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The successive-unsettled transitions of migration and their impact on postpartum concerns of Arab immigrant women

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The Successive-Unsettled Transitions of Migration and Their Impact on Postpartum Concerns of Arab Immigrant Women

by

Yousria A. ElSayed

DISSERTATION

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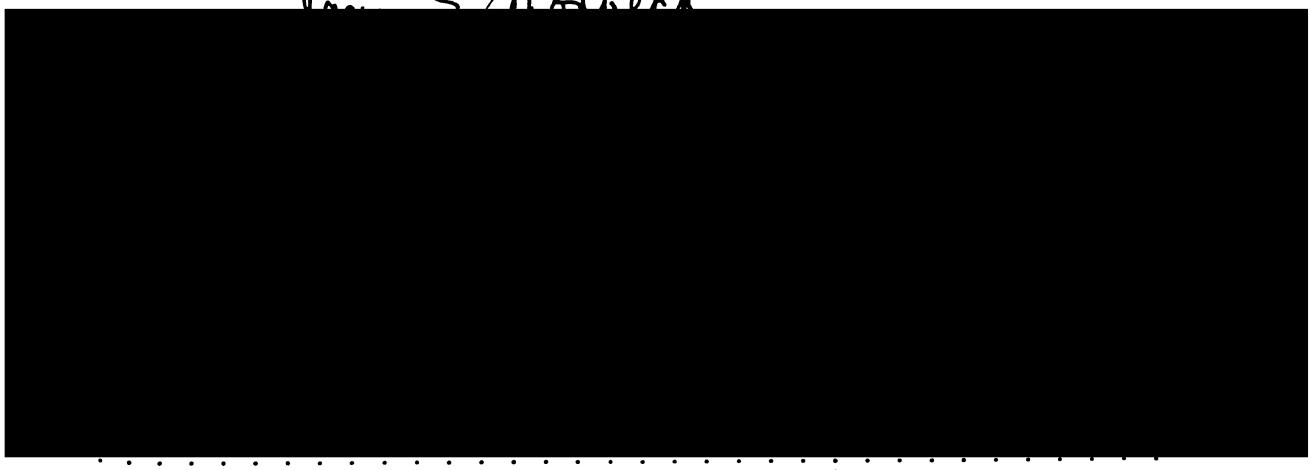

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ABSTRACT

The Successive Unsettled Transitions of Migration and Their Impact on Postpartum Concerns of Arab Immigrant Women

Yousria A. ElSayed, R.N., D.N.Sc.

This study examined the question of how Arab immigrant women manage their postpartum transition under the impact of the migration changes. Comparative analysis from grounded theory was utilized to formulate a substantive theory which illuminated the processes involved in both of migration and postpartum transitions and the interaction between them.

A prospective, longitudinal approach was followed using semistructured interviews and participant observations in a natural field research context. A total of 51 interviews was conducted with 18 pregnant women, each of whom was interviewed in late pregnancy, within the first week postpartum, and at four to six weeks postpartum.

The category of successive unsettled transitions emerged from data analysis as a key concept that described the migration experience of the women under study and identified the consequences of their relocation in the United States. Such consequences constituted the foundation for the new context within which the tasks of postpartum were undertaken.

The category of successive unsettled transitions refered to transitions that occurred in a successive manner; were not completely resolved; and resulted in the consequences of change in social roles, change in life style, change in social interaction and social support system.

The interaction of the physiological and psychological components of postpartum with the processes of relocation were found to add new dimensions to the Arab women's experience of postpartum. As a result, Arab immigrant women displayed some concerns during this period that were distinct to their own situation: constant appraisal and facing of uncertainties during late pregnancy; conflicts between old and modern systems of birth; and postpartum strain.

A number of factors were found to influence the relationship between the processes and consequences of relocation and the postpartum concerns. These factors were: parity, gender of the sibling, infant's sex, marital relationship prior to the arrival of children. However, social support and type of social network structure were the most pervasive variables that were directly related to the amount and quality of postpartum concerns. Demographic and migration characteristics influenced the relocation transition, and thus indirectly postpartum transition.

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CHAPTER 1

INTRODUCTION

The puerperium has been identified as a particularly critical phase in the childbearing cycle. Several clinicians and researchers stated that the difficulty of this period stems from a number of concerns or difficulties that the new mother has to face. These include physical and emotional restoration after delivery, bonding with the infant and learning about its needs, assuming the maternal role, and readjusting the pre-existing roles and relationships to accommodate the new baby into the family (Rubin, 1961, 1970, 1972, 1983; Tanner, 1971; Carlson, 1976; Mercer, 1981; Donaldson, 1981).

Cross-cultural investigations on reproductive behaviors demonstrate the recognition by most cultures of the first 40 days postpartum as a period of vulnerability for the mother and the infant. Every culture tends to produce a set of practices and beliefs that are consistent with its particular context to manage the biological changes of the postpartum as well as the psychological and social difficulties associated with it (Mead et al., 1967; Jordan, 1978, 1981; Wood, 1979; Kay, 1982; Horn, 1981).

Over the last several decades, a growing body of studies have examined the psychological and social factors influencing pregnancy and the periods (early/late) following birth (David et al., 1963; Grimm et al., 1966; Shereshefsky & Yarrow, 1973; Leifer, 1977, 1980; Westbrook, 1978; Entwisle & Doering, 1981; Mercer, 1980). However, none of these studies explored cultural change as a variable that might influence birth and postpartum experience.

Some empirical studies (Stern et al., 1980; Bryan, 1981) have indicated that women who were born and raised in one culture and experience their pregnancy and postpartum in another face some problems that add considerably to the difficulty of their experience with these events. It is suggested that these problems derive primarily from two sources, a) the sociocultural changes that the woman faces on her relocation in a different culture, and b) the cultural differences in the birth system between her culture and the new one. Very little is known about these two concepts in association with pregnancy and/or the peurperium. Therefore, this study will explore and describe what the early postpartum period (first 40 days) is like for women under sociocultural change. Arab American maternity patients will be the population of concern for this study.

Background

In the last two decades the number of Arabs in the United States has increased. This is thought to be due to the unsettled political climate in the Middle East. According to various sources, there are between 2-3 million Arabs residing in the United States (Meleis & Sorrell, 1981; Lipson & Meleis, 1983).

Arabs come to the United States for different purposes and motivations; their stay ranges from short to long periods, and also varies from temporary to permanent. Because of this, their relocation in the United States encompasses a diversity of experiences and a wide range of adjustments. Meleis (1981) and Lipson et al. (1983) identified three categories of variables that determined the extent of the Arab's

relocation experience and the range of difficulties triggered by its course. These include: country of origin, religion, urban or rural background, length of stay in the United States; ethnic identity, which means how strongly individuals identify with their ethnic group, and whether or not they are extensively acculturated in the new society; and the socioeconomic spectrum in which level of education is the most important aspect.

Some investigations on the Arab migration to the U.S. reported that these immigrants face numerous difficulties as a result of the social and cultural shifts which their relocation experience entails. For example, like any other immigrants, Arabs have to cope with the loss of their familiar environment, the disruption of their kinship ties and social support system, and the change in roles, family structure, and life style (Abu-Laban, 1980; Elkholy, 1976). Arab American women were described to experience even more changes in these aspects (Meleis & Sorrell, 1981). Furthermore, it was reported that Arab Americans face difficulties related to identity conflicts and the conflicts between two systems of values, customs and beliefs (Kayal et al., 1975; Wassef, 1977). Authors dealing with health care issues of Arab Americans (Meleis, 1981; Lipson & Meleis, 1983) pointed out that the unique social and cultural properties of this group and the communication barriers between them and the health care providers lead to numerous problems that add to the stressors of their relocation to the United States.

Arab immigrants appear in increasing numbers in the health care system, and despite the size of this ethnic minority, little is known about their health problems. As mentioned before, Arabs have unique social and cultural properties that shape their styles of interaction,

and their values, customs, and beliefs, especially those controlling health and illness behaviors (Meleis, 1981; Meleis & Sorrell, 1981; Lipson & Meleis, 1983). Furthermore, some literature on birth and postpartum in the traditional Arab culture describes that the concerns and dangers associated with this event are culturally learned. Specific rituals and practices have been invented by the culture to guide the management of these concerns (Morsy, 1982; Ragheb & Smith, 1978; Govearts & Patino, 1981).

The question of how the Arab women who relocated in the United States face their postpartum period under the above described social-cultural changes needs to be examined.

Purpose

The purpose of the study is: 1) to develop a substative theory that describes and explains the postpartum transition of the Arab women under the impact of relocation to the United States. The focus will be on changes in tasks, concerns, and rewards of this period as emerged from the women's experience, and 2) to provide the health care professionals who take care of Arab maternity clients with information that explain the behaviors, expectations, and needs of these clients during their early postpartum period.

Significance

The usefulness of this study stems from two perspectives, the theoretical psychosocial perspective of pregnancy and postpartum, and the clinical perspective of maternity health care.

From the theoretical perspective, this study has the potential of

contributing to the body of knowledge on the psychosocial aspects of postpartum transition. By generating knowledge on this transition in a different cultural setting, and by bringing to the focus a new variable that is impacting on its course, this research will expand the existing knowledge on the variables affecting postpartum adjustment.

From the clinical perspective, this study may be useful to the maternity health care providers who manage health care of the Arab American pregnant women. Arabs migrate in families as well as individuals (Swan, 1974; Wassef, 1977). Women constituted approximately 74% of Arab immigrants in the middle waves of Arab migration to the United States (Naff, 1983). Those who are in the childbearing age receive their maternity care in the American health care system. They face numerous problems, partly due to their inability to communicate their needs to the health care providers, and partly due to the difficulty understanding the Arab client's beliefs and values on the part of the health care givers (Meleis, 1981).

Maternity care providers in different health care settings in the San Francisco Bay Area observed that postpartum Arab patients experience difficulty in following the health instructions before and after hospital discharge. (Interviews with maternity nurses at San Francisco General Hospital and the University of California, San Francisco's obstetrical clinic, ElSayed, 1983-1984).

This study is expected to provide information to health care providers to be more sensitive to the cultural variations among clients and to assist in modifying the care plan to meet the specific variations in the case of the Arab maternity client.

CHAPTER 2

REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

This study was influenced by ideas from transition theory as developed by developmental, anthropological and sociological theories. The concept of transition provides a fruitful perspective for the study of postpartum and relocation as two events occurring consequentially at the same point in one's life situation. The basic question was: What happens when women manage their early postpartum transition under the impact of a set of sociocultural changes resulting from another transition in their lives, that is, the relocation to a new environment? The study was designed to look at the social and cultural changes of relocation as a context within which postpartum occurred.

The aim of this particular perspective was to provide a more interactional view to the meaning of the postpartum experience through adding new dimensions to its understanding and bringing to focus an additional variable that is anticipated to impact on its course and outcome. Concepts from transition theory provided a theoretical guide to examine the two variables central to this study, that is, postpartum and relocation. In this chapter, an overview of transition as a perspective will be presented, followed by a review of literature on both postpartum and relocation using the transition perspective. Three main sections will be included and will cover the following: overview of transition as a theoretical perspective, postpartum as a transition, and relocation as a transition.

Section 1: Overview of Transition as A Theoretical Perspective

Definition and Classifications

The word 'transition' was derived from two latin words meaning 'to go across'; it refers to a passage or a change from one place, state, or set of circumstances to another (Tyhurst, 1957; Chick & Meleis, in press). A transition is a period connecting two life states of greater stability. It is a process that involves the death of a status (or state) pertaining to a particular stage of life and the rebirth of another status that is defining another different stage (Van Gennep, 1961; Hughes, 1984; Levinson, 1978). A status is a combination of duties and privileges; difficulties and joys; psychological feelings and social ways of conduct that are appropriate to a particular state of life (Hughes, 1984).

Van Gennep (1961) used the term 'passages' to describe transitions. He conceived that man's life is made-up of a succession of periods with a series of passages connecting them. During these passages, special rituals are followed to guide actions through the move from a certain period (a stage, a position, a phase, a condition, a group, or a place) to another and to assume the particular status pertaining to each new period.

Levinson (1978) viewed transition as a boundary zone between two states of greater stability; the person in transition was thought of as being 'on the boundary' experiencing the termination of an ending state and the initiation of a commencing one. A sense of a gradual change is experienced until a 'turning point' or a 'threshold' is reached after

which a new period of life with new forms and structures is started. This involves ending some important aspects of the previous period, maintaining or modifying some others, and creating some new ones.

Transitions have been addressed in conjunction with the concepts of crisis, loss, stress and life events; however the theoretical and empirical distinctions between this concept and the other ones are still not clear. This might be due to the lack of a valid typology of transitions to delineate the characteristics of each transitional period and its specific areas of difficulties.

There are several ways of classifying transitions, most of which are theoretical rather than research-based. For instance, Parkes (1971) based his categorization on the notion that transitions are periods during which a person experiences the need to restructure his ways of looking at the world as a reaction to a major change in his life space. He suggested that transitions could be classified according to the area of life space that undergoes the change. The first category included those transitions that follow a change in personal relationships like getting married, having children, growing older, or losing a relationship through separation, divorce or death of a spouse. Such transitions were found to be linked to stages of the life cycle. The second category included those events that involve a change in a familiar environment or possessions, like in migration, relocation, or disasters. The third category of transition was described to follow changes in role and status or even alteration in physical capacities and body image due to loss of body parts or impairment of body function by an accident or illness.

Pearlin (1980, 1983a) classified transitions in two broad categories of scheduled and non-scheduled transitions. In the first category he included all the life cycle-transitions, and in the second one he listed all the other kinds. According to him, scheduled transitions occur gradually and take a longer time to happen, and are anticipated in most of the cases. Whereas the non-scheduled ones occur in a sudden, unexpected manner, and therefore are seen as more taxing emotionally and socially.

Finally, in a theoretical paper on transition as a central concept of nursing, Chick and Meleis (in press) outlined three groups of transitions that were organized around the different types of life events. These included, life cycle transitions, situational transitions, and health-illness transitions. It is also suggested that all transitions seem to occur and proceed in a common pattern regardless of their type (category). However, more knowledge is needed to describe and explain how the type of transition contributes to its specific properties (Chick & Meleis, in press).

Dimensions

Transition is a multidimensional concept. For example, duration, scope, magnitude of effect, degree of anticipation, and the subjective meaning attached to it are some dimensions suggested for developing measurements to assess transitional experiences (Chick & Meleis, in press). However, these dimensions are more dependent on the type of the transition itself, and therefore are not yet fully developed. On the other hand, there are other groups of dimensions that are common to all transitions, these are process, tasks, and outcomes.

Process. Contrary to the belief that transition is a 'state' of change from one situation to another (Tyhurst, 1957; Weiss, 1976), other theorists describe it as a process that encompasses phases, sequence and progression over time (Van Gennep, 1961; Parkes, 1971; Hughes, 1984; Levinson, 1978; Bridges, 1980; Chick & Meleis, in press). It is also suggested that the phases merge into one another instead of occurring discretely (Chick & Meleis, in press).

Van Gennep (1961) wrote that transitions proceed in three sequential phases, separation, transition, and incorporation, and that these phases and the rites accompanying them differ in their prevalance and duration according to the kind of the transitional event itself. In other words, the phase and rites of separation were more prominent in the event of death, whereas the phase and rites of incorporation were most elaborate in the event of marriage, and finally, the phase and rites of transition were more dominant in the event of pregnancy and birth.

More recently, Bridges (1980) outlined three stages of transition that were analogous to the above described phases. This included, an ending period of life, followed by a period of confusion and distress, leading to a new beginning.

Levinson (1978) and Hughes (1984) maintain the notion that the transitional process should occur to move the person from one world to the other, the middle phase was seen as the neutral zone between the two worlds, and the person in transition was described as waving to both of the worlds. This zone would shrink with the progression of the transitional process until a turning point to mark the entry of the

person to the new world was reached. At this point, actions of incorporation should be taken to unite the person to the new group.

