into question (Gay, Edgil, & Douglas, 1988) and a newer theory has been proposed by Martell (2001) to describe mothers' changes in behavior during the post partum experience as a process rather than discrete phases. "Heading toward the new normal" (Martell, 2001, p. 499) was the core theme of 32 post partum mothers who were interviewed in their homes at one week post partum and again two or three weeks later. The three components of heading toward normal were appreciating the

body, settling in, and becoming a new family. Mothers were acutely aware of their bodies' changes, sensations, and capabilities related to becoming a new mother and helped them settle in with a new sense of confidence in caring for their infant and move toward a new stability in their family relationships (Martell, 2001).

The postpartum period has also been described as the fourth trimester (Eheart & Martel, 1983; Rising, 1974; Rubin, 1984). The developmental tasks during the fourth trimester are to integrate the maternal identity into already established roles and to develop one's own individual definition of motherhood (Breen, 1975; Eheart & Martel, 1983; Rubin, 1984; Schectman, 1980).

A mother's ability to establish a salient maternal role is further influenced by her sense of self. A positive maternal self-concept (Curry, 1982; Mercer, 1985, 1986a, 1986b), self-confidence (Hogan, 1979; Kappleman & Ackerman, 1980; Walker, et al., 1986a), and self-esteem are related to positive role transition (Mercer, 1995; Mercer & Ferketich, 1995; Roberts, 1983; Williams, Joy, Travis, Gotoweic, Blum-Steele, Aiken, et al., 1987). Perceived and observed positive maternal behaviors are also related to maternal competency (Mercer, et al., 1982; Mercer, et al., 1984) and maternal self-efficacy (Leerkes & Crockenberg, 1998; Teti & Gelfand, 1991). A positive sense of self and one's capabilities positively influence maternal role transition.

A positive sense of self or emotional well-being however, may be most influenced by fatigue, an almost universal complaint of pregnancy and postpartum (Becker, Chang, Kameshima, & Bloch, 1991; Bondas & Eriksson, 2001; Lee & Zaffke, 1999; Lee, Zaffke, & Mcenany, 2000; Martell, 2001; Mindel & Jacobson, 2000; Parks, Lenz,

Mulligan, & Han, 1999). In fact fatigue continues to be a pervasive experience of women well past the postpartum period (Dzurec, Hoover, & Fields, 2002; Frankenhaeuser, Lundberg, Chesney, 1991; Johnson, 1986; Wortman, Biernat, Lang, 1991). Fatigue and interrupted sleep may also account for symptoms of postpartum depression (Beck, 1995; Ugarriza, 2002).

Fatigue may leave little time for attention to one's physical appearance, yet physical appearance is also related to one's self-concept. An early concern of postpartum mothers is a return of one's figure (Martell, 2001); however, the mother's figure does not return to the pre-pregnant state (Walker & Freeland-Graves, 1998). The spouse's response to the woman's physical appearance influences her acceptance of the new physical self (Gruis, 1977; Kappelman & Ackerman, 1980; Rubin, 1984).

Becoming a mother is an intense physiological, psychosocial (Avant, 1988; Mercer, 1986a, 1986b, 1990; Rubin, 1984), and personal experience, shaped by the mother's own experience of being mothered, her pregnancy, labor, and delivery experience, and is further influenced by those in her environment.

Contextual Variables and the Transition to Motherhood

While multiple contextual variables are known to influence transition to the maternal role, maternal age is the one variable which has been demonstrated to interact with other variables such as educational level, socioeconomic status, marital status, or ethnicity in support of maternal role transition. Maternal age alone was not shown to predict perceived role competence during the post-partum period (Pridham, Lytton, Chang, & Rutledge, 1991), at one month (Reece, 1995) or at six months (Grace, 1993;

Pridham, et al., 1991; Reece, 1995). For all age groups of mothers, maternal competence does increase with an infant's chronological age (Grace, 1993; Reece, 1995); however, first-time mothers have a greater increase in competency scores than mothers of subsequent children. The greater increase in competency scores of first-time mothers over experienced mothers (Walker, et al., 1986a) may be more related to the steeper learning curve of the first time mothers.

Observed maternal role performance, when educational level, ethnicity, and marital status were controlled (Mercer, et al., 1982) was also not predicted by maternal age. These findings were supported by Jones, Green, and Krauss (1980) who attempted to increase maternal sensitivity in mothers 17-24 years of age by instructing mothers on how to stroke their nude babies and providing additional information about the sensory capabilities of their newborn. While no differences were noted between mothers who received instruction and those who did not, overall, mothers 19 years of age or older demonstrated significantly more sensitive maternal responsiveness toward their infants than the younger mothers. Jones, Green, and Krauss (1980) propose 19 as a "critical" (p. 579) age for maternal readiness.

More sensitive maternal behavior, however, has been shown to be related to higher maternal age, more years of education, and higher socioeconomic status (Mercer, 1985, 1986a, 1986b); Snyder, Eyres, & Barnard, 1979; Walker, et al., 1986b). Older mothers, 30-42 years, also demonstrated more adaptable maternal behaviors and handled infants' irritating behavior in more positive ways, but had less gratification in the

maternal role (Mercer, et al., 1984; Mercer, 1985). Higher educational levels are also correlated with increased parental efficacy (Cutrona & Troutman, 1986).

While higher education levels generally result in less gratification in the maternal role, higher educational levels are more likely to result in a planned pregnancy.

Transition to parenthood may be approached with more perceived competence as parents prepare themselves for a child in their lives. The higher educational level and a planned pregnancy may also result in more introspection and concern over life change as a result of parenthood, and thus to less gratification in the parental role (Steffensmeier, 1982).

In summary, age is a relevant factor in maternal role transition, but the effect of age cannot be evaluated separate from the influence of education, income and marital status, nor can these additional demographic variables be evaluated outside of the context of culture and ethnicity. While advanced maternal age is positively correlated with advanced education, socioeconomic status, partnered relationships (Mercer, 1990; Mercer, et al., 1982; Mercer, et al., 1984), planned pregnancy (Steffensmeier, 1982), more sensitive maternal response to infant cues (Jones, et al., 1980; Mercer, 1984); Synder, et al., 1979; Walker et al., 1986b), parental efficacy (Cutrona & Troutman, 1986), it is negatively correlated with gratification in the maternal role (Mercer, et al., 1984). Neither maternal perceived role competence (Grace, 1993; Pridham, et al., 1991; Reece, 1995) nor observed role competence (Mercer, et al., 1982, 1984) were related to maternal age, although maternal competence does seem to increase with infant's advancing age (Grace 1993; Reece, 1995, Walker, et al., 1986a, 1986b). Due to the potential interactive effect of age, educational level, marital status, socioeconomic status,

and ethnicity with infant, spouse, and work characteristics and relationships, further discussion of demographic characteristics are presented in the following review of empirical literature.

Infant and Spousal Contributions to the Motherhood Experience

The infant and the spouse influence the maternal experience in a number of ways. The infant's innate capabilities engage the mother in a reciprocal relationship, and the spouse brings his experiences, values, attitudes, and beliefs to the partner and parent relationship. The interactive relationships between the infant, mother, and spouse influence each relationship with the other in the context of the family and the greater social environment (Bronfenbrenner, 1986; 1989; Imle, 1990; Steffensmeier, 1982).

Infant Contributions

The pregnant woman gets to know her fetus during pregnancy as the fetus begins to move during the second trimester and her body begins to expand its boundaries to accompany the growing fetus. It is from these early movements that a mother begins to ascribe behavioral characteristics to her infant and fantasizes about the infant's appearance (Mercer, 1981; Rubin, 1975, 1984). The common use of ultrasound adds another dimension to the reality of the fetus—the image infant. The woman's fantasy fetus/infant is compared to the image on the sonogram screen. While ultrasound may enhance the father's attachment to the infant, the mother retains the direct physical experience of the infant. After birth, both parents come to know their infant through a resolution of the fantasy infant, image infant, and actual infant (Sandelowski & Black, 1994).

The infant comes well equipped to contribute to the reciprocal relationship with her/his parents (Brazelton, 1979; 1981). The infant's ability to cry, suck, cling, follow with eyes, and smile is designed to engage the mother in interaction and ensures the infant's survival (Bowlby, 1969; Donovan, Leavitt, Balling, 1978). The mother's perception of her infant's capabilities and temperament, however, can influence how she interacts with her infant (Donovan & Leavitt, 1989).

Longitudinal studies have demonstrated that infants do display a certain temperament beginning during the newborn period, and furthermore, that temperament is fairly consistent for a particular person over time (Thomas, & Chess, 1977; Thomas, Mittelman, Chess, Korn, & Cohen, 1982). Due to the reciprocal relationship of mother and infant, an infant's temperament may influence a mother's mastery of the mothering role. However, caution must be applied with respect to labeling an infant's temperament, because the infant's temperament can change considerably over time. In addition, although mothers may report having a difficult infant, they may not have major concerns about the infant, nor report making large adjustments in their family life based on the infant's behavior (Kronstadt, Oberklaid, Ferb, & Swartz, 1979). Mercer, et al., (1982) found that neither infant temperament nor infant health status was related to maternal role attainment.

On the other hand, infant temperamental characteristics are predictive of a mother's positive appraisal of her problem-solving competence with respect to the infant and her parenting ability. An infant whose temperament is amenable to mother's intervention provides positive feedback to the mother, thereby increasing her competence

in the maternal role (Pridham, Chang, & Chiu, 1994). Mothers who have fussy babies tend to be less satisfied and more anxious in the maternal role (Brouse, 1988). An infant with a predictable temperament and a mother's confidence in motherhood are correlated with a higher improvement in a mother's role performance between six weeks and six months (Tulman, Fawcett, Groblewski, & Silverman, 1990).

Mothers who report good support from spouse and others, and perceived their infant as one who can be easily soothed also have higher ratings of maternal self-efficacy (Leerkes & Crockenberg, 1998). Mothers with good social support also demonstrate more sensitive maternal behaviors, although, despite good social support, less sensitive maternal behaviors can occur in mothers who are unresponsive to the cues of an irritable infant (Crockenberg, & McCluskey, 1986). It is the mother's perception of her infant's temperament, rather than the observed temperament that effects mother's self-efficacy and her observed behavior competence (Teti & Gelfand, 1991).

There is also evidence to suggest that a mother's perception of her infant as difficult, in the absence of perceived support, can contribute both to low parenting self-efficacy and to postpartum depression (Cutrona & Troutman, 1986). The effects of infant temperament on mother's transition to the maternal role may be more related to the resources available to her for parenting and her experience of being parented (Belsky & Nezworski, 1988; Mercer, et al., 1982; Power, Parke, & Ross, 1984; Pridham & Chang, 1989; Roberts, 1983; Rogers, 1995).

Social support would seem to be a critical element for mothers' maternal role transition. Social support is a mediating factor in one's adaptation to life (Caplan, 1974,

1976; Norbeck, 1985, 1988; Wethington, & Kessler, 1986). While received supports are those resources that are available to the mother, perceived support is the mother's perception that she is "loved, valued, and esteemed by others" (Pierce, Sarason, & Sarason, 1992, p. 297). Prior life experiences (Bower, Black & Turner, 1979; Geller & Shaver, 1976; Schacter, 1987) and the style of personal interaction (Pierce, Sarason & Sarason, 1991), influence one's response to social support. The individual's response to perceived support is further related to an individual's internal cognitive structures (Baldwin, Fehr, Keedian, Siedel & Thompson, 1993; Baldwin, Keelan, Fehr, Enns, & Koh-Rangarajoo, 1996; Markus, 1977). How one perceives and receives support is also determined by the relationship an individual has with the person providing the support (Pridham, 1993; Yee, Santoro, Paul & Rosenbaum, 1996). For the single mother, the most significant support person is her own mother, and also the person with whom she may have the most conflict. For married mothers, the most significant person is the spouse, followed by the woman's mother (Rubin, 1984)

Thus, resources available to the mother for support, her perception of those resources, and the relationship with the person providing the support for the maternal role, as well as the mother's perception of her infant play a significant role in both her observed and perceived maternal role performance.

Spousal Contributions

The marital and partner relationship can have a significant influence and an interactive effect with other contextual variables on maternal role transition (Belsky & Kelly, 1994; Belsky, Lerner, Spanier, 1984; Broom, 1984; Lewis, 1988a; Lewis, Owen,

& Cox, 1988). Supportive spousal relationships are predictors of increased role proficiency (Mercer & Ferketich, 1995), as are high marital adjustment scores (Gotlib, 1990; Russell, 1974), commitment to the marriage (Lewis, 1988b), and commitment to the parental role (Russell, 1974). A strong marital relationship and positive attitudes are perceived by the mother as very helpful during the transition to the maternal role (Majewski, 1986).

With the advent of the infant, the couple goes from being a dyad to a triad, and there are changes in roles and relationships in the family unit. Changes in marital relationships are often a source of stress reported by mothers in adapting to the arrival of the infant (Bing & Coleman, 1980; Grossman, et al., 1980; Leifer, 1977; 1980; Wolfson & DeLuca, 1981). After an initial positive experience in marital functioning, there is a dramatic decrease in marital functioning at three months postpartum (Belsky, et al., 1983).

Although parenting support groups have been recommended as a way to aid couples in the transition to parenthood, Majewski (1986) found that mothers who participated in these groups experienced more conflict between parent and self role, and had a greater difficulty in making the transition to the maternal role. Perhaps mothers who are having conflict in adaptation to the maternal role seek out a support system in order to master the conflict. In contrast, Cronenwett (1985) found that the overwhelming response to a parent support group was positive and mothers stated that the group aided them in their transition to the maternal role.

In summary, pre-delivery, the infant makes his/her presence known through movement and its increasing physical size (Mercer, 1981; Rubin, 1975, 1984). After delivery, the infant's innate capabilities engage the mother in a reciprocal relationship (Bowlby 1969; Brazelton, 1974; Donovan, et al., 1978). Some researchers believe that infant temperament is consistent over time (Thomas & Chess, 1977); however, it is more likely infant's temperament changes over time (Kronstadt, et al., 1979) and is the result of the reciprocal relationship between the infant and the mother (Pridham et al., 1994; Tulman, et al., 1990). Mother's *perceptions* of both her infant's behavior (Cutrona & Troutman, 1986; Kronstadt, et al., 1979; Leerkes & Crockenberg, 1998) and her perceptions of support *received* may have the greater influence on her transition to the maternal role (Belsky & Nezworski, 1988; Crockenberg & McCluskey, 1986; Leerkes & Crockenberg, 1998; Power, et al., 1984; Pridham & Chang, 1989; Roberts, 1983; Rodgers, 1995; Teti & Gelfand, 1991; & Yee, et al., 1996).

The infant's birth also significantly changes the spousal relationship (Bing & Coleman, 1980; Broome 1984; Grossman, et al., 1980; Leifer, 1977, 1980; Wolfson & Deluca, 1981) and there may be a dramatic decrease in marital functioning at three months (Belsky, et al., 1983). Parenting groups may be sought out by those who have greater conflict between roles (Majewski, 1986), and this support may be perceived as helpful if it aids the mother in transition to her maternal role (Cronenwett, 1985). Infant and spousal contributions to the motherhood experience are the result of interpersonal relationships that transpire within the context of the family unit, the mother's perception of the infant, spouse, and the support received and is further influenced by the greater

social environment (Bronnfenbrenner, 1986, 1989; Imle, 1990; Steffensmeier, 1982). The impacts of employment on the maternal role transition are presented in the following section.

Employment and Motherhood

For this discussion, *employed* mothers are defined as those who earn money to support the family income, and *homemakers* are defined as those mothers who do not earn income outside of the home and whose primary task is to care for the infant and home. One caveat, *all* mothers *work* whether it is as homemakers or employees (DeJoseph, 1993; Messias, Regev, Im, Spiers, Van, Meleis, 1997; Oakley, 1993).

Mothers who worked before pregnancies are more likely to report plans to continue to work, and in fact do return to work (Tulman & Fawcett, 1990). The reasons to return to work vary; however, financial need remains high on the list (Volling & Belsky, 1993), even for mothers of higher socioeconomic status (Clark, Hyde, Essex, & Klein, 1997; Tulman & Fawcett, 1990). Financial need is often reported in conjunction with the desire to maintain career status and relationships with co-workers (Hemmelgarn & Laing, 1991).

Mothers employed 40 hours or more hours per week do not differ in the personal ratings of maternal performance (Walker & Best, 1991), nor does return to work correlate with less commitment to the parent role (Volling & Belsky, 1990); less commitment to breastfeeding (Auerbach, 1984; Auerbach & Guss, 1984) or less parental sensitivity to infant needs (Broom, 1998). Mothers who want to work report positive spousal support, higher maternal self-evaluations, job satisfaction, positive expectations about child care,

increased levels of marital quality, a greater sense of psychological well-being, and experience a less stressful transition to the maternal role (Broom, 1998; Hemmelgarn & Laing, 1991; Schuster, 1993). Satisfaction with childcare received is predictive of less role strain (Dickson & King, 1992; Hemmelgarn & Laing, 1991), however, lower involvement of the father in childcare, and increased costs of childcare are related to maternal depression in younger employed mothers (Lennon, Wasserman, & Allen, 1991).

In addition to high job commitment and lower stress scores, employed mothers have more positive role transitions if pregnancy has been delayed and mothers have strong community relationships (Jimenez & Newton, 1982) and non-traditional beliefs about gender roles (Woods, 1985, 1987). A positive experience of being parented, an established salient parental role, compartmentalization of work and home roles, and compromised standards were seen as coping strategies used by mothers during the maternal role transition (Hall, et al., 1992; Myers-Walls, 1984).

Employed and homemaker mothers appear to experience similar role conflict, and the increased role conflict can lead to greater difficulty in maternal role transition (Majewski, 1986; Lewis & Cooper, 1988). The top sources of stress are in the areas of work overload, fatigue, disturbances in sleep and rest, and the lack of time needed to meet one's own needs (Hochschild & Machung, 1989; Horowitz & Damato, 1999; Hunt, & Hunt, 1987; Meleis, Norbeck, Laffrey, Solomon, & Miller, 1989; Walker & Best, 1991). For employed mothers, it is the conflict between multiple roles of self, worker, and family, however, that has the greatest impact on the mother's health and her successful adaptation to the maternal role (Beck, 1995; Jimenez & Newton, 1982;

Majewski, 1986; Mercer, et al., 1982; Myers-Walls, 1984; Power, et al., 1984; Reece, 1995; N. F. Woods, 1985).

Contrary to expectations, higher role stress has been reported for homemakers than for employed mothers (Alpert, Richardson, & Fodaski, 1983). Consistent homemakers, those that do not desire to return to work outside of the home, report significantly less role conflict (Volling & Belsky, 1993). Walker and Best (1991), however, found that employed mothers had more stress overall than homemakers during the transition to the maternal role.

In summary, mothers who work before pregnancy are more likely to return to work (Tulman & Fawcett, 1990) citing financial need, even for mothers in higher socioeconomic brackets (Clark, et al., 1997; Tullman & Fawcett, 1990), although there may also be the desire to maintain career status and work relationships (Hemelgarn & Laing, 1991). Employment overall would appear to provide support for maternal role transition provided that the woman has or perceives she has a choice about returning to work after the birth of her infant (Werbel, 1998). In the military, the EAADM mothers may perceive that they have less choice of whether or not to return to work; the EAADM mother must return to work within a prescribed time period (AR 40-501, 2002). On the other hand, by having chosen to be an EAADM mother, she may subscribe to the military culture in which all active duty mothers return to duty at a prescribed time, and therefore have less conflict about returning to work (Gerson, 1987). A short historical perspective of changes in military life that parallel those in the civilian community and factors

specific to the military work environment are discussed in order to provide the context within which to understand research findings of the EAADM mothers' pregnancies.

The Military Family and the Military Work Environment

Changes in the military family since the 1970's parallel those events that shaped families in the civilian community. There has been an increase in single-parent and dual-earner families, and the majority of women work outside the home. The stresses experienced by families relate to the changes in family structure as well as the changes in civilian and military culture (Hunter, 1982; Lakhani & Gade, 1992). The major changes in military family structure since the early seventies and a discussion of the major stressors and their impact on military families are presented below.

Changes in Structure of Military Families

The typical military family composition prior to the 1970's included an active duty (AD) father and a dependent non-military mother and dependent child (ren). Women served on active duty only if they were single and without children. Executive Order 1.02040, signed on April 27, 1951, mandated that women were to be discharged from active duty if they gave birth to a living child or if they were a parent to a child under 18 years of age. If a woman had custody of a child or stepchild under the age of 18, or if a child was present in her household greater than 30 days in a calendar year, she was also to be discharged from active duty. The post-World War II AD woman was relegated back to the home and hearth to care for her spouse and children (Hunter & Nice, 1978b; Kaslow, 1993).

Court-directed change. The male dominance in military households experienced an abrupt change with the Supreme Court ruling of May 1973, which ensured that women received the same benefits as men for their dependent children and spouse (Holm, 1992) . Prior to the Supreme Court ruling, an active duty (AD) woman with a civilian spouse could not receive benefits for her spouse. The Air Force was the first service to grant single female soldiers the ability to stay on AD when they became pregnant. (York, 1978) Although a Department of Defense Policy Statement issued in 1974 stated that a pregnant woman had to request to stay on AD, there was inconsistent implementation of the policy between and within military services. The effective date for implementation was 15 May 1975 (Holm 1992). The request to stay on AD was often denied, or women were encouraged to leave AD prior to delivery (Kaslow, 1993).

In 1976, “the second circuit court held, in *Crawford v. Cushman*, that the Marine Corps’ regulation requiring the discharge of a pregnant married as soon as pregnancy is discovered violated the Fifth Amendment” (Holm, 1992, p. 302). A Department of Defense study of lost time concluded that “differences in lost time for men and women were significant because men lost much more duty time on average than did women (because of pregnancy) for absence without leave, desertion, alcohol/drug abuse, and confinement.” (Holm, 1992, p. 303) The 1980’s saw conflict within the branches of the military about the presence of women in combat. The current policies for assignment of females soldiers is Army Regulation 600-13 (1992). The current Army pregnancy policy allows enlisted women, not officers, to leave active duty when they become pregnant on a Chapter 8 separation (AR 635-200, 2000)

Military focus on the family. The end of the Vietnam Conflict also meant an end to the draft. Military families and children became the focus for the post-Vietnam all volunteer Army (Bowen & Orthner, 1989) because the greatest influence on the post-Vietnam soldier's decision to stay on AD was his family (Bowen, 1989). The First Conference on Military Families was held in 1977 (Hunter & Nice, 1978a). Military family conferences are held yearly and the Military Family Resource Center (MFRC) provides information to both military policy makers about family issues and to family members about programs that support family life.

Despite the proclaimed focus on the military family and the increasing number of single AD parents (both men and women) and dual military couples, the Military Orphan's Bill, introduced by Senator Heinz during Desert Shield/Desert Storm, was defeated by Congress (Kaslow, 1993). The bill proposed that AD single parents and one member of a dual military couple could request an exemption from a tour of duty in a hostile environment. The Chiefs of the Military Services, citing cost and damage to unit cohesion, morale, and unit effectiveness, did not support the bill. It is interesting to note however, that many women hid their pregnancies both in order to deploy to Desert Shield/Desert Storm and to avoid being returned stateside prior to the end of their deployment (Thomas & Thomas 1993).

Composition of military families. According to DMDC 1977 statistics (as cited in Stander, McClure, Gilroy, Chomko, Long, 1998), by 1992, women comprised over 13.7% of the active force, 47.3% of whom were married. Sixty-five percent (65%) of military members' spouses were employed, either in the military or civilian workforce.

Military families can be a single AD parent, an AD member with a civilian spouse, or dual AD military. The predominant constellation of the military family is the AD male military member and a civilian wife. Civilian husbands with military wives are the smallest group, making up three to four percent of military spouses (Stander, et al., 1998). Dual-military couples comprise 7% of military marriages (Janofsky, 1989; Lakhani & Gade, 1992).

For dual military couples, the interdependence of rank and spouses' career choice determined assignment requests. Choice of assignment was most often related to which spouse had the best chance for promotion (Lakhani & Gade, 1992; Stander, et al., 1998). Dual military couples are more likely to postpone children, share household and childcare responsibilities, and adapt better if career assignments also meet family needs (Stander, et al., 1998). Familiarity with the military way of life contributes to the couples' decision to remain part of the military.

For dual working couples, knowledge of military way of life came from the civilian spouse having prior military service, being a military child, or feeling they understood the mission and demands of military life. In addition, some civilian spouses expressed less concern about traditional gender roles at the outset of marriage (Lakhani & Gade, 1992; Stander, et al., 1998). Civilian wives' positive adjustment to the military way of life was related to their attitude that the military was best for their family, and their primary expectation was to raise a family, their career field transferred with their spouses' assignment, or they were not committed to a career. For civilian husbands, there was more of a struggle with role expectations. While some husbands increased their care

giver roles over time, others maintained the more traditional division of household labor (Stander, et al., 1998).

Stressors of Military Families

Stressors of military families are similar to those experienced by nonmilitary families. In addition, military families must adapt to the changes of family separations, frequent relocations, and multiple deployments in the current down sized military (Bartone, Adler, & Viatkus, 1998; Burke & Moskos, 1996; Corbell, 1996; Ursano, Holloway, Jones, Rodriques, & Belenky, 1989; Zeff, Lewis, & Hirsch, 1997).

Family separations. Periodic family separations are a common occurrence in military families, and separations impact on all family members to some degree. As a result of separations, there has been a perception that military families exhibit more social and psychiatric pathology than their civilian counterparts. In 1978, LaGrone described the military family syndrome, characterized by out-of-control adolescent children being raised by depressed mothers and authoritarian absent fathers. This characterization of the military family syndrome was not refuted until 1981 (Morrison).

Short family separations due to military training scenarios, military schooling or one year overseas assignments have been more easily tolerated by Army families than the more recent phenomenon of rapid deployments. Planned separations with specified end dates are more easily tolerated by families than are deployments with open ended return dates (Ritchie, Ruck, & Anderson, 1996; Zeff, et al., 1997). In a study of naval families who routinely experience absence of fathers for six month tours of sea duty, mothers

reported family stress preceding the deployment and more family cohesion post deployment (Kelley, 1994).

Families who choose to live apart so that a child can complete high school, a spouse can continue in a career assignment, or the service member is near retirement have a counterpart in the civilian world where families have commuter marriages (Gerstel & Gross, 1987). Generally, it is the male member of the family that commutes, while the female spouse, civilian or AD, remains with the children or the homestead. In essence, many female family members function as though they were single parents whose partner is a periodic house guest. The majority of the mutually shared time is dedicated to shared family activities. Even for families in which the commuter spouse is able to come home on weekends, day-to-day family management issues are relegated to a time when the commuting spouse is not with the family (Gerstel & Gross, 1987; Hunter, 1982; Stander et al., 1998).

Deployments. Multiple deployments due to environmental hazards, cultural conflicts, natural disasters, and political unrest have replaced declared wars as a reason for family separations (Bartone, et al., 1998). Families still have to adapt to danger, only this time the danger is from an unknown source. While not judged to be at a pathological level, children and spouses reported elevated symptoms of depression and stress during their spouses' deployment to Desert Shield/Desert Storm (Rosen, Teitelbaum, & Westhuis, 1993). The long term effects of war-induced maternal separation on children (Pierce, & Buck, 1998; Pierce, Vinokur, & Buck, 1998) have been minimal.

While Desert Shield/Desert Storm resulted in a war deployment, families also find peace keeping and humanitarian missions stressful (Bartone, et al., 1998; Bell, 1998) despite the advantages of rapid electronic communication (Ender, 1998). Return of the deployed family member was reported as the biggest stressor for families of soldiers deployed to Somalia (Ritchie, et al., 1996). Greater family stress was reported by the non-deployed spouse, rather than the deployed AD service member (Zeff, et al., 1997). For many post-Vietnam era soldiers, Somalia was the first opportunity in their military career to exercise soldier skills in other than a training environment. The increased stress reported by families may have been due to the absence of the soldier for live combat, an ill defined mission, and an uncertain return date (Ritchie, et al., 1996; Zeff, et al., 1997).

Frequent relocations. While deployments offer a more dramatic change in family functioning, the repeated stress due to routine re-assignment remains one of the major stresses of the military life style (Martin & Ickovics, 1987; Rosen & Moghadam, 1991). Frequent family relocations require dealing with the grief and loss of relationships and expenditure of energy in order to reintegrate into a new community and establish new relationships (Gore, 1992). There is a feeling of isolation due to differences in cultural expectations of the military versus the civilian community. This is particularly common in a downsized military. While living on a military reservation offers a sense of community at the expense of privacy, families now may find themselves isolated in government leased housing in areas of the civilian community where they would not normally choose to live (Twiss, 1996).

The philosophy of the military leaders was reflected by Corbell (1996). The old saying that “the Army takes care of its own” has been replaced with assisting people to help themselves. Military members must exercise more personal and reasonable responsibility for family needs, using existing unit and installation support. Unfortunately, with a down sized military, and its accompanying down sized budget, military specific support resources are not as readily available (Lakhani & Gade, 1992; Twiss, 1996).

In summary, the changes in the structure of military families parallel those of non-military families (Hunter, 1982; Kaslow, 1993; Lakhani & Gade, 1992). Court directed change ensured women the right to stay on active duty, awarded their civilian spouses benefits, and allowed AD women to be single parents (York, 1978; Kaslow, 1993). The composition of military families can be single parent; dual military, or one AD member and a non-military member (Janofsky, 1989; Lakhani & Gade, 1992; Stander, et al., 1998). The major stressors of military families are related to family separations of varying degrees. Separation can be by choice in order to facilitate civilian or military schooling, promotion opportunities, or family considerations (Gerstel & Gross, 1987; Hunter, 1982; Stander et al., 1998) and planned separations are more easily tolerated than open-ended deployments (Ritchie, et al., 1996; Zeff, et al., 1997). While the military maintains its commitment to support families (Bowen, 1989; Hunter & Nice, 1978a; Kaslow, 1993), the philosophy has changed from “the Army takes care of its own” to providing assistance to families so they can care for themselves (Corbell, 1996) at a time when military resources are not readily available (Lakhani & Gade, 1992; Twiss, 1996).

The following discussion of military motherhood focuses on pregnancy outcomes of military women and the influence of the work environment, intention of pregnancy, and pregnancy fitness programs on the ADM mothers' pregnancy outcomes.

The Experience of Military Motherhood

Fox, et al., (1977) completed one of the earliest and most often cited studies of pregnancy outcomes of active duty military (ADM) women, comparing the ADM mother with family members (FM) of ADM, and designated the "Active Duty pregnancy a high risk category" (p.707). ADM mothers were more likely to be single, had significantly more negative antenatal outcomes including: weight gain over 30 pounds, hematocrits of less than 30, premature labor, toxemia, more incidents of upper respiratory infections, and abnormal papanicolaou smears. The ADM mothers also had more mid-forceps deliveries, a higher Cesarean delivery rate, the infants were more likely to weigh less than 2.5 kilograms, and there was an increased incidence of overall perinatal death (Fox, et al., 1977). Similar negative antenatal, delivery, and pregnancy outcomes continue to persist in comparisons between ADM mothers and FM mothers and between ADM mothers and civilian (non-military) mothers, although to a lesser degree.

Pregnancy Outcomes of Military Women

Even when controlling for age and parity, Magann and Nolan (1991) reported statistically significant differences between ADM Navy mothers and FM mothers. The ADM mothers had a greater incidence of pregnancy induced hypertension, preterm complications, cesarean delivery, and infant birth weight of less than 2.5 KG.

However, not all studies indicated negative outcomes for ADM mothers. For instance, Magann, Winchester, Chauhan, Nolan, Morrison and Martin (1995) found no difference in ADM mother pregnancy outcomes by marital status or military occupational specialty. Messersmith-Heroman, et al. (1994) found no significant differences between ADM Navy mothers and family member mothers in birth outcomes of infant weight, gestational age, cesarean deliveries, or neonatal unit (NICU) admissions. Statistically significant differences were found with ADM mothers who were more often single, less educated, younger, and had less social support. The ADM mothers also had a greater number of prenatal visits, worked more hours per week, worked longer into the pregnancy, and gained less weight during pregnancy (Messersmith-Heroman, et al., 1994)

Comparisons between ADM, FM, and civilian (non-military) mothers indicate the nature and extent of differences in pregnancy outcomes also varied between racial groups. The Black ADM and FM mothers had significantly higher rates of very low birth weight, moderately low birth weight infants, and significantly higher fetal neonatal mortality rates than the White ADM and FM mothers and civilian mothers (Barfield, et al., 1986). Low birth weight infants were also noted between Black ADM and FM mothers and White ADM and FM mothers who had live births between 1985-1990 (Rawlings & Wier, 1992) and 1986-1991 (Greenberg, et al., 1993) at a military medical center. The Black ADM and FM mothers delivered statistically lower birth weight (LBW) infants who had longer stay in the NICU, however, neither rank nor race, was associated with neonatal mortality. The trend for increased preterm delivery for Black

ADM and FM mothers over White ADM and FM mothers was also demonstrated in other studies of ADM mothers from multiple military services, i.e. Army, Air Force, Navy and Marine, respectively (Adams, Harlas, Sarno, Read, & Rawlings, 1994; Buttenmiller, 1984; Spandorfer, Graham, Forouzan, 1996).

More subtle racial differences were noted in studies that compared only *first-time* Black and White ADM mothers. Black ADM mothers had more pregnancy-induced hypertension and pre-eclampsia than White ADM mothers for singleton pregnancies; however the reverse was true with multiple pregnancies where White ADM mothers had the greater risk (Irwin, et al., 1994). In a similar comparison of singleton pregnancies, and adjusting for education, marital status, rank, type of facility, pregnancy, labor, and delivery, the only increased risk was cesarean delivery for Black ADM mothers over 30 years of age (Irwin, et al., 1996).

It is important to note that military status provides a protective factor for Black mothers and infants as compared to their civilian counterparts. Mortality rates for Black infants delivered in a military medical center were significantly lower than the mortality rates for Black infants throughout the U. S. during that same period. The Black military infant mortality rates were 11.1 per 1,000 births compared to 17.9 per 1000 births among all Black Americans (Rawlings & Wier, 1992). The trend for statistically significant lower infant birth weights, longer NICU stays, and fetal and infant mortality for Black AD and FM mothers compared to Whites in the military has persisted over time. However, these negative outcomes are significantly lower for Black ADM and FM members in the military when compared to their civilian counterparts and may be due to

the ready access to medical care (Buttenmiller, 1984; Greenberg, et al., 1993; Rawlings & Wier, 1992).

Preterm deliveries remain a significant risk factor for ADM mothers (Splonskowski & Twiss, 1995; McNeary & Lomenick, 2000). The variables most often linked to preterm deliveries are: lower rank, single marital status, being non-White, increased medical complications during pregnancy, and military job demands. In a group of ADM Army mothers, higher physical demand of the job increased the odds of a preterm delivery (Ramirez, et al., 1990). In a group of ADM mothers from all services, the majority being Army ADM mothers, the strongest predictor of preterm delivery was single marital status and more reports of medical complications during pregnancy (Rosen & Evans, 2000). Being non-White, younger and lower rank, and having less education were also associated with preterm delivery (Ramirez, et al., 1990; Rosen & Evans, 2000). In contrast, no differences in pregnancy outcomes for ADM Navy mothers could be attributed to either marital status or military occupational assignment (Magann, et al., 1995).

Work environment. Work climate and the support from co-workers and supervisors may have implications for pregnant ADM mothers (Correnti & Jensen 1989). While no differences in work support ratings were found in early pregnancy between ADM mothers and their supervisors, significant differences were reported for support during the last trimester. The ADM mothers reported job responsibilities were removed or they were relocated to office locations away from their co-workers. Both

circumstances were described as leading to isolation and decreased support (Correnti & Jensen, 1989).

Lower enlisted rank may be a predictor of less social support for pregnancy. Officers reported significantly more support from their co-workers and chain of command for their pregnancy, less harassment, higher psychological well-being, and greater work effort than enlisted women (Evans & Rosen, 1997). Planned or intended pregnancies also resulted in the greatest support, best psychological well-being and the least harassment. Planned or intended pregnancies timed to meet career demands yielded the greatest support and sense of well-being (Evans & Rosen, 1997).