Tasks and outcomes. The main purpose of transition is to terminate a certain period in an individual's life and initiate a new one. A process of reappraisal of the past should occur before approaching the future. As a result, numerous issues are raised regarding one's self and the world, and the need to settle these issues becomes a crucial task. Aspects in self or situation that are no longer useful should be cut out and new aspects may be sought. The sense of unsettlement and marginality, the definition and re-definition of self and situation, and the feeling of being suspended or 'disconnected' before a change occurs, constitute the basic ingredients of transition and are responsible for its common features (Parkes, 1971; Levinson, 1978).

Parkes (1971) postulates that the task of re-examining the self and the world is essentially painful because of the threat it carries to the 'assumptive' world that the individual has already established and upon which his sense of security depends. Levinson (1978) on the other hand, suggests that the difficulty of transitional tasks lies in the need to balance the losses and gains involved in the process of making the crucial choices that will be the basis of the coming stage of life and will determine the future life structure.

Transitions usually end with the setting up of choices for the coming life period; then a new, more stable period will start with the task of rebuilding one's life structure around the selected choices. Thus, the outcome may include both losses and gains (Levinson, 1978; Parkes, 1971) or might bring more or less change than the pre-

transitional periods (Chick & Meleis, in press). This depends on the type of transition, the magnitude of disorganization associated with it, the personal meaning attributed to it by the individual and also by the circumstances surrounding it.

The Value of Transition to This Study

The potential value of transition for research lies in the fact that this concept does not imply a prejudged stressfulness or indicate a certain kind of an outcome, which is a limitation of the other related concepts like stress and crisis (Caplan, 1961; Weiss, 1976). More over, transition encompasses a variety of responses to change and a wider range of consequences according to the magnitude of change. This is particularly true if a contextual framework is used to study questions related to whether or not transitions are stressful and to what extent this depends on the fact that a transitional event occurs in isolation from or in interaction with other events. This research examined two different transitions as they intersect with one another, that is the postpartum transition and the cultural transition of relocation.

Section 2: Postpartum as Transition

Using the various classifications of transitions, the postpartum period falls under the category of scheduled transitions that are closely tied to the life cycle. Postpartum could also be described as a psychosocial transition according to Parkes' (1971) typology, because it encompasses changes in one's life space and previous relationships.

Based on the fact that scheduled transitions are anticipated and occur in a gradual manner, they are not viewed as particularly

stressful (Pearlin, 1983a, 1983b). However, these transitions were acknowledged as significant in one's life because they call for reconstructing of relationships, life style, roles and self-concept.

Most recently, pregnancy and postpartum have been viewed as two phases of a maturational transition. While pregnancy is viewed as a phase of disorganization due to its characteristic biological and psychological changes, postpartum is defined as a period of reorganization. The two phases are proposed by the developmental perspective to carry the potential for further levels of adult development (Caplan, 1959, 1961; Bibring et al., 1961; Bibring, 1965; Benedeck, 1949, 1970; Leifer, 1977, 1980; Ballou, 1978; Shereshefsky & Yarrow, 1973; Grossman, 1980).

Being grounded in psychoanalytical traditions, the developmental perspective concentrated more on the psychological and interpersonal definitions of postpartum, with less attention to the contextual and interactional aspects. The latter aspects were provided by the social and family theories. The nursing literature, has drawn from both of the above perspectives, and in addition has examined the biological regenerative processes of postpartum. The bio-psychosocial process of postpartum involves three main domains, which have been described in literature as the tasks of bodily healing and physical restoration, psychological readjustment and orientation to the infant, and reorganization of relationships and restructuring of life style.

Bodily Healing and Physical Restoration

Parturition is an intense physical experience for a woman. During this period physiological and hormonal changes take place to assist the

body to adapt to the return to the non-gravid state and to establish the lactation process. In addition, this period is characterized by intensified fatigue and discomfort because it incorporates residuals from the long draining course of pregnancy followed by the intense events of labor and delivery (Rubin, 1961; Carlson, 1976; Sumner et al., 1977; Grossman, 1980; Mercer, 1981).

Physical restoration is a prerequisite to postpartum adjustment and assuming maternal responsibilities. The new mother is concerned about how she will be able to assume responsibilities for the baby when she cannot control her own bodily functions such as bowel movements, lactation, and uncomfortable sitting due to sore perineuim or episiotomy. Carlson (1976) and Rubin (1961, 1983) identified assimilation of body changes and reconstitution of body wholeness and integrity among the earliest needs of postpartal women. Among the concerns of women during parturition were the loss of control over body functions, feeling of loss of body intactness, and dissatisfaction with postpartum body figure (Rubin, 1961, 1970, 1972; Mercer, 1981; Russell 1974; Donaldson, 1981; Tanner 1971; Gruis, 1977; Moss, 1981; Strang et al., 1985). Gruis (1977) explored postpartum concerns among 40 mothers, 17 of whom were primiparae and 23 were multiparae. She reported that 65% of the mothers listed physical restoration and the return of body figure to normal as their major concern. Other concerns like regulating the infant's needs, household duties, and husband's demands were ordered as minor. Furthermore, Bull (1981) found that the women's concern regarding physical self care persisted until the first week postpartum, whereas the concerns regarding emotional changes increased significantly after the first week.

Fatigue is an inherent component of puerperium after the physical burden of pregnancy and the exhausting work of labor and delivery. Fatigue contributes to the woman's emotional distress and feelings of inadequacy (Gruis, 1977; Liefer, 1977, 1980). For example Leifer (1977) found that fatigue reached a peak-point at the first month postpartum among a sample of 19 mothers she studied using a longitudinal design to describe the emotional changes accompanying pregnancy and puerperium. The author also pointed out that while the physiological discomfort of pregnancy was accepted among these mothers during pregnancy as a part of its normal course, the postpartum fatigue was not anticipated by most of the mothers. The persistence of fatigue created a psychological distress that was more intense than during the period of pregnancy. Mercer et al. (1982) identified fatigue as the dominant characteristic of the physical condition of women (N=294) at one month postpartum in her longitudinal study on factors influencing maternal role attainment.

Also, fatigue can limit the amount of energy the mother has available to interact with her infant. Shereshefsky and Yarrow (1973) found that early mothering was hampered by the intense, unanticipated fatigue, along with the inability to read the infants cues during the early period of postpartum. In their study of the development of feelings of attachment toward the infant among primiparous mothers (N=54), Robson and Moss (1970) reported maternal fatigue as one of the factors that increased the emotional distance between the mothers and infants during the first few days and until 3-4 weeks postpartum. By 4-6 weeks, mothers had regained a sense of physical well-being and felt more confident and secure about handling their infants' behaviors and needs. As this happened, the intensity and quality of the mother-infant

relationship progressed.

In summary, fatigue and physical incompetence are major properties of puerperium. The notion that this physical decompensation contributes significantly to the postpartum emotional distress is conceivable although the influence of the hormonal changes during this period have been overlooked in the literature. More importantly, the non-accepting attitude of new mothers to their physical and emotional dependence during the first few weeks postpartum adds to the difficulty of managing the tasks of this period.

Psychological Readjustment and Orientation to the Infant

The earliest psychological readjustment work evolves around the recovery from delivery shock. This involves the woman's redirecting of her energy from the inner sphere of self to the outer sphere (Deutsch, 1945; Rubin 1961, 1983). Rubin (1961) observed that as labor progressed a woman withdrew her energy from what was happening around her and increasingly centered her energy on what was happening with herself. Postpartally, this process reversed and the mother gradually began to invest her energy in the immediate environment and surrounding persons. The recovery process was also described as bringing a mix of feelings of elation, surprise, gratification, and accomplishment, followed by feelings of anxiety, worry and depression (Robson & Moss, 1970; Leifer, 1977; Grossman, 1980). The latter feelings were found to increase at the second month postpartum (Leifer, 1977) and were also suggested to persist through the first year of the infant's life (Grossman, 1980). In addition, early puerpural psychological changes carry some residuals from the psychological course of pregnancy. Clinical observations

documented that women continue to show some dependency, passivity and low initiative behaviors during the first few days after delivery (Deutsch, 1945; Rubin 1961, 1972). Rubin (1961) referred to these behaviors as 'taking-in' needs that should be satisfied before the mother can progress to the active phases of assuming the maternal role.

One of the woman's crucial needs during the immediate postpartum period is to assimilate cognitively the labor and delivery experience into the self. Affonso (1977) demonstrated the need to provide each woman with opportunity to review and understand her labor and delivery experience before she can move forward to her prospective maternal role. In a group of women (N=85) that she studied she found that more than three-fourths were unable to recall their childbirth events and kept searching for the missing pieces. The inability to fill the gap in memory abut this experience was a source of stress and frustration for the women. Mercer (1981) pointed out that by reviewing the labor events, women evaluate the whole experience and appraise their own performance in relation to the labor work. The woman's perception of the events and her sense of herself in relation to them are important for providing a positive input for the validation of her ability to function in a mothering capacity.

The need to establish the initial mother-infant interaction comprises another important aspect of early postpartum. One of the purposes of this interaction is to learn about the infant's behavior and become sensitive to its needs, this will in turn facilitate the undertaking of the infant's care demands. The process of establishing the early maternal-infant relationship involves certain tasks that should be accomplished by the mother: relocating the infant outside her

body sphere, reconciliating the real baby with the baby fantasies of pregnancy, and identifying the infant as a unique individual that belongs to the self (Robson & Moss, 1970; Rubin, 1972; Mercer, 1981). Gruis (1977) explained that the pressure by the American culture on the mother to carry out the infant care demands when she is still physically handicapped and not fully acquainted with the infants' behaviors and needs, constitutes the major part of 'postpartum tension and frustration' for women in this culture (p. 184). Furthermore, uncertainty about the infant's behavior was found to contribute to the mother's emotional distress and feelings of inadequacy during the first six months postpartum (Shereshefsky & Yarrow, 1973; Leifer, 1977).

Reorganization of Relationships and Restructuring of Life Style

Upon the arrival of the newborn, a mother finds it necessary to rearrange her pre-existing relationships to incorporate the new family member. The mother is also required to redefine her previous roles to accommodate the new maternal role. Primiparae may become concerned about their relationship with their spouses, multiparae on the other hand, are concerned about their relationship both with their spouses and their previous children (Mercer, 1979, 1981). Moss (1981) found that at three days postpartum the area of family relationship, especially sibling reaction, was ranked among the highest areas of concern by multiparous mothers (N=56). Concern about postpartum physical recovery was ranked as a relatively low concern except for weight and return of figure to normal. Also, although these mothers showed a high interest in baby's growth and behavior, they ranked this area as the lowest area of worries. Gruis (1977) reported that multiparous mothers' focus of

concern is on the strain that the new child places on the rest of the family more than the demands of the daily care of the newborn.

Studies which focused on first-time mothers indicated that the early postpartum period was a time when the family reconstituted itself. During such time most of the couple's energy was spent in taking care of a helpless, dependent infant. This called for a great deal of reorganizing and repatterning of life routines to meet the infant's demands in addition to the other parental obligations (Grossman, 1980; Shereshefsky & Yarrow, 1973; Entwisle & Doering, 1981). However, little or no change was reported in relation to the quality of the interpersonal relationship between the partners due to the early demands of parenthood, especially for those couples who had a satisfying marital relationship before the arrival of the child (Entwisle & Doering, 1981; Westbrook, 1978). More recent studies indicate that the change in partner relationships took a positive more than a negative direction. In most cases, the partners felt closer and more attracted to each other during the early period of postpartum (periods ranging from 4 weeks to 6 months postpartum). This occurred, despite the disrupting effect of postpartal changes (vaginal and breast secretions) on the partner's sexual activities (Hames, 1980; Ellis et al., 1985). Although, in some instances these changes were found to produce dissatisfying responses to sexual relationships by both partners, and a drop in sexual desire from the woman's side (Fishman et al., 1986), there was no indication of alteration in the interpersonal relationship between the couple.

Transition to parenthood studies focused on the impact of the arrival of the first child on the couples relationship. Jacoby (1969) questioned the advisability of labeling parenthood as a 'crisis'.

According to him, this concept emphasized the negative aspects of parenthood and failed to differentially describe the gratification as well as the difficulties of that experience. Later studies (Hobbs, 1968; Hobbs & Cole, 1976; Russell, 1974; Miller & Sollie, 1980) used the concept of transition to study early parenthood.

Russell (1974) investigated a random sample of 271 couples in relation to their perceived degree of crisis (a change in self, spouse or relationships with significant others which is viewed as bothersome); marital adjustment; and gratification of transition in the first year of parenthood (6-56 weeks postpartum); Hobb's (1968) self-reported check list was used to measure the extent of crisis and a gratification checklist was used to assess things that parents enjoyed about their new role. Findings indicated that although parents experienced a slight to moderate degree of crisis as they entered their parenthood, they also reported rewarding and satisfying feelings. The mother's crisis scores were higher than those of the father's, and the problem areas of adjustment differed between them. For instance, mother's concerns clustered around the physical and emotional self in terms of tiredness, interrupted sleep, loss of figure and emotional upset. Fathers on the other hand, frequently checked items more related to external conditions such as financial pressures, change in plans, and the increased amount of work required by the baby. The most important variable that was found associated with the couple's crisis response was the degree of marital adjustment after the arrival of the baby. The gratification response was related to the degree of marital adjustment, planning of pregnancy, and the characteristics of the baby. In addition, it was found that more educated couples reported less gratification with

parenthood.

Russell's study was critiqued for encouraging socially-desirable responses by using 'bothersome' as connected with parenting of new children. It was suggested that, as a reaction to this phrase, parents might have reported less levels of stress than they actually experienced. Another limitation of the study was that it used a one-shot measure of parenthood transition that did not provide for examining the process of transition over time.

Miller and Sollie (1980) attempted to avoid these limitations in a longitudinal study with 109 couples at three points in time, midpregnancy, first 6 weeks, and first 6-8 months of the baby's life. Measures of personal well-being, personal stress, and marital stress were used to assess the couple's feelings about their present lives. This was done by asking them to respond to a semantic adjective pair scale on personal stress and well-being. (Life is interesting-boring, joyful-miserable). It was expected that this scale would provide for more objective responses. Marital stress was measured by a tool that indicated the degree to which the couples felt bothered, bored or tense in their day-to-day marriage relationship. Results indicated that both mothers and fathers reported an increase in their personal stress and a drop in their personal well-being from pregnancy to the first month after delivery, and from then to the eighth month postpartum. These findings are consistent with Leifer's (1977, 1980) and Grossman's (1980). Only mothers showed increased marital stress over the three time periods.

In summary, findings of the above studies have suggested that the first few months after the baby's arrival is slightly to moderately

disruptive to the couple's personal and marital lives. Mothers have been found to be more likely disrupted and less satisfied with their marriages than fathers. Late postpartum months were found to be more stressful than the earlier ones.

Conclusion

Psychosocial processes involved in puerperium as presented in the literature indicate that this period represents a transition in the woman's life. The following are the main facets:

1. Biologically, postpartum is a period that marks tremendous physiological regenerative changes that help the body bridge from the postpartum to the pre-pregnant state
2. Psychologically, postpartum is an event that brings a number of emotional transitions, including reorientation to body image and functions, redefinition of self-concept as a mother, and relocation of the infant outside body sphere to build the early mother-infant relationship.
3. Finally, postpartum is a period that calls for transitional changes in the mother's relationships, especially with her significant others. It also brings the need to redefine roles and readjust life style to fit the infant's schedule.

The description of postpartum provided an inclusive understanding of this period by looking at it from different perspectives. However, the fact that most of the existing literature derived from research studies representing a certain social, economical, and cultural group of women/couples limits the scope of the concepts defining this experience. In other words, the description of postpartum in the literature reflects

mostly the experiences of the middle class, white, American, married, first time parents. Ambiguity still exists in relation to the contribution of the socioeconomic, demographic, ethnic, and cultural variables to the understanding of puerperium and the extent to which it is actually experienced as stressful.

A few studies (Entwisle & Doering, 1981; Westbrook, 1979; Grossman, 1980; Blumberg, 1980; Mercer, 1980; Mercer et al., 1982; Mercer, 1985) demonstrated the potential influence of the above variables on the way postpartum experience is perceived and managed. Westbrook (1979) reported that Australian women selected from three different socioeconomic classes (upper, middle, and working) differed significantly in their attitudes and affective responses to their postpartum experience (207 months). Working class women had a more positive attitude and lower scores of anxiety than the other two groups of mothers who did not differ significantly. Furthermore, Blumberg (1980) found that among the demographic variables of a low socioeconomic, minority group of women (N=100), age accounted for a significant variance in postpartum anxiety among these women. Younger mothers reported higher levels of anxiety. Also, the interactions among the demographic variables correlated with these women's perception of the pregnancy and postpartum experiences. For example, black mothers were found to be single, protestant, and from lower socioeconomic groups, and they were found to express less desire for pregnancy and less satisfaction with the sex of the infant than the mothers from the other groups. Mercer (1980) and Mercer et al. (1982) examined the effect of maternal age among a number of other variables on the postpartum adaptation and the adjustment to the maternal role. Age was

found to contribute either directly or indirectly (by interacting with other social variables) to the perception of and adaptation to maternal role demands in early and late postpartum periods. However, in a more recent study, Mercer (1985) found that age did not account for variations in maternal role attainment over the first year of motherhood. Mothers in their teens, twenties and thirties presented similar patterns of achieving competency in the role and integrating mothering behaviors into their role set. More studies are still needed to draw consistent findings on the relationship between the social, demographic, and ethnic variables and concepts defining postpartum.

Section 3: Relocation as Transition

Definition

Relocation is defined as an experience that involves a move from a familiar to an alien environment (Tyhurst, 1957; Parkes, 1971; Brink & Saunders, 1976). The words relocation and migration are used interchangeably in the literature. It is emphasized that this experience represents a major life transition rather than the mere geographical move because it is less likely to be scheduled, compared to other events, and it entails various levels of change as a motive, a strategy, or a consequence (Brink & Saunders, 1976; Coelho et al., 1980). For example, Brink and Saunders (1976) used the term, cultural shock to describe people's response to the transition to an unfamiliar environment. Based on Oberg's (1959) work, the authors explained that in cultural and environmental transitions, individuals are placed in a situation where former patterns of behavior are totally unfunctional and basic cues for social interaction are absent. As a result, change

becomes a crucial task.

In addition, some migration studies have revealed that people migrate looking for a change in their life conditions through finding better jobs and higher wages (Cohen, 1981; Beca & Bryan, 1981; Population Report, 1983), or searching for a different quality of life (Saleh, 1975; Hull, 1979). It is also observed that as people relocate in the new environment, they face different levels of change in the areas of family structure, social support, occupational and material resources, and styles of interpersonal interactions (Abu-Lughod, 1962; Gheetam, 1972; Coelho et al., 1980). However, with the exception of Cohen's (1981) study, the above studies have not specifically distinguished between men and women. In the following discussion an overview on the process and consequences of relocation as a transition will be provided. More emphasis will be placed on the immigrant women.

Process and Consequences

Relocation occurs in phases that are analogous to those of general transition theory as outlined in the framework for this study, that is separation, transition and incorporation. Writings that described migration from different perspectives have consistently demonstrated that the relocation process begins with a period of separation (dislocation) from the home environment and entry to the new environment, followed by a period of transitional changes in one's self as a response to the changes in the external world, and then a period of relative settlement (integration) concludes the whole process. Each of these phases is expected to trigger certain social and psychological

difficulties that are specific to its nature (Bernard, 1967; Sluzki, 1979; Brink & Saunders, 1976). Sluzki (1979) and Brink and Saunders (1976) challenged the concept that the early period following the move to the new environment is the most stressful phase in relocation. They postulated that the middle phase of relocation is the most crucial one, because it is during this phase that the previous behaviors prove ineffective, and the need for reappraising them becomes requisite for a better compatibility with the new context.

In his model of family relocation process, Sluzki (1976) outlined three phases, namely: overcompensation, decompensation, and intergenerational conflict. The overcompensation phase is the one that follows immediately the act of migration and is organized around the tasks of family survival in the new environment, where priorities are given to the satisfaction of the basic needs of accommodation. During this period the previous family roles and styles are maintained or even emphasized. Also, the conflicts between the family roles and those of the host society are less subtle. Sluzki also wrote that as a strategy of survival, the family members assign fixed roles for each, they may even split between instrumental and affective roles. Most commonly the wife would take the affective, inward role and the husband will assign himself to the practical, outward role.

A critical phase of decompensation follows the initial phase, where the reshaping of reality becomes the major task in order to maximize the family's compatibility with the new context. According to Sluzki, this phase may take months or years after the migration act. During such time the family resources and coping styles are tested. Some roles and values that used to be effective in the country of origin may be found

less adaptive in the host country and thus may need to be changed. On the other hand, some roles may prove to be functional in both cultures and so will be maintained. In addition, many other styles will be retained in spite of their incompatibility, partly because they are part of the family identity and sense of cohesiveness and partly because the family is not able to develop other ways of coping. Sluzki emphasized that this phase of the relocation process is critical because the rigid division of roles that proved to be effective in managing the first few months can no longer hold. A discrepancy in the social and psychological status between the family occurs. For instance, while the outward-oriented members will develop autonomous adaptive traits and establish a satisfactory network, the inward-oriented members will remain isolated, and may be perceived by the other members as ignorant of the norms and customs of the new culture. This results in clashes in family relationships.

The phase of intergenerational conflict is the final phase in the process and marks a revival of cultural differences between the family and the host society. Sluski described that the offspring of the immigrant parents who are raised in the new society tend to clash with their parents in terms of values, norms, and mores. The revival of conflicts may shake the family's stability until they are resolved.

It is noted that Sluzki's (1979) model of relocation process is congruent with the transition process as presented previously in this chapter. The phase of decompensation particularly fits to explain the middle phase of transition, which carries major tenants of that event. Although the phase of intergenerational conflict explains a great deal of family relationship conflicts after migration, empirical evidence

that these conflicts are actually related to migration is insufficient, especially when there is no indication in the literature that intergenerational conflict does not exist among non-migrant families. Intergenerational conflict should not be viewed as the only interrupting variable that revives the relocation experience of a family's life.

Consequences to health. Authors who addressed consequences of migration from the health perspective (Hull, 1979; Cohen, 1981; Hackenberg et al., 1983) maintain that the move from one geographical area to another, with the changes entailed in that experience, presents a major life transition which predisposes individuals to potentially stressful challenges. The direct relationship between migration and health consequences is complicated and not well understood. Part of the complexity is related to the diversity of the migration experiences and the adaptation processes involved.

Based on an extensive review of migration and health literature, Hull (1979) concluded that there is a great uncertainty regarding how much of the risk to illness can be attributed to the change factor of migration if the following factors were considered, socioeconomic status, type of migration, similarity or dissimilarity of immigrant population to the host population, and the other predispositions to illness. In addition, some epidemiological and survey studies on migration to the U.S. (Baca & Bryan, 1981; Cohen, 1981) added variables related to gender, status (documented vs. undocumented), occupational characteristics of the immigrants, unemployment and job-related stress, and length of stay in the U.S. as additional confounding variables to the relationship between migration and risk to illness.

A growing body of literature has examined the migration outcome from stress-adaptation perspectives (Antonovsky, 1974, 1979; Graves & Graves, 1974; Glittenberg, 1981; Coelho et al., 1981). However instead of labeling migration as a disrupting event, a more dynamic approach has been adopted to understand the various ways in which individuals react to its impact. This approach may have the potential of explaining the diversity of the migration-adaptation experience and the factors involved in its course.

Antonovsky (1979) conceived that it is the way one manages the tension produced by the stressful event that influences the stress-illness relationship. He also suggested that the person's resistance resources influences his sense of coherence with the external world and consequently enhances or hampers his ability of adjustment. Antonovsky described migration as one of these events that may be accompanied by a positive or negative outcome depending on the availability of the resistance resources offered by the society and culture and on the degree of sense of coherence within the individual.

In addition, Coelho et al. (1980) addressed migration stress and its specific adaptive tasks. He identified stressors of migration as originated in the areas of: Communication, loss of sensory contact with a familiar physical environment, facing new behavioral patterns, loss of continuity in the performance of functional role, disruption of social network, and loss of intimate informal interactions.

Chick and Meleis (in press) suggested an additional area of difficulty that is consistent with the above identified stressors. The authors noted that people who are newly relocating after migration

display inhibited health seeking behaviors due to their inability to recognize and locate the appropriate health care resources for a specific health problem. Finally, Aronowitz (1984) demonstrated the complexity of the migration process and its adaptive tasks. Based on a brief review of the literature, Aronowitz suggested that migration outcome could be best explained within a psychosocial perspective, where the problems manifested by the immigrants result from the disruption and conflict of cultural values and practices. He suggested that a contextual view to the migration event would be fruitful for future research as it lends itself to examining the multiple interacting determinants which affect the immigrant's adaptation.

Immigrant Women

Over the last half century the international migration flow to the U.S. has been dominated by females (Houston, Kramer & Barrett, 1984). However, the existing literature concentrates more on issues involving male migration experiences, with the result of excluding the variable of gender as a demographic unit of analysis.

The few studies that looked at immigrant women's problems provided strong evidence of differences among male and female experiences of relocation, especially in regard to role change, employment, type of stressors and sources of support. Some of these studies have challenged the commonly conceived notion that women are but passive, dependent followers of men who are the active initiators of the migration act (Smith, 1980; Cohen, 1981; Baca & Bryan, 1981; Morokvasic, 1984). More studies are still needed to further assess the psychological and social consequences of migration specific to women.

Some recent exploratory and descriptive surveys have investigated the migration experience of women from different ethnic groups. The basic questions underlying the majority of these studies are evolving around the motive of migration, the pattern of settlement in the host country, the psychological, social and cultural changes that these women encounter upon relocating in the new environment (Bryan, 1981; Baca & Bryan, 1981; Smith, 1980; Cohen, 1981; Mirdal, 1984; Evans, 1984).

Two studies were done on Latino (Cohen, 1981) and Portuguese (Smith, 1980) immigrant women. Results indicated that these women had an active, pioneering role in their migration experience. Both studies included only working class women.

The Latino women were more likely to be undocumented workers. Because of this, these women had to separate from their youngsters. The latter were left home, taken care of by maternal kin. It was found that Latino women faced more tasks in their relocation in the U.S. than men, due to the separation from their children. Unlike other difficulties of migration, this problem was not resolved by the length of stay in the U.S. However, it was also pointed out that these women came from a culture where they were expected to be self-contained and strong. It was suggested that women's compliance with these expectations enhanced their adaptation (Cohen, 1981).

Smith's (1980) findings on Portuguese immigrant women were consistent with the above results. It was reported that Portuguese females acted as leaders in their migration experience, they were engaged in the initiation, planning and organization of the whole process. These operations presented many sources of stressors during the preparatory phases. Also, following relocation, these women were

found to face more tasks than the rest of the family members, since they were expected to run the household, manage the upbringing of the children in a foreign system, and also act as a security blanket for the family members who were strained by acculturation to the new society. Smith (1980) argued that women become exposed to more stress because they stay home as mothers and wives. The author suggested that staying home did not minimize stress, on the contrary, it left these women with the same amount of adaptation work as their husbands, but with less resources due to isolation.

Baca and Bryan (1981) studied Mexican immigrant women and men. No differences were found between the two sexes regarding the participation in labor. However, from a social aspect of migration, women tended to experience more dramatic changes in their social life than men did. For example, women were more likely to lose contact with their kin network more than men. Thirty-one percent of women were found to live with friends (usually native) as compared to 18% of men. Also, it was noted that married women who migrated without taking their nuclear families, did not receive the same quality and duration of support from their extended families as their male counterparts. More women were found to have family and marital problems prior to migration than men; such problems hindered the return of the women to their home country, and resulted in a different pattern of settlement in the U.S. For example, those who decided to stay permanently were more likely to relocate their children and establish single-parent families.

Finally, some research evolved to focus on the impact of migration on one aspect of women's life, that is childbearing and parenting practices (Bryan, 1981; Stern, Tildon & Maxwell, 1980). Bryan (1981)

examined migration induced changes on the childrearing practices among Nigerian women in the Washington D.C. area, using a survey method. The sample represented a highly educated and professional class of women. The study revealed that Nigerian women were exposed to increased strain due to the conflicts between the traditional pattern of family structure and the western pattern of work division and authority among family members. Eighty-five percent of the families maintained father as the center of authority for discipline and decision making, while 15% shifted to shared authority among both parents. More conflicts however, stemmed from shifts in the female role, absence of extended family and lack of religious institutions. The most prevalent problem for these women was the raising of their children in a foreign society, which is already known to have a general alienation towards blacks.

Significant shifts in the concepts of childbearing and rearing, such as attitude toward pregnancy; beliefs around delivery, baby feeding, weaning and toilet training; and discipline were reported by the study as consequences to the move to the new environment. For example, although 100% of the sample agreed that children should be welcome as an extension to the family, 25% were anxious about childbearing and did not want children due to apprehension, unreadiness, and demands of school work. Only 55% of respondents complied with sex and food taboos during pregnancy, and only 18% practiced the traditional birth ceremony. However, it was also indicated that a considerable shift to a more modern way of childbearing and rearing practice has been occurring among families in Nigeria as well.

Stern and others (1980) did a field research on Pilipino-American families in the Western health care settings to examine culturally

induced stress associated with the process of childbearing. The sample included 40 women, 10 husbands, 10 mothers of women, in addition to 101 health care professionals. The study revealed that Pilipino women raised with non-Western models of childbearing are exposed to cultural conflicts in three general areas: customs, cultural beliefs, and practices associated with childbearing; interpersonal style leading to differences in social approach between recipients and providers of health care; and language barriers.

The Arab Immigrant Women

Arab immigrant women are those women who were born and raised in one of the Arab countries and came to the U.S. either as permanent residents or temporary visitors who arrived with or without their families, for medical treatment, education or training.

There is not much written about the Arab women's experience of migration to the U.S. This is partly because the literature on immigrant women is generally lacking. However, the case of Arab immigrant women is more complicated by the lack of research on the Arab immigrant, and also the great diversity of this population both in their country of origin and in their site of destination after relocation.

Demographic and Migrational Characteristics

There are some 2-3 million Arab immigrants in the U.S. They came from countries of the Arab world which include: Palestine, Lebanon, Jordan, Syria, Iraq, Saudi Arabia, Yemen, Kuwait, Egypt, Countries of the Arab Gulf, and Sudan, Algeria, Tonisia and Morocco. More than half of the Arab immigrants are third or fourth generation, and 90% of them

are Christians, while only 10% are Moslem (Naff, 1983, 1985; Terry, 1981).

Arab immigrant women represented significant proportions of the Arab migration waves to the U.S. (1876 through 1980's). In the first wave (1876-1920) women composed about 47% of the Arab immigrants, who were mostly illiterate and of village origin (Naff, 1983). The majority were Christians and descended from greater Syrian background, including Lebanon, Jordan and Palestine (Naff, 1983; Elkholy, 1976). The period between 1920 to 1947 marked a decline in Arab migration to the United States because of the imposition of a U.S. immigrant quota system in the 1920's which was favorable to immigration from Western and northern Europe over other areas of the world (Abraham, 1981a) Later waves marked an increase in Arab immigrant women; for example, in the middle wave of Arab migration to the U.S. (1948-1965) women constituted 74%. They came as Palestenian refugees, Egyptian, Jordanian and Lebanese students, and later as professionals and technical workers from the other Arab countries (Abu-Laban et al., 1975; Naff, 1983, 1985). In contrast to the first wave of Arab immigrants who were mostly Christians, unskilled and an uncohesive group, more than half (60%) of the migrants in the second wave were Moslem, skilled workers, and highly educated professionals (Elkholy, 1976). It is pointed out that the second wave of Arab migration to the U.S. contributed greatly to the 'brain drain' phenomenon in Egypt, Lebanon, and Jordan (Naff, 1983, p. 24).