Unintended pregnancies. Unintended pregnancies have been reported as highest among single ADM mothers (47%), and highest among the lowest enlisted rank of E1-E2 (80%). Noncommissioned officers reported the highest level of intended pregnancies at 65%. Of the ADM mothers with unintended pregnancies, 62% reported that they did not use birth control during the month of conception (Clark, et al., 1998). Soldiers 17-19 years also had a greater number of sexual partners, more frequent intercourse, less knowledge about the risks of becoming pregnant mid-cycle, and less often used birth control during intercourse (Borsay-Trindle, Pass & Gilzean, 1991). The etiology of unplanned pregnancy among younger service members may be related to immaturity or lack of knowledge of contraceptive measures. However, Battista, Creedon, and Salyer (1999) found that while Army members reporting for advanced individual training (AIT) were well informed about contraception, they reported inability of obtaining contraception due to a variety of reasons. The hypothesis could be made that the younger

service members have less education and less life experience, are more often single, and may not have the internal or external resources needed to make healthier life decisions. It may be a combination of factors that leads to unplanned pregnancies.

Pregnancy fitness programs. Pregnancy fitness programs implemented at many military installations after March 1996 (Unclassified message, 01 05 251922Z Mar 1996 RR RR UUU) were designed to improve the health status of ADM mothers and their infants and to support the ADM mother's transition back to military duty. The Center for Health Promotion and Preventive Medicine (CHPPM) developed the program using the exercise guidelines of the American College of Obstetricians and Gynecologists (ACOG) [1992, October; 1994, February]. In addition to the three exercise sessions per week, an educational session was held one day per week. The goal of the educational session was to assist the ADM mother to prepare for and cope with pregnancy, delivery, and caring for the infant.

The outcomes of two studies using the CHPPM guidelines are presented. In a comparison group of ADM mothers who participated in the fitness program greater than or less than 50% of the time, no statistically significant differences were found in length of gestation, complications of pregnancy or delivery, or weight gain during pregnancy (Schillac, 1999). Insufficient data on the Army Physical Fitness Test (APFT) scores on the first test after pregnancy limited drawing conclusions about the effectiveness of the fitness program in either improved fitness scores or an increased pass rate. In a much larger comparison study of ADM mothers, there were also no statistically significant

differences in APFT scores between an intervention group based on CHPPM guidelines and a historical control group (Lombardi, et al., 1999).

In Lombardi et al.'s (1999) pregnancy wellness intervention study significant differences were found between the intervention group and historical control group on other pregnancy outcome variables. Black ADM mothers had significantly fewer deliveries before 269 days and less LBW infants; however their infants were shorter and had smaller occipital circumferences than White infants. For wellness participants' infants, Apgar scores at 5 minutes were higher and there was less fetal bradycardia and hyper bilirubinemia than the historical controls. The historical group, however, had less pre-eclampsia, less premature labor, and fewer meconium stained infants. Lombardi et al. (1999) suggested that the greater number of meconium stained infants in the wellness group may be due to infants' larger birth weight. The higher rates of pre-eclampsia and premature labor in the wellness intervention group are not explained by the data in this study (Lombardi et al., 1999).

Summary

In this chapter a review of the empirical literature about the experience of becoming a first-time mother and a detailed explanation of the maternal tasks of pregnancy and the maternal tasks of post partum were presented. A description of the multiple contextual variables to include demographic variables, infant and spousal contributions, and employment on mothers' transition to the maternal role were described. Changes in the military family and a description of military life were presented

in order to set the context for the research findings about the pregnancy outcomes of ADM mothers since the 1970s.

Despite guaranteed access to health care, pregnancy work profiles, and time off to attend medical appointments, ADM mothers continue to be at risk for preterm delivery when compared to family member (FM) mothers or their civilian (non-military) counterparts (McNearey & Lomenick, 2000). In the studies examined, the ADM mothers had a greater risk than their civilian counterparts for pregnancy induced hypertension and cesarean delivery (Fox, et al., 1977; Magann & Nolan, 1991); preterm delivery (Adams, et al., 1994; Buttenmiller, 1984; Fox, et al., 1977; McNeary & Lomenick, 2000; Spandorfer et al., 1996); and infants of lower birth weight (Barfield, et al., 1986; Greenberg, et al., 1993; Rawlings & Wier, 1992). There is not a clear understanding of the etiology of the increased risk for these complications although the working conditions of the ADM mothers have been cited as the causative factor (Messersmith-Heroman, et al., 1994; Ramirez, et al., 1990; Spandorfer, et al., 1996). In contrast, Magann et al., (1995) found no selective adverse effects as a result of military occupational specialties or job titles which might be considered a measure of work conditions.

Within the military, as in the civilian world, being a Black ADM or FM mother increased the risk of pregnancy induced hypertension and pre-eclampsia (Irwin, et al., 1994). Black infants of ADM mothers were also at increased risk for LBW, NICU admissions, and preterm delivery (Adams, et al., 1994; Barfield, et al., 1986; Buttenmiller, 1984; Greenberg, et al., 1993; Irwin, et al., 1994; Rawlings & Wier, 1992; Spandorfer, et al., 1996). It is important to note however, military status provides a

protective factor for Black mothers and infants as compared to their civilian counterparts. Interestingly, Black mothers in the military have lower rates for LBW infants (Buttenmiller, 1984; Greenberg, et al., 1993; Rawlings & Wier, 1992) when compared to national averages for these complications among Black mothers.

Compared to officer mothers, EAADM mothers had more medical problems during pregnancy (Fox, et al., 1977; Rosen & Evans, 2000), more unintended pregnancies (Borsay-Trindle, et al., 1991; Clark, et al., 1998; Evans & Rosen, 1997), were more often single (Fox et al., 1977; Rosen & Evans, 2000), and reported less support for pregnancy at work from their supervisors (Correnti & Jensen, 1989; Evans & Rosen, 1997) and co-workers (Correnti & Jensen, 1989). In contrast, an intervention study to increase wellness support for lower ranking EAADM and FM mothers demonstrated significant improvements in the pregnancy outcomes of these mothers approaching the level of officer ADM and FM mothers' pregnancy outcomes (Lombardi, et al., 1999). The more negative findings for enlisted personnel could be due to several factors. Lack of maturity may have the most significant influence for these results. In the military, higher rank is generally equated with increased chronological age, more life experience, more work experience, and a greater salary. It would seem logical then, that officers and senior noncommissioned officers would have greater opportunity for financial resources, a greater network of support, and more life experience to deal with the military way of life and motherhood.

Particularly disconcerting to this researcher are the results of a recent assessment of prenatal care needs of military women (ADM and FM) mothers stationed within the U.

S. and outside the U.S. “More than 20% of mothers reported receiving no information on some of the common concerns of pregnancy” (Sylvia, McMullen, Levine, Cruz, Gagnon, Malavakis, et al., 2001). The consensus in the research conducted thus far is being an ADM mother increases the risk of pregnancy complications, and enlisted status further increases the risk, however, the etiology remains elusive as does the understanding of the subjective experience of being an active duty mother. Clearly the need exists to explore and describe the phenomenon of becoming an enlisted mother on active duty in order to gain a detailed view of what the experience is like from the EAADM mothers’ perspective. Knowledge of the mothers’ experiences may lead to the development of appropriate nursing actions to promote the health of the EAADM mother in a way that maximizes her ability to care for herself, her family, and her military duties. Chapter 3 provides a brief overview of the phenomenological approach, a detailed description of the procedures used to conduct the study, and a description of the sample of the EAADM mother participants.

Chapter 3: Methodology

The purpose of this study was to explore the nature of the experience of becoming an EAADM mother and to gain an understanding of the EAADM mothers' transition to the maternal role during the first 4 months postpartum. Because of the limited information about the subjective experience of motherhood in the military, a qualitative study was conducted. *Phenomenology*, introduced by Husserl (1950/1977), was the qualitative frame for this longitudinal study (Baltes, Reese, & Nesslerode, 1998; King, 2001; Menard, 1991). The specific hermeneutic phenomenological approach for this study was guided by Cohen et al. (2000) and van Manen (1990). This chapter provides a brief description of the hermeneutic phenomenological approach, the research methodology for this study, and the description of the sample.

Phenomenological Approach

This section addresses the philosophical approach for this study and the research methods used for this study.

Philosophy of Method

Husserl (1950/1977) proposed phenomenology as a method to describe phenomena as they were experienced, rather than ascribe behavior to preconceived theories or causal explanations. "Zu den sachen" or "to the things" became the mantra for phenomenology. In the introduction to his *Logical investigations*, Husserl (1950/1977) proposed that "not mere words but the things themselves" (p. 252) be the focus for research of new knowledge. New knowledge was to be gained by investigating how

something was perceived, remembered, fantasized, or pictorially represented (McCormick & Elliston, 1981).

Hermeneutic phenomenology is more than description, it is also the interpretation of human expression of lived experience, generally texts (Harvey, 1964) “in the attempt to determine the meaning embodied in them” (van Manen, 1990, p. 38). The researcher seeks to understand how the informant experiences a phenomenon over time in the informant’s setting, and how the informant communicates that experience (Cohen et al., 2000). The end result is to describe as accurately as possible a certain way of being in the world (Merleau-Ponty, 1962) from the emic perspective.

In preparation for hermeneutic phenomenological research, the researcher must first conduct a careful and critical self-evaluation with regard to the phenomenon of interest. *Bracketing* is the process whereby the researcher evaluates research conducted about the phenomenon of interest and temporarily sets aside personal experiences with the phenomenon that could potentially bias the interpretation of the informants’ perspectives (Cohen et al., 2000; Morse, 2002). There are two types of bracketing necessary: *scholarly bracketing* and *personal bracketing* (Cohen et al., 2000; Steeves & Kahn, 1995). Scholarly bracketing includes a review of the literature and prior research about the phenomenon in order to establish what is known and provide a framework for interpretation (Morse, 2002). Personal bracketing, done prior to the data collection, incorporates the researcher’s lived experience of the phenomenon under study and assists the researcher in identifying personal biases that may influence scholarly interpretation of others’ narratives. The review of the literature was presented in Chapter 2 while the

researcher's lived experience of motherhood within the military environment is captured in Appendix B.

Research Methods

The most important job of the phenomenologist is to accurately describe what is present by “isolating, examining, and describing . . . the experience-as-lived” (Reeder, 1986, pp. 3-4). Vivid images of the just-past experience are immediately written down in great detail or captured in voice recordings. It is the careful capture of multiple descriptions of a phenomenon that may lead to the discovery of the “objective within the subjective” (Reeder, 1986, p. 5). The basic methods and tools the phenomenologist uses to obtain the multiple layers of evidence to describe and to discover the meaning of the phenomenon under study are: *interviews, field notes, field journals, and field documents* (Bogdan & Taylor, 1975; Cohen et al., 2000; Lofland, 1971; van Manen, 1990).

Interviews. Interviews are data in qualitative research. In this study, four interviews were conducted to coincide with four potentially significant transition points in the motherhood journey. The interview guide is in Appendix A. The first interview was scheduled when the EAADM mother was at least 36 weeks pregnant and potentially dealing with the anticipation of labor, delivery, meeting her infant, and taking on the tasks of motherhood. Three postpartum visits were scheduled when the infant was 4-6 weeks, 8-10 weeks, and 14-16 weeks of age. The interview at 4-6 weeks sought to capture the experience of motherhood while home on maternity leave. The interview at 8-10 weeks sought to capture the EAADM mothers' experiences soon after the return to work. The interview at 14-15 weeks was the time when the EAADM mothers approached

the time when they could be separated from their infants. At 4 months postpartum (120 days after the birth), the EAADM mothers were available for reassignment to another duty location, deployment, military training exercise, or attendance at military school (AR 614-30, 2001).

In order to elicit as much detail as possible about a phenomenon, Cohen et al. (2000) recommends three types of leading questions when conducting perspective studies. While all arise out of the phenomenon of interest, the first question is designed to articulate more clearly what the phenomenon is, not establish the context of the experience. Thus, in this study, the first question asked at the first interview was, “Describe what it is like knowing that you will soon become a mother on active duty?” The two subsequent questions at the first interview were: “How do you think your life may change once you give birth to the baby?” and “What do you think about the most (about anything)?”

At the three postpartum interviews, the first question at each interview was either: “What all has happened to you and the baby since our last visit?” Or “what is the most important thing that has happened to you and the baby since our last visit?” At some time during the postpartum interviews, EAADM mothers were also asked: “What do you think about the most (about anything)?” These basic questions helped to create an understanding of the critical aspects of the phenomenon under study as perceived by the EAADM mothers.

Asking the EAADM mothers to answer questions: “Tell me what yesterday was like from when you got up in the morning until you went to bed at night,” followed by

“Was yesterday pretty typical of your days? If not, what was different?” helped establish the context of the experience. Describing a typical day also allowed the EAADM mothers the freedom to structure their story according to their priorities and needs. It is through description and reflection on daily living that individuals create meaning and come to an understanding of themselves (Zimmerman, 1992).

The researcher’s analysis of the detailed narratives of everyday life led to an understanding of the general themes present in multiple cases. Conclusions or understandings made by the researcher were verified with the EAADM mothers on subsequent visits in order to establish trustworthiness of the interpretations of prior interviews. At each interview, additional questions were posed to clarify the researcher’s understandings of the EAADM mothers’ perceptions, recollections, expectations, or values from prior interviews.

Field notes and field journals. Field notes and field journals are the researcher’s narratives of the phenomenological experience (Cohen et al., 2000; Steeves & Kahn, 1995; van Manen, 1990). “Field notes constitute the story of the researcher’s inquiry and serve as a record of the researcher’s own construction of meaning” (Cohen et al., 2000, p 66) and assist in the documentation of the interpretive process (Smith, 1999). This researcher’s field notes included a description of the physical environment and the home setting, including such things as environmental distractions, other persons, and pets’ noises. The EAADM mother’s interactions with or comments about the infant were recorded as was her appearance, demeanor, and responsiveness to the interview. Sketches of the room in the home where the interviews took place were done when the researcher

began to notice how the rooms were rearranged, and the infant's furniture, equipment, and toy took over the living space. In order to capture these essential elements of the interview, this researcher developed a matrix for initial data capture of field notes for *each* interview (Appendix C). At the end of the interview, the responses to the questions on the matrix were either handwritten or immediately typed into the computer along with the researcher's own reflections, impressions, and evaluation of the process of the interview. The EAADM mother's pseudonym, the date, and the number of the interview, one to four, were used to identify the field notes which were then used during the analysis to the verbatim transcripts.

Field journals can be used to document the substantive or theoretical hunches, ideas, insights, and observations which are essential components of phenomenological analysis, and they serve as part of the text and context for data analysis. Rigorous documentation of the researcher's insights serves to uncover or guard against the researcher's prejudice or bias and documents the researcher's relationship with those being interviewed (Adler & Adler, 1994; Cohen et al., 2000, Hammond, Howarth, & Keat., 1991; May 1989; Spradley, 1979; Strauss & Corbin, 1998). This researcher recorded insights, ideas, hunches, observations, and interactions with the EAADM mothers, clinic staff, and others throughout data collection and chronicled the analytic process throughout the study. The field journal entries were also dated to ensure the chronology of the data analysis.

Field Documents. Field documents are those permanent documents that have meaning or significance for the informant or are an integral part of the environment of the

informant. Field documents may also be documents that the informant brings to the researcher's attention or provides to the researcher (Cohen et al., 2000; Steeves & Kahn, 1995; van Manen, 1990). For example, the prenatal instructional materials given to the EAADM mothers and their family members at their prenatal orientation visit provided the written documentation and context to understand the EAADM mothers' experiences of pregnancy care within the military setting.

Research Methodology

This section describes the methodological approach for this hermeneutic phenomenological study: the setting, sample inclusion and exclusion criteria, procedures for data collection, data management, data analysis, and data interpretation.

Setting

A convenience sample of first-time, enlisted, Army active-duty military mothers were recruited from a low-risk obstetrical clinic within the Women's Health Center (WHC) at a military hospital in the south central United States. Permission for access to the facility is in Appendix C. The primary-care providers in the clinic were midwives and nurse practitioners. This particular military medical facility was chosen because the average delivery rate is 250 births per month, and approximately 50% of deliveries were to EAADM mothers.

Sample

Inclusion criteria. The inclusion criteria were first-time pregnancy beyond 12 weeks gestation (first-time parent), enlisted, Army, active-duty military (EAADM) mothers, 19-30 years of age, who were experiencing a normal (low-risk) pregnancy. The

criteria to continue in the study after the birth were having an uncomplicated vaginal or cesarean delivery of a normal singleton newborn between 37 and 42 weeks gestation and hospital discharge within 4 days of delivery.

Exclusion criteria. Prenatal exclusion criteria were: enlisted, active-duty military mothers not in the Army; officer Army active-duty mothers; age younger than 18 years or older than 30 years; referral to the high-risk obstetrical clinic prior to delivery; or scheduled for release from active duty as a result of pregnancy. After delivery, exclusion criteria were: an infant with a gestational age less than 37 weeks or greater than 42 weeks, an infant with a congenital abnormality, or a hospital stay greater than four days postpartum. A subsequent pregnancy during the course of the study was also an exclusion criterion.

These inclusion and exclusion criteria were selected based on the literature review and the constraints of Army Regulations (AR 40-501, 2002; AR 614-30, 2001). First-time motherhood is experienced differently than motherhood to subsequent children (Mercer et. al., 1982; Grace, 1993). Approximately 25% of pregnancies result in spontaneous miscarriage prior to 12 weeks (Woods & Woods, 1998). Pregnancy loss following 12 weeks can result in different expectations for subsequent pregnancy and different behavioral responses toward a subsequent infant (Leoni, Woods, & Esposito, 1998; Cote-Arsenault & Morrison-Beedy, 2001; Swanson, 1999a, 1999b).

Although single motherhood can pose additional challenges that are less likely to be present for married EAADM mothers (Correnti & Jensen, 1989; Evans & Rosen, 1997), single and married EAADM mothers were included in the study because of the

large number of single EAADM mothers in the military and to reflect the current military environment more accurately. Officer EAADM mothers were excluded because rank can be equated to age, education, socioeconomic status, and potentially to the availability of resources (Harrell, 2000).

Maternal age alone is not predictive of the motherhood experience (Grace, 1993; Pridham et al., 1991; Reece, 1995; Walker et al., 1986b). Older maternal age is, however, associated with higher education and higher socioeconomic status, which often equates to greater availability of resources for support in the parental role (Mercer et al., 1982; Mercer & Ferketich, 1995; Fishbein & Burggraf, 1998). The experience of first-time motherhood before 18 years of age and after 30 years of age generally presents a different set of expectations about one's role as a mother, partner, and worker, and often leads to a more difficult transition to motherhood (Majewski, 1986; Mercer, 1986; Sterling, 2001).

While the type of delivery has also been associated with different responses to and more difficulty in assuming the maternal role in the initial postpartum period (Eakes & Brown, 1998; Fishbein & Burggraf, 1998), EAADM mothers who experienced a cesarean delivery were included in the study. *Normal* is interpreted as a vaginal or planned or unplanned cesarean delivery (B. Houston, personal communication, December 2, 2002) All Army active-duty military mothers are required to return to duty within 42 days following normal pregnancy and delivery (Peake, May 23, 2001).

Sample description. Thirty-six EAADM mothers volunteered for the study by returning the signed recruitment brochure or paging the researcher directly. Eighteen were enrolled in the study, 10 were not eligible to enroll, and 8 declined to participate.

Enrollment was defined as those EAADM mothers who completed the consent forms and the first interview. Of the 18 enrolled EAADM mothers, all completed the first interview, 13 completed the second interview, and 11 completed the third interview. Ten EAADM mothers completed all four interviews.

Of the 8 EAADM mothers who did not complete all four interviews, 2 were not eligible to continue in the study. One EAADM mother decided to leave active duty before the second interview, and one EAADM mother gave birth to an infant with a congenital anomaly (clubfoot). Of the remaining 6 EAADM mothers, 2 completed the second interview, and 1 completed the third interview before they were lost to follow-up for various reasons, i.e., missed appointments, phone disconnected or moved with no forwarding address.

The 10 EAADM mothers who completed all four interviews ranged in age from 19 to 27 and had a rank of specialist (E4) to staff sergeant (E6). One of the EAADM mothers had already been selected for promotion to sergeant first class (E7), the next higher rank. Length of time in the Army was from 2 to 8 years. Seven of the EAADM mothers delivered vaginally, and 3 had cesarean deliveries. There were four girls and six boys born. Independent samples tests showed no difference on age (p. 478), rank (p. 496), or length of time in service (p. 657) between those who completed all four interviews and those who did not. These and other demographic variables not reported, such as marital status, did not seem to make a difference in the EAADM mothers' journey to motherhood. Marital status was also not associated with whether or not the EAADM mothers chose to leave active duty after the end of their current enlistment. The

EAADM mothers expressed concern they could be identified because of their position or job in their units. All of the EAADM mothers enrolled in the study were from different units, and there were few women in their units. Therefore, though job data were collected on the demographic data sheet, the job data were not reported in order to maintain confidentiality.

Interviews. The final sample for this study consisted of the 40 interviews from the 10 EAADM mothers. A total of 52 interviews were completed in the period between October 2003 and January 2005 (see Table 1). The interviews lasted from 20 to 60 minutes and were conducted at the EAADM mothers' convenience within the prescribed interview schedule. The first interview was conducted in the WHC because of the military requirement for witnessed signatures on the consent forms. The postpartum interviews were held in the EAADM mothers' homes in order to better understand the context of their experiences. However, if home interview was not feasible or preferred, the postpartum interviews were conducted in an office in the WHC. Telephone interviews were conducted in circumstances where a face-to-face interview was not feasible at the designated study time. All interviews, including telephone interviews, were audio taped and transcribed for analysis.

Table 1.

Interview Schedule and Number of Interviews

| Pre-delivery Interviews at | | Postpartum Interviews at | |
|----------------------------|-----------|--------------------------|-------------|
| > 36 Weeks Gestation | 4-6 Weeks | 8-10 Weeks | 14-16 Weeks |
| 18 | 13 | 11 | 10 |

Procedures for Data Collection

The discussion of the procedures for data collection includes: recruitment, obtaining informed consent, protection of participants, and the interview process.

Procedures for Recruitment

An informational meeting about the study was held with the nurse midwives, nurse practitioners, clinic nursing and administrative staff, supervising physician staff, and other interested staff in the WHC following approval from the Institutional Review Board (IRB), Office of Sponsored Projects, The University of Texas at Austin (Appendix E) and the regional Army IRB (Appendix F) and the U.S. Army Clinical Regulatory Office (Appendix G). The main objectives for this meeting were to explain the purpose of the study and methods for recruitment of the EAADM mothers, to answer staff questions, and to enlist the staffs' enthusiasm for and support for the study. The staff was encouraged to inform eligible EAADM mothers of the study brochures (Appendix H) located in the health care providers' offices and five locations in the clinic. Study brochures were also available to EAADM mothers when they participated in the tour of labor and delivery. An ad was placed in the post newspaper during the initial recruitment phase of the study (Appendix I); however, only one EAADM mother reported seeing the ad in the newspaper.

Recruitment of the EAADM mother prior to delivery was essential because of the short inpatient stay after delivery, the EAADM mothers' limited time off, and mandatory return to duty with 42 days of the infants' births. In addition, EAADM mothers often went to visit family during the postpartum period and would have been geographically

unavailable for recruitment after delivery. The establishment of rapport prior to delivery facilitated the EAADM mothers' willingness to share the journey of motherhood with the researcher.

Procedures for Obtaining Informed Consent

The EAADM mothers volunteered for the study by placing the recruitment brochure, signed and with their telephone number, in a box in the WHC. The researcher had the only key to the locked box. The researcher was physically present in the WHC 1 or 2 days per week during the recruitment phase of the study (between October 2003 and December 2004). The researcher contacted some prospective participants using the phone numbers they provided, while other EAADM mothers contacted the researcher directly via a toll-free pager. A screening interview (Appendix J) was completed to determine eligibility and to schedule the first interview.

At the first interview, the researcher confirmed study eligibility by reviewing the demographic information sheet (Appendix K). The consent form (Appendix L) and authorization to use and disclose protected information for research (HIPAA) consent form (Appendix M) were reviewed, and the EAADM mother was encouraged to read her copy of the consent form and ask questions about her rights and responsibilities and those of the researcher. A witnessed signature was obtained prior to beginning the first interview. A copy of the consent form was given to the informant. Confirmation of consent to tape the interview was made prior to turning on the tape recorder.

Protection of Participants

The primary risk for the EAADM mothers' participation in the study was the time required for the interviews, and the possible concerns for confidentiality as a result of military status. Confidentiality risks were minimized by the following measures: (a) EAADM mothers were self-referred, either by leaving a signed study brochure in a locked box to which only the researcher had a key, or the EAADM mothers contacted the researcher directly through a toll-free pager; (b) no notation of the EAADM mother's participation was noted in any medical or administrative record; (c) except for the first interview, the locations of the interviews were determined by the EAADM mother and the researcher; (d) tapes and transcripts of the interviews were secured in a locked file cabinet in the researcher's office, and access to the tapes and transcripts was limited to the dissertation committee members or panel of clinical experts only as needed to ensure that data analysis results represented the EAADM mothers' experiences; (e) a confidentiality agreement was made with the transcription service (Appendix N); (f) audiotapes and transcripts were labeled with a pseudonym known only to the researcher, and no identifying information was linked to any written or verbal reports of findings; (g) all audiotapes will be destroyed at the completion of the study.

Sharing information about feelings of becoming a mother, partner, or military member might generate intense emotional feelings. The EAADM mothers were reassured they could refuse to answer any question and stop the interview at any time. The researcher has over 20 years of nursing experience with first-time mothers and was sensitive and able to identify women who had difficulty adjusting to motherhood and

who might benefit from referral to appropriate resources. At the first interview, the EAADM mothers were given a list of available resources at the military facility (Appendix O). The EAADM mothers were also informed that a mandatory referral would be made according to state law and military regulations if there was any suspicion of child or spouse abuse; if she threatened to harm herself or someone else, a call would be made to 911. The possible benefit of participation in the study was the opportunity to discuss thoughts and feelings about becoming an EAADM mother in the context of a confidential supportive environment. A random audit conducted by the CIRO office on May 25, 2005 confirmed all human research protections were adhered to in this study (Appendix P).

Interview Process

Four interviews were conducted during this study (see Table 1). The initial interview was conducted in the WHC. Although it was preferable that postpartum interviews be conducted in the EAADM mothers' homes, subsequent interviews were also conducted at an office in the WHC. Telephone interviews were conducted in circumstances where face-to-face interviewing was not feasible at a designated time. The interviews lasted between 20 and 60 minutes. All interviews, including telephone interviews, were audio taped and transcribed for data analysis.

At the first interview, the researcher confirmed the EAADM mother's eligibility criteria, answered any questions about the study, discussed the consent forms, and obtained witnessed signatures on the consent forms. The EAADM mothers were given a Demographic Data Sheet (Appendix K) to confirm study eligibility. Permission to

audiotape record the interviews was confirmed before asking the initial global question: “Describe what is it like to know that you will soon become a mother on active duty?” See Appendix A for the interview guide. The first EAADM mother interviewed for the study asked to have the tape recorder turned *back on* at the conclusion of the formal interview in order to record what *she* wanted to make sure the researcher knew about becoming a mother on active duty. As a result, one additional question was added to the first interview: “On the way to the clinic this morning (or afternoon) was there anything in particular that came to mind that you wanted to stay to me about becoming a mother on active duty?” At the end of the first interview, the researcher asked for and was granted permission by the EAADM mothers for the researcher to contact the mothers within 5 to 7 days of their estimated date of confinement (EDC).

Researcher-initiated contacts with the EAADM mothers aided in the continuation of a trusting relationship with them and also demonstrated the researcher’s sincerity and interest in the EAADM mothers’ journey into motherhood. A screening interview was conducted after delivery to verify continued eligibility (Appendix Q), and eligible participants made an appointment for the second interview.

The researcher contacted participants between visits to maintain the EAADM mothers’ participation throughout the study. Letters were sent confirming interview appointments, and thank-you letters were sent following interviews (Appendix R). EAADM mothers who were not eligible to participate in the study after the initial screening interview or after delivery were also sent thank-you letters. (Appendix S)

One or more of the following questions were added to the interview schedule early in the course of the study to obtain more insight into the EAADM mothers' experiences. The questions were: "Is there anything else you think I (the researcher) should know about being a mother on active duty?" or "Is there anything you wanted to make sure I (the researcher) knew about being a mother in the military at this time, but I may not have asked?" The EAADM mothers also began to give advice they thought should be shared with other EAADM mothers; therefore, these two questions were asked at some of the postpartum interviews: "What advice would you give another active-duty soldier who was planning on becoming a mother?" or "What advice would you give to another active-duty soldier about being a mother at this time?" Because data analysis began as soon as an interview was completed, the researcher had the opportunity to develop specific or probing questions to clarify or elaborate on issues brought up at prior interviews and to verify or refute the researcher's impressions and observations.

At the postpartum interviews, the EAADM mothers were asked: "What all has happened to you and the baby since our last visit?" "Tell me what yesterday was like from when you got up in the morning until you went to bed at night," followed by "Was yesterday pretty typical of your days? If not, what was different?" Describing a typical day allowed the EAADM mothers the freedom to structure their stories according to their priorities and needs. Additional questions were posed to clarify points obtained during the first and second interviews.

The third interview was scheduled when the infants were between 8 and 10 weeks of age, and the EAADM mother had been at work for approximately 2 to 4 weeks. The

fourth, final interviews were scheduled when the infant was 14-16 weeks of age. While not all EAADM mothers were scheduled for a separation from their infants at 4 months, the unstable world and increasing number of military deployments remained an ever-present reality. Questions such as: “What supports your ability to be the kind of mother you want to be?” “What hinders your ability to be the kind of mother you want to be?” “Do you feel like your old self? When did this happen?” “Are you comfortable with your decisions as a new mother?” helped in understanding the nature of EAADM mothers’ needs and concerns.

Data Preparation and Data Management Procedures

The most important data collection instrument is the researcher (Benoliel, 1984; Rodgers & Cowles, 1993). The researcher must be a careful listener and one who can also interact with the subject as a participant-observer (Bogdan & Taylor, 1975; Cohen et al., 2000), for “to listen only, without sharing, creates distrust” (Denzin, 1989, p. 43). No difficulties were experienced in the relationship between the EAADM mothers and the researcher. Generally, EAADM mothers expressed impatience and annoyance at the first interview because the informed consent process took so long; the EAADM mothers wanted to begin their stories.

Data management principles were followed as outlined by Cohen et al. (2000) and further described by Sandelowski (1995) and Rodgers and Cowles (1993). After leaving the interview, the audiotapes were labeled with the EAADM mother’s pseudonym, date, and the interview sequence, e.g., “interview #1” for the first interview. The matrix in Appendix C provided the outline for the capture of field notes and was completed as soon

as possible after each interview. The field notes also included the pseudonym, date, and interview number. The field notes were created as soon as possible after the interview to capture any behavioral mannerisms or tone of voice along with the environmental context of the interview. Initial impressions were also recorded. Field notes were part of the data and also provided an understanding of the interviews. Interviews and field notes were converted to digital format and hard copy as soon as possible. The field journal captured the researcher's data analysis hunches, interpretations, and questions throughout data collection and data analysis. A transcription service was employed to transcribe the EAADM mothers' interviews. The researcher verified the verbatim transcripts before importing them into the computer.

Data Analysis and Data Interpretation

A personal computer and a qualitative data analysis program (Ethnograph V 5.5) were used to assist in data management. "Data collection, management, analysis, and interpretation are processes that overlap temporally and conceptually in qualitative work" (Sandelowski, 1995). While data analysis leads to interpretation, it is not a linear process, and in hermeneutic phenomenology is referred to as the *hermeneutic circle* (Hoy, 1978). The whole is evaluated in relationship to its parts and the parts in relationship to the whole; meaning is discovered and maintained within the context in which it was discovered (Allen & Jensen, 1990). Data analysis was ongoing throughout the study, and "the ending is understood as tentative and historically bound" (Cohen et al., 2000).

Many methods of analysis and interpretation can be used; however, the important consideration is that the researcher develop a system that remains true to the

methodology and the research questions (Cohen et al., 2000; van Manen, 1990), maintains the confidentiality of the informants (Munhall, 2000), results in an interpretation that remains true to the informants' experiences (Allen & Jensen, 1990; Rodgers & Cowles, 1993; Sandelowski, 1993, 1995), is verifiable, and adds to a new understanding of the phenomenon (Jaffe & Miller, 1994; van Manen, 1990). The principles and techniques of Miles and Huberman (1984, 1994) and (Sandelowski, 1995) guided the data collection, management, analysis, and interpretation of this study.

Miles and Huberman (1984, 1994) suggest the use of matrices, also called a grid by Steeves (2000), as a tool that the researcher can use to facilitate a consistent pattern of data capture and to look for themes across cases or within cases across time. This researcher used two matrices consistently for documenting field notes as well as conducting data analysis. The second matrix had the pseudonyms of the EAADM mothers on the left axis and the four time periods on the horizontal axis and is in Appendix T. This second matrix was helpful in "extracting the facts" as described by Sandelowski (1995). This second matrix aided in noting clusters of responses, themes, and allowed for a visual inspection of the data, which in turn led to making contrasts and comparisons between participants and for participants over time (Miles & Huberman, 1994; Steeves, 2000) The principles and techniques of Cohen, et al., (2000) and van Manen (1990) were used to guide the data collection, management, analysis, and interpretation of this data. In generating meaning, the first step was to note patterns and themes and gain a sense of the whole (Cohen, et al., 2000; van Manen, 1990).

“Phenomenological themes may be understood as *structures of experience* (italics are van Manen’s) (van Manen, 1990, p. 79).

The interview transcripts first had to be verified with the recorded interviews. The second step, how to go about determining themes and patterns and ultimately make meaning, can best be described as immersing oneself in the data (Cohen et al., 2000). The transcripts were read and re-read, as were the field notes. Initial impressions were recorded in the field journal (Cohen et al., 2000; Lincoln & Guba, 1985; Rodgers & Cowles, 1993). Documentation of this analytic process is essential, and Rodgers and Cowles (1993) recommend that qualitative researcher record compulsively; record first, discuss later, because discussing before writing can distance, confuse, or diffuse the most important of theoretical hunches. All data for this study—whether interview, field notes, journals, or documents—were dated to ensure consistency of procedure and documentation of interpretation (Rodgers & Cowles, 1993, Sandelwoski, 1993). Matrices (Averill, 2002; Miles & Huberman, 1994) that this researcher used for initial data capture and potential analysis of field notes for each interview are in Appendix C and the matrix for analysis of the interviews is in Appendix T.

After the initial impressions and notations were made on the verified transcripts, the transcripts were imported into the computer program to systematically assign initial codes to themes. The code words assigned to sections of narrative were often defined first by an EAADM mother’s use of the word, thought, description, or meaning of an experience. In addition dictionary definitions were assigned to these code words as needed to maintain consistency of coding over the analytic process. Code words were

also assigned to portions of narrative that corresponded to the EAADM mothers' responses to interview questions. Memos were generated in Ethnograph V 5.5 during the analysis of each interview to record insights, categorize or summarize a coded section of narrative or to generate further questions to ask of the data. After the initial analysis and interpretation, the transcripts were read again line by line to check for representativeness of the phrases or lines of data that supported previously generated codes or impressions. Ethnograph searches of code words were done and narrative data from all the EAADM mothers' interviews were evaluated to determine the appropriateness of the coding, to validate the consistency of the use of the codes over time, and to determine how different code words may have captured the same structure of the experience.

To capture the whole of the experience, the memos and coded transcripts for each EAADM mother were used to generate a description of each EAADM mother's journey to motherhood. The researcher used the memos, coded transcripts, field notes, and field journals as the data. During the writing, the questions that were asked by the researcher as she reviewed the four sources of data: What is the nature of becoming an enlisted mother on active duty? What is this kind of experience like? Is this what it means to be a mother? Data analysis and interpretations were generated after each EAADM mother's journeys and these interpretations along with all the EAADM mothers' journeys were reviewed for consistency in overall themes.