A third wave of Arab migration occurred in the post-1967 war period and was followed by continuous migration from the area as a result of many forces such as: the Arab-Israeli conflict in Palestine, the oil

crisis in the Middle East in the 1970's, the civil war in Lebanon, the Iran-Iraq war, and the economic and political situations in the other Arab countries like Yemen. Over this period, thousands of Arabs, mostly Palestinians, Lebanese refugees, and Yemanite farm workers were displaced and relocated in the U.S. Except for the Yemanite farm workers, the majority of the Arab immigrants who arrived in the recent waves reside in urban areas (Abraham, 1981a).

Demographic characteristics of the Arab immigrants, especially those who came during the recent waves of migration are still lacking in the national census data. A recent census data review on international migration to the U.S. (Houston, Kramer & Barrett, 1984) did not include Arab immigrants. In addition, according to the California State Census Data Center (1980), there are no national census data reported for Arab immigrants to the U.S. Therefore data are not available as to what the most recent estimate of population size is for this group, or how much of this group is composed of women. Using a national data file of census data, the California State Census Data Center, at the request of the Mid-East SIHA (study of immigrant health and adjustment) project[1], provided some estimates on Arab immigrants. There were no figures reported for Palestinian immigrants, but many people of Palestine origin lived in Jordan before they migrated to the U.S. and the majority of Palestinians identify themselves as Jordanians. According to the California file (California State Census Data Center, 1980), of the immigrant population living in the State of California there were 4,280 immigrants who reported Jordan as their country of birth, 10,890

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[1]SIHA Project (1985), Department of Mental Health and Community Nursing, School of Nursing, University of California, San Francisco.

reported Egypt, 14,140 reported Lebanon and 6,000 reported Syria. There were also some estimates of immigrants from other Arab countries; however, the above ones were of particular interest to the study, because Arab women who participated in the study reported these countries as their place of birth.

It is not clear what the proportion of women are in the above figures. However, figures provided by the California State Census Data Center (1980) on the immigrants from Egypt, Jordan, Lebanon, and Syria in the six counties of Northern California (San Francisco, San Mateo, Santa Clara, Contra Costa, Marin and Alameda) revealed that there are 5,140 residing in the above counties, 2,040 (40%) of whom are women.

Table 1 presents a distribution of this population by gender in every county.

TABLE 1*

Gender Distribution of Arab Immigrants in Northern California

County	Male	Female	Total
San Francisco	720	520	1,240
San Mateo	820	500	1,320
Santa Clara	660	280	940
Contra Costa	260	180	440
Marin	120	40	160
Alameda	520	520	1,040
TOTAL	3,100	2,040	5,140

*Extracted from tables provided by California State Census Data Center (1980)

There are no demographic data on age distribution, religion, marital status, level of education, and occupational background of Arab immigrant women. However, it is anticipated that these women follow the general diverse pattern of the Arab immigrants. This is revealed by

some studies that have been conducted on Arab immigrant families and women (ElSayed, 1983; May, 1985). In addition, the researcher's clinical experience as a Maternity Clinical Nurse (RN) at U.C. Moffitt (1983) and San Francisco General Hospital (1985-1986), indicates that women who receive their maternity care at the University of California's Obstetric Clinic tend to be educated, working women, who are Christian or Moslem, and who came from Egypt, Syria, Lebanon and Palestine. Whereas, those women who report at San Francisco General Hospital's Women's Clinic are less educated (some are illiterate), mostly Moslem, speak very little or no English and came from Yemen or Palestine. These observations have been consistent with other sources[2] of information on the population of interest.

Social and Cultural Background

Lipson and Meleis (1985) described heterogeneity and homogeneity as one of the paradoxes characterizing the Middle Eastern and Arab immigrants. As for heterogeneity, it was noted that Arab immigrants differed not only in history, religion, ethnic identity, and heritage, but also in socioeconomic class. In other words, Arab immigrants may range from illiterate farm workers to well educated, professional and wealthy people (Lipson & Meleis, 1983). One of the weaknesses of the studies on Middle Eastern and Arab women is the tendency to collapse this population into one group with the result of stereotyping (Faulkner, 1980). Heterogeneity as a major characteristic of Arab immigrants is attributed to the fact that Arabs migrated to the U.S. in

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[2]Research and Theory Seminars, SIHA Project (1984-1985)

several waves, each of which carried a different category of immigrant with distinctive characteristics (Naff, 1983, Abraham 1981a).

On the other hand, Arabism was suggested as being a broad concept that describes the homogeneous side of the Arab culture. This concept is viewed to bridge the religious and ethnic and heritage boundaries among the Arab subgroups (Beit-Hallhmi, 1972; Wigle, 1974; Abu-Laban, 1980; Meleis, 1981; Meleis & Sorrell, 1981; Lipson & Meleis, 1985; Meleis & Jensen, 1983). Lipson and Meleis (1985) explained that Arabs speak the same language (Arabic) use similar symbols and gestures of communication and styles of interation, and share the same cultural values, beliefs and customs regardless of their religion.

In addition to Arabism, Islam has added a significant dimension to the social and cultural properties of all Arabs, including Christians (Faulkner, 1980; Terry, 1980; Naff, 1985). According to Faulkner, Islam is not merely a religion in the Middle Eastern countries, it is a rather coherent, closed system that is sociologically, legally, and politically organized as an 'ideal' (Faulkner, 1980, p. 70).

A number of concepts have been described in the literature as reflecting the major themes of the Arabic and Islamic value system. However, as explained above, a cautious use of these concepts is recommended to understand the characteristics of people coming from this cultural background without running the risk of stereotyping. Thus, variables related to socioeconomic spectrum, length of stay in the U.S., extent of exposure to Western culture, strength of ethnic identity, and urban versus rural origin should be accounted for (Lipson & Meleis, 1983, 1985). Among the concepts are those describing the interactional style of the Arab people, and those evolving around health and illness

behaviors as well as help seeking strategies. The following section will be focused on concepts central to maternal health behaviors. This will include: family structure and life style; sex role differentiation, and pregnancy and motherhood. Discussion will include a description of these concepts before and after migration.

Family structure and life style. The family is likely to be the single, most important social unit in the life of Arabs and Middle Easterners and continues to be so after migration (Wigle, 1974; Spengstock, 1981; Elkholy, 1976). The Arabic family is patriarchal in structure and the extended family is the norm (Elkholy, 1976). Marriage and family formation are considered important in the Arab Moslem tradition (Morsy, 1982; Faulkner, 1980). Children are highly valued in the Arab culture, and are seen as a source of security for their parents in later years. Sons are viewed as greater resources than daughters, since the latter are supposed to marry into other families (Morsy, 1978, 1982).

According to many (Barakat, 1973; Kayal et al., 1975; Wigle, 1974; Meleis, 1981; Meleis & Sorrell, 1981; Lipson & Meleis, 1983) it is through the family that the individual satisfies his needs for affiliation, belonging and kin support. These needs seem universal and are considered crucial to Arabs. It was also pointed out that the family plays a role in teaching and transmitting the values of honor, shame, attachment, and obligation to the group which are characteristic of the Arab culture. Finally, one of the vital functions of the Arabic family is to help individuals cope with life events and times of crisis. Turning to family members for decision-making, advice and help, or emotional and material support is a common coping strategy among the

Arab people. This is congruent with the 'turning to others' strategy, which is a major coping strategy in the Arab culture (Meleis & Jensen, 1983, p. 892).

Sex role differentiation. Arab traditions divide roles according to gender (Meleis & Sorrell, 1981; Abu-Laban, 1980; Morsy, 1978, 1982). This is partially delineated from Islam and partially from the culture (Manai, 1981; Faulkner, 1980). In spite of the woman's liberation in the Middle Eastern countries, marriage, household responsibilities, and childbearing and rearing still constitute the central issues in the women's role in life (Meleis & Sorrell, 1981; Faulkner, 1980).

In a study by Youssef (1974) that compared statistics of Moslem women in all Middle Eastern countries, it was found that 45% of all girls aged 15-19 years were married and by age 30 only about 2% remained unmarried. Furthermore, it was found that the Arab Moslem women constituted only 27% of secondary education (High School level) and 25% of higher education (Youssef, 1974). It was also reported by the another study (Youssef, 1971) that Arab female participation in non-agricultural work was 3.7% compared to 32% in the U.S. during the same time period. Faulkner (1980) reported similar observations in this regard. The author pointed out that the percentage of Moslem Middle Eastern females working in non-agricultural jobs is the smallest in the world, and the birth rate among them is the highest. These observations were viewed as indicating low status of women in this region.

Pregnancy and motherhood. Although Arab women do not derive status solely from motherhood, children are valued, and the ability to conceive, carry a pregnancy to term, and bring forth a healthy child continues to be one of the challenges that an Arab mother should meet in

order to develop her status and improve her acceptance by significant others. This is even enhanced if she carries a male baby (Meleis & Sorrell, 1981; Morsy, 1978, 1982; ElSayed, 1979). ElSayed (1979) did a correlational study on variables affecting postpartum depression and anxiety among Egyptian first-time mothers (N=160). The sample included low socioeconomic class women. Findings indicated that 48% of women did not strongly desire to become pregnant; however, they decided to conceive to fulfill their role in life as females and seek the approval of their husbands and extended families.

Pregnancy is expected soon after marriage, and subsequent pregnancies are not planned, since planning is not an Arab value, and it is usually interpreted as questioning God's will (Meleis & Sorrell, 1981). Along this line, antenatal care and/or childbirth preparation are not common practices among the Arab women, although this is also due to the belief that pregnancy is a normal, physiological process that requires no preparation (Maloof, 1979; Ragheb & Smith, 1978; Morsy, 1982). Furthermore, Meleis & Sorrell (1981) pointed out that nesting and the other preparations for the child arrival are not practiced by the Arab expectant mothers. However, rather than taken as signs of disinterest in the newborn, this is interpreted in the context of the Arab cultural structure that defers planning to protect the self against life's unexpected failures.

Birth is considered to be a time of great suffering. Women in the Arab culture are not required to maintain control; they are instead expected to respond to labor pain by screaming and yelling (Morsy, 1982; Meleis & Sorrell, 1981). Men are excluded from the birth event, whether

delivery takes place in a hospital or at home. The women is closely attended by her kin females, especially her mother (Nelson, 1977; Morsy, 1982; Govearts & Patino, 1981, ElSayed, 1984).

The period that follows delivery is perceived as a time of increased susceptibility for illness and evil eye that could harm both the mother and infant (Morsy 1982; Meleis & Sorrell, 1981). The belief that delivery is upsetting to the balance of the mother's body, and that the mother, infant, and those caring for them are in a state of pollution (Mead et al., 1967; Horn, 1981; Brownlee, 1978) seems to apply to the birth beliefs in the Arab culture; however, this is not adequately supported in the literature. ElSayed (1984) did a preliminary field investigation (interviewing and observation) on a small sample (N=8) of Egyptian women during the first 2-4 weeks postpartum. Women of various socioeconomic status, parity and age were included. The focus of investigation was to explore the values and beliefs controlling the postpartum management, and the role of the family as a support system during this event. It was found that socioeconomic status did not differentiate between the subjects in regard to the practices and beliefs of managing postpartum. Mothers and infants were considered weak and vulnerable up to a minimum period of 2-4 weeks. During such period the mother and baby were taken care of by members of the extended family, especially the grandmothers. Mothers were observed eating and drinking traditional foods and drinks specifically recommended for body strengthening and stimulation of breast milk.

In an anthropological study of childbirth in an Egyptian village, Morsy (1982) reported that women are considered both polluting and

vulnerable during the period of confinement (extends for 40 days) and that they should be secluded for protection against the danger of sickness or even death. During this period the mother is considered weak and in need of rest and good food; she is also advised to avoid drafts, colds and chills. The author however pointed out that not every mother in the village could follow the above practices, since this was controlled by the socioeconomic resources of the family. Therefore, some poor farmer-mothers were forced to resume their responsibilities a few days after delivery. However, little is known about the effect of this interrupted confinement on the mother's and infant's wellbeing.

Two exploratory studies were done in two different urban settings in Egypt to examine the beliefs and customs regarding breast-feeding (Ragheb & Smith, 1978), and to study attachment behavior of the Egyptian mothers (Govearts & Patino, 1981). Some findings of these studies reflected the rituals and practices that were followed by mothers during the postpartum period, and also supported the findings reported by Morsy (1982), and ElSayed (1984). For example, some observations in Govearts and Patino's study revealed the role of the extended family, especially the grandmother, in taking care both of the baby and the mother. The study included only middle class mothers (N=20) and took place during the postpartum hospital stay. It was observed that the mother became the center of attention during the early period following birth. Her physical and emotional restorations were the focus of care. Rest was provided by allowing minimum activity. Also, special kinds of food were offered to the mother, in addition to traditional hot, nonalcoholic drinks.

One of the significant postpartum practices that is reported to be perpetuated by the Egyptian culture is breast feeding. Ragheb and Smith (1978) interviewed 88 Egyptian mothers of various socioeconomic statuses regarding their beliefs and practices on breast feeding. It was reported that breast feeding was considered the best source of infant nutrition. Many practices around foods that increase milk production as well as conditions that might interfere with it were religiously followed by the majority of the mothers in the study. It was implied that both physical and emotional factors were seen by the mothers as influencing breast feeding, and therefore, careful protection of the mother against these factors were described as primary concerns of the mothers and families during the early postpartum period.

Although postpartum concerns among Arab (or Egyptian) mothers were not the primary focus of any of the formerly mentioned studies, some of the findings shed the light on these concerns. Morsy (1982) reported that fear of the evil eye for both mother and infant, especially when it was a male one, was the primary concern of the mother, in addition to concerns about physical weakness and susceptibility to illness. On the other hand, Govearts and Patino (1981) observed that the mother's concerns were primarily related to the infant's well being, physical appearance, and feeding. It was also mentioned that although the mothers showed some universal maternal-infant attachment behaviors, they had a unique pattern of interacting with the infant to build him into the family circle and shape him according to cultural values. The assimilation of the child into the family and acceptance of him by the culture were among the major maternal concerns.

Arab Immigrant Women and The Migrational Change

Some literature (primarily impression papers and historical reports) on the migrational changes experienced by the Arab immigrants in the U.S. and Canada emphasize the fact that this population is highly adapted and accepted by the new societies (Wassef, 1977; Kayal et al., 1975; Swan et al., 1974; Abu-Laban, 1980). However, some areas were reported to undergo major changes under the effect of the sociocultural shift. Although these changes might not necessarily be perceived as negative in all situations, they are generally viewed as testing the individual's and family's resources; and requiring considerable modification in many aspects of life. Meleis and Sorrell (1981), and Lipson and Meleis (1983) agreed that the areas of family structure, social life style and social interaction, and women's role are exposed to significant changes after migration. Elkholy (1966, 1976) noted that unlike the Arab family in the Middle East, the majority of the Arab immigrant families are of nuclear structure and also smaller size. In other words, the patriarchial extended family has been broken down under the impact of migration. The diffusion of the patriarchial family style was identified as one of the stressors faced by the Arab immigrant representing the first generation. The source of stress originated in the loss of control over the new generation and the diffusion of authority among the family members rather than being assumed by the solo figure of the father (Elkholy, 1976). Moreover, due to the differences in modes of communication and styles of interaction, Arab families seldom socialize with the host society on an intimate, permanent basis (Wassef, 1977). This was found to be particularly true in the case of the earlier Arab immigrant groups (Elkholy, 1976). Also, due to work

pressures, scatteredness, or absence of the extended family, frequent spontaneous visiting may not be allowed. Consequently, small immigrant families may become lonely and isolated (Lipson & Meleis, 1983). It is pointed out that although the family relation and kinship obligations are maintained after migration, some changes in the traditional function of the extended family have been observed. Wigle (1974) mentioned that the majority of the Arab immigrant extended families, instead of functioning as an economical cooperative unit, only provide informational support regarding job opportunities, housing, and coping with the new life.

One of the major stressors facing the Arab American family is that of family disintegration arising from intergenerational gaps. Elkholy (1976) reported that the Arab immigrant family with two generations living in different social atmospheres with separate outlooks on life experiences, have extensive conflicts. Both generations were found to be equally distressed because of these conflicts.

These changes in family structure have direct consequences to Arab women's position in the family and society after migration. For example, due to the shifts in the authority figures, the Arab family has become dominated by the mother and children (Elkholy, 1976). It has been noted that Arab immigrant women especially those representing the first generation, are exposed to a higher degree of role changes than their men counterparts (SIHA Project, 1982).

Abu-Laban (1980) mentioned that after migration it becomes necessary for Arab women to seek work outside the home. Maloof (1979) found that 10% (N=30) of Palestinian women in Washington, DC worked outside the home and 15% worked in their family's business.

Meleis and Sorrell (1981) supported the above position in their description of the Arab American women's experience in the United States. They noted that these women become more liberated under the new life style and might add some new roles and responsibilities to their traditional ones. However, they also retain many of their Arab norms and values, especially in relation to their family responsibilities and maternal duties.

Some research findings on the Arab women's experience with the migrational changes were consistent with the above writings. Wassef (1977) for instance, interviewed 27 Egyptian immigrant women in Canada as a part of a larger field study of the Egyptian immigrants to Canada. The author reported a high rate of participation in the work force by women. She also found that the working women appeared to be satisfied with their work experience, they made friends in the work place, and they were more adjusted to the new life. This was more enhanced by the change in the husband's role that involved more participation in household responsibilities and childrearing demands. Non-working women on the other hand were found to be more isolated, feeling more lonely and identifying more with the life in Egypt.

ElSayed (1983) interviewed a group of Arab immigrant women in San Francisco (N=12) on the migrational changes that they faced on their relocation to the U.S. Both single and married women were included. The sample included women of different levels of education, occupational background, religions, and country of origin. Open-ended questions were administered for data collection, and responses were analyzed using thematic analysis. Two main themes evolved to describe the changes of migration for these women: 1) extensive changes were reported in the

areas of social interaction, life style, role, and self-concept. These changes were perceived as positive and as producing a sense of growth, expansion and independence. 2) Because of changes in life style and role, women communicated that they were overburdened by their added roles and responsibilities and the pressure of keeping up with life demands, especially after the decrease in their emotional and social resources as a result of being isolated from their extended families.

In summary, literature on Arab immigrant women reveals various degrees of change in these women's lives after migration. Some of these changes are perceived as gains towards a better status; however, a portion of these changes are considered as psychologically and socially taxing on these women's resources. Variables that determine the degree of change, specific areas of stress, and sources of support are still lacking in the literature.

Conclusion

Migration is a process of transition in many facets. Basically, the elements of reappraisal followed by change in self, roles and modes of functioning to fit into the new world are central. However, migration may be viewed as a transition of a more complicated course and consequences due to the following distinct characteristics: a) migration encompasses all the three phases of transition collectively in contrast to other transitions such as postpartum which is organized around the phase of incorporation; b) being a non-scheduled type of transition, migration usually takes place with little or no prescribed, anticipatory rituals to guide actions; and c) passing through migration, an individual may be exposed to the various levels of change that bring

about some degree of adaptation; however, complete adaptation is not necessarily reached. As a result, a constant strain may be experienced due to discontinuity and unbelongingness.

Relationship of Components

The interaction of sociocultural and developmental conditions with the event of relocation is suggested to influence the way an immigrant responds to the relocation experience. Based on a stress and coping paradigm, it was proposed that the burden of uprooting may be aggravated if the environmental change occurs during critical developmental transitions like adolescence, pregnancy, menopause, or retirement. Likewise, people are more likely to experience greater stress if changes in their environment cluster at a stressful life situation like death of a loved one, divorce or separation, or accidental injury (Coelho et al., 1980; Coelho & Stein, 1980).

The above propositions lend themselves to the study of postpartum transition as it takes place at the same time when the relocation transition is in action. The latter is assumed to produce certain social and cultural changes on different levels, depending on the structural variables of the relocation itself, that interact with the course of postpartum and may add to its parameters as a transition such as, the meaning attached to it, the extent of concerns and problems it carries, and the amount of resources available during its occurrence. All of which are important to understand more explicitly the magnitude and consequences of the transition to postpartum.

Derived Assumptions

1. For each individual there is a certain set of life transitions that are stressful to him/her, but not necessarily to any others.

2. Features of a transition, such as desirability, anticipation, duration, or degree of change, influence its range of impact.

3. Interaction of a transitional event with other conditions in the context determines both the subjective meaning of the event and the individual's capacity to manage it.

Research Questions

The following were the guiding questions that emerged from the framework and that directed the inquiry process.

1. What is the relocation experience like for the Arab immigrant women?

2. What is the postpartum period like for the Arab immigrant women?

2.1 What concerns and difficulties do these women face as they go through the postpartum period?

2.2 What resources do these women have during their transition to postpartum?

3. To what extent does the relocation transition of the Arab women influence the course of postpartum period, and amount and quality of concerns associated with it?

Definition of Terms

Arab Immigrant Women. Women who were born and raised in one of the Arab countries (Palestine, Lebanon, Jordan, Syria, Iraq, Saudi Arabia, Yemen, Kuwait, Egypt, Countries of the Arab Gulf, Sudan, Algeria, Tonisia, Morocco) and have been residing in the U.S. for a period not less than one year and not more than 12 years.

Postpartum Period. The first 40 days following delivery.

Relocation. A process of transition from a familiar to an alien environment with the result of large - scale social and cultural changes.

CHAPTER 3

METHODS

This study utilized grounded theory methodology for data collection and analysis. The purpose of this chapter is to present the techniques of this method in detail and to describe the research setting, sampling, data collection procedures, and the ethical considerations. The chapter concludes with a discussion of the methodological issues faced in this study.

Research Design

The study followed an exploratory design to examine a phenomenon that has not been studied by previous researchers (Brink & Wood, 1978; Diers, 1979). A naturalistic, longitudinal approach in conjunction with grounded theory method was used to study the participants through their late pre-birth, and postpartum periods, in consideration of the impact of relocation to a different country.

The primary goal of the study was to generate a theoretical explanation for the sociocultural processes involved in the interaction of both environmental and cultural changes of relocation with the postpartum period. Such an explanation emerged from and was grounded in the data.

The Grounded Theory Approach

Grounded theory was chosen for analyzing the data based on the rationale that this approach draws from an interactionist orientation to social phenomena. Because of that, it bears more on the contextual and

interactional perspective of a core problem, bringing to focus the course of the problem as it happened in reality and the ongoing processes of its interactions with the existing conditions. This approach is congruent with the primary task of this study as described earlier.

The method is based on the systematic generation of a theory from data that are systematically obtained from a social setting. Such a theory is relevant to the world it emerges from and is developed in intimate relationship with data, in contrast to other theories that are generated by logical deduction from a previous assumption (Glaser & Strauss, 1967; Glaser, 1978).

Grounded theory was developed by Glaser and Strauss in the early 1960's during a field observational study of hospital staff's handling of dying patients (1965, 1968). This method has its foundation in the theoretical perspective termed symbolic interactionism which was developed by the tradition of "Chicago Sociology" at the University of Chicago in the period of the 1920's through the 1950's (Strauss, in press). This perspective places social interaction and social processes at the center of attention, and emphasizes the necessity of grasping the actor's view point of a problem for understanding the interaction process.

Grounded theory style of qualitative analysis includes a number of distinct features such as theoretical sampling, constant comparisons and the use of a coding paradigm to ensure conceptual development and density (Glaser & Strauss, 1978; Strauss, in press). This style generates a theoretical scheme that evolves from the systematic formulation of major concepts, the conceptual theoretical properties and

the relationship between the two. Rather than searching for the frequency distribution of events, the purpose of this method is the delineation of the conditions under which certain events occur, the conditions under which they vary, and the corresponding consequences. The emerging theoretical scheme guides and integrates the processes of collecting data, codifying them, integrating categories and constructing the theory. Because the data are qualified and not quantified, the predictive power of the theory generates hypotheses rather than verifying them. Theory derived by this method, as with many other methods, is constantly developing by means of modification, extension, and revision of new and available data.

Research Setting

Two major health care facilities in the San Francisco Bay Area were utilized to recruit subjects for this study.

1. The University of California San Francisco's Ambulatory Obstetric Clinic and Moffitt Hospital, and

2. The Women's Health Clinic and the Postpartum Unit at San Francisco General Hospital Medical Center.

Both settings are found to attract Arab maternity clients, as well as other Arab health clients from various locations in the San Francisco Bay Area. This allowed for obtaining a representative sample of the Arab pregnant women residing in that area. Following approval by the University of California San Francisco's Committee on Human Research, a permission to conduct the study was obtained from the persons in charge of nursing and obstetrical services in each setting. Furthermore, the investigator met with the nursing staff at each site to explain the

nature of the study and the procedures of data collection. The investigator received a good cooperative response from staff in both settings.

In addition to the health care settings, interviews were conducted in the subjects' homes especially for those subjects who were recruited from other sources. For example, two subjects were recruited through a referral of a colleague who had access to the Arab Immigrant Community in the San Francisco Bay Area, and all of their interviews were conducted in their homes.

Sample Selection

The target population for this study were women who migrated from countries in the Arab World to the United States. This included Palestinian, Egyptian, Lebanese, Syrian, Saudi Arabian, and Yemeni women.

The intention of sample criteria was to select a group of Arab maternity patients who underwent a 'normal' experience of childbirth and motherhood and who were free from conditions that generally produce additional stresses other than those resulting from moving to a different culture. Such conditions were included single motherhood and/or threatening complications to self or infant beyond minor conditions that required the mother or infant to stay two-three days extra in the hospital. Subjects who met the following criteria constituted the study sample and were selected on a convenience basis: Arab women who, (a) identified themselves as first generation immigrants and who were in the childbearing age; (b) presently lived in the U.S. in one of the six counties of Northern California; (c) came to the U.S. at

not less than 15 years of age and intended to stay for a temporary period of time or live permanently; and (d) had lived in the U.S. for a period of not less than a year and not more than 12 years.

The last two criteria were emphasized in order to capture the social and cultural transition of these women. Both Arabic and English speaking women were invited to the study, and primiparae and multipare were included. No specific age group or religious affiliation was required.

Sample Acquisition

The investigator reviewed patient records daily at the selected hospitals for patients who were scheduled for antenatal visits the next day. Arabic and Muslem names were identified, then verified by checking the ethnic background and country of origin which were given as a part of the patient's routine information. Eligible subjects were selected and contacted in person during the prenatal visit. The investigator introduced herself and explained the study by saying that she was conducting a research project as a part of fulfilling the requirement for a doctoral degree in nursing at the University of California San Francisco; and she was interested in studying how Arab immigrant women experience the period after delivery when they migrate to the United States. Women who agreed to participate were given an information sheet that explained, both in English and Arabic, the purpose of the study and the procedures of data collection.

Sample Characteristics

The sample consisted of 18 subjects, each of whom was interviewed three times except for one subject, who was interviewed only two times;

and another one, who was interviewed one time. Twenty-two subjects were originally approached for recruiting, however two refused to participate and another two were dropped by the investigator. Those subjects who refused to participate were both Palestinian, one was 28 years old and pregnant for the second time, whereas the other was 36 years old and pregnant for the third time. The first woman refused to participate because her husband did not want her to share her pregnancy and life experience with a stranger, while the second one explained that she did not have time for the interview sessions. The other two subjects were dropped by the investigator after the first interview. The first one was an Egyptian woman who had a cesarean section delivery, and the second was a Yemeni woman who was not able to respond to the interview questions, because she was unable to speak either English or Arabic. This women spoke a tribal language, which the investigator was not familiar with. Although the husband volunteered to interpret, it was felt that he would shape the interactions and responses of his wife to the questions by selectively interpreting the questions, or by volunteering to answer for her.

The sample represented a variety of social classes, educational backgrounds, and migrational experiences, with regard to country of origin, length of stay in U.S. and intention to stay permanently in the U.S. Table 2 summarizes the sample demographic, obstetrical and migrational characteristics.

TABLE 2

Sample Distribution by Demographic, Obstetrical and Migrational Characteristics

Code	Age	Education	Religion	Parity	Country of Origin	Duration of Stay in U.S.	Type of Residency
01	24	10 yrs	Muslem	3	Palestine	3.5 yrs	Permanent
02	20	10 yrs	Muslem	2	Palestine	2 yrs	Permanent
03*	38	16 yrs	Muslem	2	Egypt	4 yrs	Permanent
04	19	12 yrs	Coptic	1	Palestine	6 yrs	Permanent
05	19½	10 yrs	Muslem	2	Palestine	3.5 yrs	Permanent
06	25	16 yrs	Muslem	2	Syria	10 mos	Temporary
07**	20	None	Muslem	2	Yemen	1 yr	Permanent
08[a]	25	9 yrs	Muslem	3	Palestine	3 yrs	Permanent
09	23	16 yrs	Catholic	1	Lebanon	10 mos	Not Decided
10	22	12 yrs	Muslem	1	Lebanon	10 mos	Permanent
11	30	16 yrs	Muslem	2	Egypt	4 yrs	Permanent
12	20	12 yrs	Coptic	1	Palestine	3 yrs	Permanent
13	34	12 yrs	Muslem	3	Syria	4 yrs	Permanent
14	25	16 yrs	Catholic	1	Lebanon	3 yrs	Permanent
15	19	10 yrs	Muslem	1	Palestine	3 yrs	Permanent
16	20	10 yrs	Muslem	3	Palestine	4 yrs	Permanent
17	34	18 yrs	Muslem	2	Egypt	4 yrs	Temporary
18	34	16 yrs	Muslem	2	Egypt	4 yrs	Not Decided
19[b]	30	16 yrs	Muslem	1	Egypt	1 yr	Not Decided
20	36	17 yrs	Muslem	2	Egypt	4 yrs	Permanent

*Dropped by investigator after the first interview due to a C-section delivery

**Dropped by investigator due to language barriers

[a]Dropped voluntarily after the first interview

[b]Has not completed the third interview

Human Subject Assurance

The study was reviewed by the University of California San Francisco, Committee on Human Research and was approved (No. 940411-01). Approval was renewed on August 30, 1985. A waiver was requested from the use of a signed Consent Form because of the cultural aversion to signing forms, as well as to the potential concerns about identifying oneself which may be a threat to confidentiality and privacy. Confidentiality of interviews and the option to withdraw at any time were explained. Participants were given a copy of the information sheet as a substitute for informed consent (Appendix A), that was written in both English and Arabic for their records.

Procedure

Interviews

A total of 51 interviews were conducted, of one to 2.5 hours in length, over a period of a year. Each participant was interviewed three times: during the last three months of pregnancy, within the first week postbirth and at the end of the 4-6 weeks postpartum. The last interview was conducted by telephone as a follow-up. One of the subjects had her second interview between 10-15 days after delivery and another one had her final interview at the completion of two months postpartum. This was due to an uncontrollable event that happened to the researcher during this period.

All the interviews were conducted by the investigator and took place at different times, under different conditions, and sometimes with different people in the room during the interview. This was valuable in providing "slices of data" and also allowed the investigator to observe

the variation in the participant's actions and interactions under the different conditions. In cases of second and third time mothers, the siblings were often present, in two interviews the sister-in-law was present and in another three interviews the grandmothers joined in the discussion for a lengthy period of time. When participants were interviewed in the clinic, their interaction with health care professionals was recorded.