After analyzing the whole of each EAADM mother's journey, a further confirmation of overall themes was done by first collapsing code words into general themes. For example, the theme "being scared" was assigned to limited sections of

narrative. The initial cluster of code words that might also mean “being scared” were selected for a search of the narratives for these codes. For example, a search was conducted of all narratives for sections coded as *anxiety*, *apprehension*, *conflict*, *fear*, *worries*, *uncertainty*, *mortality*, and *deployment*. This search confirmed the initial hunch and subsequently yielded a better understanding of what the EAADM mothers meant by being scared. The second matrix (Appendix T) was used to compare sections of narrative that accompanied these codes to see how the trajectory of being scared developed over the course of the interviews. This analysis was not as fruitful in helping to determine all of the general themes to answer the research questions.

While it was clear the EAADM mothers experienced a lot of emotions, had multiple reasons for being scared, and responded in different ways to being scared, how these factors influenced the journey to motherhood was not clear. Another detailed analysis was undertaken by going back to the whole of the EAADM mothers’ narratives at each interview period. An analysis was conducted of all the EAADM mothers’ interviews at *each* time period before proceeding to the subsequent time period, until all four time periods were analyzed. This analysis was more congruent with a prospective longitudinal study. This is not to say the other processes in the analysis were misleading, for after each analytic process, the understandings of the narratives were documented in the field journal and led to a deeper understanding of the whole. Rather than using a paper and scissors approach to cut the narratives up into significant themes and placing them side by side to formulate the meaning of the experience, by using Ethnograph V 5.5

the researcher was able to retrieve sections of narratives for comparison in determining the themes that best represented the lived experience.

After the narratives from the first interview, just before delivery, were analyzed and themes developed, the narratives of the subsequent three postpartum interviews were analyzed by time period. During this analysis by time periods, an *overarching* theme emerged for each time period that represented the EAADM mothers' experiences at the time period. The time periods with the corresponding overarching themes are: just before delivery--preparing for self as mother; home on maternity leave--gaining a new sense of self; return to work--integrating self as mother into self as soldier; just before potential separation from infant--self as mother competing with self as soldier. There were also four major themes *across* the four time periods: integrating the infant into one's life; experiencing a sense of loss for the future with their infants, acknowledging their own and the infants' fathers' mortality, and demonstrating one's competence as a soldier. There were sub-themes for each of these four themes across time and will be described in detail in Chapter 4. The use of the matrix in Appendix T aided in noting the clusters of the emerging themes and sub-themes across the time periods and provided for visual inspection of the process.

In order to strengthen the scientific rigor of the conclusions, this researcher used several methods for reducing bias and confirming conclusions. The first was to review the prior understanding of the phenomenon as reflected in the literature review in Chapter Two. Second, the researcher's experience as an active-duty mother, personal bracketing was written before data collection and is in Appendix B. Third, field journals were

examined for any personal self-reflection, assumptions, or prejudices that may have occurred during the study. Since the most difficult task of analysis was, as van Manen (1990) said, “to differentiate between essential themes and themes that are more incidentally related to the phenomenon under study,” (p. 106) two other methods of verifying findings were also used: a member checking and consultation with two maternal child nurse experts were used to confirm findings and reduce bias.

Member checking was done with all study participants throughout the study as the researcher clarified issues from prior interviews, and probing questions helped clarify or confirm tentative codes or themes. To reduce potential bias by the two nursing experts for this study, they were interviewed as to their understanding and attitude toward enlisted, Army, active-duty military mothers. The summaries of their interviews were documented by the researcher and verified for accuracy by each expert *before* data analysis findings were discussed with the nursing experts. One of the nursing experts was a doctoral prepared nurse who had experience in qualitative research with first-time mothers. This individual’s expertise was invaluable throughout the process of data analysis. For example, when this researcher was mired in the throws of data analysis, this expert provided direction to ensure appropriate measures for data analysis and interpretation were implemented. Discussions were held periodically to evaluate the data reduction process, the emerging themes, and the appropriate measures for representing the data. These discussions were documented in the field journal. The other nurse expert was a midwife who provides care to pregnant active-duty soldiers. Once the themes were

derived, the whole of Chapter 4 was provided to the midwife and the qualitative expert for confirmation of findings.

Summary

In this chapter, the hermeneutic phenomenological approach was described. For this study, descriptions were provided of the setting; sample inclusion and exclusion criteria; sample description; procedures for data collection including procedures for recruitment, obtaining informed consent, and the interview process; data preparation and data management procedures; data analysis and data interpretation. The findings are presented in Chapter 4.

CHAPTER 4

The Experience of Motherhood for First-Time, Enlisted, Army, Active-Duty Military Mothers

This chapter addresses the experience of becoming a first-time, enlisted, Army, active-duty military (EAADM) mother from the month before delivery through four months postpartum. Four interviews were conducted with ten EAADM mothers at about 36 weeks gestation just before delivery (interview one), at four to postpartum just before the EAADM mother returned to work (interview two), at eight to ten weeks postpartum soon after the return to work (interview three), and at 14-16 weeks postpartum just before the EAADM mothers were subject to possible separation from their infants due to military re-assignment or deployment (interview four). The results of the analysis of 40 narratives of ten EAADM mothers were the data for this study. While these data represent a composite thematic description, it by no means should detract from the uniqueness of each EAADM mother's journey into motherhood.

The Overall Nature of the Motherhood Experience

The lived experience of becoming an EAADM mother involved the daily consciousness of competing commitments between developing one's role as a mother and being a competent soldier in the context of the current military environment. The major themes for the four time periods were: preparing self as a mother; gaining a new sense of self as a mother, integrating self as mother into self as soldier; and self as mother competing with self as soldier. The major themes across the four time periods were: integrating the infant into one's life, experiencing a sense of loss for the future with one's

infant, acknowledging one's own and the infant's father's mortality, and demonstrating one's competence as soldier. The context of the experience will be presented followed by a description of the themes which evolved over the course of the four interviews conducted just before delivery, home on maternity leave, the return to work, and just before a potential deployment or reassignment away from the infant.

Establishing the Context

In order to establish some context for the EAADM mothers' journey into motherhood, the following information will be addressed below: the reasons why the EAADM mothers volunteered for the study, their prior experiences with the military, and their reasons why they joined the military.

Reasons Volunteered for the Study

The EAADM mothers volunteered for the study mainly because they believed in the research process. There was also a strong belief that research study findings might make a difference in the treatment of pregnant soldiers, and there was a desire to know how other EAADM mothers managed motherhood in the military. Two EAADM mothers wanted to tell of the differences in their treatment as pregnant soldiers between their old units and the current units. There was a consensus of the EAADM mothers that their stories were important. Pamela had carried around the recruitment brochure for the study for several weeks before making the commitment to participate in the study. Her reasons for participating in the research study were that the research addressed an important issue, her experience was important, and she wanted to know how other active duty mothers handled becoming a mother. She said:

I thought it was very interesting. . . . Hey, well my experience is important . . .
How (do) other women feel—and I think that it is very difficult . . . all the
logistics that surround it, how do people make it work?

There was universal eagerness to participate in the study. At the first interview, most EAADM mothers were frustrated with the time it took to discuss and to complete the HIPPA consent and the informed consent—they wanted the tape recorder turned on so they could begin the interview. After the first interview, the EAADM mothers referred to the interviews as visits. Except for the two mothers who wanted to share the differences in treatment between their prior units and their current units once they became pregnant, the reasons for volunteering for the study were not mentioned during the interviews.

Prior Experience with the Military

The EAADM mothers had varied experience with the military before their own enlistment. Some EAADM mothers had knowledge of the military through one or more relatives who were currently on active duty, retired, or had a time of active duty service. Eight of the EAADM mothers had one or more family members who were currently serving on active duty: mother (n = 1), sibling (n = 2), spouse (n = 3), and former spouse (n = 1), had retired family members: stepfather (n = 2), father (n = 1). Other family members had served a time in the military either as active duty (n = 4) or in a reserve status (n = 2). Two EAADM mothers were not aware of any family members who had served with the military and believed they were first in their family to join the military. Having a family member who either served on active duty or was retired did not necessarily mean the EAADM mothers had direct knowledge of the military lifestyle.

Half of the EAADM mothers did not have direct experience with the military lifestyle. While eight EAADM mothers had family members who were currently on active duty or served a time on active duty, this fact did not necessarily mean the EAADM mother understood the military lifestyle.

Reasons for Joining the Army

The reasons the EAADM mothers went into the military were varied: It was a lifestyle they were familiar with (n = 1), a way to repay college loans (n = 1), on the advice of a relative (n = 1), a way to save for college (n = 3), a chance to do something different (n = 1), to get away from home (n = 2), or a long-standing desire to join the military (n = 1). The military was also seen as a way to become independent and responsible for one's own life and future. For the EAADM mother who joined the military to pay off her college loans, the birth of her infant did pose an additional stress because she would need to repay part of her enlistment bonus if she left active duty before the end of her enlistment contract. For the other EAADM mothers, their reasons for joining the military did not seem to be a negative factor in their journey into motherhood.

Army life between October 2003 and January 2005, when the interviews were conducted, was a time of increasing operational tempo. The possibility of deployment was not a matter of *if* the EAADM mothers would deploy; rather it was the anticipation of *when* would the EAADM mothers deploy. Two EAADM mothers had served in prior deployments, one in Bosnia and one in Iraq, and they were acutely aware of the experience of deployment. All of these EAADM mothers were affected by the possibility

of their own or the infants' fathers' deployment. The EAADM mothers' journey into motherhood will be described by each interview period: Just before delivery, home on maternity leave, the return to work, and just before a potential deployment or re-assignment away from the infant. The themes for each time period and the themes across time are presented in *Table 2, Themes by Time Period*, which is located on pages 85-86.

Just Before Delivery: Preparing Self as a Mother

The first interview was in the Women's Health Center of a military medical facility in the southern part of the United States. The interviews were conducted when the EAADM mothers were at least 36 weeks pregnant. At the completion of the consent process, permission was obtained to record the interview on audiotape. The theme of *preparing self as a mother* is the over-arching theme for this time period and includes the themes of integrating the infant into one's life, while simultaneously dealing with experiencing a sense of loss of the future with one's infant, acknowledging one's own and the infant's father's mortality, and demonstrating one's competence as a soldier. Integrating the infant into one's life included accepting the pregnancy, bonding with the unborn infant, facing the challenge of labor, preparing for breast feeding, and coping with the return to work.

Table 2.

Themes by Time Period and Themes Across Time

| Themes by Time Period | | | | |
|---|---|--|--|---|
| Themes Across Time | Just Before Delivery Preparing for self as a mother | Home on Maternity Leave Gaining a new sense of self as mother | Return to Work Integrating self as mother into self as soldier | Just before Potential Separation Self as mother competing with self as soldier |
| Integrating the Infant into Their Lives | <p>Accepting the pregnancy</p> <p>Bonding with the fetus</p> <p>Facing the challenge of labor</p> <p>Preparing for breast feeding</p> <p>Coping on the return to work</p> | <p>Relating the birth experience</p> <p>Mastering breast feeding</p> <p>Knowing how to meet the infants' needs</p> <p>Experiencing a new dimension of time</p> <p>Preparing for the return to work</p> | <p>Experiencing a new dimension of time</p> <p>Maintaining the supply of breast milk</p> <p>Coping on the return to work</p> | <p>Developing a support network</p> <p>Developing one's own identity as mother</p> <p>Adjusting to a new self</p> <p>Enjoying breast feeding</p> |
| Experiencing a Sense of Loss for the Future with Their Infants | <p>Anticipating loss</p> <p>Missing out on infant's developmental firsts</p> <p>Fearing the infants would not recognize them as their mother</p> | <p>Keeping the infant in close proximity</p> <p>Relating infants' developmental firsts</p> | <p>Grieving lost time with one's infant</p> <p>Prioritizing one's time</p> <p>Missing out on infants' developmental firsts</p> <p>Fearing the infants would not recognize them as their mother</p> | <p>Grieving time lost with one's infant</p> <p>Missing out on infants' developmental firsts</p> <p>Fearing the infants would not recognize them as their mother</p> |
| Acknowledging Their Own and the Infant's Father's Mortality | Acknowledging their own and infants' fathers' mortality | Fostering the relationship between infants' and their fathers | Acknowledging their own and infants' fathers' mortality | Acknowledging their own and infants' fathers' mortality |

| | Themes by Time Period | | | |
|--|---|---|---|--|
| Themes Across Time | Just Before Delivery Preparing for self as a mother | Home on Maternity Leave Gaining a new sense of self as mother | Return to Work Integrating self as mother into self as soldier | Just before Potential Separation Self as mother competing with self as soldier |
| Demonstrating One's Competence as Soldier | Dealing with units' attitudes Dealing with changes in work hours Dealing with job changes Experiencing family oriented units | Preparing and regaining their competence as soldiers | Demonstrating one's competence at work Dealing with units' attitudes Dealing with job changes | Re-establishing competence Dealing with units' attitudes Dealing with job changes |

Integrating the Infant into One's Life

When the EAADM mothers described how they integrated the infants into their lives, they discussed how they came to terms with pregnancy, bonded with the unborn infants, sought information to prepare for the challenges and pain of labor and breast feeding, and wondered how they would cope with the return to work.

Accepting the pregnancy. Only one EAADM mother consciously planned her pregnancy; the other nine EAADM mothers experienced unintended pregnancies. Several EAADM mothers viewed the unintended pregnancies as a blessing and an opportunity not afforded to all women. Pamela felt her infant was a blessing. "Everything's for a reason, so I guess just—it's a blessing." Wendy characterized her pregnancy as a gift:

You've been given a gift from God, a beautiful baby. And it's something that you know some people would give their lives for to be able to have a child. I've been

blessed to be able to have a child even though I didn't plan on it. It's like a blessing, and I would never give it away.

Ophelia also believed that while her pregnancy was unintended, the infant was a gift. Speaking to her grandmother, Ophelia said, "Did you think that's what the Lord probably chose for me, that he wanted me to get pregnant and not go to Iraq at this time?" Samantha felt she had "bad luck" concerning the pregnancy and the gender of the infant; however, she also resolved these feelings in a spiritual way. "I guess you could say that I wanted a girl. I'm happy that God gave me a boy though. I'm getting used to it now." Even though the majority of EAADM mothers had unintended pregnancies most of them accepted pregnancy as a blessing or a gift, and the initial negative feelings were often resolved in a spiritual way.

First of all, the EAADM mothers expected they would have to change after the birth of their infants. The EAADM mothers expected they would become less selfish and egocentric, and there would be changes in their spousal and other significant relationships. Samantha said, "(I can no longer) be selfish and just do everything for me. Now I have to do it for the baby; so it's going to be different." Pamela wanted to know how she was going to work out her relationships with the baby, her mom, her husband, and with her work situation. Uncertainty was difficult for Pamela, who liked to be in control of her life. She said, "Just the uncertainty about—not being in control of anything really. You know, letting it all happen as it's supposed to happen . . . It's all going to work out, I have faith in that, but still . . . I want answers." The enormity of an infant's birth as a permanent life-changing event was eloquently put by Anna and Ophelia. Anna

said, “There’s no turning back.” Ophelia commented, “A child is for the rest of your life.” Pamela and other EAADM mothers expected their lives would change after the infants’ arrival.

The life change after the infant was born also included the EAADM mothers wondering what kind of a mother they would be and how would they know what to do to meet the infants’ needs. Samantha articulated her fears about how she would know what the infant needed:

Am I going to be a good mom? Am I going to know exactly what to do? How many times is he going to cry? Am I going to be scared to pick him up and give him a bath? What do I do if he spikes a fever so high? . . . Am I going to actually learn those certain cries for him when he’s wet, hungry, wants attention?

Ophelia was overwhelmed at the prospect of meeting the infant’s needs by herself:

Yeah, I’ve had experience with kids, but when you have a kid of your own, and you know, you have to have that baby with you 24/7, it just isn’t the same as taking care of somebody else’s baby for a couple of hours . . . So—it was kind of overwhelming with the whole fact of my husband being gone.

Candace summed up the sentiment about knowing the meaning of the infant’s cries and the irrevocable life change of becoming a mother: “I mean, now I’m going to be have to be responsible for this baby. I mean—you can’t give this one back when it cries. It’s real scary.”

The EAADM mothers acknowledged that integrating their infants into their lives was likely to be overwhelming, all encompassing, and uncertain. Pamela eloquently voiced the concerns of the majority of the EAADM mothers:

But it's going to be totally different, all encompassing . . . A complete shift of a person's role in society, in everything you do. You're now a mother. You know, it's—it's you and them now. It's all those people that are mothers versus all the, you know—I—I can't say. I—I—I wouldn't be able to define it until the moment.

Overall, the EAADM mothers predicted they would have to change their priorities in life and become less selfish and egocentric. There would be a change in familial relationships. The EAADM mothers questioned knowing how to meet the infant's needs and were very concerned about the impending separation from the infant upon the return to work, including potential deployment (once the infant was four months old). Separation from one's infant was a concern for all the EAADM mothers, as was acknowledging their own and the infant's father's mortality.

Bonding with the fetus. The overwhelming, intense feelings experienced during the pregnancy were expressed best by Ophelia, who said, “I never thought that being pregnant would feel so weird and—comforting—and emotional all at the same time . . . I never thought it would be so overwhelming.” Pamela, amazed at the intensity of her feeling for the infant, said, “I have such an intense love already for—I haven't even seen this thing (the infant) that's inside of me, but I just know it'll be great.” When asked when she began to feel love for her infant, she gave a big sigh—the love she felt for and the reality of the infant happened after she heard the heart beat:

After I heard the heartbeat I think. Yeah, because until then you're like "I don't look pregnant." (Laughs.) "I don't think I am pregnant." You know, you still have that doubt you know. But then once you—hear it—and everything like that, it's real. It's real!"

The reality of becoming a mother was signaled either by hearing the infant's heart beat, feeling the infant's movements, or viewing the infant via sonogram. Ophelia's story illustrates this transition to the reality of the infant:

Well, at first it was kind of scary. Yeah, I loved saying that I wanted to have kids of my own, but when I really started to feel the baby moving and all, I'm like "Okay." I already had the ultrasound and I'm like, "Okay, you're having a little boy. So now let's see it."

Once the reality of the infant was confirmed both by ultrasound and the infant's movements, Ophelia was ready to have the baby.

Candace described her infant's activities: "He'll be like this little running thing, and then he'll try to pop out the side." Upon seeing her abdomen move as a result of the infant's movements, Ophelia's husband asked, "'Doesn't that feel weird?'" Her unit members, who were predominantly male, also asked Ophelia the same question, "Doesn't that feel weird? You have something inside of you, and then he starts pushing and shoving?" She felt the movement of the baby also helped her "bond with the baby." Ophelia ascribed the purpose of the baby's movements and the mother's awareness of them as a way to develop the bond with the infant and to prepare for the all encompassing role of being a mother.

Preparation for the infant in one's life also included imagining the infant's presence in one's life. Wendy would get up in the morning, go into her infant's room and imagine his presence in the room:

I'll get up in the morning, and I'll just walk, because I have one room set up as his nursery, and I'll walk in the room, and I'll look around, and I'll see, like the crib and the curtains on the wall and the clothes in the cabinets and the toys. And I'm like, "Oh, my God. I can't believe this. In a little bit I'm going to have a little baby in here."

Samantha, on the other hand, would sit down in the rocking chair in her infant's room at the end of the day and talk to her infant. "I talk to my baby and tell him, 'Oh, I can't wait until you come,' and you know, he keeps my spirits up. And when I feel him kick, I get even happier." Samantha also described this time as developing a bond with her infant. Samantha defined bonding: "It means the baby—he knows you and he—he feels that closeness to you, and you make him feel secure and safe, like nothing can go wrong when he's around you."

One EAADM mother had a particularly challenging journey into motherhood. At the first interview, "difficult" would be an understatement to describe Shannon's view of impending motherhood. Initially, she described her husband's lack of attachment to the infant.

Until he could see it moving from the outside of my stomach, he really didn't have any sort of particular attachment to it. It was, "Yeah, my wife is pregnant," and that's all there was to it, just because—and I hear it's the same with a lot of

other guys—its just not real to them until they see some differences or feel something. Because in the beginning, you know, until you're four months pregnant, sometimes you can't even tell to look at you, and that's just the way it is.

As the interview continued, the researcher sensed Shannon's description of her husband's reaction to the pregnancy may have been her own. "My unit's under pre-deployment orders, which means I get four months unless their orders get rescinded. In four months, I have to say 'bye' and go somewhere else."

Shannon's perspective on how life would change after she had the infant was also very different from how other EAADM mothers described their expectations after delivery.

Right now it's mostly plan, because since this is my first baby, I don't really know what I need to do yet, but just making sure—I have plans for what I want to do with my children, what I want—how I want them to be raised.

Perhaps the thought of leaving her infant at four months and returning when the infant was 16 months old may have accounted for the inability to focus on the present reality. What Shannon thought about most in the month before delivery were the logistical rather than the emotional aspects of becoming a mother.

Right now I mostly think about the—the logistics and the financial part. It's really hard to think about the emotional because it's harder to be attached to someone that's not here yet. I mean, it's a—there's an attachment, but it's not personal really. It's—it's just not as intimate or immediate in a sense. It's just, "Oh, yeah,

there's something in there kicking, and it's going to be a child." But right now, it's harder to say, you know, "When I go away, I'm going to miss this baby so much," because you don't know—how much—of an attachment it is until it happens.

When she was asked what she meant by the word *attachment*, Shannon made a point to define the difference between *love* and attachment. "Attachment, I think, is the automatic—emotional and—and mental response to something you're around, whereas love is something—that progresses—from the relationship." While other EAADM mothers could describe their attachment, bond, or love for their infants, Shannon may simply have been unable to express these same feelings for her infant. The idea of giving birth to an infant only to have to leave it in four months may have been too overwhelming for Shannon

The first activity the EAADM mothers experienced in preparing for self as mother and integrating the infant into one's life was the acceptance of the pregnancy. Realizing the reality of the infant was facilitated through hearing the infant's heart beat, viewing the infant on sonogram, and feeling and seeing the infant's movement. Each EAADM mother further described bonding with the unborn infant by imagining the infant in her life.

Facing the challenge of labor. Not knowing what to expect during labor and delivery was a great concern to the EAADM mothers at the first interview. The pain of labor, coping with the labor, and the risk of having a cesarean delivery worried them more than becoming a mother. Samantha said, "I don't want no needles in my back, scared of complications, scared of everything that might go wrong, instead of everything that might go right. It's my first time so I don't know what to expect." In addition to not

knowing what to expect, the EAADM mothers were faced with going through the pregnancy and the birth experience without the infants' fathers. Only four EAADM mothers had their infant's father with them during the delivery; therefore, each faced the challenge of labor by developing a network of support. Ophelia said,

So it was kind of overwhelming with the whole fact of my husband being gone and not being here . . . Okay, how am I going—how am I going to cope with things and how exactly am I going to look? And like what will be the chances of having a vaginal or a cesarean? Will there be complications and stuff?

Donna found out she was pregnant while she was preparing for her unit's deployment, and her husband had already deployed; the length of the shared pregnancy experience was one week.

Except for one EAADM mother, the EAADM mothers prepared for labor and delivery by attending childbirth classes and taking a tour of the labor and delivery unit. If the infants' fathers were deployed or no longer a part of their lives, the EAADM mothers arranged to have other family members and friends with them during labor.

Preparing for breast feeding. All ten of the EAADM mothers planned to breast feed their infants at least during the time of maternity leave. The most common reasons for breast feeding were that it was the best for the infant and the mother, it was a way to bond with the infant, and it was also a way to lose weight. After reading literature and attending a breast feeding class, Ophelia was particularly convinced breast feeding was the best for her infant:

Your baby needs your milk for the first couple of months because that way, you know, he's colic-free, he has less earaches and less ways to get sick and stuff.

That's why I wanted to do to benefit my baby as well as myself. I looked it up, and it said breast feeding helps, like contract the uterus and helps to lose weight.

Several EAADM mothers expected to breast feed their infants for at least six months. Donna focused her preparation for breast feeding on learning what worked best to maintain the milk supply after the return to work. "I'm just trying to learn how to go about the best way to deal with being at work and pumping and just making sure I have enough milk for her." The determination to breast feed was evidenced in that eight of the EAADM mothers had either purchased or rented breast pumps before the birth of their infants. In preparation for returning to work, the EAADM mothers also planned to practice pumping and to store breast milk while on maternity leave.

Coping on the return to work. Even before the infants' births, the EAADM mothers were having difficulty thinking about having to leave their infants and return to work. The angst of how it would be was best expressed by three EAADM mothers. Donna did not know how long work days would allow time for the infant: "How am I going to do it and still work 14 hours a day . . . Terrifying. Just—I don't know what's going to come of it. It's just a lot." Ophelia worried about child care arrangements, and Wendy wondered if her usual high energy level would last after she returned to work. Ophelia said:

Once I have the baby, how am I going to feel after the six weeks and having to go back to work and my husband not being here and actually having to

take the baby to a babysitter . . . that's one of my biggest worries: I take my baby to the babysitter, and something happens to my baby . . .?

I'm scared to see how I'm going to manage it all. They (Wendy's coworkers) say I'm hyperactive. They say I'm always full of energy, always running around. It's like: Is this energy level going to last or am I going to crash?

At the first interview, the EAADM mothers questioned how they would manage to care for their infants and meet their responsibilities at work. They also expressed concern about who would take care of their infants upon the return to duty after maternity leave. The EAADM mothers described being scared and having worries and fears related to what could be considered more common concerns of pregnant employed women: facing the challenge of labor, preparing for breast feeding, and worries about coping on return to work. However, the military context altered the perspective of these concerns. The bonding with the unborn infant contrasted with the feelings of dealing with potential separation from the infant, acknowledging personal and the infant's' father's mortality, and demonstrating one's competence at work. These three military-related themes are presented below.

Experiencing a Sense of Loss for the Future with Their Infants

The EAADM mothers were experiencing a sense of loss for the future with the infant. The return to work is governed by military regulation. All EAADM mothers were scheduled to return to work at six weeks postpartum, when their infants were 42 days of age; therefore, potential separations from their infants was a universal given for these mothers. When describing their concerns of separation from their infants, "scary" was

most often used to describe the anticipation of separation, sadness at missing out on the infant's developmental firsts, and fearing the infant would not recognize them as mother post-deployment. All EAADM mothers expressed some degree of anxiety about potential separations from their infants.

Anticipating loss. "Drastically" was Anna's immediate response to the question, "How do you think your life will change once you give birth to the baby?" She added, "I'm going to hate to come back to work." Samantha and Pamela both thought life would be "hectic." Rebecca's friends predicted changes such as: She would not want to go back to work, she would have difficulty leaving the infant at daycare, and she would miss her infant so much she would spend her lunch time visiting the infant. However, Rebecca said:

I don't see me changing. I don't see anything changing, but I don't know, I guess I'll see. . . Things like that they don't want to come to work . . . I know one of my friends, one of my coworkers, she, um, when she dropped her baby off at daycare she couldn't leave. Like she was just crying, and she couldn't leave. And at work she was just like, miserable. So when we'd be at lunch, instead of her going to eat lunch, she went to see her baby. So I guess, you know, stuff like that.

Anna's, Samantha's, Pamela's, and Ophelia's comments reflected how the majority of the EAADM mothers anticipated the life change after the birth of the infant, while Rebecca's comments were less common.

Missing out on infant's developmental firsts. At the first interview, the word *fear* was most often verbalized in the same segment of conversation where the EAADM

mothers described being scared, terrified, or worried about some aspect of becoming a mother in the military. There was fear and concern of missing out on infants' developmental firsts such as rolling over and walking, missing out on their infants' childhood, or not being able to be the kind of parents they wanted to be. Samantha described the fear of missing out on her infant's development due to deployment:

And little things like I'm deployed down range, he gets his first tooth, I miss that. I miss his walking, crawling, and stuff like that. I mean a real mom that's at home is going to see it . . . It hurts, it hurts, I just—I just don't know how I'm going to do it, especially that my unit's getting deployed for a year.

The fear of not being present for the child later in life and not being able to be the kind of parent one wanted to be was expressed best by Anna, who said, “And I think that's our biggest fears: being effective supportive parents and not having the time to do it because of our obligations to the military. I think that's probably our biggest fear.” Missing out on the infants' developmental firsts because of separation from the infant was a deep concern the EAADM mothers had for the not-too-distant future. They were also cognizant that a separation was a likely possibility if they remained on active duty. The EAADM mothers also often stated that a real mother would be home to see her infant's developmental accomplishments.

Fearing infants would not recognize them as their mothers. Fear that their infant would not recognize them as mother, either because of deployment or the return to work, was expressed by the EAADM mothers at the first visit. For Samantha, fear the infant

would not know her as his mother was what most occupied her thoughts at the first interview:

Me coming back from deployment and my baby doesn't recognize me as his mom. He recognizes my mom and dad as his mom and dad, and (him) crying when I pick him up because he doesn't know who I am—like he won't know who I am.

The EAADM mothers were also concerned about how the infant would respond to the childcare person and questioned their responsibilities as parents. Wendy voiced this concern, “I want to be there for him. I don't want a babysitter raising my child.” Several EAADM mothers feared the infant would become more attached to the childcare person and not recognize them as mother.

The EAADM mothers' fears and worries over their own mortality was a deeper concern to them than separation from their infants.

Acknowledging Their Own and the Infants' Fathers' Mortality

The biggest and most pervasive fears which permeated all the interviews and escalated over time were the EAADM mothers' concerns of not coming back from Iraq if deployed or of something happening to their infants' fathers before returning from Iraq.

At the first interview, the EAADM mothers expressed the fear of their own mortality, as well as the fear of separation from their infants. Candace, describing her fears of what life would be like after the infant was born, said, “It's just the only thing that would be hard would be leaving the baby when I have deployment and then having to worry about—about the possibility of not coming back.” (Concerns over one's own

mortality escalated after the infants' birth and will be covered in more detail under this theme as it develops over the course of this paper.)

Uncertainty about the infants' fathers' mortality was mentioned briefly at the first interview, and worries escalated after the infants' fathers met their infants.

Another military-related concern of the EAADM mothers was the change in the units' attitudes. In spite of the mothers' reporting their continued competence and commitment as soldiers, they felt they were perceived as being less than a soldier. These issues are presented below under demonstrating one's competence at work.

Demonstrating One's Competence as a Soldier

Once a medically confirmed positive pregnancy test was obtained, each EAADM mother received a *physical profile* (See Appendix U). The purpose of the physical profile or, as it is more commonly called, the *pregnancy profile*, was to protect the EAADM mother and her infant from reproductive and developmental hazards in the work place and to prescribe parameters for work assignments, work hours, and PT (physical fitness). The EAADM mothers described being treated as "handicapped" or a "less-than" soldier as soon as their units were aware of the pregnancy profiles. This treatment took the form of overt and covert comments about their intentions in getting pregnant and their usefulness as soldiers. There were also unexpected changes in work hours and duty assignment. The attitude of the EAADM mothers and attitude of units' members toward families played an important role in the treatment of pregnant soldiers. The following sections describe the EAADM mothers' treatment by the units and the EAADM mothers' responses to the units' attitudes, changed duty hours, and changes in duty assignments. A

description of a *family-oriented unit* will also be addressed. In spite of all the challenges placed before the EAADM mothers, they reported working hard at demonstrating their competence as soldiers.

Dealing with units' attitudes. The units' attitudes toward the pregnant soldiers were demonstrated by overt and covert comments about the soldiers' intentions for the pregnancy and their usefulness as soldiers. The EAADM mothers experienced an abrupt change in their treatment by the unit upon confirmation of their pregnancy. Rebecca summed up the units' changed attitudes, saying, "One thing I have a problem with is as soon as your chain of command knows that you're pregnant, they automatically treat you different." Donna said:

Once you get pregnant, all of a sudden unless you're dealing with the exception rather than the rule—you're ostracized. You're pulled out of leadership positions. All of a sudden, you're looked at like you're not a good soldier anymore, you know? And it's—it's really tough.

Maintaining a positive attitude was seen as a coping strategy. Samantha's philosophy, even before pregnancy, was to remain positive. She said:

It's all about being positive in the Army, and if you just—it's like a game basically. That's what it is. It's a game. If you can show up to work with a smile on your face and just play their game with them, then you'll do just fine . . . You have to be (positive) because if you're not, then I mean it'll just make people around you have the same attitude, and that's not good.

The units' changed attitudes toward the pregnant EAADM mother were also evident by the overt and covert comments made to the EAADM mothers by peers and supervisors. Such comments questioned the EAADM mothers' goals in getting pregnant. The most common theme of units' attitudes was that the EAADM mothers got pregnant on purpose to get out of deployment. Men and women in the units made such comments, which were reported by all the EAADM mothers, including Donna. She said comments to her included, "It must be nice not to be going to Iraq.' You know, stuff like that, not necessarily insidious in—in themselves, but just the fact that they're stated at all, you know."

The relationships between soldiers and the units' support of the soldier changed as a result of pregnancy status. Ophelia's said her identity as a soldier was questioned:

I'm still a soldier. Just because I'm pregnant doesn't make me less of a soldier than any male there is in the company. They were like "Well yes, you know, you were a good soldier." I said, "I *was*?" I said, "I—I still am. Just because I'm pregnant doesn't change the fact that you know—that I'm a soldier."

In another example, one of the EAADM mothers felt her presence was ignored at the work site. Anna felt she was treated as if she were handicapped even though she enjoyed her work and did not complain or draw attention to her pregnant state. She said:

Prior to me having the baby—actually, I get a lot of support at work, but I also feel like sometimes people treat you like you're handicapped . . . I don't go to work every day and whine and complain and mope around . . . I still do my work like anybody else, but um, when it just comes to taking on a task that is not

physical . . . whether it be taking care of another soldier or soldier's issue, they'll get someone else. And I'm like "I'm right here!" It's kind of like they forget that you're there in a way . . . It is a little frustrating. And I've seen other women throughout the different jobs that I've had since I've been in the military that have been pregnant that they kind of get treated the same way.

While Anna first used the term *handicapped*, the term was verified by several EAADM mothers. Rebecca and Pamela shared instances where they were treated as handicapped. They developed personal strategies to deal with the handicapping attitude and continued to perform their duties. Rebecca said, "Yeah, I would say, handicapped. . . It's hard, but if you're determined, you really like the military, and you know what you signed up for. I think you'll—you don't let nobody get to you." Pamela agreed, saying:

Some people try to do that (treat you as handicapped), but I think it's out of good intentions. You don't—I mean, I just like, overlook it and do whatever I know that I need to do, yeah, the physical aspect.

Pamela was also able to deflect what could be perceived as handicapping treatment by not taking the comments seriously. Pamela's positive attitude, combined with the type of unit she was assigned to (tactical unit), may have significantly influenced her treatment by the unit as a result of her pregnancy. She explained:

Tactical, which means we're not doing a lot of physical labor every single day. . . Almost everybody works in an office environment, and I think maybe that negates that kind of disparity between being treated like a handicapped . . . Everyone's sitting down on their cush chair.

Pamela had the experience of being sought out for her expertise on the job and also had a very strong work ethic. She said these conditions also diminished the sense of being treated as handicapped:

I work very hard—people notice that (and) being pregnant doesn't change that. I take my work as a reflection of myself . . . (and always try) very hard to be the best at what I do . . . (I always) work longer hours than probably I should.

An abrupt change in how the EAADM mothers' treatment occurred once they had a pregnancy profile and was manifested in overt and covert negative comments. The EAADM mothers' identity as a soldier was brought into question and unit support for the EAADM mother declined. The mission of the unit may have played a role in how the EAADM mothers were perceived and how they were treated. Strategies the EAADM mothers used to demonstrate their competency as soldiers were maintaining a positive attitude, ignoring the comments, and working longer hours and harder.