The interviews took an informal style, often done in the form of a conversation but not in the pure social sense. Participants responded to questions in their original language (Arabic language) which the investigator spoke fluently, and which encouraged the openness and spontaneity of the interview process, especially for those who did not speak English fluently. An interview guide (See Appendix B) that contained open-ended as well as semi-structured questions was used to collect data. This was done with the intention of being open for the subject's responses to flow naturally, but also ensuring that the central topics would be covered by each interview. This guide was followed more strictly during the first few interviews, without a specific focus of inquiry, then as themes began to emerge, the direction of inquiry was focused around new themes. Subsequent interviews became more structured around developing categories, eliciting their properties and verifying their relationship to each other (hypotheses). Meanwhile, participants were given the opportunity to discuss subjects that were of importance to them. This was done during additional phone calls that were initiated by the participants to keep in touch or to seek help in the form of information, consultation, or just support. However, a

great deal of contact was initiated by the researcher as well to keep in touch with participants and make herself available for any arising needs. These contacts provided important background data that helped in the interpretation of the findings. Table 3 presents a summary of the data collection process.

Table 3

Summary of Data Collection

Contact	Timing	Place	Content	Duration
1	7-9 months during pregnancy	Antenatal clinic or subject's home	Interview on relocation and prebirth period	1½-2½ hrs.
2	2-7 days after delivery	P.P. floor or subject's home	Interview on labor and early p.p. period	1-1½ hrs.
3	4-6 weeks p.p.	Subject's home via phone	Follow-up on late p.p. period	30-45 min.

Observation Notes

As is common in naturalistic research, field notes were used to record descriptions of the setting, behavior of the respondents, or other interactions observed during the interview. Information obtained was useful in giving clues and insights for further verification and monitoring of information obtained through interviewing.

Data Recording

Due to the reserved nature of the group under study with which the researcher was familiar, taping of the interviews was not ever considered. The researcher anticipated that taping interviews would lead to increased refusals or would jeopardize the intimate-trustful relationship with the participants. Extensive note-taking was not always possible as it blocked the natural flow of the interview. Thus, the investigator resorted to taking brief notes that included key phrases, sentences or paragraphs. Some of these segments were recorded in Arabic to capture the linguistic as well as the cultural meaning of the response. The above segments were then expanded immediately following the interview session (1-2 hours after), relying on memory and on the stimulant effect of the key brief notes to recall the whole session. Further steps included typing and keeping the standard form of field notes.

Data Analysis

The constant comparative method of data analysis was adopted to analyze data gathered for this study. The emphasis in this method is on generating a theory based on the data which describes concepts and hypotheses that are relevant for the phenomenon of interest.

The emerging theory should capture the complexity of the phenomenon and render a meaningful explanation for its course. This is accomplished through three means: 1) data collection should be guided by the successively evolving interpretation done during the course of the study; 2) conceptual density, that is, the generating of many concepts and many linkages among them, should be ensured; and 3) data should be

examined in a detailed, intensive, microscopic manner to bring out the complexity of "what lies in, behind, and beyond the data" (Strauss, in press p. 13).

The use of comparative analysis fulfills the purposes of: (a) checking out the accuracy of an evidence from which a concept was generated; (b) establishing empirical generalization of categories, so that they become more generally applicable and have greater explanatory and predictive power. In other words, by comparing where the facts are similar or different, more properties of categories can be generated to increase their generalizability; (c) specifying a unit of analysis (concept) by specifying its distinctive elements, as a consequence clear understanding of the different definitions of concepts is insured, and ambiguity of similarity can be eliminated; and (d) verifying hypotheses that emerged from a set of data by continuously seeking different groups or settings (Glaser & Strauss, 1967; Glaser, 1978).

Process of Analysis

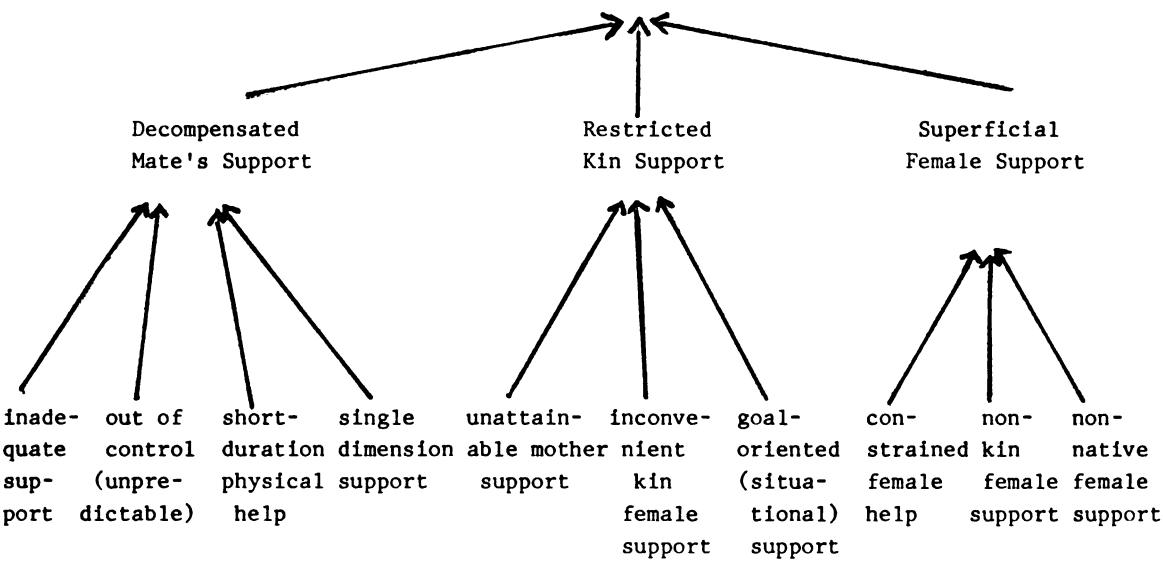
Conceptually, the analysis involved a mix of inductive, deductive and verification modes of inquiry. Five main steps were included in the process of analysis and carried out simultaneously rather than subsequently. In doing that, the researcher was usually engaged in a triad of operations: data collection, coding and writing memos. In the following section each of the five steps of analysis will be briefly described.

Open Coding. The initial step of data analysis is unrestricted coding of the data. This is done by reading the field notes very closely: line by line or even word by word. Each event (action,

expression, thought, happening or experience) is coded as a concept and written in the margin. These events are referred to as indicators of the concept (Glaser, 1978; Strauss, in press). The concepts are then raised to a more abstract level by coding them into categories, each would include a number of concepts that seem to fit together. Constant comparing of concept indicators to each other, concepts to other concepts under the same category, or to those under different categories are an essential part of open coding, since through these comparisons of codes, the concepts and categories are sharpened to achieve their best fit, and then the unique properties are further defined. Looking at the data for new indicators that work for the same concept and also for new concepts that fit into the same category, is a related operation that is carried out until the categories and their properties exhaust the data. One of the categories generated from data for this study was "defective social support system." Figure 1 illustrates the generation of the category and its properties.

Figure 1

Defective Social Support System



Throughout the process of open coding one should continuously ask a set of questions which Strauss (in press) calls 'coding paradigm,' about the conditions under which the categories emerged, the interactions among individuals involved, the strategies and tactics they used to handle it and the resulting consequences. This paradigm forces the analyst to keep the coding focused around the problem expressed by the participants, generate analytical questions for further exploration, think about possible hypotheses and what direction of further sampling will be required to verify them. Some of these questions include: "What is happening here?" "What seems to be the major problem?" "How is it being handled?" "What are the consequences?" "What else is happening?" "Who else is involved?" "Where is it taking place and under what conditions?"

In summary, open coding is the technique utilized to formulate concepts from empirical data, which are then built into theoretical categories. Open coding serves many purposes: it fractures the data which allows for transcendence of its empirical nature and renders it more abstract so that apparent unrelated concepts can be related; it directs the process of theoretical sampling; and it allows for the verification, densification, expansion and saturation of categories. Proper successful open coding depends on the extent to which an analyst uses the following set of questions as rules in guiding the coding. The most general question is, "What study is this data pertaining to?" that is, what was it that the researcher intended to study. The next important question is, "What category does this incident indicate?" this helps the analyst think about what category or property of category, or what part of the emerging theory this incident indicates. The last

question is "What is actually happening in the data?" that is, what seems to be the main problem faced by the participants. This question is especially important because it forces the generation of what is called 'a core category' which will be discussed shortly.

Theoretical Coding. Theoretical coding is the drawing of a number of 'provisional' linkages (hypotheses) among the 'discovered' categories (Strauss in press, p. 23). It is a process of conceptualizing how the substantive codes (concepts and categories) may relate to each other to be integrated into a theory. Through theoretical coding, data that have been fractured by open coding are brought back together into a conceptual scheme that seems to explain 'what is happening in the data' (Glaser, 1978, p. 55). Adherence to this scheme is determined by continued verification using repeated theoretical sampling, more structured interviews, and further comparisons with data. Among the substantive codes that described the relocation experience of the Arab women in this study were up-rooting and defective social support. One of the ways to link these two categories was to think of one (defective social support) as a consequence to the other (up-rooting). Both categories were further linked to a third one that described concerns of women during pregnancy, that is, facing uncertainties. Women expressed uncertainties about their mates support, about their own ability to rely on self in carrying out maternal tasks, and about the amount and quality of help they would received from other persons in their social new network. The above linkages varied with variations in the conditions under which up-rooting and defective social support occurred. For example, the data indicated that women under different up-rooting experiences had different types of social networks that in turn affected

the degree of defectiveness in social support. Based on that, further sampling was sought to test the above linkages under a range of various types of networks and to follow-up on the consequences in relation to the concept of 'facing uncertainties'.

In summary, while open coding produces substantive categories that conceptualize the empirical substance of the area under investigation, theoretical coding aims at relating these substantive codes as hypotheses to formulate a model.

There is not one specific way of integrating conceptual categories into a model by means of theoretical codes. Glaser (1978) suggested several 'coding families' (p. 74) as different ways of organizing and relating categories and their properties. Among these families were: 1) the six c's family (causes, contexts, contingencies, consequences, covariances and conditions); 2) the process family (stages, staging, phases, phasing, progression, passages, gradations, transitions, cycling...etc.); 3) the strategy family (strategies, tactics, mechanisms, manipulations, ...etc.); and 4) the degree family (limit, range, intensity, extent, extreme, rank, continuum...etc.).

Theoretical codes are implicit and flexible; they operate mainly to sensitize the researcher to possible relationships that may exist between the categories. While coding an incident against the properties of the categories, the data are further explored for questions such as: Does this incident indicate a degree or a range in a broader continuum? Does it indicate a phase, a stage of transition or a process? Is it a tactic or strategy of a broader process? As might be noticed, the above questions reflect different types of coding families. For categories that emerged from data for this study, a blend of process and six 'c'

codes were found most appropriate to relate them into hypotheses that were further verified by means of comparing it with new data. As the process of building connections continues, the theory begins to emerge. At the beginning, the categories appear hazy, but they become more integrated as the analysis continues.

Theoretical Sampling. Theoretical sampling is the operation whereby the analyst decides, based on the emerging theory, what data to collect next and where to find them. The basic question in theoretical sampling is: What groups or subgroups of people, events, activities or behaviors one should turn to next in data collection, and for what theoretical purposes?

The purpose of theoretical sampling is to generate as many properties of categories as possible, to note the degree to which these properties vary according to the diverse conditions, and to verify relationships between categories. Referring back to the example mentioned previously on the degree of defectiveness of social support system as related to the structure of network, further sampling was employed looking for subjects with different network structures. Three categories of network structure emerged and were found to be a consequence of another category that is, the up-rooting experience, but were also found to shape the amount and quality of support: 1) women who lived in the U.S. for a few years with their own families before marriage had two complementary networks that were comprised of their own extended families and their husband's. These women became distant from their extended families upon marriage. They received emotional and informational help from this network in addition to the physical help they received from their husband's families; 2) women who were separated

from their own families because they were brought by their husbands to the U.S. shortly after marriage to live with their in-laws. These women received limited support in the form of physical aid and informational help. However, this support was contingent upon meeting other demands like sharing the household, sharing economical resources, facing conflicts of power and control among the other women in the network; 3) women who relocated in U.S. after being married in their home countries for a number of years, became up-rooted both from their own and their husband's extended families, and were faced with the task of reformulating their own social network. These women were found to have superficial, weak networks, and they lived with the most deficient social support, but this was compensated by gaining self-reliance, and freedom of the unnecessary demands and rules imposed by the traditional networks.

In summary, through the process of theoretical sampling the researcher was able to develop the full range of variations under a certain category and establish the conditions under which the relationship between such a category and other categories exists and the conditions under which it does not.

Integration of the Theory. To integrate the theory is to delineate it to a 'core category' that would best hold together the other categories as they relate to it and to each other. Upon choosing a core category, the analysis becomes focused around it and only relevant variables will be included in the theory, so the two major requirements of parsimony and scope of a theory will be achieved (Glaser, 1978; Glaser & Strauss, 1967).

A core category is the essence of the problem under study; it is the theme that appears to dominate the other themes to speak to what is reflected by the data as the major concern of the participants (Stern, 1985). A core category is developed early in the analysis process when most of the substantive categories are developed and saturated. Through the process of analysis, one or two categories would seem to account for most of the variations in a pattern of behaviors and so would formulate the core variable (problem, process, behavior...etc.). Once a commitment to a core category is decided upon, further coding becomes less opened (selective coding) and more directed toward establishing the properties of the core category and verifying its relationship to other categories through data collection.

Through coding the data for this study, two major categories emerged to describe the context where the participant's pre-birth period occurred. This included, "feeling out of place" and "ambivalent adjustment." It was decided, on a provisional basis, to consider these two categories as the core categories of the analysis since they appeared to reflect what the participants communicated as their major concern. With further analysis the above two categories were found to relate to each other in a process fashion, that is, women in this study manage their successive, transitions through a process of ambivalent adjustment and feeling out of place without reaching a complete settlement. 'Unsettled transitions' is the category that best describes the above process. As a result, 'successive-unsettled transitions' was suggested as a core category, with 'ambivalent adjustment' and 'feeling out of place' being its two dimensions that both delineated its properties and explained the consequences of managing the birth and

postpartum under the conditions of the other transitions. Further analysis became focused on saturating the above categories and densifying the interrelationships between them and those concepts describing what birth and postpartum were like for these women.

Writing the Theory. Writing sums up all the preceding work. At this stage the researcher is convinced that the theoretical framework is integrated, systematically formulated and has achieved the major requirement of parsimony, density and scope. Two procedures should lead to writing: theoretical memoing and theoretical sorting.

Memos are the researcher's storehouse of ideas about codes and their relationships as they occur while the analyst is coding. Writing memos is a technique which allows advancing beyond description of data to that of theory development. Memos are usually generated when comparing data. An idea may occur to the researcher when analyzing how an incident coded into a category may relate to other incidents coded into that category and thereby developing its theoretical properties, or later, how categories might relate to one another and integrate the theory. These ideas are written as either an extended or brief memo. Memos should be written and kept in a manner that facilitates sorting them for subsequent organization of the theory parts. Sorting is the step that follows memoing prior to the formal writing of the theory. The organization of the theoretically sorted memos (sorted according to an emerging theory) forms the basis for an outline to guide the final writing. There are two levels of sorting: 1) sorting for sections and then within the section. This is done when writing a paper or lecture; 2) sorting for chapters, then sections of each chapter and then within sections. This happens when writing a book or dissertation.