Dealing with changes in work hours. Maintaining physical fitness standards is a condition of employment as an active-duty soldier and was taken very seriously by the EAADM mothers. By 28 weeks gestation, the pregnancy profile limited the EAADM mothers to an eight-hour work day. If the EAADM mothers attended PT (physical training), then the duty day began at 6:30 a.m., which meant they would be released from duty by 2:30 p.m. In order to maximize their contribution to the unit, their work hours were changed to a nine-to-five work day. Participation in unit PT was not an option, and PT was a personal responsibility. Anna shared, "I wish the military would still allow me that time, you know, but . . . I mean it doesn't allow me the option." For some EAADM

mothers, the nine-to-five work day schedules meant they were too exhausted to do PT on their own time.

The EAADM mothers were also cognizant of the need for physical activity as an important component of pregnancy health and very much wanted to continue with pregnancy PT. Physical training was seen as a way to maintain health, physical stamina, limit pregnancy weight gain, and improve emotional well-being. “I’ve talked to other mothers and doctors, you know, and I know how important it is to be physically active while you’re pregnant,” Anna said.

One EAADM mother convinced her sergeant to re-institute pregnancy PT and change the nine-to-five work schedule back to 6:30 a.m. to 2:30 p.m. in order to allow the pregnant soldiers’ time for PT. Samantha convinced her first-line supervisor, who then convinced the unit’s ranking enlisted supervisor, that PT was important. “PT is something that pregnant females need to do; we need to walk. And I said it helps labor. And her and the first sergeant agreed, and now every single pregnant female has to show to do PT.,” Samantha said, adding that PT improved her emotional stability and decreased her fatigue.

Walking was the most frequent PT activity during organized unit PT. One EAADM mother continued to participate in unit PT as much as possible. “I just jog about two miles—two, three miles a day, um, or walk. That’s pretty much about it, and I get on my bike. Just normal PT stuff,” Pamela said. She was also quick to point out she was able to participate in PT because her pregnancy was without complications. “I’ve been really lucky. I haven’t had any complications, and you know I continued exercising and

things—of anything that people have said it’s been like ‘Wow! I can’t believe you’re still doing all that stuff.’” For example, Pamela completed a 5K race at 37 weeks gestation. Samantha gained physical and emotional benefits from pregnancy PT; she was convinced that PT was a way to limit weight gain and had the added benefit of showing the EAADM mother was a contributing member of the unit. She said:

I think if I wouldn’t be walking, I think I would’ve blown up. Blown up and gotten big. But it’s a form of exercise for us, so it makes us feel better, like okay, we’re not just sitting on our buns, doing nothing. It’s like we’re contributing. And we’re not considered lazy or anything like that.

Ophelia’s physical fitness was questioned before delivery. “They thought me being pregnant and me being married would affect my performance (as a soldier).” Determined to measure up when she returned to duty, she told her unit, “When I come back to work . . . I’m going to smoke y’all doing exercise.” Her coworkers replied, “No you’re not, because you’re just going to have had the baby.”

When the EAADM mothers’ units changed their work schedules to meet unit needs, the EAADM mothers understood the need for this change. However, several EAADM mothers described their work day as having nothing to do, the nine-to-five work day was incredibly long, and the EAADM mothers felt even less than a soldier. Participating in PT gave a sense of well-being, the EAADM mothers felt more a contributing member of the unit, and the pregnancy was seen as less of a handicap to the unit.

Dealing with job changes. The mission of the unit determined how significantly the pregnancy profile limited the EAADM mothers' duty assignments. If the units were scheduled to deploy, the EAADM mothers were re-assigned to the units' rear detachment, along with other soldiers who were unable to deploy. Most of the EAADM mothers' were re-assigned from their primary MOS (military occupational specialty) to administrative positions. Donna's job change was much like other EAADM mothers whose units deployed: There was little work to be done. "So there's nothing for me to do. . . . We'd just sit around and argue about politics and stuff . . . I don't like being useless. It was very frustrating." Donna described the impact of this job change on her life:

It's very frustrating because I'm somebody that gets a lot of adrenaline out of my work, I like what I do. And for me to go from—having a purpose in life to having no purpose in life. It's an interesting transition.

Donna took matters into her own hands and completed her bachelor's degree during the down time, although she said, "There were several points when I would have rather gone to Iraq." When asked what caused her to feel that she would rather have gone to Iraq; she replied, "It's my job. And these are my soldiers. And—they're gone, and I'm back here . . . on the computer all day. It's just not right."

The EAADM mothers' duty limitations as a result of the pregnancy profile could also be used to the advantage of the units as well as the EAADM mothers. In one unit, motor pool duties were the only limitation in the duty assignment. Normally, the service center where this EAADM mother worked was closed so the unit could perform motor pool duties. The unit's answer was to have the office remain open and to assign Gracie to

manage the office. “(The) office (was) open all day, which is something they really needed anyway. So I was really kind of an advantage to them . . . They made that an advantage instead of me sitting around doing nothing.”

The EAADM mothers understood the necessity for a change of work assignment or re-assignment to another unit. However, in some cases the re-assignment was done in a less than professional manner and discounted the EAADM mothers’ prior contributions and status within the unit. Donna was a platoon sergeant, and because she could not deploy with her unit, another soldier was assigned to be sergeant. Donna’s supervisor did not speak with her once after she became pregnant. She added:

Being the platoon sergeant was an additional duty. And he just moved—he just moved somebody else into that. And like I said, they needed to have somebody who was going to deploy to it, but he didn’t have the common courtesy to say, “Hey look. Hey, I’m making her the platoon’s sergeant effective this day.” I got it through the grapevine.

Donna experienced the negative fallout from her pregnancy from her unit even after the unit left the country. Members of Donna’s deployed unit told her they heard comments such as, “Oh, we should have punished her for that. She did that on purpose.” Donna said her commitment to the military was questioned, and it didn’t matter that she had an outstanding record before the pregnancy. “I’m going to make E7 next month—which is less than nine years in. All of a sudden, I’m a piece of crap—because I’m pregnant?” she said. Lack of communication from her supervisor about the reassignment, combined with

the negative comments from down range (Iraq), only intensified Donna's feelings of being a lesser soldier.

Anna realistically realized her unit's workload required filling her job during her maternity leave; so one of her big worries was the loss of her job when she returned. She was preparing herself for the unexpected, as if the choice to become an EAADM mother came with the cost of a job change. She said:

That's a worry that I have, you know. So in a way that's why I kind of feel like they treat us like we're kind of handicapped, you know, like they just kind of treat you, like if you don't come back forever. I wish I could be more detailed . . . but that's the best way that I can explain it.

The units' missions determined whether an EAADM mother would be assigned to a different duty in her current unit or re-assigned to another unit. The re-assignment could be to the benefit of the units and the EAADM mothers. The EAADM mothers preferred to be assigned meaningful work.

Experiencing family-oriented units. At the first interview, several EAADM mothers shared that it would be more difficult during and after pregnancy if they were not in a family-oriented unit. *Family oriented* was interpreted to mean a unit where priority was placed on the soldiers and ensuring the soldiers were able to care for their families. The EAADM mothers were more likely to call their unit family-oriented if other unit members also had children and spouses. Samantha's comments articulate the sentiments about a family-based unit: "If you're a family unit and they understand, they won't be so hard on you, but if . . . if they aren't, then you're going to have trouble." Samantha's

statement about the benefit of a family-oriented unit was supported by other EAADM mothers.

The pregnancy profile signaled a change in the units' attitudes and support for the pregnant soldier. The pregnancy profile also mandated changes in duty hours and work assignments. In spite of their demonstrated competence as soldiers, some of the EAADM mothers reported being treated as "handicapped" or a "less-than" soldier upon confirmation of their pregnancy. Changes in work hours generally meant the EAADM mothers were no longer able to participate in PT, and PT became a personal responsibility. Many of the EAADM mothers believed PT was important to their health and well-being and a benefit to the unit. The EAADM mothers understood and accepted the changes in duty assignments in order to protect their infants. However, the re-assignments were not always handled in a professional manner. The assignments were often outside of the EAADM mothers MOS, and at times there was little meaningful work at the new assignments. There was no difference with respect to age, rank, and length of time in the Army in how the EAADM mothers reported their treatment by the units.

Summary of Just Before Delivery

There was universal eagerness by the EAADM mothers to share their experiences of becoming an EAADM. Although the first interviews were conducted during the last month of pregnancy, the EAADM mothers reflected on their feelings when they first became pregnant—as the resolution of these feelings was affected by the units' response to the pregnancy. The process of becoming a mother on active duty to this point in the

pregnancy included accepting the pregnancy and bonding with the infant. Reality of the infant was signaled by hearing the infant's heart beat, viewing the ultrasound, or feeling the infant's movements. The EAADM mothers were not prepared for the intense feelings they experienced as they bonded with their infants. They described these intense feelings of bonding as a love for the unborn infant. Integrating the infant into one's life was also described as overwhelming and all-encompassing and was met with a great deal of uncertainty. Potential separation from one's infant was the negative aspect of pregnancy once the EAADM mother accepted the pregnancy and bonded with the unborn infant.

Separating from their infants included being scared, terrified, or worried about anticipating the separation, missing out on the infants' developmental firsts, and fearing the infants would not recognize them as mother. The most pervasive fear was of their own and the infants' fathers' mortality.

The EAADM mothers expected their lives would change drastically, and the major priority in their lives would be the infant. The EAADM mothers expected they would become less egocentric and selfish. The EAADM mothers also had fears of how they would cope with the pain of labor and initial breast feeding, as well as the success of breast feeding. Coping on the return to work and finding a child care arrangement were also on the EAADM mothers' minds.

The EAADM mothers were very much affected by their units' responses to their pregnancies. There was a sense of being treated as handicapped or a less-than solidier because of the pregnancy, in spite of having been well regarded by their units and, in two instances, promoted ahead of their contemporaries. The EAADM mothers dealt with the

units' attitudes by maintaining a positive attitude and ignoring the units' comments. Unexpected, changed duty assignments often meant there was little meaningful work, and the changed work hours meant PT was an individual responsibility. In spite of all of these challenges, the EAADM mothers worked hard to demonstrate their competence. The next section addresses the experience of being home on maternity leave.

Home on Maternity Leave, Gaining a New Sense of Self as Mother

The second interview was conducted when the EAADM mothers were between four and six weeks postpartum. Their maternity leave ended automatically 42 days from the infants' births. The EAADM mothers were eager to share the story of the infants' births and the breast feeding experiences. They were delighted they knew how to meet their infants' needs and credited their knowing with maternal instinct. The EAADM mothers were amazed at how much connection they felt to their infants and couldn't imagine having to leave their infants to return to work. There was also a lot of contemplation and preparation for the return to work. The impending separation from their infants was distressing to all of the EAADM mothers, and they dealt with this sense of loss by keeping the infant in close physical proximity or within view. There was a heightened concern about one's own mortality and an even greater concern for infants' fathers' mortality, and the EAADM mother worked to foster the relationship between the fathers and their infants. The EAADM mothers worked hard at preparing and regaining their competence as soldiers by beginning a physical fitness routine and working on losing weight. The themes addressed in the following section are: integrating the infant

into their lives, keeping the infant in close proximity, acknowledging their own and the infants' fathers' mortality, and preparing and regaining their competence as soldiers.

Integrating the Infant into Their Lives

At the second interview, the EAADM mothers could hardly wait for the tape recorder to be turned on so they could tell the story of their infants' birth and their challenges with breast feeding. They were amazed at their ability to know how to meet the infants' needs, life was hectic, and they were already preparing for the return to work. The following aspects of integrating the infant into their lives are presented below: relating the birth experiences, mastering breast feeding, knowing how to meet the infants' needs, experiencing a new dimension of time, and preparing for the return to work.

Relating the birth experience. The fears, worries, and anxieties of coping with the pain of labor and how they would feel about their performance during labor were replaced with awe of their infants at birth. The EAADM mothers were grateful for their support persons during their labors. The EAADM mothers had a positive self-assessment of their birth experience.

The EAADM mothers were, however, surprised at the level and intensity of pain which accompanied labor. Several EAADM mothers planned on going "natural" yet were very grateful for epidural anesthesia. Anna talked about their desire to have a natural birth and how the intensity of the pain caused them to change their perception of the need for and the use of epidural anesthesia:

Throughout my pregnancy I claimed left and right that I was going to have this baby natural. Nah. . . . It—it was too painful. It was too painful. . . . I was having

contractions day and night, but when I realized I wasn't dilating, I said, you know what, give me that epidural NOW! . . . So they gave me the epidural and I was on cloud nine.

Wendy had a similar experience:

I (didn't) want to go in yet (to the hospital). I want to see how much, you know, I can do at home. Because I wanted to see how much I could get through. And then it was like, oh, this really hurts! . . . I was like I want an epidural, even though I did—planned on never having one. . . . I knew it was going to hurt, but I had no idea how much it was going to hurt.

Other EAADM mothers were relieved the pain of labor either wasn't as bad as expected or the labors were not that long. Donna described the pain of labor as bad, but, the short labor made the pain bearable. "It wasn't worse than I expected; it was really bad. But it went so fast that I didn't have time for an epidural or anything. Before I knew it, she was born." Gracie did not talk much about the labor except to say it was short and she was pleased not to have needed any medication. "So I was only in hard labor for about 40 minutes. I did no—I did no drugs. I did it all natural." Ophelia confirmed the pain was not what she expected, and she also had a positive self-assessment of her performance during labor:

I did it natural. I had no drugs or anything. . . . I expected the pain to be worse . . . but it didn't really hurt. It just felt like menstrual cramps. . . . To me it wasn't as bad as everybody said that it is. . . . I think for me it was pretty well for the first.

Three EAADM mothers had unplanned cesarean deliveries. The EAADM mothers reported this was due to the size of their infants. “So I had an epidural . . . which ended up being the best thing when they decided to do a C-section. . . . She was just too big for me.” In spite of fears and worries of labor and delivery, the EAADM mothers had positive self-assessments for the birth experience. Anna’s statement is an example which communicated this positive assessment: “The whole birth experience—it was quite amazing. . . . I would do it all over again in a heartbeat. It was so worth it.”

The EAADM mothers often said they would not have gotten through their labors without their support persons. The EAADM mothers had varied support persons available to them, and often they had more than one support person with them during labor and delivery. Support persons during labor and delivery included: their partners, spouses, parents, grandparents, mothers, mothers-in-law, sisters-in-law, friends, spouses of friends, and coworkers. Anna was very grateful for the support during labor and delivery: “I know that I never would’ve been able to make it without my husband and my friend here.” Gracie said, “My—my grandmother and my mom were here, and they were both in the delivery room with me so it was nice. It was very nice.” Donna was grateful her husband was able to share in the birth experience:

Then I was just in awe that this baby came out of me, and I just wanted to hold her. And I had a husband and a baby, and it was—it couldn’t have been better. It really couldn’t. I’m so grateful that he was here to be able to go through the birth with me. And he was here when she was born. I mean, it was just incredible. You know, it was just awesome.

These descriptions of support during labor and delivery demonstrated the essential roles of support persons for the EAADM mothers during the birth experiences. Only four of the EAADM mothers had the infants' fathers available to participate in the birth experience.

Participating in the delivery of their own infants and immediately breast feeding the infants were memorable occasions for the EAADM mothers. Family members often assisted in the delivery process. Candace was pleased her mother was able to cut the infant's cord while her friend videotaped the event so Candace could share it with her infant's father. Pamela said:

The delivery was neat. My mom was there, and baby's father was there, and you know, he grabbed her and pulled her out and held her and everything, and they're like, "It's a girl?" And I'm like, "It's a girl." He's like, "It's a girl?" But then immediately he started crying and stuff; so it was kind of cool.

Wendy had perhaps the most touching birth experience because she assisted more in the delivery of her son. She said:

The midwife actually let me deliver half—she delivered his shoulders and then let me deliver him the rest of the way, which was like wonderful . . . I was crying. It was wonderful. He was so cute. . . . He was breast feeding before the placenta was out.

Because Ophelia's husband was deployed, her mother-in-law and sister-in-law were with her during labor. When her husband came home on leave, her husband said, "I'm sorry,"

because he could not be at the delivery. Ophelia's response was, "I know, you know, we're in the military, we can't have everything as we want it."

The EAADM mothers managed the challenges of the labor experiences. While the EAADM mothers were not prepared for the intensity of labor pains, they gave a positive assessment of their performances, whether or not they had epidural anesthesia. Support of significant and trusted family members and friends were critical to the positive birth experiences. Videotaping of the event was a way to share the birth experiences with the infants' fathers who were not able to be present at the delivery and to have permanent memories of this life-changing event. The EAADM mothers' breast feeding experiences will be presented next.

Mastering breast feeding. At the second interview, the EAADM mothers reported the initial breast feeding experiences were not as difficult as they had anticipated. There was a consensus that breast feeding was a lot of work and time consuming, but it was also a very satisfying experience and a way to spend time with their infants. They were also pleased and surprised at the enjoyment of breast feeding

Ophelia and Shannon reported breast-feeding difficulties which were temporary. Ophelia said, "It wasn't as bad as everybody (said). It just blistered a little bit the first two or three days, he was still getting accustomed to it, but after like the first week, it was just so normal" Shannon said, "Yeah, after the first couple of days where it was just getting used to it. Like, she gave me blood blisters; she's got suction like a vacuum. But after that it's been fine. She does really well."

In spite of consultation with a lactation counselor, two of the EAADM mothers discontinued breast feeding within a few weeks of the infants' births, mainly because of cracked or bleeding nipples as a result of their infants' difficulties with latching on. Engorgement and bleeding were problems for Gracie. At a few days old, her infant had lost weight and was having problems latching on. Although she stopped latching the infant to her breast when the infant was a little over a week old, she continued to pump her breasts until the infant was three weeks of age. She said:

He just wasn't getting enough, so I stopped nursing—he made my nipples really sore, and he made them bleed, and they scabbed over and stuff, and so it hurt really bad when I was nursing, and so I quit. And, then I tried pumping, but I wasn't getting enough because he eats, in one sitting he'll eat between four to seven ounces of formula. But I got to feed him for three weeks, nursing for three weeks, so he got a little bit of it.

Gracie was pleased to have had the opportunity to give her son a “little bit of it,” i.e., the benefits of breast feeding.

Some of the EAADM mothers experienced a special bond with their infants' during breast feeding. Anna especially enjoyed this bond. “So I really enjoy breast feeding and the whole bonding thing and the, uh, the natural part of it.” Samantha was delighted her son knew how to breast feed with little help. “Oh, he latched on so fast, and he just started drinking.”

The initial breast feeding experiences, while somewhat uncomfortable, were temporary experiences for all but two of the EAADM mothers, who stopped breast

feeding before the end of maternity leave. These two EAADM mothers stated their breast feeding experiences met their expectations. They were able to breast feed their infants for part of their maternity leaves. There was a general sense of satisfaction with the breast feeding experiences for all of the EAADM mothers.

Knowing how to meet the infants' needs. At the first interview, the EAADM mothers were concerned about their ability to interpret their infants' cries and meet the infants' needs. At the second interview, the focus was on the transformation the infants' made in their lives. Anna described the transformation of becoming a mother as a sense of completeness: "Never in my entire life have I felt so complete. It's really a feeling of completeness. . . . It was just amazing how life can be formed in—in your own body and come out of you."

The EAADM mothers were amazed at the extreme awe, joy, and wonder of becoming a mother. Giving birth to an infant was a life-altering event; the worry, fear, pain, or discomforts of the experience were history, and the focus turned to their infants. Ophelia was in awe of her feelings of love for her infant: "I mean, it's—its' a different feeling because now, you know, I never thought you could actually love some—someone so little as much as I do. And he's so precious." Wendy said, "Yes, yes, perfect! Perfect health, everything. He was just perfect. He is perfect. So I just really love him probably the most."

When questioned after the infants' arrival, the EAADM mothers were no longer concerned how to meet the infants' needs. Rebecca said a colleague told her before the

birth of her infant not to worry: “Girl you’ll just know.” At the second interview, Rebecca validated she did “just know”:

And I think it’s just motherly instinct because I didn’t know half that stuff, and now I’m like WOW! Believe me! Um, I know when she’s wet. I know when she’s uncomfortable. I know when she wants to play. Um—I know when she’s about to take her nap. . . . And I think it’s just motherly instinct because I didn’t know half that stuff, and now I’m like WOW! I know so much about babies.

Rebecca’s description was voiced by other EAADM mothers, who described a pattern of responding to the infants’ cries.

The EAADM mothers related the following process for discerning the meaning of their infants’ cries. The first cue to the EAADM mothers when their infants cried was to see what activity the infants were engaged in at the time. If the infants had just eaten, then perhaps the infants needed to burp. If that didn’t work, they checked their infants’ diapers. If the diapers were dry, and infants were still upset, the EAADM mothers attempted to breast feed their infants. If the infants were playing with a toy, perhaps their infants were bored and needed another toy. If the aforementioned attempts to soothe their infants did not work, the solution was to hold their infants.

The philosophy of not letting their infants cry was common. Crying was seen as the infants’ way of communication, and therefore, crying should not be ignored. Pamela and Donna were especially vocal about not letting their infants cry. Wendy and Donna put their infants in a carrier when doing household chores, except when cooking. While cooking a meal, the infants were placed in a carrier or in the swing, away from harm and

within view of their mothers. The EAADM mothers sought to keep their infants within view or arms' reach, and holding the infants were ways to stay connected to their infants. The infants' needs superseded the EAADM mothers' needs. The tempo of the EAADM mothers' lives increased significantly on the arrival of the infants.

Experiencing a new dimension of time. The tempo of the EAADM mothers' lives revolved around the infants' needs, most notably breast feeding. Donna described her daily schedule: "There's not really anything set. It's kind of based around her eating and feedings." When asked to describe yesterday, the first activity mentioned by the EAADM mothers was breast feeding. The rest of the days' activities were caring for their infants, often to the exclusion of the mothers' needs. It was also interesting that the descriptions of yesterdays rarely included anyone outside of themselves and the infants, in spite of the presence of other persons in the households soon after the births. Even though two EAADM mothers returned to their parents' homes during a portion of maternity leave, they too focused on the infants' needs. The EAADM mothers mentioned themselves only as needed to take care of their infants.

Time took on a new dimension for the EAADM mothers. Yesterdays become difficult to recall—the narrative sequence of the prior days' activities—as the infants' needs overtook the day. Shannon said, "Mom doesn't have any time. Mom doesn't get time. Mom's time comes later." Samantha said, "It's tiring, man—it feels like you can't—you can't do things for yourself now. You have to do everything for the baby. And it's like—it's kind of like you have to give up your selfish ways." The days were

scheduled around the infants' feeding schedules. Donna articulated a typical experience if she had to leave the home to run errands:

Any outings are really short, now like a quick run to the store . . . you got a two-hour window maybe, sometimes we can push it to three. But by the end of that third hour, we have to stop and eat.

It was evident the EAADM mothers were amazed at the transformation in their lives as a result of giving birth. They also realized their lives were changed forever and that time for them was in short supply. The EAADM mothers were also anticipating their separation from their infants when they returned to return to work.

Preparing for the return to work. At the second interview, the EAADM mothers used “drastically” and “miserably” to describe their feelings about the prospect of returning to duty, with being miserable the predominant expression. The EAADM mothers also anticipated the return to work by pre-planning how they would manage the infants' needs, their needs, and the requirements of work. The strategies they developed for coping with the return to work are discussed in more detail.

Anna was vehement in her utterance of how she thought her life would change when she returned to duty: “Drastically, miserably. I so much am ready to get out now . . . There is nothing I would rather do than get out of the military and be with my baby as a job.” While, the EAADM mothers expected to be very tired after they returned to work, they also expected a schedule would emerge soon after the return to work. Gracie believed she would adjust to being tired, at least physically: “I’m going to be dead tired. I’m sure I’ll eventually get used to it, like my body will get used to it.” Pamela, who

described herself as a perfectionist at work, expected a schedule would emerge soon after she returned to duty. “There’ll be an adjusting period, you know, there at the very beginning, but once—once you get a pattern established, a routine, it’ll be okay. It’ll all work out.” Donna also anticipated a schedule would facilitate the adjustment of the return to work and that there would be less time for her:

I think it’s going to be a lot more regimented as far as schedule-wise . . . I’m going to have to be much more strict on—as far as my schedule goes. I can never just go home and sit down. I’m going to have to come home, nurse her, get her ready for bed, and spend some time with her. And I’m just going to have—I think less time—but—it’s worth it.

The EAADM mothers had successful careers and worked hard and long hours prior to giving birth. It was clear they anticipated significant changes in their lives as a result of their status as active-duty soldiers.

In preparation for the return to duty, the EAADM mothers focused on the present time they had to devote to their infants. Wendy tried not to project the future: “I just try not to think about it. I’ll deal with it when it happens. And in the back of my mind, I’m worrying.” Anna coped by trying to prepare for this life change: “It’s going to be hard, but I try to prepare myself for it now.” In addition to spending as much time as possible with their infants, the EAADM mothers prepared for the eventual return to work in two areas: breast feeding and child care. The EAADM mothers also experienced anxieties and uncertainties about the return to work.

There was the anxiety of the “what ifs” of returning to work. The EAADM mothers worried: Would they remember everything their infants needed during the day? Would they pack enough breast milk? Would the infants become more attached to their sitters than to them? Wendy elucidated these myriad feelings:

It’s very nerve-wracking if you let yourself sit down and think about it. Am I going to pack enough milk? Is the baby going to like the baby sitter? Do I need to have a mini-cam on the baby sitter? I’m nervous about leaving him with anyone but me—but we have to.

The EAADM mothers’ biggest worries were about the safety of their infants’ while in the care of others.

Family members in residence provided the child care for five of the EAADM mothers’ infants: three mothers, one grandmother, and one spouse. The infants of the other five EAADM mothers were either placed in home day care or in a day care facility. The EAADM mothers selected their child-care persons because of a sense of trust, and, for some EAADM mothers, a personal knowledge of the child-care persons. Anna’s child-care person was someone from her church: “The only reason why I would want to go with her is just the security of knowing who will be caring for our child.” Rebecca met her infant’s child-care person during her pregnancy and felt her infant would be well cared for: “I—I brought (the infant) to her, and she was amazed. She was like, ‘Oh, I can’t wait to babysit your baby, and this, this, and that.’ And she’s cool.”

Several EAADM mothers evaluated their child care arrangements before the return to work. Donna took her infant to the child-care provider for two hours a day while

she went to the gym to work out. Wendy visited with her child-care person to see how her infant would respond to the woman:

Yes, I do trust her. She seems amazing. Like, she loves to cuddle, and we know when we first met her, when we first met her—he seemed perfectly at home in her house. He was just sleeping, he was calm. I was like, okay, I'll take this as a good sign.

Another difficult issue in making child care arrangements was the EAADM mothers' work schedules. Shannon anticipated there would be frequent and unexpected changes in the duty roster, which in turn made it extremely difficult to plan for child care needs. She said, "Sometimes you don't know more than 24 hours in advance that you have 24-hour duty."

The EAADM mothers might also work different shifts. Wendy was delighted she found a child-care provider who understood military duty requirements:

But thank goodness I have a good babysitter than has no problems—I have a home daycare—she has no problems with doing nights, doing weekend, doesn't charge extra. She really understands. Her husband's in the military so she understands the difficulties of being in the military.

Arranging child care was a significant concern to all the EAADM mothers whether their infants were cared for by relatives in the home or by persons outside of the home. Trust and flexibility were two criteria the EAADM mothers used when they selected a child-care person. The cost of child care was mentioned by only two EAADM mothers.

The EAADM mothers did not want maternity leave to end. One of the strategies for coping with the anxieties of the return to work was to stay focused on the present time they had with their infants and to make preparations for the transition back to work. The most significant preparation for the return to work was making child care arrangements. In spite of knowing the person and trusting the person who would care for their child, there was anxiety about leaving the infant in the care of others.

Experiencing a Sense of Loss for the Future with Their Infants

Before their infants were born, the EAADM mothers were looking forward to their maternity leaves. However, soon after the infants' births, they also anticipated the impending separation from their infants when they returned to work. At the first interview, the EAADM mothers expressed concerns about missing out on the infants' developmental firsts; while at the second interview, these concerns were replaced with relating the wonder of their infants' accomplishments. The anticipation of separation on return to work will be followed by a description of the strategies the EAADM mothers used to maximize their contact with their infants.

Keeping the infants' in close proximity. Shannon summed up the dimension of time for the maternity-leave experience: "Six weeks sounds like a long time before you start doing it, and then it's just all over in no time." The EAADM mothers experienced an intense connection with their infants and couldn't imagine what it would be like to be without their infants when they returned to work. Wendy described what it felt like just days before returning to work:

(Maternity leave) went too fast. I see now that I'm so attached to him. I'm, like, I'm dreading Monday so bad because he's never been away from me longer than like five minutes in the next room while I'm using the bathroom or something. . . . I can't imagine him being away from me. He's always been with me.

The EAADM mothers tried to spend as much time as possible interacting with or being in the presence of their infants before they returned to work. Shannon gave a typical description of her days with her infant: "We mostly just socialize for most of the day since I have to go back to work. And I'm just having trouble doing (anything else)—just do a lot of interacting." Anna enjoyed sleeping with her infant as a way of increasing the time with the infant and as a way of bonding: "I think that's why I really like sleeping with the baby, because at night time we have that bonding that, um, well, that once I go back to work I'm not going to have during the day." Spending all their time with their infants' and co-sleeping experiences were typical for the EAADM mothers during the time of maternity leave. Only one EAADM mother was adamant about not taking the infant into her bed, yet she would sleep with the infant on her chest while they slept at night sitting in a recliner. All of the EAADM mothers mentioned, "I don't want to leave my baby" or "I can't imagine leaving my baby" at least once during this second visit.

Relating infants' developmental firsts. A few comments were made by the EAADM mothers about fear of missing out on the infants' developmental firsts. However, at the second interview, they were much more focused on relating their infants' accomplishments. The EAADM mothers reflected on the wonder, awe, and amazement of the transformation of the infants. Pamela described this transformation:

Oh, my gosh, I can't believe just, you know, just a little while ago you were right inside of me. How did you fit—inside of me? . . . I'm just amazed how perfect—like this little being she is—how everything works. . . . They're their own—they're their own person. They are completely—I mean they're not completely separate from you, but I mean they're their own perfect little package.

The EAADM mothers shared their wonder and awe at the infants' capabilities. Wendy especially enjoyed her infant's smile and expressive face: "When he's mad, he'll get this frown that will just break your heart. You'll want to smile at him because he's frowning so hard." Wendy also related an experience when she wasn't sure if the infant smiled because her infant saw her as a source of food or because he recognized her as his mother: "I don't know if it was the just the sight of my face or the sight of his food, but he just let out the biggest grin in the world." Gracie said her infant's smile would negate the negative feelings she had about losing sleep: "When he just laughs or does this little funny face—he's got some great facial expressions—it just cheers you all up when he's all happy again." Gracie said the best thing about being a mother at this stage was that the baby changed every day: "Just the fact that everyday he—he changes. . . . And it's just so much fun." Rebecca said the best thing about having a baby was being able to spend time with her: "Spending time with her—everything, everything, I'm going to say everything."

There was an outright joy at watching their infants. When Pamela was asked to describe how she played with the infant, she clarified the question first: "What do we do with the baby that makes her do cute things?" Watching the infant's ability to lift up her head, look around, and become transfixed by different forms of light and shadows were

some of the cute things Pamela described, adding, “That is just the neatest thing in the entire world (to watch your baby).” Candace was also fascinated at watching her son watch TV: “He likes TV (because he) sees lights and shadows.” The infants’ smiles and responsiveness to the EAADM mothers were the most often reported infant accomplishment.

Ophelia anticipated not seeing the infant’s firsts but felt it was a sacrifice she had to make by returning to duty: “And like my grandma will see it (the firsts) before me, but you know, it’s something I have to sacrifice to go back to work.” The EAADM mothers did not mention much about missing out on their infants’ developmental firsts at the second interview, except for Ophelia. The EAADM mothers instead shared their wonder and awe at the infants’ capabilities. The focus for this interview was on the delight, wonder, and joy of being able to watch and be with their infants as the EAADM mothers anticipated their upcoming separation from their infants. Pamela summed up the experience of being with her infant during maternity leave as a great beginning: “It’s just so magical and kind of neat at the very beginning. It’s very neat.”

Fostering the Relationship between Infants’ and Their Fathers

Because the infants’ fathers often were unable to be physically present in their infants’ lives, the EAADM mothers went to great lengths to maintain the fathers’ presence in their infants’ lives. At the first interview, the EAADM mothers expressed concerns for their own mortality, but at the second interview, concerns for the infants’ fathers’ mortality superceded their concerns about themselves. The EAADM mothers focused on fostering a relationship with the infants’ fathers as the major way of coping

with their concerns about the infants' fathers' mortality. The strategies the EAADM mothers developed to foster a relationship with the infants' fathers are presented below.

The level of the uncertainties and worries for the infants' fathers' safety escalated after the infants' fathers met their infants. Only four of the infants' fathers were present at the delivery, and the remaining fathers met their infants some time during the postpartum period. The fears of something happening to the infant's father before meeting the infant was expressed best by Gracie: "There's just so much stuff going on in Iraq right now. That really bothers me . . . there's a chance that he might not ever know his son at all, and that his son will never know him.

All of the EAADM mothers, including the single EAADM mothers who did not have a current relationship with the infants' fathers, made it a priority to maintain and foster a relationship between the infants and their fathers through frequent e-mails, photographs, phone calls, and visits. Gracie's description of how often she e-mailed her son's father was typical of all EAADM mothers: "Every time the baby does something new, I'll write him and e-mail him."

When the infants' fathers came home for mid-tour leave from Iraq, the EAADM mothers made sure the fathers got as much time as possible with the infants and tried not to interfere. For Donna, the best thing about being a mother at this stage was being able to watch her husband spend time with their daughter: "The best thing was having him here for a whole month, and being able to (watch him) interact with her."

Ophelia also had the infant spend as much time as possible in his father's arms so the infant would pick up his father's scent as a way to maintain the father's presence in

the infant's life. Ophelia would not wash the shirt her husband wore on his last day at home in order to preserve the father's scent for the infant. Ophelia related advice the other EAADM mothers might want to follow: "Have him wear a shirt for like, the whole day or something, or (preserve) something that he's touched or something that has his smell on it so that the baby can smell it." Ophelia and her husband also took pictures of him with their son so her son could know what his father looked like. She enlarged some of the pictures and placed them in the home where she interacted with her son.

The EAADM mothers communicated frequently with the infants' fathers as a way to maintain the presence of the infants in their fathers' lives and in their own lives. While e-mail and telephone communication were welcomed, they also generated uncertainties and anxieties with regard to the infants' fathers' safety. If a death or injury occurred to a soldier in the unit, e-mail and phone access were denied to the whole unit until the family members of the injured or deceased soldier were notified. The time between phone calls was also related to missions out of the compound, 24-hour duty shifts, or simply a lack of access to e-mail or a telephone. The lack of correspondence or communication from the infants' fathers resulted in increased anxieties. One strategy for coping with the anxieties between the fathers' phone calls was shared by Candace and was also common to the EAADM mothers. Candace did not watch news shows:

I don't watch the news. I can't stand the news because they talk about (the city) blew up in this area, and so many soldiers got killed, and I don't want to hear it because my husband is in that city. So I don't want to hear it.

The topics for discussion on the phone calls created a dilemma for the EAADM mothers. Generally the focus for the conversations was about the infants' latest accomplishments rather than discussions about each other's work situations. The deployed fathers spoke in generalities rather than specifics about their activities so as not to increase the anxieties and worries of family members.

The EAADM mothers related several strategies for fostering a relationship between the infants and their fathers. When the infants' fathers were able to come home from Iraq to meet their infants, the EAADM mothers tried not to interfere with the time the infants had with their fathers. Pictures of the infants with their fathers were taken and were used to familiarize the infants with the fathers. The EAADM mothers maintained frequent communications with the infants' fathers about the infants' accomplishments. Frequent communication could, however, also be a source of stress.

Preparing and Regaining Their Competence as Soldiers

In addition to the difficulties of leaving their infants, the EAADM mothers were also concerned about how they would be perceived by their units. There was agreement that a family-oriented unit facilitated the transition to work. Two EAADM mothers anticipated changed work hours as a consequence of new duty assignments. The EAADM mothers engaged in physical fitness activities so they might meet Army weight and physical fitness standards by six months postpartum. All of the EAADM mothers anticipated that their lives would be more stressful when they returned to work.

The EAADM mothers worried whether or not they could be able to meet the units' expectations for work and physical fitness. The EAADM mothers' expectations

were shaped by their perceptions of their units as family-oriented units. They were also concerned if the family-oriented units' positive treatment before pregnancy would continue after the return to work. Samantha summed it all up:

And how are they going to treat me? Like were they just being nice to me because I was pregnant? Or, you know, and I was like, okay, am I going to be able to hold a high standard as in PT-wise? . . . I love PT, but I was wondering if they're going to . . . going to hold me back or let me . . . or let me do stuff on my own, or are they going to say, "Well, we know you have a (pregnancy) profile, but, you know, you've got to run with us," or it just—I don't know what to expect.

The first unit Samantha was assigned to when she became pregnant was not supportive of pregnant soldiers. Samantha was subsequently re-assigned to another unit during the last half of her pregnancy. The second unit was very supportive of Samantha, and she wondered if the unit would remain supportive when she returned from maternity leave.

Two EAADM mothers experienced job changes when they returned to work. Wendy was slated for promotion and was assigned to another unit in a leadership position. Wendy described her concerns of learning a new job at the same time she was learning how to be a new mother:

I think it's going to be more difficult for me . . . I have to learn a lot of new things so I'm going to be basically learning an entire new job while I have a brand-new baby, and it's like . . . I'm scared there is going to be a lot of stress at one little bit of time.

Although she remained in the same unit as before delivery, Pamela's job expanded in scope after maternity leave. Her primary duties prior to maternity leave were in her assigned MOS (military occupational specialty). After maternity leave, she was assigned to an administrative role within the unit outside of her MOS; in addition, she was assigned the duty as a platoon sergeant. Pamela said the administrative role was more challenging:

(The administrative job) is actually more harrowing because it—we deal with people's pay and their administrative requests. You can't—there's no room for error. . . . That's why they put me in that position, because I'm quite a perfectionist when it comes to work.

These two EAADM mothers' job changes could be interpreted as an acknowledgement of their competence at work: Wendy was going to be promoted to the next rank on the return to work, and Pamela was selected for her attention to detail.

All EAADM mothers must meet physical and weight standards by six months postpartum; during maternity leave, the EAADM mothers worked to lose weight gained during the pregnancy and to regain physical fitness. The EAADM mothers reported weight gains of nine to 58 pounds during pregnancy. By the second interview between eight and ten weeks postpartum, several EAADM mothers reported they met Army weight standards, although not necessarily their own desired weight. EAADM mothers used a variety of methods to regain physical fitness: going to the gym for cardio and strength training, attending Jazzercise, working out at home using their own home PT

equipment or doing Tae Bo, Pilates, or other exercise tapes. Two EAADM mothers were exercising daily at two weeks postpartum.

Anticipating the return to work was stressful for all of the EAADM mothers and was even greater for the two EAADM mothers who were returning to new work assignments. All but one of the EAADM mothers actively sought to regain physical fitness and lose weight during maternity leave in order to meet Army physical fitness and weight standards by six months postpartum.

Summary of Maternity Leave

The second interview was conducted while the EAADM mothers were home on maternity leave, about four to six weeks postpartum. All of the EAADM mothers reported positive self-assessments of their performance during the birth and breast feeding experiences. The two EAADM mothers who ceased breast feeding due to cracked and bleeding nipples met their goal of breast feeding at least some of the time during maternity leave. Eight of the EAADM mothers were still breast feeding, and there was a sense of joy and connection to their infants as a result of the breast feeding experience.

The EAADM mothers were delighted they knew how to meet their infants' needs. There was consensus that one should not let the infants cry, for the infants' cries were the way infants communicated their needs to their mothers. The tempo of life increased significantly. Their infants had first priority in their lives. There was heightened concern for the infants' fathers' mortality after he was able to meet his infant. Even the single

EAADM mothers who no longer had a personal relationship with the infants' fathers' continued to foster a relationship between the fathers and their infants.

During maternity leave, except for one EAADM mother, the EAADM mothers began an exercise program in order to get back into shape and to lose pregnancy weight. All but one EAADM mother reported attaining Army weight standards, and all EAADM mothers reported they were not at their own weight standards. The next section covers the EAADM mothers' experiences on the return to work.

The Return to Work, Integrating Self as Mother into Self as Soldier

The transition back to work was more difficult than the EAADM mothers anticipated. The phrase, "I don't want to leave my baby," which was verbalized by all of the EAADM mothers at least once during the first two interviews, became what could best be described as a mantra at the third and fourth interviews. The EAADM mothers continued to maximize the time with their infants and experienced an intense sense of loss upon the return to work. At the third interview, integrating the infant into one's life became much more difficult because work also had to be integrated into the EAADM mothers' lives. Eight of the EAADM mothers were still breast feeding, even if only at night. Pumping enough milk for the infants' supplemental feedings became a new challenge. The units' were glad to have the EAADM mothers back at work, and, for the most part, the EAADM mothers appreciated the challenge of their work and time with their coworkers. The manner in which the EAADM mothers integrated their infants into their lives after the return to work was experienced as a new dimension of time.

Experiencing a New Dimension of Time

The EAADM mothers were interviewed the third time when they had been at work between one and two weeks (8-10 weeks postpartum). Integrating the infant into one's life was a greater challenge than anticipated, and they developed strategies to help them through this transition. The tempo of life increased significantly upon the return to work. The EAADM mother described the tempo of their days as "ripping," "running," "hurrying," "constantly moving," and "racing." The EAADM mothers' daily schedules had a similar pattern: attend PT, return home to shower, change into their uniforms, feed the infants, eat breakfast, and return to work by 9 a.m. Some EAADM mothers were able to return home at lunch time except when their units were in the process of deployment. After work, the EAADM mothers either picked the child up from day care or hurried directly home. The most common evening schedule was feed, bathe, and prepare the infants for bed time. The time between the end of work and bed time was too short. Anna's morning was typical, she said:

I'm running from PT (to) home, hurrying to get back to work by 9:00, jet back to work. (After work) I was just—we were ripping and running, and I was like, "Here's a bottle," you know, I'd pump, and I would just throw the bottle at my husband and have him feed (the infant).

Samantha's evenings were typical, she said:

It's so hectic. I'm mean there—there are days when I pick up my son and run out of the babysitter's house and run home so that I can take him a bath and—and

then get to bed. (And next day I do it) all over again. And—it's the whole day I'm constantly moving.

The fast tempo of the typical work day was governed by the work schedules and the infants' needs.

Further discussion of the EAADM mothers' preparations for the return to work will be discussed in greater detail under mastering breast feeding and coping on the return to work, which are presented below.

Maintaining the supply of breast milk. After the EAADM mothers returned to work, the frequency of breast feeding varied. One EAADM mother continued to breast feed only at night as a way to comfort the infant and to get a good night's sleep. Three of the EAADM mothers continued to pump their breasts until their infants were between three to four months old, in spite of the infants choosing not to latch on to the breast except during the night. At this third interview, the four EAADM mothers who were still breast feeding exclusively said they planned to continue breast feeding until the infants were at least six months old. Donna was especially determined to breast feed her infant until six months. She said, "I'm determined that we're not going to stop. . . . I want to make it at least six months—because it's the best thing for her."

The EAADM mothers maintained their milk supply by pumping between three to four times a day—right before PT, on return from PT, at lunchtime, and as soon as coming home from work. Some EAADM mothers placed the infant on one breast while pumping on the other. Pamela and Wendy recounted feeding and pumping at the same time. Pamela said, "And she'll pretty much drink one—from one breast (while) I pump

on the other.” Wendy shared the same experience: “(I) nursed him on one side while pumping on the other so that I could have some food saved up.” Breast feeding while pumping was an expedient way to maintain the milk supply and have enough breast milk for supplemental feedings.

The EAADM mothers also went to great lengths to pump breast milk. One EAADM mother reported pumping at work while standing in the middle of the bathroom because there was no other area for privacy, another EAADM mother pumped in the front seat of a truck while she waited at the railhead for the truck to be placed on the train for shipment to Iraq, and several EAADM mothers pumped while driving in the car on the way to or from work. Shannon’s experience is perhaps the most inventive way to use downtime. She described her pumping experience:

It depends on how discreet you can be which when you’re out in the cold with lots of layers of clothing is actually fairly easy. Because I just, I did it in the front seat of my truck, you know, three or four times a day. I’d just unbutton the shirt, push up way underneath, and put my jacket over the top of me.

Eight EAADM mothers continued to breast feed part of the day, and seven EAADM mothers continued to pump their breasts after they returned to work, although they may not have been able to pump consistently. Three of the EAADM mothers continued to pump even after their infants would only latch on during the night and four EAADM mothers’ pumped and nursed their infants simultaneously.

The joy and motivation for continued breast feeding could best be attributed to the infant-mother interaction which transpired during breast feeding. Donna couldn’t imagine

feeding her infant any other way. She said, “I had no idea it would be this much fun! . . . Breast feeding is the easiest choice. . . . It’s just so easy all around; I can’t imagine anybody not wanting to (breast feed).” Ophelia described breast feeding as the best thing about being a mother because of the bond it created between her and her infant. She said:

(The) bonding thing. Because he—when I breast feed and he just sits there and looks at me. And he’s just looking and I’m like—And it just—it just feels so—like I don’t—I don’t know how to explain. Just—I’m looking at him, and he’s just feeding and I’m like—then he just smiles at me. And I can just imagine he’s like, “I love you.”

Eight of the EAADM mothers were still breast feeding to some degree at the third interview, and they had varied experiences of pumping while at work and at home.

Coping on the return to work. Planning ahead was the most common way the EAADM mothers prepared for the return to work. One way of coping which made life less stressful was to develop a schedule or routine for the infant and for oneself. On the advice of a close friend, Donna put her infant on a daily routine when the infant was five weeks old. Part of the routine included swaddling the infant to signal to the infant it was bedtime. Donna described her routine:

I still swaddle her. I mean she’s a little old for it—I still wrap her up at night, that’s her cue so she knows its time for bed. Cause I don’t swaddle her during the day. So when she gets swaddled, she knows it’s time for sleep . . . As long as I try to keep things as normal as I can—for her—she’ll let me continue to function.

Also on the advice of friends, several EAADM mothers prepared food in bulk on weekends or days off and wrapped individual portions for lunches. The EAADM mothers prepared for the next day by setting out their own and the infants' clothing and also packing the diaper bag, the breast feeding bag, and the PT bag. In the evening while the baby napped, Wendy described her routine: "He'll take a nap while I'm racing around trying to get stuff sort of set up for the next morning so we're not late running out the door." Daily and weekly preparations were strategies to increase the amount of time for the infants and to decrease stress.

Four EAADM mothers' units were deploying, and three EAADM mothers were unable to and one EAADM mother was able to come home for lunch. Pamela's mother, the primary child-care person, awoke the infant so the infant would have time with Pamela during lunch. Pamela cherished time with her daughter at lunchtime. She said:

She usually is alert during the times that we're here. You know, my mom tries to wake her so, you know, when we're here we can actually spend some time with her and, you know, play with her a little bit and stuff, especially at lunchtime because we get about 45 minutes—just 45 minutes, just time to see her and everything like that.

Pamela was grateful for this accommodation by her mother which afforded Pamela time with her daughter. It should be noted that Pamela also breast fed her infant and pumped during lunch time. Pamela expressed most eloquently the crux of the EAADM mothers' sentiments about dimension of time after the return to work:

Just having enough time in the day for what you would like to give to people, I guess. I think as women we want to give things to show that we love them, and so it's hard when (you're working full-time). . . . That's it, just having enough time in the day. That's the hardest thing. I really would like to spend way more time with her, and I'd just like to spend more time with (infant's father) alone.

Weekly and daily preparations for the logistical aspects of life were effective ways of coping and decreasing the stress in their lives. Time was the element in shortest supply in their lives; therefore, the EAADM mothers prioritized their time for their infants.

Separation from their infants, best be described as grieving, was the most difficult part for the EAADM mothers as they made the transition back to work..

Grieving Lost Time with One's Infant

Time away from their infants increased the sense of loss. Leaving their infants for the day was a difficult transition. When the EAADM mothers were not on duty, they prioritized their time in order to maximize the time with their infants. Except for one EAADM mother, they reported co-sleeping with their infants at least some of the time. The EAADM mothers were happy to share their infants' accomplishments. The two EAADM mothers whose units were scheduled to deploy described their fears of missing infants' developmental firsts. Fear their infants would not recognize them as their mothers was voiced during these interviews to a degree, even for those EAADM mothers who were not scheduled to deploy at the time. The themes presented below further describe the EAADM mothers' experience of loss: prioritizing one's time, missing out on

the infant's developmental firsts, and fearing the infant would not recognize her as mother.

Prioritizing one's time. The EAADM mothers prioritized their time to maximize the amount of physical connection they had with their infants. The practice of co-sleeping continued after the EAADM mothers returned to work and was one way the EAADM mothers used to increase the time with their infants. While all of the EAADM mothers at some point slept with their infants, they were also quick to point out to the researcher that they knew they were not “supposed to” sleep with their infants. Wendy said, “You know he's not supposed to sleep in the bed with me, but he does.” The EAADM mothers obtained this information from childbirth classes, reading, or directly from health care providers.

The EAADM mothers acutely felt the reality of how little time in the day was available with their infants or other family members. Candace said the hardest thing about being a mother at this stage was “not being able to spend all day with him, (and when) I come home some nights—he's sleeping so I can't really play with him.” Because Shannon's unit was preparing for deployment, she was working 12-15 hours per day, including weekends, and she rarely saw her infant those first few weeks of work. She said, “Most of the time, by the time I get home—she's asleep or just about to go to sleep. So I don't get to see her because she's sleeping the entire time I'm home.”

Leaving the infant with a child-care person was a more difficult transition than some EAADM mothers imagined it would be. Wendy described her behavior when leaving her infant. She said, “It took me about five more minutes to get out of the door

because I'm always kissing him. I don't want to leave him." Even though five of the infants were cared for by family members, the EAADM mothers found it difficult to walk out their doors to go back to work.

Four of the EAADM mothers' units' were scheduled for deployment when they returned to work. The understanding of all the EAADM mothers was that it was not a matter of *if* they would deploy, rather it was an issue of *when* they would deploy. Gracie expressed this understanding: "And so that's really, really hard because I know that if I stay in the Army, I'm going to end up going to Iraq—eventually. And I'm not so sure I want to do that and leave the baby." Becoming a mother also changed the EAADM mothers' perspective on deployment. Wendy's statement clearly defined the change in life priorities after the birth of her son:

Before I had a baby, I was asking to go (to Iraq). I actually volunteered to go. . . .
But after having him, I'm like I don't want to do this right now. . . . I don't want to be separated from him.

There was a concern by all of the EAADM mothers that their infants might be separated from both parents due to overlapping deployments. The couples and infants would not be together as a family unit for extended periods of time. Deployment had separated Candace from her husband for all but five months of her two-year marriage, and said she was not willing to be separated from both her infant and her husband.

The EAADM mothers experienced increasing difficulty separating from their infants, whether on a daily basis or projecting to a future deployment. The EAADM mothers prioritized their time in order to maximize time for their infants, which included

co-sleeping. Separation as a result of the EAADM mothers' and the infants' fathers' deployments were anticipated in the future, and the EAADM mothers said they were not willing to be separated from their infants and their significant others.

Missing out on the infants' developmental firsts. At the third interview while most of the EAADM mothers continued to revel in their infants' accomplishments and placed less concern on missing the developmental firsts, this was not true for the one EAADM mother who was already scheduled to deploy. Samantha's fear of missing the infants' developmental firsts was heightened. She said, "He's growing before my eyes. It's scary because I'm going to miss a lot of things I see now." Samantha related that getting ready for deployment while taking care of her son was the hardest thing about being a mother. Therefore, she made a conscious effort to maintain emotional and physical contact with her son and maximize the time she had with him. She described her emotional demeanor when she was with her son: "(I want) to enjoy my time to the fullest, so I just put on a happy face—and just hold him and make faces at him."

While Rebecca had not yet made the final decision to deploy, she also was cherishing the time she had with her infant and with the infant's father and thought this was the best thing about being a mother. Rebecca shared:

Cherishing the moments that (I) have with her. . . I'm just, everyday I've had is I'm—I'm happy with her and seeing him with her—I can't ask for anything more. This is what I always wanted, and I have it. So I've been cherishing every second that I have.

Excitement at the infants' developmental firsts continued and might have been related to the infants' increased capabilities to interact with their mothers and their environment. It was also the infants' increased capabilities which brought attention to the possibility of missing out on the infants' developmental firsts. At the third and fourth interviews, the two EAADM mothers who were scheduled to deploy expressed a heightened sense of loss at missing the infants' developmental firsts. Both of these EAADM mothers cherished and spent as much time as possible with their infants. For one EAADM mother who had been deployed before her infant's conception, missing her infant's developmental firsts was not something she would tolerate.

Fearing the infant would not recognize them as mother. The EAADM mothers feared their infants would become more attached to the child-care persons and not recognize them as their mothers. At the third interview, Wendy was amazed at her son's ability to recognize her voice, and, to a degree, some of her fears were diminished as a result of a developmental assessment. Wendy described her infant's responsiveness:

We did it, um, a little baby assessment, and they checked him, and I didn't even realize he could do this. It's like I'm across the room, he hears my voice, and he'll look around for me. I didn't realize he'd do that so early.

While Wendy felt secure of her place in the child's life, Anna's experience was less reassuring for her in this regard. Anna expressed frustration because she had difficulty in soothing the infant and getting him to sleep at night. She related, "I almost felt like I didn't know what worked for him anymore—to put him to sleep." The babysitter had taken over the role of mother in Anna's eyes.

Seven of the EAADM mothers were not as concerned their infants would not recognize them as their mothers as a result of their return to work or potential deployments. It was a concern for three EAADM mothers and an even greater worry for the two EAADM mothers who were scheduled to deploy. Wendy's fears were lessened when a health care provider demonstrated that Wendy's infant recognized her voice. However, Anna was very distressed because her prior bedtime routines no longer worked to settle her son down for the night. The potential deployments increased the EAADM mothers' awareness of their own and the infants' fathers' mortality and will be described next.

Acknowledging One's Own and the Infants' Fathers' Mortality

At the time of the third interview, fear of one's own and the infants' fathers' mortality had continued to escalate. Some EAADM mothers also expressed fears about the safety of their deployed units. The EAADM mothers' strategies for coping with these fears are described below.

Strategies to decrease these fears were: to not think about the possibility of something happening to the infant's father, to communicate with him as much as possible by e-mail and regular mail, and to rely on one's faith or God to protect the deployed loved one and/or unit members. Candace and her husband planned to visit relatives in several states when he returned from Iraq. She said, "But if he makes it, then we're going to (long pause) go to see everybody." Daily communication with the infants' fathers or the unit members was an important way to stave off the fear for their safety. Donna and her spouse e-mailed a couple of times a day. Donna shared her coping strategy:

Every day I think about something happening to him; so I keep telling him how great he is. And hope he'll be right back . . . I'm not so much religious. I just, you know, I believe that God is always there, and you know, and God is always working in everybody's lives whether they choose to acknowledge it or not.

Pamela was reassured of the well-being of her unit members through the unit's blog. She shared her experience:

So I hear about their lives every single day (via a unit blog), and that makes me feel really good because when they're so far away I pray that they're safe, and that's all I can do really. It's reassuring, though, when I hear from them.

For all but one of the EAADM mothers, a strong faith was a significant factor for coping with fears for the safety of the infants' fathers and/or unit members. This EAADM mother lamented she wished she had faith like her own mother that things would all work out because it would have been easier to cope with her own impending deployment.

Demonstrating One's Competence at Work

The EAADM mothers worked hard to dispel the treatment of being handicapped or a less than soldier when they returned to work. Demonstrating one's competence took the form of ignoring negative comments, accepting additional responsibilities at work, and participating in unit PT even though the EAADM mothers all had a *postpartum profile* which stated they were to do PT at their own pace. After an initial adjustment, generally a week of being back to work, the EAADM mothers described being back on schedule. The EAADM mothers' responses to units' attitudes and job changes are presented below.

Dealing with units' attitudes. The units were eager to have the EAADM mothers back on the job, and the EAADM mothers, for the most part, were also glad to be back at work and to be appreciated for their contributions. Ophelia's dedication was initially questioned by the unit, which was only 10% female, on her first day back to work. She described the unit's questions:

Everybody was like, "Are you sure you want to be here, or do you want to stay at home?" I said if I could stay home, I said I wouldn't be at work. I would be home already because I miss him so much. They're like, "Well we're glad you back.

We need this, this, and this and this, and this done."

Ophelia felt pretty secure about her job and her value in her unit because she was called at home during maternity leave for work-related issues. Her positive attitude most likely contributed to her unit's acceptance of her as much as her immediate response to their work requests.

Gracie really enjoyed being back to work and was especially grateful that the unit still treated her in a positive way, as they had while she was pregnant. She said, "Work's been great. We've been, really busy . . . and I'm really glad to be back. It's nice to be back. They haven't treated me any differently or anything like that since I've been back."

Dealing with job changes. Except for one EAADM mother whose work cycle was episodic, the other EAADM mothers' jobs kept them busy; the four EAADM mothers assigned to deploying units experienced 10-15-hour work days. Regardless of assignments, all of the EAADM mothers reported they were exhausted at the end of the day. Candace summed it up when she said, "Right now—it's exhausting."

The EAADM mothers reported it was especially challenging their first week back to work, even when they did not experience a job change. Anna called the experience a “brain dump” and described it as:

I mean, (a departure) of everything that I knew about work in the (location of her job). So, like, all my knowledge of experience just kind of vanished. But it started coming back to me. Slowly but surely it started coming back to me. Come—by Friday I felt like I was back on track a little bit, more so—a lot more so than I was on the first day.

The brain dump was only temporary. Although she was initially frustrated, by the end of the first week, Anna enjoyed being back at work. She said, “I loved it. I’m just a people person. I draw energy off of being around crowds.”

Both Wendy and Pamela returned to new jobs and new responsibilities which increased their work hours. After being at the new job for about two weeks, Pamela’s described her work: “Its’ just more stress. Instead of just—just being responsible for yourself and going in and doing your job, you’re responsible for just so much more.” Wendy also reported more stress because in addition to being reassigned to another unit, she was responsible for additional duties as a result of her impending promotion. She was responsible for leading PT and parade practice in addition to her regular schedule of technical work. Wendy reported getting only about three to four hours sleep in 24 hours and was grateful for an understanding child-care person and supportive friends who would watch her child if the home day care person was not available.

Preparation for and participation in unit PT was important to the EAADM mothers, as was their performances at PT and their appearance as soldiers. Gracie went to the gym and walked on the treadmill and lifted weights to get back in shape. She was pleased that members of her unit recognized her efforts. She said, “I still get people that go, ‘You have your body’ (back).” Anna felt she was back to her pre-pregnant weight and expressed her enthusiasm for unit PT:

I never realized how much I missed running. I mean I was like doing 10 miles, you know, before I got pregnant, and I missed it so much. . . . I never realized how much I missed doing PT until after I had this baby. It feels great to just put on BDUs (field uniform). I’m still the shape that I was before I had the baby.

Samantha was one EAADM mother who did not prepare herself for unit PT. Even though she had a postpartum profile, she felt it was important to demonstrate her physical fitness because she was going to deploy with her unit. She said, “I have a profile that says I can walk at my own pace and run at my own pace. But I still felt like I needed to stay in this run. So I made the whole company run.” Samantha reported extreme exhaustion from the experience as well as a sense of accomplishment at being a part of the unit’s activities.

The EAADM mothers also worked harder and longer hours to help dispel their feelings of being treated as handicapped or lesser. The units were glad to have the EAADM mothers back at work, and for the most part, the EAADM mothers gained a sense of satisfaction from their work. Being able to participate in unit PT was not only a way to demonstrate their capabilities, it also provided a sense of accomplishment and for one EAADM mother, and her unit members noticed her efforts at physical fitness.

Summary of the Return to Work

The third interview was conducted when the EAADM mothers were back to work between one or two weeks, at about eight to ten weeks postpartum. The angst of leaving one's infant was acutely felt by all of the EAADM mothers even though there was a sense of satisfaction and even enjoyment of being back at work among colleagues. Integrating the infant into one's life was more difficult as the EAADM mothers integrated work back into their daily routines. The EAADM mothers experienced a new dimension of time.

The EAADM mothers were grieving the time lost with their infants and prioritized their limited time at home for the infants. Except for one EAADM mother, co-sleeping was the norm. The EAADM mothers continued to revel in relating their infants' developmental capabilities and to be amazed at their infants' accomplishments. Eight EAADM mothers were still breast feeding, even if only at night, and seven of these mothers went to great lengths to supply breast milk for their infants by pumping at work, at home, between work and home, and/or while the infants were breast feeding on their other breast.

Acknowledging one's own mortality and the infants' fathers' mortality continued to escalate over the course of this time period. Units were eager to have the EAADM mothers back at work. The EAADM mothers did not report being treated negatively by their units' once they demonstrated their commitment to being back at work and demonstrated their physical fitness. The two EAADM mothers who returned to new duty

assignments reported that their work hours were much longer. The next section will address the fourth interview which was conducted between 14 and 16 weeks postpartum.

Just Before a Potential Deployment or Assignment Away from the Infant:

Self as Mother Competing with Self as Soldier

The fourth interview was conducted with the EAADM mothers between 14 and 16 weeks postpartum, right before the EAADM mothers could be separated from their infants due to deployments or reassignments. Though every EAADM mother said, “I won’t leave my baby,” two EAADM mothers were deploying with their units (two other EAADM mothers remained with the rear detachment of their deploying units). The increased demands from work and the impending threat of deployments caused the EAADM mothers to question their priorities. There was increased enjoyment of breast feeding for four of the EAADM mothers. The EAADM mothers were regaining their competence at work and managed best if they kept a positive attitude, were assigned to family-oriented units, and the units had a heavy workload. The EAADM mothers continued to feel a deep sense of loss for the time spent away from their infants. The fourth interview was also a time for personal reflection on life as a mother, and the EAADM mothers began to articulate their own definitions of motherhood. Their significant others were essential to life as active-duty mothers. Under the theme of experiencing a new dimension of time, are these sub-themes: developing a support network, developing one’s own identity as a mother, adjusting to a new self, and enjoying breast feeding.

Experiencing a New Dimension of Time

Integrating the infant into one's life became more difficult, and time away from their infants became more distressing. The tempo of the days continued to revolve around the infant and the work schedule. One EAADM mother's description is representative of this experience. Gracie said, "It's all about him. So everything revolves around him. I mean, we still get out, things done . . . But mainly everything revolves around him right now because he's the baby." Wendy's description of her days was typical of the angst of the EAADM mothers. She said, "(Days are) kind of rough right now. Getting enough time to do all the things that I want to do. It's kind of hard." Every day the EAADM mothers were reminded how difficult it was to be the kind of mothers they wanted to be.

The question, "What makes it hard for you to be the kind of mother you want to be?" yielded almost universal comments: "just work," "working," or "the Army." Pamela addressed the uncertainty of the military work schedule. She said, "Just work. It's just like some of the hours and not knowing definitely when I'll be home and I mean definitely when I'll get a break." Shannon further described the difference between employment as an Army soldier and a non-military employed mother. Shannon's comments were typical of the EAADM mothers:

My job—I mean my job makes it a little more difficult. But the fact the Army does not have a set schedule, does not help. You know, that I can go into work and not know what time I'm coming home. Or know that I'm coming home—but then have it changed.

Long work hours, the uncertainty of the work hours, as well as the 24/7 nature of the military duty day caused additional stress for these EAADM mothers.

As a result of returning to work, the shortness of the time the EAADM mothers had to spend with their infants remained a challenge, even when the EAADM mothers had developed a schedule or routine for their morning activities. Wendy summed up the morning routine and lack of time the best:

I have an hour to get ready for work, and it's like, I'm trying to play with him, but at the same time, I have to get his bottles ready, and get my food ready, and get on my uniform, and get his bag ready to go to the babysitter's. So it's like I want to be spending more time with him, but having to do everything else, too.

In addition to the lack of time, the EAADM mothers reported a lack of sleep. Not having enough sleep resulted in difficulty coping with work. Donna described the results of being over-tired. She said, "When I'm really over-tired . . . It was I had to make sure I got some rest because when I don't, I don't cope as well with things."

Developing a support network. The EAADM mothers acknowledged that one of the things that helped them be the kind of mothers they wanted to be was the support of significant persons in their lives. At the time of the fourth interview, four of the EAADM mothers had either their grandmother or their mother living with them. The EAADM mothers remained the infants' primary care providers when they were at home. The EAADM mothers reported the relationships with their mothers and grandmother in a positive light. The EAADM mothers and trusted friends provided physical and emotional support.

Wendy's mother did not live with her, yet they were in contact almost every day. Wendy stated it was her mom and her sister who provided the greatest support. Wendy said, "My mom. Talking on the phone with my mom everyday, and my sister and also my friend" The EAADM mothers who turned to long-time best friends for advice did so because they trusted them. Rebecca's description of her relationship with her friend expressed the other EAADM mothers' sentiments. She said, "The one person that I turned to (growing up), and she's still by my side, is my best friend. . . . Yes, because she knows everything about me. She—she knows everything." Donna also valued the advice from a high-school friend because her friend was also an employed mother who continued to breast feed her infant after returning to work.

Even a husband who was deployed could be supportive. Donna's husband provided a reality check and a relief from the stress of Donna essentially being a single mother. Donna cited her husband as her greatest support. She explained:

He makes me laugh and that's the biggest help he can do from where he is at (Iraq). You know, I mean—just him helping me see perspective and helping me sit back and laugh at situations. That's the best—that's the best help he can give. Developing a network of support for one's self was an essential component of becoming an active-duty mother. The relationship with her own mother was a major factor in the development of her own identity as a mother.

Developing one's own identity as a mother. The most important thing that helped the EAADM mothers become the kind of mothers they wanted to be was the role their own mothers played in their lives. One EAADM mother stated she wanted to be different

from her own mother. Rebecca described what she did with her daughter to give her the kind of experience Rebecca did not have as a child:

Trying to avoid being like my mother. Everything I do, every minute of the day, I try to stay away from how my momma was. I always tell my baby how much I love her . . . I'm always hugging her. . . . She is just—she's everything to me.

The reason Rebecca left her daughter with paternal grandparents before her deployment, rather than her own mother, was because Rebecca wanted to give her daughter what Rebecca felt she missed in her own childhood. Rebecca described the paternal grandparent's behavior: "They're so loving. . . . I wanted my daughter to go to them because I want her—I want her to have nothing but love—nothing but love because it feels so good."

Samantha, the other EAADM mother who left her infant with the infant's grandparents, also described how her parents were shaping her concept of what kind of mother she wanted to be. Samantha said:

I guess it was the way my mom raised us kids. It's like I see how well we turned out, and I want the same for my son, if not better. . . . Um, she found a great person: My dad is wonderful. He raised my brother and my sister, and they're his step kids. And that's their daddy and can't nobody tell them difference, and you know, we all get treated the same. . . . They were always there for us when we needed them, and birthdays, I mean memorable things. . . . It didn't matter the occasion; it would just be there. And—that's something I want to pass down to

my son. . . . We always had that communication, all of us. So that was a good thing.

Samantha and Rebecca were deploying to make a better future for themselves and their infants at the expense of separation from their infants. However, they ensured their infants would get the best care while they were deployed.

As in Samantha and Rebecca's lives, support from other people made it possible for the other EAADM mothers to be the kind of mothers they wanted to be. While the EAADM mothers came up with their own unique definition of a *good mother*, one EAADM mother gave a job description of mother which was congruent with the sentiments of the other mothers. Wendy said:

(Being a mother is) the toughest, but most rewarding job in the world. It's tough because it's a full-time job on top of a full-time job, but no other full-time job that I know of that you feel so good with at the end of the day when you just look down and see him sleeping, looking like a little angel, and you're so happy. You can't believe I'm part of this baby. He came from me.

Whether the EAADM mothers experienced a positive or negative relationship with their own mothers, the definition of a good mother was someone who was verbally, physically, and emotionally present, and demonstrated love by touch, words, and presence.

Adjusting to a new self. During the fourth interview, the EAADM mothers also reflected on their emotional and physical state between pre-pregnancy and postpartum. Ophelia's words best described how the EAADM mothers perceived themselves before

and after pregnancy. She said, “In (one) sense, yes. But in a sense, no.” Donna described how she felt:

It’s not the same. . . . Before it was just me to worry about. I can’t just go hop in the car and go. I’m a mom now. It’s not just me and my husband and the dogs. It’s me and my husband and a baby. I feel like everything’s back to normal. . . . Physically—my body’s getting back to normal.

One EAADM mother explained that while her personality and physical stamina were essentially the same, her priorities in life had changed. Wendy said:

Like I’m still my happy, perky self that I always was when I was pregnant, and then a lot of things I feel like I’ve grown up and learned a lot. . . . My priorities have completely changed. Instead of me, he’s my top priority right now. He’s like the most important thing. . . . I’d rather play with him than do almost anything else.

Differences between the old self and the mother self were described with regard to one’s physical and emotional states and priorities in life. Pamela described the conundrum of EAADM motherhood experience when she said:

Everything. I mean everything—everything that I don’t know. My body’s different. It’ll never be the same, you know. . . . Just think about it, and my priorities and things that I get excited about and things that I used to think about really, you know, interesting, you know. I’ve changed on.

Gracie, one EAADM mother who felt she had become much more mature, asked herself one critical question before making any decisions: “How is this going to impact me and

the baby's life?" Anna's description of how life changed after the baby was the most poignant of all. She said, "I feel more complete than I ever have in my entire life. Um—I do. I feel so complete. I always felt like something was missing in my life before he came." Becoming a mother changed the EAADM mothers' emotional and physical being and rearranged the priorities of their lives. Becoming a mother gave her a sense of completeness and was the toughest and most rewarding job of all. One very rewarding part of being a new mother was breast feeding.

Enjoying breast feeding. At the fourth interview, six EAADM mothers were still breast feeding. One EAADM mother continued to pump three times a day to feed her infant breast milk, although he no longer was latching on, because she was determined to feed her infant breast milk until he was six months old. Ophelia said, "(He) stopped breast feeding, but he still gets breast milk. I pump in the morning before I go to PT, when I come back for lunch, then after work." One EAADM mother described how work stress had decreased her milk production and resulted in the infant being supplemented with formula. Shannon said:

Probably mostly the stress, you know, my body's shutting things down. So, she's had to go to formula. I still breast feed several times a day. Like when she's hungry, I'll breast feed her first, and when she's not getting anything else, then I'll give her a bottle to make sure she got enough to eat.

At the fourth visit, there was intense enjoyment for the four EAADM mothers who were still breast feeding their infants. They were all still pumping, two infants were exclusively breast fed, and the other two infants received occasionally supplemental formula. One

EAADM mother's unit's support for breast feeding diminished when it was known she made the decision to leave active duty at the end of her current enlistment.

Because she was having difficulty getting the time to pump, she purchased a battery operated pump which she would apply under her uniform and return to work during the pumping time. Anna described the steps she went through to continue pumping her breasts while at work:

It's a hands-free battery operated (pump). You stick it in your bra and you go on about your business. And then when you fill up (the plastic bags), you go back to the bathroom, unplug it, wrap it up, and stick it in the freezer. . . . I just, every three hours—I'll say, "I've got to go to the bathroom," and when they see me walk away with my little black bag they know what I'm planning to do. So I'll go in the bathroom, I'll put it together, stick it in my bra, and go back out to work, leave it on for about 30-45 minutes—I know that's a long time, but it's such a small pump it takes a little bit longer, but it's just as effective, and so I can make—actually I make more milk.