Methodological Issues

The Issue of Confidentiality

Several procedures were carried out to maintain the confidentiality of information obtained for this study. Information to the identity of each subject was kept in a locked file. File folders were identified only by numbers. It was the original intent of the investigator that no one would be informed even of who had participated in the research. This was successfully fulfilled except in the few cases when subjects referred the researcher to other subjects whom they thought would be interested in participating and they recommended that their names be mentioned as actual participants. Also, in one case, two women recognized each other as they met in the clinic during one of their prenatal visits and they told one another about being part of the study.

The Issue of Data Validity and Reliability

Environmental effects on the subjects' responses were controlled in the majority of the interviews. This was ensured by interviewing the subject in the absence of any other person who might influence the responses. In a few cases it was not possible to isolate the subjects from other persons during the interview, however, the researcher included them in the interview to obtain data that was useful either as a validation of the subject's responses or as useful background data for the analysis. Moreover, the frequent and persistent contact between the investigator and the participants enhanced their openness and encouraged unbiased responses. More important, home visits allowed for a great deal of verification of previous observations that were recorded in

earlier contacts.

The Issue of Subjectivity in Data Collection and Analysis

Because in field research the various forms of data collection and recording occur through interaction, one's previous life experiences, values, beliefs, education and training, can shape the process of data recording and interpretation of responses. Since the researcher came from the same culture as the participants, and experienced the same kind of transitions (relocation and transition to motherhood), it was possible that her asking of the questions and recording of the responses were influenced by her own perception of the situation under investigation. Therefore, it became essential to control for such a subjective bias by constantly examining one's own perspectives and attitudes and utilize them only to increase the understanding of behaviors and to bring insight to the interaction process. Another control technique was utilized by the researcher by introducing some of the initial field notes to graduate nursing and medical anthropology students who interacted with Arab Immigrants either in a research milieu or in other settings. Their impressions about the recorded and interpreted data validated the investigator's. A third technique was carried out in which the researcher gave the field notes to the corresponding subjects after being translated into English and typed in the standard format. The subjects were asked to verify the field notes as reflecting their responses to the interviews, and to identify the researcher's misunderstanding, or misinterpretation of the responses. Only subjects who spoke and read English were invited to the cross-validation technique. Minimum or no misinterpretation of responses were

reported by the subjects.

However, the investigator's cultural and personal background could not be underestimated, because it was due to her background and her training as a professional nurse, who provided care for maternity patients both in her home country an the U.S., that she was able to understand the Arab women's experience of birth under their particular conditions. Such an understanding enabled her to empathize with these women and view their situation from their perspective. In some situations the researcher combined the roles of clinician, resource person and a patient confidant in addition to the role of researcher. However, as one trained in the objectivity of research methods, the investigator constantly moved back from the situation and compared what she heard and observed in a situation with one subject to her observations in other situations with different subjects. This comparative information was utilized to formulate the theory.

As for the validity of the data analysis, this was obtained by presenting extensive sections of the raw data to nursing and sociology graduate students* for open coding. Initial codes that were derived by students validated the investigator's codes. A later step was followed whereby the emerged core category and its linkages to other categories were presented by the investigator to the same group for critiquing. The group's input was utilized to further verify, expand and modify the theoretical model evolved from the data analysis.

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*Seminar on qualitative data analysis, led by Dr. Anselm Strauss, Ph.D., Department of Sociology, School of Nursing, University of California, San Francisco, Spring 1985 to Winter 1986.

CHAPTER 4

FINDINGS

The pre-birth period is viewed in this study as an early beginning of the post-birth transition, the latter is the main concern of the investigation. Both pre-birth and post-birth were examined as they interacted with the social and cultural changes of relocation. The core problem as communicated by the participants is that of managing late pregnancy and early transition to postpartum within a context of successive-unsettled transitions. The aim of the analysis is to examine the question of, "what happens when women face pregnancy and postpartum under the consequences of other successive, unsettled transitions"?

In this chapter, findings from data analysis will be presented in three parts: the first part will include codes (categories and concepts) that conceptually describe the process of the successive unsettled transitions, as it constitutes the foundation of the theory of managing birth and postpartum under the conditions of relocation; the second part will describe the periods of late pre-birth, early postpartum, and late postpartum; and the third part will briefly describe the interaction between relocation and early and late postpartum.

PART I: Relocation Transition

The Concept of Successive-Unsettled Transitions

The concept of successive-unsettled transitions emerged from data analysis to describe and explain the process involved in the relocation experience of the women under study. It should be realized that relocations are variable experiences that take different courses and

result in different consequences depending on the conditions under which they take place.

This theoretical scheme provides an explanation of the relocation experience as communicated by women under this study. It is understood that there are numerous groups of Arab women who relocated in the U.S. with experiences that might be different from the one presented in this study. For instance, there are women who have relocated for only a few months, and those who migrated 20 years ago. Moreover, there are women who know that they will stay permanently, those who know that they are going back to their countries after a certain period of time, and those who have not yet determined. This analytic scheme works for those women who came to the U.S. to stay permanently as well as those who have stayed for a few years but are not quite certain about their situation. More importantly, this analysis concerns the women who have passed the initial phases of their relocation but are still managing its associated consequences. However, it should also be borne in mind that this analysis has emerged from a great scale of comparisons that provided a variation in experiences within the particular group of women under study. Therefore, it accounts for a wide range of various conditions, strategies and consequences.

Up-rooting is the core consequence experienced in relocation. However, for the women under study, relocation involved an additional number of events that occurred in a close succession to each other and were either a cause, a condition, or a consequence to relocation. This includes events like marriage; having a baby just prior to relocating; and/or going through maturational periods from late adolescence to early adulthood. The range and magnitude of these transitions varied

according to certain general and structural conditions.

Conditions under Which Successive-Unsettled Transitions Occur

Relocation was a major event in the participants lives according to this study. It was because of this event that the other transitions came into play in the successive-unsettled manner that will be explained shortly. Therefore, relocation was a basic condition for the successive-unsettled transitions.

Other structural conditions emerged from data analysis to determine the range of the successive-unsettled transitions. These conditions clustered around the country of origin. Thus, country of origin became a larger structural condition of which other conditions were smaller parts. Three categories of women representing four countries of origin were identified: Palestinian; Lebanese and Syrians (were collapsed in one group as they were similar in many respects); and Egyptians. Table 4 represents the size of each group in relation to the study sample.

Table 4

Distribution of Subjects by Country of Origin

Country of Origin	Number	Percentage
Palestine	8	44%
Lebanon & Syria	5	28%
Egypt	5	28%
Total	18	100%

The Palestinian women were found to experience the most extensive range of successive transitions, because they migrate at a very young age, and upon migration quit school at the early stages of education,

and in the meantime marry and become pregnant shortly afterwards. Of the eight, six were Moslem, five were under 19 years of age when they came to the U.S., and six had to separate completely from their original networks (extended families) upon relocation. On the other hand, Lebanese and Syrians faced a less extensive range of transitions. Although the majority of them (four out of five) were completely up-rooted from their original networks, and a portion of them (two out of five) were in early phases of their marriage when they migrated, they came to the U.S. at an older stage of adulthood (three were 25 years of age and older), moreover two of them went through a previous motherhood experience before they migrated. Egyptians on the other hand, showed a distinctive picture of successive transitions that differed in the range and quality from the above sub-groups. Although they migrated at a more developed stage of adulthood (over 30 years of age, post-college education, established careers), they combined newly established marriages, change or loss of careers, and complete loss of social network. Because of that, Egyptian women fall under a category of successive transitions that is less extensive in range than the one demonstrated by the Palestinian women, but more intense in the magnitude of the adjustment work.

In summary, a number of conditions were important in determining the range and quality of successive transitions that emerged from the Arab women's experience of relocation. These conditions were country of origin, age, level of education, stage of marital life (married for just one week, one year, or longer), presence or absence of occupation. It was also suggested that country of origin would be a major condition that provided the specific characteristics of every sub-group of women

and in turn influenced the properties of their successive-unsettled transition. Other conditions such as religion, length of stay in the U.S., and type of migration were not rigorously tested, because the sample was homogeneous with regard to these variables. For example, 78% of the women were Muslem, 72% were permanent residents in the U.S., and the range of stay was five years, with the shortest stay being just under one year and the longest being six years.

Consequences of Successive-Unsettled Transitions

The above transitions resulted in a number of changes on different levels such as self and the external social structure. Three categories have emerged from data analysis to demonstrate areas of major change in each level. These include: a) social roles, b) life style, and c) social interaction, social support, and social networks.

Social roles

Changes in social roles are common consequences of life transitions. Women in this study have undergone complete or partial re-structuring of self-concept as a result of moving along the expected periods of adult life. However, under the conditions of relocation, these changes occurred in an intensified, non-gradual pattern. This is illustrated by the following portions of data:

> "...I cannot compare my life here with my life back home...here, I became a wife and a mother...back there I was just a school girl". (Subject #5)

> "...I came here with my husband a few days after our wedding, I found it very hard to leave home and family... I think for me it was double hard, because I left home and family for the first time in life, I got married and this was a big change by itself, then I got pregnant, which again was another shift in my life...all these changes happened in a very short time...it was very tough... I

think it still is...I mean I am not a college student anymore, I am a wife and soon I will become a mother...". (Subject #9)
"...by coming here, I changed a lot of myself. I lost my career and became a housewife...I had to give up so many things by giving my career up...I mean, I used to be a big boss and have people working under my supervision... I also had my own money, I was free to do whatever I wanted to do with it...besides, I was the eldest child in the family...I used to have my position among my family, especially when my father died and I had to take over a lot of responsibilities...when I came here, I just stayed home as a house wife, very isolated, dependent on my husband's help...this was real difficult for me...". (Subject #20)

Life Style

This category is multidimensional, it has developed from sub-categories which describe areas such as life responsibilities, perception of time, and also relationship between the conception of time and social interaction. Data suggested that there were considerable changes in the above aspects of life style most of which occurred in correspondence to maturation and assuming new roles in life upon relocation. Thus, a considerable portion of them was a direct consequence to the successive transition.

Expansion of responsibilities was an example of these changes.

"I think I became more responsible now...by coming here I added a lot of responsibilities to my shoulders...it was like every day I was faced by something new which I got to carry...I know now what a responsibility is...I believe it is also related to being married and carrying a family responsibility...things that I used to think about have changed. I used to think about myself, my friends, my work at college, now, my thinking is focused on bigger responsibilities...also, I felt like I lived my life day-by-day...my plans were short and around the near future and they usually changed once I accomplished what I wanted...now, I have long-term goals and I think about life in a broader sense." (Subject #9)

"...when I came back from home after I had my baby there, I had become a different person...I felt more grown-up and responsible...I was not that little girl anymore...I carried my son over my shoulder, I felt I was responsible to take care of him and my new family...". (Subject #2)

Perception of time was another example of change in life style.

Women had a different experience of time since they had lived in the American culture. A sense of increased amount of time due to decreased activities, accompanied by some degree of inflexibility and lack of control constituted the major theme of change in time-experience for these women.

> "...life here is simple, technology has made everything easy, laundry and all home cleaning take less time, people have more time to use in other things...I have more time for reading, watching T.V. or sewing...also, it is different how people organize their time here, like the other day I stopped by a neighbor's door for a chat, I found a sign at the door saying 'Nap Time'...these things don't work for us...although they would be nice to copy sometimes...". (Subject #11)

> "Since I came here, the way I use my time changed, for example, when I was back home, I was single, I used to go out with friends, my time was more flexible and I used it the way I wanted, I had no other things to arrange my time for...now, I share my time with another person, my husband. I know he has work to go to, I modify my day to fit his schedule, besides, there is no other way to arrange my time, I mean where could I go by myself and with whom...I have no friends here...". (Subject #19)

> "...it is hard to attend any of the classes that are offered in the clinic, every time they tell me about them I decide not to sign-up...I just don't have time...I mean the clinic appointments and the time I spend in each visit should follow my husband's schedule...because he is the one who drops me and picks me up...". (Subject #5)

The above responses were not just individual responses, but they represented a continuum of experiences as communicated by the participants. Through the comparing and contrasting of responses, sub-groups of subjects were found to fit under different points along the continuum. Both aspects of change in relation to time, increased time and decreased flexibility, had consequences for the woman's adjustment to their successive-transition. These consequences are not necessarily generalizable to all women under study, however, they constituted significant sources of stressors for women who were under the following conditions:

-newly arriving or being in the early period after relocation

-having no social resources (family or friends)

-complete or partial unfamiliarity with the language

-having no occupation

For these women, consequences of time change included increased sense of emptyness, isolation and social vulnerability, and limited exposure to the American community resources and the external (environmental) stimulation.

Social Interaction, Social Support, and Social Networks

Among the major concerns of women in this study was the loss of intimate social and personal contacts, and also the decrease in the quality of relationships due to the shifting to a more superficial level under the impact of up-rooting. The category of social support and social network revealed to have a broad scope because it was verified under a variety of conditions. The problem of change in relationships was generalizable to a great variety of conditions including: country of origin, experience of migration, duration of stay in the new country, and structure of social network.

The quality of relationships shifted along the dimensions of intimacy, commitment, sharing, continuity and stability. Relationships under the conditions of up-rooting were perceived as superficial, unreliable and not meaningful because they were limited in sharing and commitment, fluctuated over time, and were easily broken.

> "...life here is empty of relationships...I made some friendships, but they were different...I guess they were O.K. on the regular basis, but once I had a problem I could not rely on anybody...my problems are for me to deal with, even when I talk to somebody about them, they always say that my problems are for me to take care of, they cannot tell me what to do...!! I think relationships

here have certain limits and you cannot go beyond these limits...". (Subject #20)

"...in Egypt, relationships are a lot more stable...people give of their time and selves to each other... You always have the feeling that you are surrounded by people, you are never alone...this is the way we are, nobody is alone, even in good times people like to share...whereas here, sometimes I worry that I forget how people look like...I mean I could spend almost the whole week without seeing or talking to somebody but my husband!!" (Subject #19)

"...there is no social life here at all, we are stuck at home all the time, the only recreation we do is to go out, maybe have dinner sometimes and then come back home again...". (Subject #15)

The researcher: "Do you have American friends?"

"...never, we meet some of the neighbors in the laundry, we say hi, they answer, hi...but I mean if we won't say it they won't bother...we also meet Americans in campus parties at my husband's school, but we never make relationships...even the Arab families who are here are different...we meet, we talk, and exchange news, but most of the meetings are pre-planned for certain occasions, when the gathering is over, we go back to the same point where we began, very superficial, never grows deeper...". (Subject #2)

The concerns over the meaning and quality of support were reported by participants in spite of the differences in the type and structure of their social networks. Participants came from three different types of social networks, none of which were perceived by them as providing a a satisfying support. Spouse's family network was perceived as competitive and unreliable. The types of networks were: 1) own family network, 2) spouse's family network, and 3) non-family network. Own family network included the woman's whole extended family; a sister or a brother, or both; or a mother who came from home to attend the delivery. Spouses' family network included mother in-law and brothers and sisters in-law. Non-family network included friends and neighbors from the native and/or non-native country.

For example, women who had members of their own family as their social network perceived the family support, though meaningful, yet

scant in amount and inconvenient to the felt need.

> "...even with my family around, it is not the same like back home, I mean I see my sister once every weekend!! Also, my mother is here for a visit, but she spends most of her time with my sister...sometimes I wonder why she likes to stay with my sister more...I feel I need her more, after all, I am the one who is pregnant...(looking sad)...". (Subject #20)

On the other hand, women who had members from their spouses families, perceived the support as scant in amount and unmeaningful in quality.

> "...I had a very hard time when I had my first baby, although I had my mother-in-law who is also my aunt, and who actually raised me when I was a kid...I expected her to be like a mother for me here, but she was not really...we lived together in the same household, and there were also two of my sister-in-laws who helped a little with the household duties, but the work was just too much with all these people living in the same place...so nobody had time for me...it was hard to expect help and not to get it...any ways, I have never felt comfortable with my mother-in-law, she is not as close and warm to me as my mother, I never talk to her when I feel sad or have a problem...". (Subject #1)

> "I have my husband's family, and they have been nice to me, but they also have their own friends...they are always busy. I cannot expect much from them, I still could not relate to them like I related to my own family, I could not expect from them what I used to expect from my family, especially my mother, you know how the mother is for us...there is nobody like her...". (Subject #9)

And finally, women who had a non-family network perceived themselves as receiving the lowest level of support in both quantity and quality.