Interaction with the infant during breast feeding increased over time and brought joy to the EAADM mothers. Donna was able to use her lunchtime to go to the day care center and breast feed her infant. Because she was able to go and breast feed the infant at lunch time, the infant would not eat supplemental breast milk from the bottle. Donna described the joy she felt at spending her lunchtime breast feeding her daughter:

Going to see her every day at lunch you know, she is now on strike at the daycare—she won't eat until I get there. I mean, it's so nice because—she likes it

you know, and I—I never expected to enjoy it so much. . . . She'll look at me, and just like, I go feed her during lunch, and she's so happy that I got there. I nurse, and she'll look up at me and grin.

Anna also liked the connection she felt with her infant. She said, "I like the connection. I like his little hands grabbing at my breasts and looking up at me, you know, when he's doing his thing, and I—I like that." Wendy treasured the time she had with her infant and said, "Because it's like, when I'm nursing him, that's just me and him time. He looks up at me and like—he'll even start smiling—and like my heart just melts."

The joy of breast feeding along with the connection these EAADM mothers experienced with their infants motivated them to find solutions to challenges of pumping at work.

Except for one EAADM mother, all the mothers admitted to co-sleeping with their infants for two major reasons: to get some sleep and to get time with their infants. One EAADM mother reported that her son had been sleeping in bed with her; however, she wanted to spend more time with her husband because he was to deploy soon. Therefore, her son was just being put back into his own crib. Anna stated that, "Last night was the first night in a long time the baby actually slept in his own crib because he had been sleeping with me." Pamela brought her infant into the bed because she was tired. She said, "Yes that's what I'll do—drag her into bed with me, and I'll just lie there (and feed her)." Their perception that co-sleeping was not entirely acceptable persisted. Wendy's comment is typical of other EAADM mothers. She said, "Even though I

shouldn't, he stays in the bed with me because it's a lot easier when I'm trying to get some sleep at night.”

Samantha and Rebecca, the two EAADM mothers scheduled for deployment were no longer breast feeding their infants, but the infants were brought to the bed to maximize the time with their infants. While Samantha was at her parents' home, just before leaving her son because of deployment, Samantha's mother would bring her son to her. Samantha said:

He has his crib that he slept in. He would only come and sleep with me in the bed like, um, when my mother went to work. He would come to the bed with me, and just go to sleep all over again.

Rebecca also wanted her daughter to be near her and described how she would wake the infant up and bring her to bed with her. She said:

She slept with me (all the time) . . . I guess she got used to sleeping in the bassinet (when the infant's father was visiting from Iraq) so I just left her there. But sometimes I'll wake her up and put her on the bed with me just because I don't—you know—I like to feel her near to me.

It was interesting that Samantha also reflected the perception that co-sleeping was not to be done. Both Samantha and Rebecca maximized the time with their infants before deployment by bringing their infants into bed with them.

The joy of breast feeding and the connection these EAADM mothers experienced with their infants motivated them to find solutions to challenges of pumping at work. Co-

sleeping continued to be a way the EAADM mothers could get more sleep and increase their physical proximity to their infants.

Grieving time Lost with One's Infant

The number of times and the intensity with which the EAADM mothers issued the statement, "I don't want to leave the baby," only increased over time. They expressed fear of missing out on the infants' developmental firsts and the infants not recognizing them as their mothers. By the fourth interview, when the baby was about 14-16 weeks old, seven EAADM mothers made the decision to leave the Army, two EAADM mothers had chosen to deploy, and one EAADM mother had not made a final decision about her military career. Of the seven who chose to leave, six chose to leave the Army at the end of their enlistments rather than immediately on a *Chapter 8*, and one EAADM Mother had chosen a Chapter 8 exit from the Army. A Chapter 8 is an administrative discharge when the soldier is not able to arrange a care provider for one's child. The EAADM mothers' enlistment times had also been extended by the *stop-loss program*. Stop loss was an involuntary extension of an enlistment due to military necessity.

When asked what she thought about the most, Anna vehemently stated, "Him (the infant). Him. Him and the Army. Him and me getting out of the Army." The question of whether or not to leave active duty occupied Anna's thoughts most of the time at the fourth interview. Another EAADM mother replied it was a struggle between thoughts about the infant and thoughts about work. Shannon described her situation:

It has to be an even split. When I'm at home I think about her all the time. (And when) I'm at work, that's all I think about: is that I'm not happy and I don't want to be there, and I want to go home. And what can I do to fix things?

Wendy especially enjoyed her military career and had planned to re-enlist; however, re-enlistment would lead to a tour of duty where dependents were not allowed, and she could not imagine leaving her son. She said:

So I basically have to make a choice in (month) as to whether I'm going to get out next year (or) whether I'm going to stay. Don't like being forced to make a decision, but I can't imagine leaving him.

Donna outlined the priorities in her life when she said, "She is my number one priority—when it comes to anything. Work, the Army does not override her. Nothing does."

While neither Samantha nor Rebecca wanted to leave their infants, both saw deployment as being best for their families and as a way to secure their futures with their infants. Rebecca expressed the significance of this decision when she related her childhood experience and her desire to provide a better life for her child:

(Deployment) is really hard, but at the same time, I love the military. And I've struggled before. . . . And I know what it's like to eat crackers and mayonnaise. And it's sad because I have to leave my daughter, but at the same time I'm doing this for the good.

Samantha also found the decision to deploy very difficult and felt she needed to sacrifice in order to provide a better life for her child. She replied, "Sometimes you have to make sacrifices in life in order to accomplish things."

Neither EAADM mother was quite prepared for the intensity of feelings after leaving their infants. Rebecca was upset at how easily the infant adjusted to her paternal grandmother. She said, “Oh, it killed me—to see her, you know, happy with somebody else.” Samantha was not prepared for the visceral reaction to the loneliness and sadness after leaving her infant. She said:

It was actually harder than what I thought it would be because I was like, oh, okay, you know, I’m just doing to drop him off, and I’m going to be okay, and then . . . I just started crying. I was just in tears. And then I got back here, and it was so lonely because it’s always been me and him. You know, even when he was in my belly it was still me (and infant) everywhere, I looked at his room, and I was just crying. I was so sad.

After the end of the fourth interview, Samantha asked the researcher to stay a little bit longer. Samantha reminisced about the experience of motherhood as she showed the researcher pictures of the infant’s empty room and the computer, web camera, and digital camera she purchased to stay connected to her infant during deployment. One family member gave her a special bag and vacuum cleaner to keep the sand out of her laptop computer. She also showed pictures the new long-term caregivers (her out-of-town parents) had taken of her son. Samantha’s response to these photographs was, “Oh, my baby, he’s getting so big. And it was just (two days ago) that I left him!” In the short time of two days, Samantha already noted the changes in her infant.

All but one of the EAADM mothers continued to bring their infants to bed with them in order to experience the closeness to their infants and to increase the amount of

time they had with their infants. Two EAADM mothers, Samantha and Rebecca, were scheduled to deploy and had already left their infants with their long-term care providers before the fourth interview. Though the mother-infant separations had been short, Samantha and Rebecca already worried they had missed out on some of the infants' development.

Missing out on the infants' developmental firsts. At the fourth interview, all the EAADM mothers, even the ones planning to leave active duty, reported a heightened sense of missing out on the infant's developmental firsts. It may have been due to the infants' increasing developmental capabilities and the realization that the EAADM mothers were nearing the time when they could be separated from their infants as a result of deployment, reassignment, training, or existing workload. Gracie's description summed up most of the EAADM mothers' sentiment at the fourth interview. She related how exciting it was to be the one to see her infant roll over for the first time and lamented she might not always be the first one to see her son's accomplishments:

He rolled over the first time, what two, three weeks ago? I said, "Mom, mom, mom, you won't believe what happened." That was really exciting. . . . I got lucky to be the first one to see him roll over, but that's not always going to be. I might not be there for the first time he says something, or I might not be there for the first step that he takes because I'll be at work, and he'll be at day care or with my mom or something.

Describing how it might feel to be deployed and not see her infant's developmental firsts, Candace said:

I won't do it. I won't leave the baby behind. It's too hard. And then—I do sitting over in Iraq crying because of the baby being over here and him learning to crawl and his first words and he starts walking and I wouldn't be here to see any of it. I would get really depressed over that. I wouldn't be able to do that.

Candace's very adamant reaction may have occurred because she was deployed to Iraq prior to the conception of her infant, and her husband deployed when she was five months pregnant.

Intensity of feelings about missing out on the infants' developmental firsts was related to the increased capabilities of the infants to interact with their mothers and the environment. One EAADM mother summed up the experience with the infant at this time. Donna said, "I love being a mom. I love her to death. It's so much fun—something new every day." It was the infants' increased capabilities which brought attention to the possibility of missing out on the infants' firsts.

Fearing infants would not recognize them as their mothers. Fear the infant would not recognize her as mother was a significant concern expressed by one EAADM mother (Anna) at the third visit and was an escalating concern by the fourth visit. For the two EAADM mothers scheduled to deploy, there was also heightened concern the infants would not recognize them as their mothers at the end of their deployments.

One EAADM mother was concerned at the third interview because the babysitter was taking her place in the infant's life. She had greater concern by the fourth interview because she felt the infant was taking longer to recognize her as his mother. Anna related

her infant's behavior when she picked him up at the end of the day at the home of the child care person:

I try not to let it get to me because when I go over there and the baby starts smiling . . . he'll smile for her. I'm dying. But when I smile at him, it kind of takes him a minute (to know that I'm his mom). And so when I have him on weekends, he'll go "Okay, wait a minute. This is my mommy." So he'll be more responsive now to my smiles on the weekend, and then as soon as you know it, Monday's right on back so I have to be separated again from him. So it's not as easy as I thought it would be at all, whatsoever.

Anna saw these experiences with her son as a sign and validation that the decision to leave active duty at the end of her enlistment was the right one for her son and her family. Missing out on the infants' developmental firsts and acknowledging their mortality was a greater concern for the two EAADM mothers scheduled to deploy.

Acknowledging One's Own or the Infants' Fathers' Mortality

For the two EAADM mothers who were scheduled to deploy after the fourth visit, there was further acknowledgment of the possibility of their own mortality. Samantha expressed this dilemma rather poignantly:

It's hard because you don't—you don't know actually know, you know if you're coming back because, yeah, I could be inside an office, but, God forbid, a missile comes through and hits my office. Well, then I'm not done no more—so it's still—like, oh my gosh, I'm not safe no matter what. . . . I just hope to be here next . . . sometime next year this time.

If something happened to her, another EAADM mother hoped her daughter would understand her decision for going to Iraq. Rebecca said, “I’m not doing this for the bad, you know. And if, God forbid, something happened to me, I would want her to understand that I, you know, I was doing this for her.”

While Samantha and Rebecca were the only two EAADM mothers scheduled to deploy, acknowledging one’s own mortality was a part of life for all the mothers. Even EAADM mothers who no longer had a personal relationship with the infants’ fathers had a heightened sense of fear of the infants’ fathers’ mortality. Donna’s fear for her own mortality and that of the infant’s father is representative of these continuing fears. At the second interview, Donna said, “My biggest fear is that something is going to happen to my husband before he comes home.” At the third interview, she showed continued concern for her safety and for the infant’s father’s safety by saying, “What if something happens to us? (Long pause) What happens to her? I think about that a lot. I try not to worry about it. . . . Everyday I think about something happening to him.” At the fourth interview, Donna said, “I think its scary . . . you know, I’m terrified that something’s going to happen to him before he gets home. I pray to God not; I want him home safely. That’s my biggest concern right now.”

Reestablishing Competence at Work

The EAADM mothers had reestablished their competence at work in spite of having to deal with units’ attitudes, long work hours, and/or job changes. The existence or lack of a family-oriented unit and an EAADM mother’s attitudes about work were two factors which shaped the EAADM mother’s experiences at work.

Dealing with units' attitudes. One EAADM mother, Anna, perceived the unit's attitudes changed when it became known she was leaving active duty at the end of her enlistment. Her experience was described under the theme of breast feeding. Two EAADM mothers were scheduled to deploy with their units. Two other EAADM mothers' units were also deploying, but both EAADM mothers were assigned to the rear detachments of their units. Family-oriented units enhanced the EAADM mothers' work experiences as EAADM mothers perceived the units also cared about them.

Prior to deployment, Samantha reported that her unit also cared about her as a soldier by asking about her health and well-being. She said:

They saw me a couple of days before I went on leave, and they were like, "You are starting to look pale—what's wrong with you?" "Is something wrong?" "Do you need to talk?" I'm like, "No, I'm just extremely tired." Because we had been working like, oh my gosh. It was really crazy how much we were working. Samantha perceived that her unit did not give preferential or discriminatory treatment to female soldiers. She believed the unit members treated one another as they wished to be treated. She explained, "I think everybody knows that if it was them, they would get the same treatment."

Dealing with job changes. Long work hours were still an issue and cause of distress at the time of the fourth interview for the EAADM mothers. The uncertainties of the work hours affected the length of separation from their infants and affected the supply of breast milk. Pamela said it was stressful "not knowing definitely when I'll be home . . . (or when I'll) definitely be getting a break (to pump)." The EAADM mothers said

additional job duties made their lives more stressful than the lives of working mothers with regularly scheduled work hours. For instance, active duty soldiers are considered to be on duty 24 hours a day. Wendy described the consequences of this obligation: “You’re a soldier 24/7. So whenever anything happens, you have to be ready. . . . Okay, you’re going to deploy in about 48 hours. You need to find somebody to take care of (the infant).” Potentially and actually uncertain work hours accounted for child care difficulties, diminished the time with their infants and significant others, and were factors influencing EAADM mothers to leave active duty.

Summary of Conditions Just before Potential Separation from One’s Infant

The EAADM mothers described the major changes in their lives as a result of becoming a mother. The EAADM mothers also described being a different self before and after pregnancy. The EAADM mothers were comfortable with their decision-making as mothers, and several EAADM mothers also defined what it meant to be a good mother. Motherhood was an awesome life-changing event. What once fit—a career as a soldier—no longer fit. Eight of the EAADM mothers chose not to risk their own mortality and planned to leave active duty, while the two mothers who did deploy were hoping for a better future. At the fourth interview, Anna summed up the change in her life as when she became a mother: “Everything changed. Everything I thought I could do, I can’t do anymore. I can’t be away from him.”

Chapter 4: Summary

The experience of becoming a first-time enlisted Army active duty military (EAADM) mother was a life altering event that transformed the woman from having a

sense of self as soldier to self as mother and soldier. There was a constant tension between the overwhelming nature of motherhood and the nature of being a soldier 24/7. In the month before delivery the EAADM mothers were preparing for their new role as mother. They described their acceptance of the pregnancy and bonding with their infant, which was signaled by seeing the infant on sonogram, hearing the infant's heart beat, and by feeling the infant's movements. They prepared themselves for motherhood by reading, attending classes, and developing a support network to be with them during labor, delivery, and the early postpartum period. They made physical space by moving to larger apartments, purchasing a car seat, swing, changing table and other baby furniture, toys, clothes, and supplies to care for the infant. There was a sense of loss for the future with the infant because of the mother's military assignments. There was acknowledgement of the mother's own and the infant's father's mortality and the fear increased in intensity throughout the experience of the first four months postpartum.

During maternity leave, the EAADM mothers were gaining a new sense of self as mother. As the EAADM mothers watched in wonder and awe at the transformation of their infants, they too were transformed. Integrating the infant into their lives at this time meant integrating the birth and breast feeding experience, knowing how to meet the infant's needs, and feeling comfortable with their decisions as mother. Fostering a relationship between the fathers and their infants was a high priority in light of the military environment and continued throughout the study period. The EAADM mothers prioritized time with their infants by keeping the infant in close physical proximity and

within sight. Preparation for the return to duty included preparing one's self physically, emotionally, and obtaining trusting childcare persons.

Integrating the self as mother into the self a soldier was the nature of the experience on the return to work. The return to work also heralded a new dimension in time and a grieving the loss of one's ideal image of mother—being there for ones' child. The duty assignments governed the daily schedule and the infants' needs governed the off-duty time. There was a sense of accomplishment at demonstrating the new mother's competence at work in duty assignments and in the realm of physical fitness. The EAADM mothers also enjoyed being at work among colleagues; however, it did not diminish the daily angst of leaving the infants to go to work. The EAADM mothers prioritized off-duty time for the infant often to the exclusion of others.

Anticipating a possible separation from their infants either through deployments or reassignments resulted in the EAADM mothers changing the priorities in their lives, while hoping for a better future. For the two EAADM mothers who chose to deploy, honoring their commitments meant deploying because it was a soldier's responsibility and a way to secure theirs and the infants' futures. Honoring one's' commitments meant that seven EAADM mothers chose to leave active duty at the end of their current enlistments. For the one EAADM mother who left the military before the end of her enlistment, honoring her commitment meant training others to take her position in the unit.

The EAADM mothers' journey into motherhood was a journey of conflicting public and private responses to the pregnancy and they were unable to find an acceptable

balance to their lives as mothers and as soldiers. The EAADM mothers expressed the desire to fulfill their enlistment contracts even though they had been extended by the stop loss program, yet they were now facing an even greater demanding responsibility of being a mother. In the end, the requirement of separation from their infants and perhaps the loss of their own lives were too overwhelming a sacrifice and they chose to leave active duty.

Essence of the Experience of Becoming a

First-time, Enlisted, Army Active-duty Military Mother

Becoming an EAADM mother was experienced as an ever-present tension between competing commitments: the mother's intense love for her infant and honoring her commitment to the military. Throughout the pregnancy and postpartum periods in each EAADM mother's personal and public life, a daily struggle occurred between her identity as mother and her identity as soldier. The acceptance of the pregnancy and bonding with the unborn infant was countered with anticipatory grief for the irreplaceable lost time with her developing child. The intense joy, awe, and delight the infants brought to their mothers' lives in the present were simultaneously overshadowed by these mothers' thoughts of their own and the infant's father's mortality.

Chapter 5

Summary, Conclusions, and Recommendations

This chapter presents a summary of the study, the discussion of the findings, and recommendations for future research. The summary provides an overview of the purpose, research question, methodology, data analysis procedures, and the findings of the study. A discussion of the conclusions of the findings will be followed by recommendations for future research.

Summary

The purposes of this hermeneutic phenomenological study were to gain and understanding of the meaning of the lived experience of becoming a first-time, enlisted, Army, active-duty military (EAADM) mother and to gain an understanding of the EAADM mother's transition to the maternal role. Ten EAADM mother completed all four interviews scheduled to coincide with four transition points: just before delivery, home on maternity leave, soon after the return to work, and just before the EAADM mothers faced a potential separation from their infants due to deployment or military reassignment at four months postpartum. The first interview was conducted at the Women's Health Center (WHC) at a military hospital in the southern United States. The postpartum interviews were scheduled at the EAADM mothers' convenience either in their home or the WHC. In addition, there were five telephone interviews for which a face-to-face interview was not possible at the designated study time period. The interviews lasted between 20 and 60 minutes and were audio taped. The audio tapes were transcribed by the researcher or professional transcription service.

The 40 narratives were analyzed using the qualitative data analysis procedures recommended by Cohen, et al., (2000) and van Manen (1990). There was an overarching theme for *each* time period: just before delivery—preparing for self as mother; home on maternity leave—gaining a new sense of self as mother; return to work—integrating self as mother into self as soldier; and just before potential separation—self as mother competing with self as soldier. There were four major themes that the women voiced at each of the time interview periods: integrating the infant into their lives, experiencing a sense of loss for the future with their infants, acknowledging their own and the infants’ fathers’ mortality, and demonstrating one’s competence as a soldier. Sub-themes within the four major themes occurred at each interview. For example, while home on maternity leave, the sub-themes under experiencing a sense of loss for the future with their infants were: grieving lost time with their infants, prioritizing their time with their infants, missing out on the infants’ developmental firsts, fearing the infants would not recognize them as their mother.

Discussion

This was one of the first known studies that examined the experience of becoming a first-time, enlisted, Army, active-duty military (EAADM) mother during the transition to motherhood from the month before delivery through four months postpartum. Becoming an EAADM mother caused significant tension in the lives of the EAADM mothers as each sought to develop an identity as a mother and a personal identity as a soldier while integrating the infants’ into their lives. Findings from this study indicated that the EAADM mothers faced extraordinary demands on their lives during the

pregnancy and postpartum. The EAADM mothers experienced some of the same challenges of motherhood as non-military mothers (Lynn, 2005; Martel, 2001; Nelson, 2003) however, the depth and breathe of their fears were magnified by the military culture and context. The EAADM mothers' experiences were of greater intensity and their efforts to maintain a presence in their infants' lives in spite of separations were exceptional. Differences and similarities of the EAADM mothers' journey to motherhood will be compared to non-military mothers and will be organized by the interview time periods.

Just before delivery: preparing self as mother. The military context was one in which each positive experience of motherhood was juxtaposed with an ever present fear for the future. For example, the EAADM mothers' pregnancies were public knowledge as soon as they received their pregnancy profile around six to eight weeks gestation. While the profile was to protect the mother and the fetus (AR 40-501, 2002), the EAADM mothers' usefulness as a soldier and motives for the pregnancy were questioned. As EAADM mothers developed a strong connection to the infant, and prepared for its birth, they were simultaneously anticipating the loss of time with their infants either in the immediate sense of the return to duty at six weeks postpartum, but more vividly there was a fear of their own and their infants' fathers' mortality because of deployment.

The intense connection they felt with their infants was simultaneously overshadowed with the fears they might not be there to see their infants grow up. The argument could be made that other employed mothers such as fire fighters also face issues of their mortality on the job (Berkman, Floren, & Willing, 1999). The difference

between these women and the EAADM mothers is that even though fire fighters may have 24 hours shifts, they are generally not geographically separated for prolonged periods of time, nor is there a daily threat of death from their jobs when *off* duty. After their shift, fire fighters are able to return to the safety of their homes and be with their families, while deployed EAADM mothers will not be home for about one year of their infants' lives.

Home on maternity leave: gaining a new sense of self as mother. At the second interview, which was conducted between four and six weeks postpartum, the sub-themes were relating the birth experience, mastering the art of breast feeding, knowing how to meet the infants' needs, relating the infants' developmental firsts, and preparing and regaining their competence as soldiers. The EAADM mothers described a very positive self assessment of their birth experiences. Once the birth stories were related, the EAADM mothers it was not discussed further at this interview or the subsequent two interviews.

In their description of the birth experience, the EAADM mothers were amazed the infant they saw at delivery had been a part of them and was now a separate being, yet not separate. Their intense bond to their infant pre-delivery was replaced with an intense connection to their infants to the point of keeping the infant in close physical proximity and within sight. The EAADM mothers began thinking differently from the perspective of rearranging their priorities in lives; mainly they couldn't imagine ever leaving their infants. The experiences of the EAADM mothers during the first four to six weeks postpartum are similar to Martel's (2001) category of the early postpartum period of

“appreciating the body” which included the components of “restoring the body, connecting to the newborn, and thinking differently” (pp. 499-500)

Two patterns emerged as the EAADM mothers integrated the infants into their lives: some of the mothers seemed to integrate the infants into their own lives, while other mothers integrated their lives around the infants’ needs. This description corresponds to what Martel (2001) respectively called *integrating* and *accommodating*. The EAADM mothers also reported feeling comfortable in their decisions as mothers in this early postpartum period stating they did “just know” what their infants needed and were able to distinguish the infants’ cries. They attributed the ability to meet their infants’ needs as “motherly instinct.” The EAADM mothers did not allow their infants to cry for crying was the infants’ way of communicating.

When the infants’ fathers’ were home on leave from Iraq, the EAADM mothers’ did not interfere with the fathers’ time with the infants. One difficulty for all of the EAADM mothers, except one EAADM, was the presence of others in the home during the early postpartum period. While there was acknowledgement of the need and desire for help from family members by all the EAADM mothers, they also wished for the time alone as a family. This desire to be alone as a family was acutely felt by the EAADM mothers whose infants’ fathers were home for two weeks from Iraq to meet their infants. Because of fears for the mortality of the infants’ fathers other family members also visited during maternity leave.

The EAADM mothers were also very physically active exercising within two weeks of delivery, preparing for their return to work. These exercise guidelines are within

the recommendations of the American College of Obstetricians and Gynecologists (1994). Also, exercising did not seem to affect the supply of breast milk and these findings are supported by two other studies of non-military women (Dewey, 1998; McCrory, Nommsen-Rivers, Mole, Lonnerdal, and Dewey, 1999). This early dedication to consistent physical fitness and weight loss was not addressed in studies of non-military mothers (Horowitz & Damato, 1999; Lynn, 2005).

The EAADM mothers did not have to make the decision about *when* to return to work, regulatory guidelines (AR 40-501, 2002) prescribe a 42 day postpartum leave. As so eloquently put by Shannon, “Six weeks sounds like a long time before you start doing it, and then it’s just all over in no time.” Because of the short time with their infants, the EAADM mothers responded by keeping the infant in close physical proximity and within their line of sight during the day. Except for one mother all were co-sleeping whether or not they were breast feeding. While non-military mothers may also be co-sleeping with their infants, it was not a subject mentioned in other studies (Lynn, 2005; Martel, 2001).

The cultural definition of motherhood generally is experienced as a set of unwritten expectations and for the EAADM mothers to deploy and leave their infants for a year, resulted in these women suffering a cultural contradiction of being with one’s child. The EAADM mothers displayed an extra ordinary commitment to becoming a mother and their experiences were intensified over non-military mothers (Nelson, 2003). While attachment is developed “during the first nine months of life,” and “is readily activated until the end of the third year (Bowlby, 1977, pp. 139-131), there is no prescriptive age at which a mother can return to work. The EAADM mothers were

required to return to work within 42 days of the infants' births, and as in other studies the EAADM mothers early return to work did not negate her commitment to the parental role (Bernal & Meleis, 1995; Hall, Stevens, & Miller, 1993; Meleis, Kulig, Arruda, & Beckman, 1990). The EAADM mothers' priorities were to spend time with their infants often to the exclusion of meeting their own needs and while changed priorities are a consistent behavior of first-time non-military mothers (Martel, 2001; Mercer, 2004) the EAADM mothers also limited their contacts during maternity leave. These changed priorities as well as the intense pre-planning of their lives by the EAADM mothers were consistent with qualitative findings in a study of how active-duty military women with children met their health promotion goals (Agazio, Ephriam, Flaherty, & Gurnery, 1999). "Being organized and setting priorities appeared to be the key points for meeting responsibilities at home and at work." (p. 77)

Return to work: integrating self as mother into self as soldier. At the third interview the EAADM mothers had been back to work two to four weeks. The activities described by Martel (2001) and proposed by Mercer (2004) for the time between two weeks and four months *heading toward the new normal*. For the EAADM mothers their lives were anything but *normal*. The EAADM mothers described this time period as one of "constantly being on the move" the entire day and further they used terms like "running," "ripping" and "hectic" to describe their day. The EAADM mothers' military backgrounds and demonstrated competence at work for organization and self-sufficiency resulted in the establishment of routines before the return to work that eased the logistical aspects of the return to work. One EAADM mother described herself as very organized,

did a lot of pre-planning for the return to work and at the third interview described being back to work as “not much change” and life had “just kind of gotten back to normal”.

Anna talked of grieving having to go back to work “It’s still there you now, in my head and it aches,” as well as having gotten “back on track and in my schedule.” While the EAADM mothers enjoyed a routine and interaction with colleagues at work there was also a deep sense of loss at this time with their infants. The EAADM mothers were again experiencing the positive aspects of motherhood, while dealing with the negative aspects of a prescribed time for the return to duty. The sub-themes for this time period were: experiencing a new dimension of time, maintaining a supply of breast milk, coping on the return to work, grieving lost time with one’s infant, prioritizing one’s time, missing out on the infant’s developmental firsts, and fearing the infant would not recognize them as mother.

The EAADM mothers went through extraordinary measures to continue pumping their breasts to maintain the physical connection to their infants. For example, EAADM mothers reported pumping while sitting in the front seat of a truck, wearing their breast pumps while driving to and from work, wearing a battery operated pump while on duty, and standing in the middle of the bathroom pumping because there was not a private place to pump. Pumping represented a physical link to their infants during periods of separation.

The EAADM mothers were also very organized, comfortable with their decisions as mothers, yet they were also very tired—an almost universal complaint of women during pregnancy and postpartum (Becker, Chang, Kameshima, & Bloch, 1991; Bondas

& Eriksson, 2001; Lee & Zaffke, 1999; Lee, Zaffke, & Mcenany, 2000; Martell, 2001; Mindel & Jacobson, 2000; Parks, Lenz, Mulligan, & Han, 1999). The EAADM had taken on their maternal identity while simultaneously developing a daily consciousness of their conflicts between their identity as mothers and as soldiers.

Just before potential separation: self as mother competing with self as soldier.

The EAADM mothers achieved their maternal identity, most by the second interview by the second interview. Between 14-16 weeks postpartum, the time of the fourth interview, the EAADM mothers struggled with the daily awareness of competing commitments between their identity as mother and their identity as soldier. They had developed a network of support, adjusted to their new sense of self, enjoyed breast feeding, while at the same time grieving the time lost with their infants and fear for themselves and their infants' fathers' place in the infants' futures. The EAADM mothers were very adept at developing their own networks of support, which generally consisted of one close long time friend with whom they felt they could just be themselves, their own mothers or mother figures, and other active-duty colleagues or family member mothers rather than health care professionals.

Eight of the EAADM mothers made the decision to leave active duty because they did not want to have to leave their children, while two EAADM mothers did deploy. The historical context for this study was that the war in Iraq began on March 17, 2003 and data collection began in October 2003 and continued until January 2005. Donna expressed the concern of deployment facing all the EAADM mothers:

I mean the biggest thing is just deploying. I mean, that's the biggest factor for anybody in becoming a mom right now. It's the fact that in sometime in the next two—two to five years you will be out to deploy away from your children. And that's the biggest thing that anybody has to consider. And that's something that—weights on us.

The EAADM mothers knew that it was not a matter of if they were going to deploy, but rather when.

Theoretical Considerations

Mercer (2004) proposed that the *maternal role attainment (MRA)* be replaced with the term *BAM (becoming a mother)* because “BAM more accurately encompasses the dynamic transformation and evolution of a woman's persona than does MRA” (p. 226). This researcher agrees that BAM is much more reflective of the experience of the journey into motherhood. Use of the term MRA always seemed to indicate to this researcher that women who became mothers would somehow *arrive* at an endpoint: maternal competence. Giving birth to an infant and choosing to be that infant's parent is a lifelong commitment, and there are many more transitions the mother has yet to experience in her life with the child. The social environment of the military did alter the process of becoming a mother; however, many of the descriptive terms of BAM proposed by Mercer (2004) were supported by the EAADM mothers' experiences.

The transition theory (Chick & Meleis, 1986; Meleis & Trangenstein, 1994; and Schumacher & Meleis, 1994) and maternal role integration theory (Hall et al., 1992, Stevens, Hall & Meleis, 1992) were proposed as a framework for understanding the

EAADM mothers' transition to the maternal role prior to data collection. While these theories provided an awareness of essential components of the process of the developmental transition of motherhood, the hermeneutic phenomenological approach (Cohen, et al, 2000; van Manen 1990) was the ultimate guide for making meaning of the EAADM mothers' motherhood journey.

Implications for Enhancing the Lived Experience of Becoming an Active-duty Mother

In the publication *A leaders' guide to female soldier readiness* (USACHPPM TC 281 A, March 2004), pregnancy is described as "a major life-cycle event for soldiers and a major concern for commanders. Pregnancy is not a disease or affliction" (p. 8). Further, the publication advises commanders to maximize the use of the female soldier:

It may require some creative thinking or temporary internal reassignments within a unit. While this may be mildly disruptive, it also can present the opportunity for cross training. A female soldier can continue to work in a worthwhile position and be a value-added resource for your unit throughout her pregnancy. (p. 8)

The EAADM mothers reported they also wanted to be gainfully employed, and there were instances where the EAADM mothers' pregnancy also benefited the unit, provided service to other soldiers as in Gracie's case. Gracie managed the office and the office remained open while other unit members performed motor pool duties. Candace benefited from being reassigned during her pregnancy in that she learned a new skill and was considering re-enlisting to another career field. In Candace's case she filled an empty slot in her new unit.

One area of difficulty that bears further study is the EAADM mothers' ability to pump her breasts once she returned to work. The EAADM mothers did not have the time to pump either because of the workload, negative unit attitudes or there was simply no place of privacy in which to be able to pump. These findings are consistent with findings that were identified by Bell & Ritchie (2003a) and are not in keeping with the recommendations made by Bell and Ritchie (2003b) to delegate resources and change policies to support breast feeding. Further, the publication for unit commanders (TG 281 A, 2004) incorporated the recommendations made by Bell and Ritchie (2003b) which were to provide "social and administrative support" and that "time and space (were) needed to successfully continue breast feeding after returning to work" (p. 18). The guidelines recommended that the EAADM mothers would need "two to three 20-minute breaks to pump or breast feed during an 8 hour shift." (p. 18). Unfortunately, during the current military environment, the units may not have the funds to designate a place of privacy or often the time to allow women the opportunities to pump or breast feed their infants. In this study only two EAADM mothers left their work sites at lunchtime for breast feeding purposes. As described by Bell and Ritchie (2003a) the EAADM mothers who were able to leave their worksite were of higher rank and therefore had more flexibility and authority to leave the work site.

Findings indicate the EAADM mothers took advantage of the prenatal, breast feeding, and labor and delivery classes offered by the staff of the WHC. Some of the EAADM mothers also attended the classes offered by the local Women's Infants and Children's (WIC) program. The EAADM mothers valued the usefulness of the practical

information about what to expect during labor and delivery, breast feeding, and the post partum period. The EAADM mothers' positive evaluation of practical advice offered during the breast feeding classes and the availability of lactation counselors supports the findings of a qualitative study by Graffey and Taylor (2005). The breast feeding mothers in Graffey and Taylor's (2005) study also found the practical advice for specific concerns, knowing the benefits of breast feeding, and encouragement to continue breast feeding to be especially helpful for their success in breast feeding and a positive evaluation of the breast feeding experience. The EAADM mothers had access to lactation counselors during the week and the staff of the mother-baby unit at night or on weekends. Duration and success of breastfeeding has been linked to availability and interaction with lactation counselors (Rishel & Sweeney, 2005).

The Army has already changed the approach to basic training in order to retain soldiers and because of the focus on the soldiers' adaptation to the military. The changed attitude of training to one of support for those who are having difficulty adapting has resulted in a drop in the recruits lost for failure to adapt by 9% from 2004 to 2005 (Jaffe, 2006). Perhaps it is also time to focus on the support not only of the EAADM mother but the active-duty fathers as well in order to improve family relationships and enhance the retention of trained and qualified men and women.

By telling their stories and reflecting on their experiences during the journey to motherhood, the EAADM mothers' experiences of the transition to motherhood may have been changed. This conclusion was supported by two EAADM mothers. At the end

of the final interview, in response to the question “Is there any last comment you want to make to me?” Anna responded,

Well, you know, when we’re angry we like to vent, and it helps us as human beings feel better when we vent. And well, this talking is kind of like venting, but not out of anger. It’s venting out of, um, just kind of putting things in perspective. What is really important to me? You have asked question that I probably wouldn’t have asked myself. . . It just help(ed) me to reiterate and remind myself really what’s important to me, and it’s him. It’s him.

Another EAADM mother sent a note and picture of the baby when he was about a year old. Wendy said, “I will always remember our conversations we had and how they made me actually sit down and think about how good it feels to be a mom.”

Recommendations

Further study is needed with first-time EAADM mothers to determine if the findings from this study at one Army installation are consistent or representative of other EAADM mothers. In addition, the effects on active-duty Army women with more than one child needs further study. Studies are needed to evaluate the impact on the maternal-child relationships of the EAADM mothers’ re-entry into their infants’ lives post-deployment and comparisons made between the re-entry of fathers into the lives of their children and families.

The military is one of the best equal-opportunity employers (Lundquist, 2004). However, being a soldier is not like most civilian jobs. The mission of the military is to protect and defend our country, and, therefore, all soldiers, male or female, must be ready

to deploy. Pregnant soldiers, therefore, affect the units' readiness, day-to-day operations and the units' abilities to conduct their missions. It is the female soldiers' responsibility to maintain optimum health, fitness, and job proficiency and not consider pregnancy an illness or a way to get out of responsibilities as soldiers. The EAADM mothers in this study were particularly cognizant of their responsibilities as soldiers. However, all but one of the 10 EAADM mothers had an intended pregnancy.

Unintended pregnancies can come at great cost to the EAADM mothers' psychological well-being, impact on the units' readiness and ability to perform their missions. A program aiming to decrease the number of unintended pregnancies in the military, *Sexual responsibility, control your own destiny*, should be studied to evaluate its effectiveness. An unintended pregnancy costs the Army an estimated \$16,000, and training a replacement for a soldier that leaves active duty costs an estimated \$44,200. Therefore, evaluation of the effectiveness of existing health education resources has the potential to be cost effective with regard to the female soldiers' health and well-being, relationships between male and female members of the unit, and the units' ability to perform their mission. The Marine Corps instituted a randomized controlled program of cognitive-behavioral interventions and found the program was "effective for reducing behavioral risk and preventing sexually transmitted infections and unintended pregnancies in our sexually active women who were not seeking health care." (Boyer, Shafer, M., Shaffer, R., Brodine, Pollack, Bestinger, et al., 2005, p.420). The Navy instituted a multi-disciplinary program for unmarried women and also found a statistically significant ($p, < .001$) decrease in pregnancies for women who were enrolled

in the program (Hughes & Staren-Doby, 2003). The disadvantage of these two studies, while successful, did not report addressing the male members of the Services. There is a mutual responsibility in relationships; therefore; the recommendation is for all first-time soldiers to be included in the evaluation of the effectiveness of existing Army health education resources. This type of study has the potential to be cost effective with regard to the female soldiers' health and well-being, relationships between male and female members of the unit, and the units' ability to perform their mission.

Another area for future study is the effect of pregnancy and postpartum fitness programs on pregnancy outcomes, as well as the effects on lost duty time and the ability of EAADM mothers to return to pre-pregnancy fitness standards. The Army's pregnancy and postpartum fitness programs are designed to support healthy pregnancies and postpartum recovery so a soldier can return to duty physically fit. A standardized program has been developed and is soon to be implemented (J. Dalmas, personal communication, March 22, 2006). The training slides for the implementation of the standardized pregnancy and postpartum physical fitness programs are available online. Other online topics available to pregnant soldiers for maintaining health and well-being during and after pregnancy to name a few that are available at the U. S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) are *psychological and interpersonal issues postpartum; reproductive and developmental hazards; breastfeeding: mom on the move*. The effects of the availability of such resources and the outcomes of their use are other areas for future study of EAADM mothers' health and fitness.

Service in the Army is voluntary and the responsibility between the Army and the soldier are mutual: the Army offers many opportunities and the soldier must be ready to serve. Because the transition to becoming a first-time, enlisted, Army military mothers was such a struggle, it bears comment that these EAADM mothers were able to make the choice as to whether or not they would remain in the military. The EAADM mothers' commitment to their duties were not diminished by becoming a mother, rather their lives were transformed by the birth of their infants and their lives in turn were transformed and their priorities changed. While the birth of their infants brought wonder and joy to their lives, it simultaneously triggered the awareness of their own and the infants' fathers' mortality and eight of the EAADM mothers chose to leave the military, while two EAADM mothers deployed in order to make a better future for them and their infants.

Appendix A: Interview Guide

The goal of the interview was to establish a dialogue with the enlisted Army active duty military (EAADM) mothers in order to elicit their reflections on the every day experience of mothering, and the meaning of the motherhood experience in the context of the military culture. The questions below served as a *preliminary guide* for EAADM mothers' interviews.

The open-ended questions for the initial interview (visit one) during the last month of pregnancy were: "Describe what it is like for you knowing that you will soon become a mother on active duty?" "How do you think your life may change once you have given birth to your baby?" "What do you think about the most (about anything)?"

The questions asked at *each* of the interviews following the birth of the baby (visits two-four) were:

- "What all has happened to you and the baby since our last visit?" Or "What is the most important thing that has happened to you since our last visit?"
- "Tell me what yesterday was like from when you got up in the morning until you went to bed at night," followed by "Was yesterday pretty typical of your days? If not, what was different?"
- "What do you think about the most (about anything)?"

Additional specific questions for the second interview (visit two) were:

- "How do you think your life may change once you go back to active duty?"

- “What experience did you have with the military before you became an active duty member (to include parents in the military)?”

Additional specific question for the third interview (visit three) was:

- “How has your life changed now that you have returned to active duty?”

Additional specific questions for the final interview (visit four) were:

- “What helps you to be the kind of mother you want to be?”
- “What make it hard to be the kind of mother you want to be?”
- “Do you feel like your old self?” “When did this happen?”
- “Are you comfortable with your decisions as a new mother?”
- Final question: “What do you think about the most (about anything)?”

Additional questions that assisted in clarifying issues brought up during an interview:

- “Can you describe how your felt?”
- Can you describe what the place looked like?
- Can you remember what you said then?
- Can you give me an example of that?
- What do you mean by that?
- I’m still not clear on that. What happened exactly?” (Bogdan & Taylor, 1975, p. 114)

Appendix B

Personal Bracketing

In order to reduce bias during the data analysis and data interpretation phase of this study, this appendix will serve as a copy of this researcher's personal bracketing of the phenomenon under study, *The lived experience of becoming a mother on active duty*.

Personal Experience of Becoming and Being an Active Duty Military Mother

I delivered my first child in October 1975; five months after active duty women were granted the right to remain on active duty and could no longer be involuntarily separated from service due to pregnancy (Holm, 1992). My experience of becoming a mother on active duty must be viewed in light of this event and the women's liberation movement. Much controversy surrounded active duty military women's capability to continue to serve once they became pregnant and subsequently a mother.

I did not plan to have a military career, nor did I plan to work outside of my home when I had children younger than school age. I came into the military out of financial necessity and was able to complete my bachelor's degree. I thoroughly enjoyed the professional autonomy, pay, travel, and service to my country, and became a regular career Army officer before the end of my three year obligation. My experience as a military mother began while I was in graduate school. I got married, had an infant and finished my master's degree in 16 months. I missed only one week of classes and one examination during the week I took off for delivery. I returned to classes when the baby was a week old. Approximately three weeks after delivery, I was called and asked by Student Command if I had been attending classes, and if I wanted to leave active duty

immediately. I was most annoyed that my commitment to the military and my education was in question merely because I had delivered a baby.

When I finished my master's degree, I had a four year military service obligation. I was not prepared for the intensity of the joy and satisfaction of motherhood and career. My strong belief and value of family, of being a stay at home mother was also juxtaposed with my desire to take advantage of equal rights for women. If I was to live by my convictions of equal rights, I needed to complete the service obligation incurred for my civilian graduate degree as would any male service member. The distinct advantage of the military as opposed to the private sector was that I knew I would receive the same pay as a male with the similar rank and longevity. Once I made my decision to remain a career Army officer, I structured my life in a way to optimize career opportunities and time with my family.

The behavior of active duty persons or those connected with the military did not change as quickly as the change in military regulation. An observation often shared by my female colleagues was that male supervisors much more readily accepted the fact that parents occasionally would need duty time to care for family. Perhaps life experience shaped the male perspective.

My response to the perceived female bias was to compartmentalize my roles as mother, spouse, and career military officer. I would literally turn on work when I turned the key in the ignition of the car as I was ready to leave for work. At the end of the duty day, I would turn on home as I turned the key in the ignition and headed for home. In order to maintain my career goals, I followed the prescribed career template (career

ladder) completed the required advanced military education, and maintained weight and physical fitness standards. I was fortunate to be able to plan all of my four pregnancies to meet my career goals and to coincide with geographic moves.

Regulation maternity uniforms did not come into existence until after my second pregnancy. The lack of an appropriate pregnancy uniform made pregnant soldiers even more noticeable among their active duty colleagues. Lack of a pregnancy uniform seemed to signify that the pregnant soldier was not a legitimate member of the service.

It was not until I was pregnant with my fourth child that I felt free enough to talk about my children at work without fear of being viewed as not committed to my career, thereby risking receipt of a less than stellar performance rating. Until that time I did not mention my children while at work. Becoming and being a military mother was a team effort. I also had significant spousal, child care giver, and extended family support. My civilian spouse, an active drilling Reserve Army Officer, had the most significant influence on my selection of a military career. My personal philosophy of God first, family second, and Army third was in contrast to the prevailing motto, Army first. My own personal journey of becoming a mother on active duty was extremely challenging as well as rewarding. I, however, cannot offer guidance or prescription for the nursing needs of active duty mothers merely from my experience which occurred in a different historical context, and from the perspective of an officer with many resources.

The mission of the military has changed from one of fighting war to supporting peace missions in other countries and humanitarian efforts in the United States and other countries. Deployment to another country is the norm rather than the exception. There is

much more uncertainty in the world, especially after the events of September 11, 2001.

Soldiers who are being deployed no longer can feel that they are leaving their family in a safe environment, for terrorism has arrived on US soil.

How will my experience of becoming a mother as an active duty Army officer influence my ability to interview married, enlisted mothers? There can be no doubt that my experience of becoming a mother so soon after the regulatory change in the military will influence my reflection on the meaning of the experience as expressed by the current enlisted mothers. My military experience will however, provide a baseline for my understanding of military life, the military health care system, and the specific military language that is used to describe everyday life.

Appendix C

Grid for Initial Data Capture for *Each* Interview

ADM Mother Pseudonym _____

Date/Time of Interview _____

| Main area of Concern Addressed | Researcher comments/ <u>initial</u> impressions or themes or words that organize researcher thoughts |
|---|--|
| Initial impression about anything, the mother, the baby, the setting, interactions between researcher/mother/infant/others in the setting. (gut response in a few words about the context of the interview) | |
| Mother's appearance, demeanor, responsiveness to interview | |
| Any other noteworthy activities/behaviors/interactions of mother with others present during the interview | |
| Mother's interaction with/comments about the baby. | |
| Physical setting descriptors (size of room, temperature, lighting, pictures, books, etc. & furnishings) | |
| What does researcher wish had asked at THIS interview? | |
| Issues <u>not</u> discussed by ADM mother (that perhaps other ADM mothers have mentioned or intuitive researcher thoughts) | |

| | |
|---|--|
| <p>What did mother talk about in this interview with regard to?</p> <ul style="list-style-type: none"> • Being a mother • Being a spouse/significant other • Being a worker | |
| <p>What did mother not talk about in this interview with regard to?</p> <ul style="list-style-type: none"> • Being a mother • Being a spouse/significant other • Being a worker | |
| <p>Issues that need clarification at subsequent interview.</p> | |

Appendix D
Approval Letter
Access to Facility

IMPACT STATEMENT

Project Title: The Lived Experience of Becoming an Enlisted Mother on Active Duty

Principal Investigator: Mary P. King, RN, MSN
Doctoral Candidate
The University of Texas at Austin

Dr. David L. Kahn, RN, PhD
Assoc. Professor
School of Nursing
The University of Texas at Austin

Dr. Lorraine O. Walker RN, EdD
Dissertation Co-Chair
Asst. Dean & Luci B. Johnson Centennial Professor
School of Nursing,
The University of Texas at Austin

Service/Department: Well Woman Center
Darnall Army Community Hospital

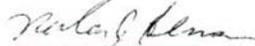
Assistance Requested: Use of one office or examination room to conduct interviews

Total Number of Patients to be Studied: Up to 50
Number of Patients Per Month: 12-18
Length of Study: 1 Year

- Disapproved, cannot support activity.
 Approved, no comment.
 Approved with comment.

Support is based on deployment (current world events)


BRENDA J. HOUSTON
Major, AN
Chief, Well Women Center


NOLAN J. HINSON
Colonel, AN
Deputy Commander for Nursing



DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
38000 DARNALL LOOP
FORT HOOD, TEXAS 76544-4752

MCXI-DON

24February 2003

MEMORANDUM FOR Mary Podmolik King, RN, MSN, Doctoral Candidate, School of Nursing,
The University of Texas at Austin, 1700 Red River,
Austin, TX 78701-1412

SUBJECT: Letter of Support

1. I am pleased to give my support for your dissertation research "The Lived Experience of Becoming an Enlisted Mother on Active Duty." I understand that you are submitting this proposal to the School of Nursing, Departmental Review Committee, and the Institutional Review Committee at The University of Texas at Austin. Once that approval has been granted, your proposal must also be reviewed by Brooke Army Medical Center/Wilford Hall Medical Center, Institutional Review Board and Human Subjects Review Board, therefore, I have attached the Impact statement that is required for submission to that review committee. As all active duty soldiers are increasingly involved in peacekeeping and humanitarian missions around the world, so little is known of the subjective experience of motherhood in the military context, your study assumes exceptional importance.

2. I understand that you are requesting the use of an empty clinic office in the Women's Health Center, at Darnall Army Community Hospital, to conduct interviews with enlisted active duty women. Major Brenda Houston, Chief of the Women's Health Center, will coordinate your use of an office in the clinic after Institutional Review Board Approval is obtained.

3. Best wishes for your proposed research.

NOLAN J. HINSON
Colonel, AN
Deputy Commander for Nursing

Appendix E

Office of Research Support & Compliance

The University of Texas at Austin

Institutional Review Board Approval Letters



OFFICE OF RESEARCH SUPPORT & COMPLIANCE
THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, TX 78713 (512) 471-8871 - FAX (512) 471-8873
North Office Building A, Suite 5.200 (Mail Code A3200)

Date: 8/12/2003

PI(s): **Lorraine O Walker** Department & Mail Code: **NURSING SCHOOL** **D0100**
Mary P King

Dear: **Lorraine O Walker** **Mary P King**

IRB APPROVAL - IRB Protocol # **2003-04-0062**

Title: **The Lived Experience of Becoming an Enlisted Army Active Duty Mother**

In accordance with Federal Regulations for review of research protocols, the Institutional Review Board has reviewed the above referenced protocol and found that it met approval for the following period of time:

Your amendment has been approved from 08/12/2003 - 05/06/2004

The following requested changes have been approved:

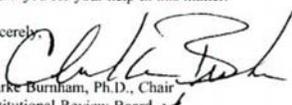
Change in title (Previously: The Lived Experience of Becoming an Enlisted Active Duty Mother)
Protocol modification/Addendum
Change in consent form

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

- (1) Report **immediately** to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated.
- (2) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.
- (3) Insure that only persons formally approved by the IRB enroll subjects.
- (4) Use **only** a currently approved consent form (remember approval periods are for 12 months or less).
- (5) **Protect the confidentiality of all personally identifiable information collected and train your staff and collaborators on policies and procedures for ensuring confidentiality of this information.**
- (6) Submit for review and approval by the IRB all modifications to the protocol or consent form(s) prior to the implementation of the change.
- (7) Submit a **Continuing Review Report** for continuing review by the IRB. Federal regulations require **IRB review of on-going projects no less than once a year** (a Continuing Review Report form and reminder letter will be sent to you 2 months before your expiration date). Please note however, that if you do not receive a reminder from this office about your upcoming continuing review, it is the primary responsibility of the PI not to exceed the expiration date in collection of any information. Finally, it is the responsibility of the PI to submit the Continuing Review Report before the expiration period.
- (8) Notify the IRB when the study has been completed and complete the Final Report Form.
- (9) Please help us help you by including the above protocol number on all future correspondence relating to this protocol.

Thank you for your help in this matter.

Sincerely,


Clarke Burnham, Ph.D., Chair
Institutional Review Board

cc: DRC



OFFICE OF RESEARCH SUPPORT & COMPLIANCE

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, TX 78713 (512) 471-8871 - FAX (512) 471-8873
North Office Building A, Suite 5.200 (Mail Code A3200)

Date: 9/18/2003

PI(s): Lorraine O Walker

Department & Mail Code: NURSING SCHOOL

D0100

Mary P King

Dear: Lorraine O Walker Mary P King

IRB APPROVAL - IRB Protocol # 2003-04-0062

Title: The Lived Experience of Becoming an Enlisted Army Active Duty Mother

In accordance with Federal Regulations for review of research protocols, the Institutional Review Board has reviewed the above referenced protocol and found that it met approval for the following period of time:

Your amendment has been approved from 09/16/2003 - 05/06/2004

The following requested changes have been approved:

Change HIPAA consent expiration date

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

- (1) Report **immediately** to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated.
- (2) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.
- (3) Insure that only persons formally approved by the IRB enroll subjects.
- (4) Use **only** a currently approved consent form (remember approval periods are for 12 months or less).
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- (8) Notify the IRB when the study has been completed and complete the Final Report Form.
- (9) Please help us help you by including the above protocol number on all future correspondence relating to this protocol.

Thank you for your help in this matter.

Sincerely,


Clarke Burnham, Ph.D., Chair
Institutional Review Board

cc: DRC



OFFICE OF RESEARCH SUPPORT & COMPLIANCE
THE UNIVERSITY OF TEXAS AT AUSTIN

P. O. Box 7426, Austin, Texas 78713 (512) 471-8871 - FAX (512) 471-8873
North Office Building A, Suite 5.200 (Mail code A3200)

Date: 4/16/2004

PI(s): **Lorraine O Walker**
Mary P King

Department & Mail Code: NURSING SCHOOL

D0100

Dear: **Lorraine O Walker** **Mary P King**
IRB APPROVAL - IRB Protocol # 2003-04-0062

Title: **The Lived Experience of Becoming an Enlisted Army Active Duty Mother**

In accordance with Federal Regulations for review of research protocols, the research study listed above has been re-approved for the following period of time:

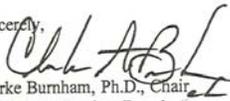
Your research study has been re-approved from 05/06/2004 - 05/06/2005

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

- (1) Report **immediately** to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated.
- (2) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.
- (3) Insure that only persons formally approved by the IRB enroll subjects.
- (4) Use **only** a currently approved consent form (remember approval periods are for 12 months or less).
- (5) **Protect the confidentiality of all personally identifiable information collected and train your staff and collaborators on policies and procedures for ensuring confidentiality of this information.**
- (6) Submit for review and approval by the IRB all modifications to the protocol or consent form(s) prior to the implementation of the change.
- (7) Submit a **Continuing Review Report** for continuing review by the IRB. Federal regulations require **IRB review of on-going projects no less than once a year** (a Continuing Review Report form and reminder letter will be sent to you 2 months before your expiration date). Please note however, that if you do not receive a reminder from this office about your upcoming continuing review, it is the primary responsibility of the PI not to exceed the expiration date in collection of any information. Finally, it is the responsibility of the PI to submit the Continuing Review Report before the expiration period.
- (8) Notify the IRB when the study has been completed and complete the Protocol Closure Report.
- (9) Please help us help you by including the above protocol number on all future correspondence relating to this protocol.

Thank you for your help in this matter.

Sincerely,


Clarke Burnham, Ph.D., Chair
Institutional Review Board

cc: DRC



OFFICE OF RESEARCH SUPPORT & COMPLIANCE

THE UNIVERSITY OF TEXAS AT AUSTIN

P. O. Box 7426, Austin, Texas 78713 (512) 471-8871 - FAX (512) 471-8873
North Office Building A, Suite 5.200 (Mail code A3200)

FWA #00002030

Date: 04/15/05

PI(s): Mary P King

Department & Mail Code:

Dear: Mary P King

IRB APPROVAL - IRB Protocol # 2003-04-0062

Title: **The Lived Experience of Becoming an Enlisted Army Active
Duty Mother**

In accordance with Federal Regulations for review of research protocols, the research study listed above has been re-approved for the following period of time:

Your research study has been re-approved from 05/06/2005 - 05/06/2006

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

- (1) Report **immediately** to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated.
- (2) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.
- (3) Insure that only persons formally approved by the IRB enroll subjects.
- (4) Use **only** a currently approved consent form (remember approval periods are for 12 months or less).
- (5) Protect the privacy and confidentiality of all persons and personally identifiable data and train your staff and collaborators on policies and procedures for ensuring the privacy and confidentiality of this participants and information.
- (6) Submit for review and approval by the IRB all modifications to the protocol or consent form(s) prior to the implementation of the change.
- (7) Submit a **Continuing Review Report** for continuing review by the IRB. Federal regulations require **IRB review of on-going projects no less than once a year** (a Continuing Review Report form and reminder letter will be sent to you 2 months before your expiration date). Please note however, that if you do not receive a reminder from this office about your upcoming continuing review, it is the primary responsibility of the PI not to exceed the expiration date in collection of any information. Finally, it is the responsibility of the PI to submit the Continuing Review Report before the expiration period.
- (8) Notify the IRB when the study has been completed and complete the Protocol Closure Report.
- (9) Please help us help you by including the above protocol number on all future correspondence relating to this protocol.

Thank you for your help in this matter.

Clarke Burnham, Ph.D., Chair
Institutional Review Board

cc: DRC



OFFICE OF RESEARCH SUPPORT & COMPLIANCE

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, TX 78713 (512) 471-8871 - FAX (512) 471-8873
North Office Building A, Suite 5.200 (Mail Code A3200)

Date: 5/26/2004

PI(s): Lorraine O Walker

Department & Mail Code: NURSING SCHOOL

D0100

Mary P King

608 Palo Alto Lane
Cedar Park, TX 78613-2941

Dear: Lorraine O Walker Mary P King

IRB APPROVAL - IRB Protocol # 2003-04-0062

Title: The Lived Experience of Becoming an Enlisted Army Active Duty Mother

In accordance with Federal Regulations for review of research protocols, the Institutional Review Board has reviewed the above referenced protocol and found that it met approval for the following period of time:

Your amendment has been approved from 05/25/2004 – 05/06/2005

The following requested changes have been approved:

Revised HIPAA consent form, Update UT-IRB approval to revised HIPAA and Original Consent form

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

- (1) Report **immediately** to the IRB any severe adverse reaction or serious problem, whether anticipated or unanticipated.
- (2) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.
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- (8) Notify the IRB when the study has been completed and complete the Final Report Form.
- (9) Please help us help you by including the above protocol number on all future correspondence relating to this protocol.

Thank you for your help in this matter.

Sincerely,


Clarke Burnham, Ph.D., Chair
Institutional Review Board

cc: DRC

Appendix F

Department of the Army

Brooke Army Medical Center

Institutional Review Board Approval Documents



DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF

MCHE-CI

18 July 2003

MEMORANDUM FOR Ms. Mary King, RN, UT Austin (Principal Investigator)

SUBJECT: Institutional Review Board Approval Memo

1. Your application for clinical investigation project of: "The Lived Experience of Becoming an Enlisted Army Active Duty Mother" was approved at the 4 June 2003 IRB and assigned work number **C.2003.148**
2. To meet FDA and DoD requirements for maintaining records of participation in clinical investigation studies and documentation of informed consent, as the principal investigator, you must maintain the original **signed** informed consent.
3. As the principal investigator your responsibilities are as follows:
 - a. A change in the research plan must be reported to the DCI for submission to appropriate committees for approval prior to implementation.
 - b. If transferred or released from active duty, submit to the DCI the name of the individual who will continue the study.
 - c. If the study is terminated, submit a report to the DCI stating the study is terminated and the reason for termination.
 - d. If any serious adverse reactions occur during the study which were not expected, they must be reported to the Chief, DCI, within 24 hours.
4. An annual research progress report, to include a copy of the most current **IRB STAMPED** Consent Form, must be submitted to my office NLT **1 MAY 2004** or upon completion, whichever comes first. Failure to comply could result in curtailment of funding for the project and/or termination.

JENICE N. LONGFIELD
COL, MC
Chairman, IRB

/djm



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

MCHE-CI

8 SEP 2003

MEMORANDUM FOR Ms. Mary P. King, RN, MSN (UT Austin Graduate Program),
Principal Investigator

SUBJECT: Approval for requested change to HIPAA Authorization for protocol "*The Lived Experience of Becoming an Enlisted Army Active Duty Mother*" (C.2003.148)

1. The Brooke Army Medical Center (BAMC) IRB and Privacy Board met on 3 September 2003 and approved a change to the HIPAA Authorization expiration statement, as requested in your Memo dated 15 August 2003.
2. The protocol office has forwarded the revised HIPAA form, marked with the BAMC Approval stamp to you.
3. If you have any questions, please contact Ms. Diane Marra at (210) 916-2598 or Ms. Ileana King (210) 916-2000 in the BAMC Department of Clinical Investigation Protocol Office, for assistance.

JENICE N. LONGFIELD
COL, MC
Chief, Department of Clinical Investigation

MCHE-CI

SEP 05 2003

MEMORANDUM FOR Principal Investigator

SUBJECT: Latest Approved ^{HIPAA} ~~Consent Form~~

1. Attached please find the reviewed ^{HIPAA} ~~Consent Form~~ with approval stamp date. You must begin using a copy of this ~~Consent Form~~ with the approved stamp to document informed consent of all subjects. ^{HIPAA} ~~HF PAA~~
2. Any future changes to ^{HIPAA} ~~Consent Form~~ must be submitted and approved by the Institutional Review Board (IRB) before use.

Jenice N. Longfield

JENICE N. LONGFIELD
Colonel, MC
Chairman, IRB

MCHE-CI

MAY 05 2004

MEMORANDUM FOR Principal Investigator

SUBJECT: Latest Approved Consent Form

1. Attached please find the reviewed Consent Form with approval stamp date. You must begin using a copy of this Consent Form with the approved stamp to document informed consent of all subjects.
2. Any future changes to Consent Form must be submitted and approved by the Institutional Review Board (IRB) before use.



JENICE N. LONGFIELD
Colonel, MC
Chairman, IRB

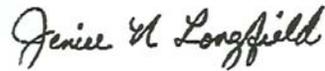
MCHE-CI

OCT 06 2004

MEMORANDUM FOR Principal Investigator

SUBJECT: Latest Approved Consent Form

1. Attached please find the reviewed Consent Form with approval stamp date. You must begin using a copy of this Consent Form with the approved stamp to document informed consent of all subjects.
2. Any future changes to Consent Form must be submitted and approved by the Institutional Review Board (IRB) before use.



JENICE N. LONGFIELD
Colonel, MC
Chairman, IRB

Appendix G

Department of the Army

U. S. Army Medical Department Center and School

Clinical Investigation Regulatory Office (CIRO) Approval

Marra, Diane J Ms BAMC-Ft Sam Houston

From: Jones, Christina D Ms AMEDDCS

Sent: Thursday, July 17, 2003 1:41 PM

To: Marra, Diane J Ms BAMC-Ft Sam Houston

Subject: Protocol "The Lived Experience of Becoming..." /M. King. C.2003.148. CIRO 2003675.

17 Jul 03

Hi, Diane:

Thank you for the faxed revisions to the above-referenced protocol from Darnall ACH. It's good to go from CIRO's view.

Chris

Appendix H
Recruitment Brochure

(Back cover)

(front cover)

**Enlisted Army Active Duty Mother
First-Time Mother's Study**

You are invited to participate in a
Graduate study conducted
by Mary King, RN, MSN
From The University of Texas at Austin
School of Nursing

This is a chance for you to talk about
what it is like to be a first-time mother on active duty,
and what your life is like after the baby is born.

Please read the inside of this brochure to find out more about the
study. If after reading the brochure you would like Mary King to
contact you and give you information about the study, you may

- Contact Mary directly at **1-877-989-6471** (toll free page)
- **OR** you may sign the brochure below and return it to the
locked box at the clerk's desk in the Women's Health
Center. This does not mean that you have agreed to be in
the study, just that you are interested and would like more
information.

Print your name

Sign your name

Telephone number: Home _____

Other _____

(inside left/page 2)

Why is the study being done?

To find out what it is like for enlisted women to become mothers for the first time. While much research has been done about pregnancy outcomes, little is known about what actually happens to active duty mothers once they give birth.

Who is doing the study?

Mary King is a graduate student in the School of Nursing, at The University of Texas at Austin. She is a Registered Nurse with over 20 years of experience in working with new mothers in the military setting. The study is a requirement for her doctoral degree.

Who can participate in this study?

Enlisted Army Active Duty Mothers who are:

- 19 to 30 years of age
- having their first baby
- Are at least 8 months pregnant (36 weeks gestation)

Active duty mothers can stay in the study after baby is born if they:

- have an uncomplicated vaginal or cesarean delivery
- give birth to a child between 37 and 42 weeks gestation

and both mother and baby can leave the hospital together within 3-4 days after delivery

(inside right/page 3)

What are the benefits?

Being in the study gives you the chance to talk about your feelings about becoming a new mother in a confidential interview. New mothers find that talking about their experiences before and right after their baby is born may be personally helpful. There is no guarantee you will receive any benefit other than knowing that your information may help future mothers and provide information to those who give health care to pregnant active duty mothers.

Briefly, what is expected if I participate in this study?

- An initial visit (interview) the month before you deliver
- Three more visits (interviews) after baby arrives
 - Before you return to work, at 4-6 weeks
 - Soon after you return to work, at 8-10 weeks
 - Before the baby is four months old, at 14-16 weeks
- Each interview will be tape recorded
- Each interview is expected to take 45-60 minutes of your time

If I contact Mary or sign this study brochure, can I still say NO to be in the study now or at a later time?

Yes. Agreeing to have Mary contact you or giving her your name and telephone number only means that you are interested in finding out more information about the study. It does not mean that you have agreed to participate in the study.

Appendix I: Flyer and Newspaper Ad

Enlisted Army Active Duty First-time Mothers Study

You are invited to participate in a new study about:
What it is like to be a first-time mother on active duty?
What is your life like after the baby is born?

Who can participate in this study?

Enlisted Army active duty mothers who are:

- 19 to 30 years of age
- Having their first baby
- Are at least 8 months pregnant (36 weeks)

Active duty mothers can stay in the study after the baby is born if they:

- Have an uncomplicated vaginal or cesarean delivery
- Give birth to a child between 37 and 42 weeks gestation
- Both mother and baby can leave the hospital together within 3-4 days of delivery

What are the benefits?

- Chance to talk about feelings in confidential interview
- You may find talking about your experiences before and right after the baby is born to be personally helpful
- You may not benefit from the study other than knowing that the information you provide may benefit other mothers or those who give health care to pregnant active duty mothers

For more information contact:

Call Mary King at 1-877-989-6471 (Toll-free pager)

Registered Nurse
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix J

Eligibility Screening Interview

Hello, name of potential participant, my name is Mary King. I am a graduate student in nursing at The University of Texas at Austin. My research study is about what it is like to be a first-time mother on active duty and what your life is like after the baby is born.

I am really excited that you are interested in this study. I'd like to ask you a few questions to see if you are eligible to be in it. Your answers to these questions will be kept confidential and you can refuse to answer any question at any time during this interview.

| Questions | Eligibility | | Qualifier |
|---|-------------|----|---|
| | Yes | No | |
| 1. Are you on active duty? | | | Family members are not eligible to participate. |
| 2. What is your enlisted rank? | | | Rank is equal to pay grade, either response is acceptable to determine status |
| 3. Are you married? | | | Must be married |
| 4. When is your due date? _____ | | | Can calculate to ensure dates are equivalent to between 36 to 41 weeks & 6 days for first interview . |
| 5. When will you be starting your weekly prenatal visits? | | | Weekly visits start at 36 weeks until delivery. Weekly visits before 36 wks may mean pregnancy complications and not a "normal" pregnancy |
| 6. How old are you? _____ | | | Must be between 18 and 30 years at <u>time of first interview</u> . |
| 7. Are you having your first baby? | | | May have prior pregnancies terminated before or at 12 weeks, this pregnancy <u>must</u> result in first-time parenthood |
| 8. Are you expected to have a normal delivery? | | | Cesarean deliveries are considered normal deliveries. |

Any NO will exclude the person from the study.

(Ineligible response). I'm so sorry, but you won't be able to be part of this study, because (reason why not eligible), but I do appreciate your interest in being a part of this very important research. Thank you again for your time, I've enjoyed speaking with you.

(Eligible response). Congratulations! You are eligible for this study. Now I would like to go over what we will be doing in this study. The study involves talking with me at four different times:

- The first visit (interview) will be in the last month before you deliver
- If you have a normal delivery and you and the baby get to go home together within 72 hours or 3 days after delivery, then there will be
- Three more visits (interviews) after baby arrives
 - Before you return to work, when baby is 4-6 weeks,
 - Soon after you return to work, at 8-10 weeks,
 - Before the baby is four months old, at 14-16 weeks
- Each interview will be tape recorded
- Each interview is expected to take 45-60 minutes of your time.
- The interviews will be transcribed at a later

What will you get out of participating in this study?

- You will have a chance to talk about your feelings about becoming a new mother in a confidential interview.
- New mothers often find that talking about their experiences before and right after their baby is born may be personally helpful.

What are the incentives for participating in this study?

- There is no guarantee that you will receive any direct benefit from this study other than knowing that the information you provide may help future mothers,
- And providing information to those who take care of pregnant active duty mothers.

Do you have any questions of me?

Would you like to participate in this study? YES No

Please give me your name and the address where I can send you some more information about the study and a reminder of your appointment time.

Name: _____

Preferred Mailing Address _____

City _____ Zip _____

Home telephone number or other number where I may contact you:

When can we schedule your first visit for the study?

Date _____

Location of first visit will be at the Women's Health Center. We can meet at your convenience, either after one of your prenatal visits or I can meet you on another day.

Can I answer any more questions? (Will stress confidentiality of interview, i.e., NO record of this interview will be made in the medical record or any administrative record. You will not be personally identified; all information will be presented as anonymous data).

I've really enjoyed talking with you and I look forward to meeting you on date of first visit at the Women's Health Center. I will be wearing an orange ID badge from The University of Texas at Austin, School of Nursing.

Appendix K

Demographic Information Sheet

Please verify the following questions about you and your family:

1. Your name _____
2. Your preferred mailing address:

3. Home number: _____
4. Alternate number (if any) where you can be reached: _____
5. Mother's rank: _____
6. Mother's duty assignment: _____

7. Mother's Date of Birth. _____ Current Age _____
8. Spouse's Name: _____
9. Baby's due date: _____
10. This is the first pregnancy beyond 12 weeks (3 Months gestation). Yes ___ No ___

Appendix L
Informed Consent

**BROOKE ARMY MEDICAL CENTER
INFORMED CONSENT DOCUMENT
(ICD Template Version 4, Jul 02)**

The Lived Experience of Becoming an Enlisted Army Active Duty Mother

PRINCIPAL INVESTIGATOR: Mary P. King, RN, MSN, Doctoral Candidate, School of Nursing, The University of Texas at Austin

If you choose not to participate in this research study, your decision will not affect your eligibility for care or any other benefits to which you are entitled.

DESCRIPTION/PURPOSE OF RESEARCH:

You are being asked to consider participation in this research study. The purpose of this study is to learn about your experience of becoming an enlisted mother while on active duty and what it is like to be a mother during the first four months of your baby's life.

This study may enroll up to 50 enlisted active duty mothers who receive their care at the Women's Health Center at Darnall Army Community Hospital (DACH) over a period of approximately one year, in order to obtain 12-18 enlisted active duty mothers who will be able to complete all four interviews for the study.

During your participation in this study, you will be asked to make four, 45-60 minute visits with the principal investigator, Mary King, RN, a graduate student at The University of Texas at Austin, School of Nursing. The first visit will be scheduled during the last month of your pregnancy (visit one), between 36 weeks gestation and prior to delivery. The remaining visits will be scheduled at your convenience, after your baby arrives. The three (3) subsequent visits will be scheduled when the baby is 4-6 weeks (visit two), between 8-10 weeks (visit three), and between 14-16 weeks (visit four) of age. The first visit before you deliver must be conducted at the Women's Health Center at DACH. The visits after your baby is born will be conducted at your home, however if this is not feasible or you prefer, the visits can also be held at the Women's Health Center at DACH or a location of your choice where there is privacy and the interview can be recorded.

You have been selected to participate in this study because (1) you are an active duty enlisted, (2) *you are* at least 36 weeks pregnant with your first pregnancy, (3) you receive your care in the Women's Health Center at DACH, and (4) you are anticipated to have an uncomplicated vaginal or cesarean delivery. If you have an uncomplicated vaginal or cesarean delivery of a healthy infant, and you and your baby are able to leave the hospital within 3-4 days of delivery, you will be able to continue in the study until your baby is approximately four months old.

PROCEDURES:

As a participant, you will undergo the following procedures:

- a. The principal investigator will conduct a screening interview to determine if you meet the criteria to participate in this study. If you are eligible, an appointment will be made for the first interview. The first interview will be conducted at the Women's Health Center.
- b. At the first interview, the principal investigator will reconfirm your eligibility to participate in the study. The consent form will be discussed with you in detail and you will be asked to sign it.
- c. Once you have sign this consent form the principal investigator will ask you about what it is like to know that you will soon become a mother while on active duty.
- d. The interview will be audio-taped and the taped interview will be transcribed at a later date.
- e. At the end of the first interview you will be given a demographic information sheet to complete and return to the principal investigator in the addressed, stamped envelope which will be provided to you.
- f. You will be asked to contact the principal investigator once you have delivered or the principal investigator will call you within 5-7 days of your due date.
- g. The principal investigator will conduct a short telephone interview with you, after you deliver, to determine your eligible status for participation in the study.
- h. The second taped interview will be scheduled when your baby is between four and six weeks of age (visit two) and before you return to duty. The interview will be conducted at your home, or if a home interview is not feasible or you prefer the interview may be conducted at the Women's Health Center at DACH or at a location agreeable to you and the principal investigator.
- i. An appointment for the interview, when your baby is 8-10 weeks (visit three), will be scheduled at the time of visit two. The interview will be conducted at your home, or if a home interview is not feasible or you prefer the interview may be conducted at the Women's Health Center at DACH or at a location agreeable to you and the principal investigator.

j. An appointment for your interview, when your baby is 14-16 weeks (visit four), will be scheduled at the time of visit three. The interview will be conducted at your home, or if a home interview is not feasible or you prefer, the interview may be conducted at the Women's Health Center at DACH or at a location agreeable to you and the principal investigator.

RISKS OR DISCOMFORTS:

The primary risks for your involvement in this study are the investment of your time required for the four interviews or a concern of confidentiality as a consequence of your active duty military status. It is *also* possible that sharing information about your feelings of becoming a mother or being a mother, partner, and military member may generate intense emotional feelings. You may choose to not answer a question or you may stop the interview at any time. The principal investigator has over 20 years of nursing experience with first-time military mothers and would be sensitive to and able to identify mothers who may need intervention. If you experience emotional difficulty or symptoms of postpartum depression you will be referred to the Department of Psychology, Thomas Moore Health Clinic during duty hours or to the Darnall Hospital Emergency Room after duty hours. At the first visit, the principal investigator will also provide you with a copy of Resource Telephone Numbers for New Mothers. You may request another copy of the resource list at any time during the study.

Confidentiality risks will be minimized in the following ways:

a) All contact for your participation in this study will be made directly between you and the principal investigator.

b) No notation of your participation will be made in your medical or administrative record.

c) Except for the first interview, the location of the interviews after delivery will be determined by you and the principal investigator.

d) All taped interviews and transcripts will be secured in a locked file cabinet in the home of the principal investigator.

e) Access to the tapes and transcripts, once transcription is completed will be limited to the principal investigator and the dissertation committee members only as needed for the principal investigator to complete degree requirements.

f) Audio tapes and written transcript of your interviews will be labeled with a pseudonym (made up name) known only to the principal investigator.

g) Your name and any identifying information will not be linked to the audio tapes, transcripts, or to any written or verbal reports of the study findings

h) Audio tapes will be destroyed at the completion of the study.

There may also be unforeseen risks associated with this study.

Mandatory referral will be made to the military Family Violence Hotline at 1-254-287-2273 if you live on post or the Child and Family Protective Services at 1-800-252-5400 if you live off post for suspected abuse or neglect.

If there is concern that you will harm yourself or others a call will be made to emergency services at 911.

If you have concerns about your pregnancy report to the Women's Health Center at DACH between 07:30-16:30 or you may contact the Women's Health Center triage nurse at (254) 288-8133. If your pregnancy or labor concerns occur during duty hours call the Women's Health Center triage nurse at (254) 288-8133. If you have labor or postpartum concerns after duty hours call Labor and Delivery at (254) 288-8400 or report to the emergency room at Darnall Army Community Hospital for non-pregnancy related illness or trauma. During the study if you become pregnant again or feel that you might be pregnant after your baby is born contact the Women's Health Center at (254) 286-7780 and the study investigator listed in the voluntary participation section.

BENEFITS:

The possible benefit of your participation in this study is the opportunity to discuss your thoughts and feelings about becoming a new mother in the context of a confidential supportive environment. Most military members are geographically separated from immediate family support, and previous research about military pregnancies has shown that many active duty mothers may not have adequate support from co-workers or others.

By talking about your experiences, you may develop an awareness of your strengths and capabilities as a mother, and you may have the opportunity to develop solutions to the practical concerns of being a mother on active duty.

There is no guarantee you will receive any benefit from this study other than knowing that the information may help future mothers and to those who provide health care for the pregnant active duty member.

PAYMENT (COMPENSATION):

You will not receive any compensation (payment) for participating in this study.

ALTERNATIVES TO PARTICIPATION:

Choosing not to participate in this study is your alternative to volunteering for the study.

CONFIDENTIALITY OF RECORDS OF STUDY PARTICIPATION:

Records of your participation in this study may only be disclosed in accordance with federal law, including the Federal Privacy Act, 5 U.S.C. 552a, and its implementing regulations. DD Form 2005, Privacy Act Statement-Health Care Records, contains the Privacy Act Statement for the records.

By signing this consent document, you give your permission for information gained from your participation in this study to be published in nursing and medical literature, discussed for educational purposes, and used generally to further nursing and medical science. You will not be personally identified; all information will be presented as anonymous data.

The audio tapes will be destroyed upon completion of the study. The verbatim transcripts, labeled with a pseudonym (made up name) known only to the principal investigator, will be retained by the principal investigator for possible future analysis.

Your records may be reviewed by the U.S. Food & Drug Administration (FDA), other government agencies, the BAMC Institutional Review Boards. Authorized persons from The University of Texas at Austin and the Institutional Review Board have the legal right to review your research records and will protect the confidentiality of those records to the extent permitted by law.

Complete confidentiality cannot be promised, particularly for military personnel, because information regarding your health may be required to be reported to appropriate medical or command authorities.

ENTITLEMENT TO CARE:

In the event of injury resulting from this study, the extent of medical care provided is limited and will be within the scope authorized for Department of Defense (DoD) health care beneficiaries. Your entitlement to medical and dental care and/or compensation in the event of injury is governed by federal laws and regulations, and if you have questions about your rights as a research subject or if you believe you have received a research-related injury, you may contact the Brooke Army Medical Center Protocol Coordinators (210) 916-2598, or BAMC Judge Advocate General (210) 916-2031, Darnall Army Community Hospital or Legal Services (254) 288-8270, and/or Clarke Burnham, PhD, Chair, Institutional Review Board, Office of Sponsored Projects, The University of Texas at Austin, Austin, TX at 512-232-4383.

BLOOD & TISSUE SAMPLES:

No blood or tissue samples will be taken as part of this study.

VOLUNTARY PARTICIPATION:

The decision to participate in this study is completely voluntary on your part. No one has coerced or intimidated you into participating in this project. You are participating because you want to. Mary King has adequately answered any and all questions you have about this study, your participation, and the procedures involved. If significant new findings develop during the course of this study, that may relate to your decision to continue participation, you will be informed.

You may withdraw this consent at any time and discontinue further participation in this study without affecting your eligibility for care or any other benefits to which you are entitled. Additionally, your refusal will not influence current or future relationships with The University of Texas at Austin. Should you choose to withdraw, you must notify the principal investigator at 1-877-989-6471 (toll free page).

The investigator of this study may terminate your participation in this study at any time if she believes this to be in your best interest or if you become pregnant with a subsequent child.

CONTACT INFORMATION:

Principal Investigator (PI)

The Principal Investigator, or the co-chair of her dissertation committee at The University of Texas at Austin, School of Nursing, Lorraine Walker, EdD at 1-512-232-4720 will be available to answer any questions concerning procedures throughout this study. In addition, if you have questions about your rights as a research participant, please contact Clarke A. Burnham, Ph.D., Chair, and The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects at 1-512-232-4383.

Principal Investigator: Mary P. King, RN, MSN
Phone: 1-877-989-6471 (toll free page).

Appendix M

Authorization to Use and Disclose Protected Health

Information for Research

(HIPPA Consent)

BROOKE ARMY MEDICAL CENTER
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
FOR RESEARCH

(APHI Template Version 1, Apr 03)

You are being asked for permission to use or disclose your protected health information for research purposes in the research study entitled The Lived Experience of Becoming an Enlisted Army Active Duty Mother

The Privacy Law, the Health Insurance Portability & Accountability Act (HIPAA), protects your individually identifiable health information (protected health information). This law requires you to sign an authorization (or agreement) in order for researchers to be able to use or disclose your protected health information for research purposes in the study listed above.

Your protected health information that may be used and disclosed in this study includes:

- Demographic Information: Age will only be used to describe the study sample.
- Medical History/Surgical History: First pregnancy after 12 weeks that resulted in live birth used only to ensure study eligibility.
- Imaging Studies, Laboratory Results: None
- Other: Audio tapes and verbatim transcripts will be labeled with pseudonyms (made up name) known only to the principal investigator.

Your protected health information will be used for:

The purpose of this study is to learn about your experience of becoming an enlisted mother while on active duty and what it is like to be a mother during the first four months of your baby's life.

This study may enroll up to 50 enlisted active duty mothers who receive their care at the Women's Health Center at Darnall Army Community Hospital (DACH) over a period of approximately one year, in order to obtain 12-18 enlisted active duty mothers who will be able to complete all four interviews for the study.

During your participation in this study, you will be asked to make four, 45-60 minute visits with the principal investigator, Mary King, RN, a graduate student at The University of Texas at Austin, School of Nursing. The first visit will be scheduled during the last month of your pregnancy (visit one), between 36 weeks gestation and prior to

delivery. The remaining visits will be scheduled at your convenience, after your baby arrives. The three (3) subsequent visits will be scheduled when the baby is 4-6 weeks (visit two), between 8-10 weeks (visit three), and between 14-16 weeks (visit four) of age. The first visit before you deliver must be conducted at the Women's Health Center at DACH. The visits after your baby is born will be conducted at your home, however if this is not feasible or you prefer, the visits can also be held at the Women's Health Center at DACH or a location of your choice where there is privacy and the interview can be recorded.

You have been selected to participate in this study because (1) you are an active duty enlisted, (2) you are at least 36 weeks pregnant with your first pregnancy, (3) you receive your care in the Women's Health Center at DACH, and (4) you are anticipated to have an uncomplicated vaginal or cesarean delivery. If you have an uncomplicated vaginal or cesarean delivery of a healthy infant, and you and your baby are able to leave the hospital within 3-4 days of delivery, you will be able to continue in the study until your baby is approximately four months old.

The disclosure of your protected health information is necessary in order to be able to conduct the research project described. Records of your participation in this study may only be disclosed in accordance with federal law, including the Federal Privacy Act, the Health Insurance Portability and Accountability Act of 1996, 5 U.S.C.552a, and its implementing regulations. DD Form 2005, Privacy Act Statement - Military Health Records, contains the Privacy Act Statement for the records. Note: Protected health information of military service members may be used or disclosed for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.

By signing this authorization, you give your permission for information gained from your participation in this study to be published in medical literature, discussed for educational purposes, and used generally to further medical science. You will not be personally identified; all information will be presented as anonymous data.

The Principal Investigator may use and share your health information with:

- The BAMC Institutional Review Board
- State and Federal Government representatives, when required by law
- BAMC or Department of Defense representatives
- The University of Texas at Austin Institutional Review board for the Protection of Human Subjects

- Dissertation committee members only as needed for the principal investigator to complete degree requirements.

The researcher Mary King, RN, a graduate student at The University of Texas at Austin, School of Nursing agree to protect your health information by using and disclosing it only as permitted by you in this Authorization and as directed by state and federal law.

If your protected health information is disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

You do not have to sign this Authorization. If you decide not to sign the Authorization:

- It will not affect your treatment, payment or enrollment in any health plans or affect your eligibility for benefits.
- You may not be allowed to participate in the research study.

After signing the Authorization, you can change your mind and:

- Notify the researcher that you have withdrawn your permission to disclose or use your protected health information (revoke the Authorization).
- If you revoke the Authorization, you will send a written letter to Mary P. King, RN; Enlisted Army Active Duty First-time Mother's Study; P. O. Box 384, Cedar Park, TX 78613-0384 to inform him/her of your decision.
- If you revoke this Authorization, researchers may only use and disclose the protected health information already collected for this research study.
- If you revoke this Authorization your protected health information may still be used and disclosed should you have an adverse event (a bad effect).
- If you withdraw the Authorization, you may not be allowed to continue to participate in the study.

During your participation in this study, you will not be able to access your research records. This is done to ensure the study results are reliable. After the completion of the study, you have the right to see or copy your research records related to the study listed above. A Request for Access must be made in writing to Mary P. King, RN; Enlisted Army Active Duty First-time Mother's Study; P. O. Box 384, Cedar Park, TX 78613-0384.

If you have not already received a copy of the brochure entitled "Military Health Care System Notice of Privacy Practices," you may request one. DD Form 2005-Privacy Act Statement – Military Health Records (located in your medical records jacket), contains the Privacy Act Statement for the records. If you have any questions or concerns about

your privacy rights, you should contact the Brooke Army Medical Center Privacy Officer at phone number (210) 916-1029.

This Authorization expires at the end of the research study.

You are the subject or are authorized to act on behalf of the subject. You have read this information, and you will receive a copy of this form after it is signed.

**Volunteer's Signature or
Legal Representative**

Volunteer's SSN

Date

**Volunteer's Printed Name or
Legal Representative**

Sponsor's SSN

Relationship of Legal Representative to Volunteer

Signature of Witness

Date

Appendix N

**Enlisted Army Active Duty
First-time Mothers Study**

Confidentiality Agreement

As a member of the _____ transcription service for the Enlisted Army Active Duty First-time Mothers Study, I understand the confidentiality issues involved in the project and agree to abide by the following guidelines:

1. Under no circumstances will the content or nature of any work received be disclosed to any outside party.
2. I have read the consent forms signed by the participants and will do my part to honor those agreements.
3. All audiocassettes and completed transcripts will be identified by a pseudonym assigned by the Principal Investigator.
4. I will keep all tape recorded conversations I listen to in the process of transcription confidential.
5. Names of participants will not be used on the tapes I receive from the researcher for transcription nor will participant names be placed on the transcript that I type.
6. In case someone inadvertently reveals their identity or identifiable information during the interview, I will notify Mary King, Principal Investigator at 1-877-989-6471 (toll-free page), and I will edit the transcript to obscure such information.
7. I will only use information provided by the Principal Investigator in an approved work area, and I will not make additional copies of information for personal use. Violation of this guideline is ground for dismissal from this project and disciplinary action.

Signature of Transcription Service Member

Date

Printed Name of Transcription Service Member

Signature of Transcription Service Supervisor

Date

Printed Name of Transcription Service Supervisor

Signature of Principal Investigator

Date

MARY P. KING, RN, MSN
Printed Name of Principal Investigator

Appendix O

**Resource Telephone Numbers
For Enlisted Army Active Duty Mothers**

| Emergency | 911 |
|---|-------------------|
| Abuse Hotline (On Post) | 287-2273 |
| Abuse Hotline (Off Post) | 1-800-252-5400 |
| Army Community Services (ACS) | 287-2214 |
| Army Family Advocacy | 286-6774 |
| Birth Registration | 288-8584 |
| Central Appointments (MON-FRI 07:00-16:00; Weekends & Holidays 07:00-12:00) | 288-8888 |
| Chaplain (MON-FRI 07:30-16:30) | 288-4357 |
| On-call Duty Chaplain | 287-2427 |
| Child Development Centers (MON-FRI 05:45-18:00) | |
| Clear Creek | 288-5222 |
| Comanche | 287-4848 |
| Hood Road | 287-6037 |
| Community Health Nurse (MON-FRI 07:30-16:30) | 287-0281/6789 |
| DEERS (Defense Enrollment Eligibility Reporting System) | 1-800-538-9552 |
| Families in Crisis Hotline | 634-1184 |
| Health Care Information Line (TriCare) | 1-800-611-2875 |
| Hospital Information | 288-8000 |
| Labor and Delivery | 288-8400/8401 |
| LaLeche League of Killeen | 547-2229 |
| Legal Assistance | 287-3199 |
| Mental Health Services | |
| Department of Psychology Thomas Moore Health Clinic (Emergency and Walk-in MON-FRI, 07:30-16:00) | 285-6347 |
| Mental Health Emergency (After duty hours Report to Darnall Emergency Room) | |
| Mother/Baby Ward | 288-8430/8431 |
| Neonatal Intensive Care Ward | 288-8415 |
| Newborn Follow-up Clinic | 288-8440 |
| New Parent Support Program (MON-FRI 08:00-17:00) | 287-2286/287-2291 |
| Nutrition Clinic (MON-FRI 07:30-16:30) | 288-8860 |
| Patient Representative (MON-FRI 07:30-16:30) | 288-8156 |
| Planned Parenthood | 1-800-951-7258 |
| Psychiatry | 286-7820 |
| Red Cross, Darnall (MON-FRI 09:00-15:00) (After hours military emergency 1-877-272-7337) | 288-8144 |
| Red Cross, Fort Hood (MON-FRI 08:00-16:30) | 287-0400 |
| Social Work Service (MON-FRI 07:30-16:30) | 288-6474 |
| TRICARE | 1-800-406-2832 |
| Water Aerobics Classes (MON, THU 08:00-09:00 Abrams Pool) | 287-3550 |
| Well Baby Clinic | |
| Two Week | 902-0930 |
| Two Months and Older | 288-8888 |
| WIC (Women, Infant, and Children) | |
| Killeen (MON-THU 07:00-18:00) | 526-2033 |
| Copperas Cove (MON-THU 07:00-18:00) | 547-9571 |
| Fort Hood (MON-THU 07:00-17:15) | 532-8680 |
| Women's Health Center | 286-7780 |
| Triage Nurse-Pregnancy Health Concerns (07:30-16:30) | 288-8133 |
| Labor-Unit-Pregnancy & Labor Concerns (16:31-07:29) | 288-8400 |

Appendix P

Results of U. S. Army Medical Department Center and School

Clinical Investigation Regulatory Office (CIRO)

Research Record Audit



DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
CLINICAL INVESTIGATION REGULATORY OFFICE (CIRO)
ATTN: MCCS-GCI, BLDG 2268, 1608 STANLEY ROAD
FORT SAM HOUSTON, TEXAS 78234-5055

31 May 2005

MEMORANDUM FOR Chief, Clinical Investigation Regulatory Office, ATTN: COL James M. Lamiell, AMEDDC&S, Fort Sam Houston, TX 78234

SUBJECT: Research Record Audit, Darnall Army Community Hospital, Fort Hood, TX

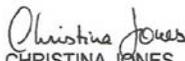
1. The undersigned conducted a Clinical Investigation Regulatory Office (CIRO) research record audit at Darnall Army Community Hospital (DACH) on 25 May 2005. The purpose of the audit was to review ongoing DACH protocols, approved by the Brooke Army Medical Center (BAMC) Institutional Review Board (IRB), for compliance with Federal and Army regulations pertaining to human research protections.
2. Pre-audit review of DACH studies identified only one active protocol with enrolled subjects: "The Lived Experience of Becoming an Enlisted Army Active Duty Mother" by Mary P. King, RN, MSN. I met with the principal investigator at 11:00 hours on 25 May 2005 in the conference room of the Pediatric Ward at DACH, and then proceeded to review her records pertaining to this study for the next three hours.
3. The audit results were as follows:
 - a. Protocol History. The more than minimal risk study was approved by the 4 Jun 03 BAMC IRB, with second level approval/concurrence by CIRO on 11 Jul 03. The study was expected to last 24 months and was authorized to enroll up to 50 subjects, in order to obtain a sample of 12-18 subjects who complete a total of four interviews. Its purpose was to explore the nature of the experience of becoming an enlisted mother on active duty and to gain understanding of the transition to the maternal role, including a new mother's coping with job performance, health, and well-being of the baby, which in turn would lead to better guidance and programs for future pregnant enlisted Army active duty members. The protocol received BAMC IRB continuing review in May 04 and in Apr 05. It was closed to new enrollment in December 2004, with the total enrollment reported to be 18. Data analysis is ongoing. There is no extramural funding.
 - b. Protocol Procedures. The study consisted of four 45-60 minute audiotaped interviews/visits between PI and subject. The first visit took place at the Women's Health Center at Darnall during the last month of pregnancy, while the subsequent visits at baby's age 4-6 weeks, 8-10- weeks, and 14-16 weeks took place at either the hospital or at the subject's home or a place of her preference. Privacy concerns were well documented and addressed through permission form to tape interview and through transcription service confidentiality agreement (appendices to the protocol).
 - c. Protocol Master/Administrative Binder. All required documents were on file in the well-arranged binder, provided by the BAMC DCI.

d. Research Subject Folder. Each subject had a separate folder with comprehensive documentation. The 18 informed consent forms were appropriately signed, dated, and IRB-stamped.

e. Concluding Observation. The protocol was fully compliant with all Army and Federal regulations pertaining to human research protections.

4. The principal investigator, Ms. King, is to be highly commended for her meticulous work on this study protocol and the exemplary manner of documenting her research. It was a pleasure to review her research records, and I thank her for her cordial and professional cooperation.

5. I also want to express my thanks and appreciation to the hospital Command, including the Department of Nursing, for allowing me to come to their facility and for providing a comfortable room to facilitate the audit process.


CHRISTINA JONES
Clinical Studies Specialist
Clinical Investigation Regulatory Office

CF:
DCCS, Darnall ACH
Chief, BAMC DCI
Chief, BAMC Nursing Research
Mary P. King, RN, MSN

Appendix Q

Post Delivery Screening Interview

Hello (name of potential participant), this is Mary King. I really enjoyed talking with you on (insert date of first interview). Is now a good time to talk for a few minutes?

I'd like to ask you a few questions to see if you are eligible to continue in the study. Your answers to these questions will be kept confidential and you can refuse to answer any questions at anytime during this interview.

| Question | Eligibility | | Qualifier | Comment |
|---|-------------|----|--|--|
| | Yes | No | | |
| 1. Is now a good time to talk for a few minutes? Time to call back: _____ | | | If no, ask when is a good time to call you? Keep mother's needs uppermost may improve rapport. If yes, ask | |
| 2. Have you delivered your baby? Date to call back: _____ | | | If no, ask when would you like me to call you to check on you? If yes, ask | |
| 3. Did you have a boy or girl? | | | Note if: Boy Girl | |
| 4. What did you name the baby? Name: _____ | | | Note response. Keep focus on mother & baby, not research. | |
| 3. How is the <u>name of baby</u> doing? | | | Keep focus on mother & baby unit, not researcher needs. | |
| 4. What date did you deliver? Date: _____ | | | Baby must be between 37 to 42 weeks gestation to be eligible to continue in study. If yes, continue question #5 | If no: Go to script for ineligible response. |
| 5. What kind of delivery did you have? Uncomplicated Vaginal ___ Uncomplicated Cesarean - | | | If no, not eligible to continue in the study. If yes, continue question #6 | If no: Go to script for ineligible response. |
| 6. Did you get to go home from the hospital together? | | | If no, not eligible to continue in study. If yes, continue question #7 | If no: Go to script for ineligible response |
| 7. What day did you go home? Date: _____ | | | If more than 96 hours or 3-4days | If no: Go to script for ineligible response |

Post Delivery Screening Interview

Any NO will exclude the EADM mother from the study.

(Ineligible response) I'm so sorry, but you won't be able to be part of this study, because (reason why not eligible), but I do appreciate the time you gave for this very important research. Thank you again for your time, I've enjoyed speaking with you.

(Eligible response). Congratulations! You are eligible to continue in this study.

Would you like to continue in this study? YES No

I would like to set up the second visit (interview) before you return to work when baby is about 4-6 weeks old.

I would prefer to visit you at your home. (If EADM mother does not want me to come to her home, will go to alternate location script.)

What date would be best for you? What time of the day is best for you?

Date for visit: _____ Time for visit: _____

What is the best way to get to your home? (Get directions and landmarks if needed)

(Alternate location script). If you would prefer, we can meet again at the Women's Health Center or at a location of your choice where we can have privacy and I can tape record the interview. (The last alternative would be a telephone interview, however, prefer to do maximum of one telephone interview during course of study.) If location other than Women's Health Center:

How can we have privacy at (alternate location)?

Will we be able to tape record the interview at (alternate location)?

What is the best way to get (alternate location)? (Get directions and landmarks if needed, write directions on back of form.)

Appendix R
Appointment Letters and
Thank You Letters for Interview Participants

Appendix R

Thank You Letter for Agreeing to First Interview

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name):

Thank you for agreeing to participate in this very important research. You will be making a significant contribution to the understanding of what it is like to become an enlisted mother on active duty.

As we discussed on (insert date of telephone contact) I have included a copy of the consent form for you review (Enclosure 1).

Please bring the consent form with you to our first visit.

Our first visit is scheduled for:

DATE: _____

TIME: _____

Day of the Week: _____

Location: Women's Health Center

Darnall Army Community Hospital

If you have any questions or would like to contact me before our visit, I can be reached at 1-877-989-6471 (toll-free page). I am looking forward to our first visit.

Sincerely,

Enclosure Consent Form

Mary P. King, RN, MSN
Graduate Student
School of Nursing
The University of Texas at Austin

Appendix R

Thank You for Completing First Interview Letter

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name);

Thank you for sharing your thoughts and feelings about what is like to be expecting your first baby. Thank you for making a significant contribution to the understanding of what it is like to be a mother on active duty. If you have not yet completed the Demographic Information Sheet, please do so and return the sheet to me in the enclosed addressed, stamped envelope.

I look forward to talking with you after the baby is born. I will be calling you within 5 to 7 days of your expected due date of (insert expected due date) to find out how you are doing. If you are still eligible to continue in the study, I will schedule our second visit before you return to work, when baby is about 4 to 6 weeks old

If you have any questions or would like to contact me before my call, I can be reached at 1-877-989-6471 (toll-free page).

I am looking forward to talking with you.

Sincerely,

Mary P. King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix R

Congratulations Letter and
Appointment Letter for Second Interview

**Enlisted Army Active Duty First-time
Mother's Study
P. O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name):

Congratulations on the birth of your baby (insert girl or boy). I hope you are doing well and are able to rest and enjoy this time with (insert baby's name). I look forward to your continuing support for this study, and I will do whatever I can to make your participation convenient for you.

I will be at location for our second visit on:

DATE: _____

TIME: _____

Day of the Week: _____

Address: _____

Your Home number: _____

If you have any questions or would like to contact me before our visit, I can be reached at 1-877-989-6471 (toll-free page).

I am looking forward to meeting (insert baby's name) at our second visit.

Sincerely,

Mary P. King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix R

Thank you for Completing Second Interview

Appointment Letter for Third Interview

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 786130384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name):

It was a joy to talk with you and to meet (insert baby's name). I look forward to talking with you about how things are going now that you have returned to work. Thank you for your continuing support for this study. I will do whatever I can to make your participation convenient for you.

I will be at location for our third visit on:

DATE: _____

TIME: _____

Day of the Week: _____

Address: _____

Your Home number: _____

If you have any questions or would like to contact me before our visit, I can be reached at 1-877-989-6471 (toll-free page).

I am looking forward to talking with you.

Sincerely,

Mary P. King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix R

Thank you for Completing Third Interview

Appointment Letter for Last Interview

**Enlisted Army Active Duty First-time
Mother's Study
P. O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name):

Thank you for taking the time to talk with me so soon after returning to work, and for your continued support for this study. We have only one visit left to complete the study, and I will do whatever I can to make your participation convenient for you.

I will be at location for our fourth visit on:

DATE: _____

TIME: _____

Day of the Week: _____

Address: _____

Your Home number: _____

If you have any questions or would like to contact me before our visit, I can be reached at 1-877-989-6471 (toll-free page).

I am looking forward to talking with you.

Sincerely,

Mary P. King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix R

Letter of Appreciation for Completing the Study

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name);

Thank you for all of your time and for sharing your thoughts and feelings about becoming a mother on active duty and what it has been like for you since you returned to work. I have enjoyed getting to know you and (insert baby's name).

I hope that you have benefited from the time we spent together. The information you shared will benefit future mothers and those who provide health care for the pregnant active duty member.

I wish you continued success in all of your endeavors.

Sincerely,

Mary P. King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix S
Thank You Letter for Agreeing to First Interview
(NOT ELIGIBLE TO PARTICIPATE)

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name);

Thank you for talking with me about the Enlisted Army Active Duty First-time Mother's Study, however, you are not eligible to participate in this study because insert why not eligible.

I do appreciate your interest in being part of this very important research. Thank you again for your time, I've enjoyed speaking with you.

I wish you continued success in all of your endeavors.

If you have any questions, or would like to contact me, I can be reached at 1-877-989-6471 (toll-free page).

Sincerely,

Mary King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix S
Thank You Letter for Agreeing to Second Interview
(NOT ELIGIBLE TO PARTICIPATE)

**Enlisted Army Active Duty First-time
Mother's Study
P.O. Box 384
Cedar Park, TX 78613-0384**

Date: _____

Preferred Mailing Address:

Dear (EAADM Mother's Name):

Congratulations on the birth of (insert baby's name)! Thank you for talking with me as part of this study before (insert baby's name) was born, however, you are not eligible to continue in this study because insert why not eligible.

Thank you for all of your time and for sharing your thoughts and feelings about what it was like knowing that you would soon become a mother on active duty. I enjoyed getting to talk with you.

I hope that you have benefited from the time we spent together. The information you shared will remain confidential and may benefit future mothers and those who provide health care for the pregnant active duty member.

I wish you continued success in all of your endeavors.

If you have any questions, or would like to contact me, I can be reached at 1-877-989-6471 (toll-free page).

Sincerely,

Mary King, RN, MSN
Graduate Student, School of Nursing
The University of Texas at Austin

Appendix T

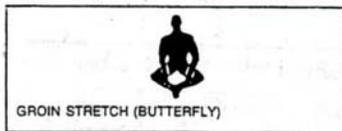
Data Analysis Grid

Code word or theme:

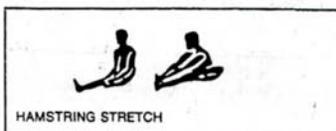
| | | | | |
|----------|--|--|--|--|
| Anna | | | | |
| Shannon | | | | |
| Samantha | | | | |
| Wendy | | | | |
| Gracie | | | | |
| Pamela | | | | |
| Rebecca | | | | |
| Ophelia | | | | |
| Candace | | | | |
| Donna | | | | |

Appendix U

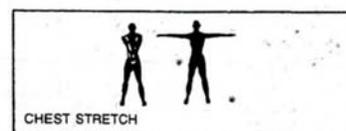
Physical Profile (*Pregnancy Profile*)



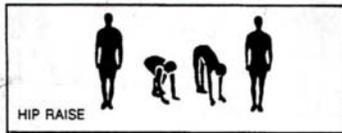
GROIN STRETCH (BUTTERFLY)



HAMSTRING STRETCH



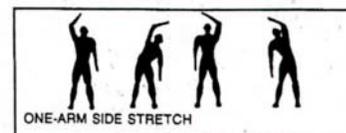
CHEST STRETCH



HIP RAISE



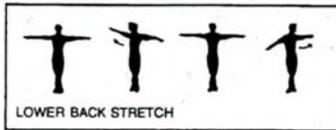
HAMSTRING AND CALF STRETCH



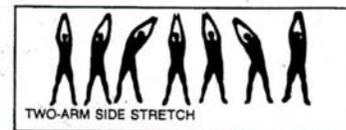
ONE-ARM SIDE STRETCH



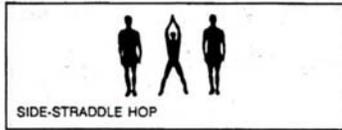
KNEE BENDER



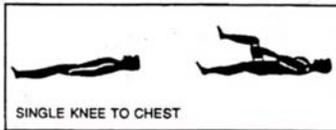
LOWER BACK STRETCH



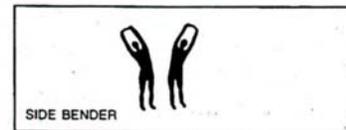
TWO-ARM SIDE STRETCH



SIDE-STRADDLE HOP



SINGLE KNEE TO CHEST



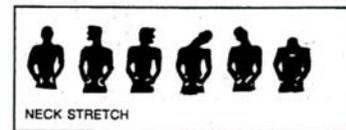
SIDE BENDER



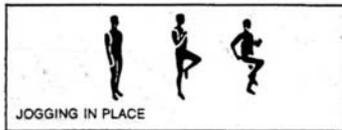
HIGH JUMPER



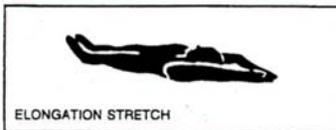
SINGLE STRAIGHT LEG RAISE



NECK STRETCH



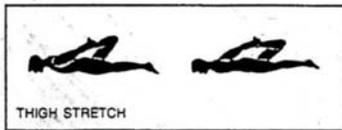
JOGGING IN PLACE



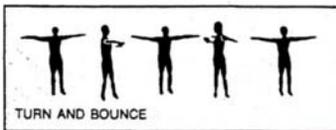
ELONGATION STRETCH



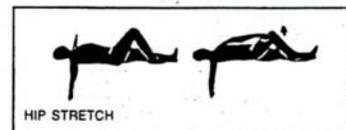
ANKLE STRETCH



THIGH STRETCH



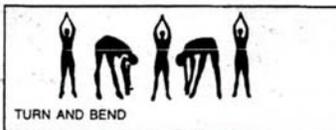
TURN AND BOUNCE



HIP STRETCH

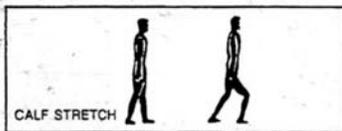


QUADS STRETCH AND BALANCE

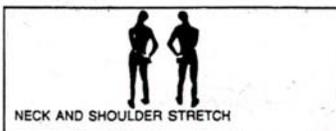


TURN AND BEND

UPPER BODY WEIGHT TRAINING
(See FM 21-20)



CALF STRETCH



NECK AND SHOULDER STRETCH

LOWER BODY WEIGHT TRAINING
(See FM 21-20)



LONG SIT



UPPER BACK STRETCH

FOR WRITTEN DESCRIPTION
OF THESE EXERCISES
SEE FM 21-20, AUGUST 1985

REVERSE OF DA FORM 3349, MAY 86

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VITA

Mary Podmolik King was born in Phillips, Wisconsin on October 23, 1949, the daughter of Francis Joseph Podmolik and Mildred Smidl Podmolik. She graduated from Phillips High School in Phillips, Wisconsin in 1967 and attended the Wisconsin State University-Eau Claire, Eau Claire, Wisconsin where she received her Bachelor of Science degree in Nursing. After graduation in 1971, Mary began a military service over the next 28 years as a U.S. Army Nurse Corps officer. She had duties as a pediatric staff nurse at Valley Forge General Hospital, Phoenixville, PA; pediatric nurse practitioner at Silas B. Hayes Army Hospital, Fort Ord, CA; pediatric clinical nurse specialist at Walter Reed Army Medical Center, Washington, DC and Frankfurt Regional Army Medical Center Frankfurt, Germany; staff Nursing Research Service, Walter Reed Army Medical Center, Washington, DC; ambulatory supervisor and assistant chief nurse, Walson Army Community Hospital, Fort Dix, NJ; Chief, Department of Nursing, U. S. Army Medical Activity, Fort Drum, NY; and Deputy Commander for Nursing, DeWitt Health Care System, Fort Belvoir, VA. In January 1977 she obtained her Masters in Science in Nursing from Indiana University School of Nursing, Indianapolis, IN. Upon leaving the military in August of 1997, Mary worked part-time as graduate research assistant at the University of Texas at Austin while completing course requirements for her PhD.

Permanent Address: 608 Palo Alto Lane, Cedar Park, Texas 78613-2941

This dissertation was typed by the author.