> "...Americans are hard to make relationship with. Egyptians who are here are not like the Egyptians back home...well, they are not my school and college buddies, they are not my family either...that is why I am having difficulties...some friends would interfere in my life and try to tell me what to do, some others are just hard to get along with because the way they spend their time and money does not suit me...all these are Egyptians...". (Subject #11)

The Course of Successive-Unsettled Transitions

The successive-unsettled transitions according to the data for this study occurred in a process. Women in the study were found to be at

different points along the process. Feeling out of place, and ambivalent adjustment were two phases of the above process. However, it should be realized that there was not a clear line between the two phases to mark the end of the first phase and the beginning of the second one. Instead, there were some periods that were part of both phases, also, there was strong evidence that the participants continued to feel out of place after they had done a great deal of adjustment work. These unresolved feelings of being out of place added to the work of adjustment in the later phases of relocation. Figure 2 presents the process in a diagram.

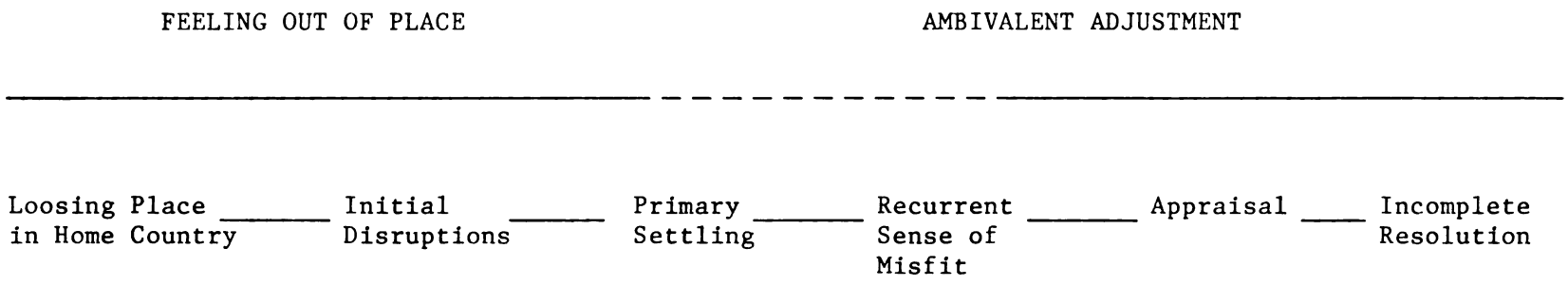
Feeling Out of Place

Feeling out of place is a concept developed from the participants' own language to describe their sense of being caught between two different social systems, represented by home culture and the American culture. Feeling out of place denoted the experience of becoming no longer a part of the home country, and being unable to integrate completely with the new one. The following sub-concepts constituted the concept of feeling out of place: a) losing place/fitness in the home country; and b) recurrent sense of misfit in the new country.

Losing place/fitness in the home country. For women who came to the U.S. because of the war in the Middle East, especially in Lebanon and Palestine, losing place in home country was a fact that they faced before they decided to leave. These women realized that they had no place in their lands due to the foreign occupation and the constant war. They came to the U.S. to stay permanently. A Palestinian woman who came to the U.S. with her family at the age of 15 expressed that she no

FIGURE 2

The Process of Successive-Unsettled Transitions



longer belonged to her home land, she also did not show any expression of sadness or grief over her lost home. Instead, she conveyed a sense of acceptance of reality.

> "...life here is free...back home it is like a terrorism, people are afraid to go out of their homes, it is just difficult to live like that...I mean the Jewish are everywhere, the guns and bombs are all over the place...I would like to go back home, but only if the land is free...but with the way it is now, I have no place there...". (Subject #4)

The above response was typical to women who had similar conditions like the above woman. *Their experiences of losing place in home country had the properties of involuntary displacement and complete acceptance of situation.* With these properties, women had no choice but thinking of home as a dream or a novel, which consequently pushed their adjustment to relocation in a single direction toward one goal, that is the assimilation in the new culture. The theoretical question that evolved here was: what consequences did this have for the course of adjustment in these women's case? There was some evidence from the data that these women's experience of adjustment shared the common features of adjustment of the other Arab women in the study. However, there were also indications that these women might be having a more demanding experience of adjustment due to other structural conditions that were unique to them. One of these conditions was the radical change in their lives as a result of the high-range transitions as explained before. The majority of these women communicated that their lives in their home countries were not comparable to their lives in the new country, the former life was more of a child life, where as the latter one has become more of an adult life; the shift happened in a short period of time.

The experience of losing place/fit in the home country differed along the dimensions of *displacement* and *acceptance* when it occurred

under a different set of conditions. Because of these conditions, the event of losing place in home country was more *voluntary* and not *completely accepted* due to the presence of conflicts between choices. For example, two Egyptian women (#19 and 20) lost their place in their country as they experienced an urge to move-on with their own lives and search for new opportunities. The following is an excerpt from an interview with one of them.

> "...I was 34 years old when I developed my career to the top. I made enough money, I helped my family to a great extent, I did everything I wanted to do...after a while, things did not make sense anymore...I was becoming saturated with all what I did...I was getting old, I wanted to marry, I needed a family of my own...it was hard to get married at this age back home. I mean it was hard enough to make me marry my husband once I met him and I knew he was going to U.S....". (Subject #20)

Two other women (#11 and 13), one of whom was Egyptian and the other was Syrian said that they and their families began to lose place in their home country when they experienced a sense of instability due to a constant desire by their spouses to move to a different place, because they (spouses) were not satisfied with their life situations.

> "...my husband has always wanted to live in the U.S. Although he had a good job and earned good money...he did not want to stay...it was hard for me to leave home, but then my husband was miserable. I knew he wanted to leave...our life would not settle down when he was unhappy all the time...So, I decided to help him in the move...". (Subject #11)

Recurrent sense of misfit in the new country. This concept involves the awareness that one has lost her place in the old country to the extent that she cannot go back. Meantime, there is also this awareness of being unable to fit completely in the new system of the host country due to some aspect of unresolved adjustment not only to relocation changes, but also to the other transitions along side its course such as marriage, career change, changes in social network. Women in the study

faced a recurrent sense of misfit on a greater scale than would be the case for other groups because of these multiple transitions. The feeling of misfit was related to the women's inability to resolve completely all the consequences of these transitions. Their recurrent feeling of misfit was most concentrated around the following areas: self-identity and boundaries; marital relationship; social relationships and social support; health care system; and values of parenting and childraising. Not each of the above issues was communicated by each individual subject in the study. However, they were the most frequent areas of concern for the majority of the women.

Ambivalent Adjustment

Adjustment is defined as functional and transitory alteration by which an organism is better adapted to its immediate environment. Also, the verb to adjust means to settle or resolve conflicts. To become adjusted is to bring oneself, especially ones acts, behaviors and mental state into harmony with changed conditions or environment (Webster's Third New International Dictionary, 1961, p. 27).

The concept of ambivalent adjustment was developed based on the evidence from data that completely settled adjustment has not yet been reached by subjects. Absence of strong motivation to make the transition (relocation) incomplete willingness to leave home environment, having to choose from limited choices, none of which provide an ultimate satisfaction, and the difficulty to come to terms with the change were all indicators of ambivalence. Only three women (17%) said that they came to the U.S. based on personal choice to try a new life and look for opportunities. The rest of the participants

mentioned reasons such as: a) war in home country and marrying a husband who has been living in the U.S. for several years (33%); b) war in home country (28%); or c) husband's desire to live in the U.S. or husband's coming to U.S. to study for degree (22%). Those who came because of the war came as single, young women or teenagers who left home as part of their families; then they married a few years later and settled in the new country.

In addition to the above aspects of ambivalent adjustment, it was found that the sense of ambivalence was intensified because of the following three conditions, massive or successive nature of the transitions associated with relocation; the persistent sense of misfit in the new culture; and the uncompensated social and emotional resources.

Properties of Ambivalent Adjustment

The phrase ambivalent was used to draw the distinctive features of adjustment as evolved from data versus other classes of adjustment which are 'non-ambivalent'. By theoretical comparing and contrasting among the two classes of adjustments along such dimensions as conditions, strategies and consequences, ambivalent adjustment was identified as being based on limited choices and incomplete readiness as a condition; achieved on a cognitive level with the exclusion of the emotional and social level as a strategy; and has incomplete resolution as a consequence. This was reflected by recurrent themes in the data, as shown in the following examples.

> "...I feel better now...I think I got used to it...I have convinced myself that traveling is a sueful experience...I mean I am learning good things just dealing with a different world...but the thing

> that is really helping me is my belief that I am going back after a certain period of time...things become easier to take when I think about that. I always tell myself that whatever it will take, I will not have to do it forever..." (Subject #9)
> "...I just got used to it...although every once in a while I feel bad, I still wish I had good friends, but I am managing...I mean I am not going to make myself and my family miserable...!! I guess I came here too old to make those kind of friends that I dream of...I have tried though..." (Subject #11)
>
> "...I don't think I can raise my daughter here in this society...this is one of the things that really makes me think twice about my staying here permanently..." (Subject #14)
>
> "...my husband is very depressed, I guess he is guilty because he brought us here and he knew that we had a good life back home...I mean, what we got here is nothing comparing to what we used to have back there..." (Subject #11)
>
> "...I am sending my daughter (6 years) to my family back home this summer, because she will start school there...she will stay there all the time and I will visit her...I just don't want to raise her in this country..." (Subject #16)

Ambivalent adjustment is composed of two sub-concepts, a) constant appraisal; and b) incomplete resolution.

Constant appraisal. Constant appraisal is a process in which women in the study were continuously involved to locate their position along the course of adjustment, and to evaluate the losses and gains of the experience. Also, previous difficult situations were reflected upon to evaluate one's present and future resources of adjustment. The latter was indicated by the women's communicating a sense of 'having come a long way' as they discussed their early relocation period.

One level of appraisal included personal accomplishment, which motivated women to continue with managing the work of the successive transitions. Separating from the family and assuming new roles and responsibilities created a sense of pride of becoming independent and self-accountable. The shift to a more mature level of life was another achievement that women had become aware of due to

adding new aspects to self. They communicated a feeling of expansion and growth, accompanied by changes in the ways of thinking and communication that had become part of a new self that they discovered. The mastering of new skills, such as maternal-role skills for those who relocated with newborn babies, or learning the language skills, or knowing about the new environment resources increased the sense of competency and control. The latter added to the women's achievements which assisted them to appraise their experience of successive-unsettled transition in a more balanced way.

Another level of appraisal involved broader areas, such as external societal structure. Women have continuously compared and contrasted their original traditional culture against the western culture. As a consequence, they discovered flaws in the old culture and challenged or rejected some of the old behaviors. Also, some aspects of the new culture became more accepted and valued by these women. For example, they appreciated freedom and liberation in general, and freedom from old, traditional rules in particular, they also valued the availability of the numerous opportunities in life which opened new options for them.

Incomplete resolution. Incomplete resolution is the opposite state of the constant appraisal. Part of the incomplete resolution happens as a consequence to the appraisal procedure. For example, in some situations, appraisal revealed some holes in the new culture for the Arab women, especially in those areas related to the decreased quality of interpersonal relationships, values of child raising, health care system, and extreme freedom and violence in the new society.

Another aspect of incomplete resolution was related to the difficulty to manage the extensive work of the other successive

transitions. For instance, some marital relationships have not quite settled, some parenting issues have still not been resolved, some maternal skills have not been mastered, and some consequences of career changes have not been come to terms with.

In summary, Arab women in this study faced a number of transitions as they relocated in the U.S. which occurred successively as part of the relocation event, but were not completely resolved. These transitions touched on various levels of the women's lives such as: self (roles, identity, and status); life style (type and amount of responsibilities, conception of time, ways of interaction and relationships); and finally, social support and social network. To manage the work of the above transitions, women were engaged in an on-going process of adjustment which did not lead to a complete settling-down, it began by a phase called 'feeling out of place' which when not completely resolved led to a phase called 'ambivalent adjustment'. The latter had two consequences that became the structural conditions under which these women managed their experience of pregnancy and birth. These are: constant appraisal and incomplete resolution. In the following part of this chapter, findings on the course of late pre-birth period through late post-birth under the above conditions will be presented.

PART II: Postpartum Transition

Section 1: The Late Pre-Birth Period

Being experienced under the particular social and cultural context explained in the previous section, the course of pre-birth period for these women demonstrated unique features which were a blend of both their traditional culture and the modern-American culture. For example,

pregnancy continued to be a socially and culturally sanctioned path of gaining status and actualizing self for these women. This is because the maternal role is still viewed by their culture as a major part of women's role in life. Thus, the decision to become pregnant is not only controlled by the number of children desired, the family financial readiness or the women's career future, but also determined by the desire to fulfill one's role in life and meet a social expectation.

> "...I did not really want to get pregnant soon after marriage, but I did it for my husband, I knew he wanted a child soon...". (Subject #2)

Another Palestinian woman said,

> "I came from a big family...I plan to have a big family too. I can't wait to see my children sitting around the dining table occupying all the seats...". (Subject #5)

A third Egyptian woman said,

> "...I got married just to have a baby, I wanted to make a family, this was a goal for me...I had my first baby girl, and this was enough for me...but then my husband wanted a boy, and he kind of had some sneaky ways to make me pregnant...any way, I am just hoping to have a baby boy, just for him...". (Subject #20)

However, the other aspects of pregnancy like its course and its management have been influenced by the context of the successive-unsettled transition. Late pregnancy has become a situation of continuous assessment and facing of uncertainties. Each of these two situations will be discussed below.

Continuous Assessment

Assessment included a number of areas, the following two were the most prominant: the pregnancy experience itself, and the social support system.

Assessment of pregnancy experience. Assessment seemed to be an important strategy of keeping up with the changes of pregnancy. When asked to describe how their pregnancies were going and if they had any concerns, women responded by explaining 'how far they have come along' through the course of pregnancy. They compared the period of early pregnancy to late pregnancy. Moreover, women who were expecting a second baby compared their present pregnancy with the previous one.

By doing this assessment, women were able to come to terms with their pregnancy and to stretch their tolerance of the suspense and waiting of its course, especially the late part. Also, by doing this assessment, women placed their pregnancy in a biographical context, whereby they connected it to the other events in their lives in an attempt to scale their accomplishments in other areas, and to think about the coming periods following the term of pregnancy and delivery.

Assessment of social support system. As demonstrated in previous sections, one of the consequences of the relocation event for women in the study was the disruption of their social support system. While they managed to live with the deficient support under the usual conditions, they began to re-appraise their resources of help and support under the conditions of pregnancy. This re-appraisal became even more intensified through the late part of pregnancy to find out if they have enough resources to face the demands of birth and the period following delivery. Since multiparas had more demands, they were more involved in the assessment than primiparas.

Amount and quality of support received in previous situations were used as a base-line according to which future support was anticipated. Women who's spouses were not adequately supportive in previous

pregnancies began to think about going to their home countries to have their baby and maybe come back after they regained their energy and strength. Other women, who did not have a previous experience to rely on, decided to send for help back in their countries; some of them brought their own mothers. Still other women chose to live with the uncertainty about the source and quality of prospective support. However, this became one of their distressing concerns.

Facing Uncertainties

Uncertainties constituted the core of pregnancy concerns for the women in the study. Several categories of uncertainties were identified, some of which were related to the pregnancy as a physiological and psychological experience, whereas some other uncertainties were associated with the interaction of pregnancy and relocation. Categories of uncertainties included: 1) pregnancy and pregnancy outcomes; 2) labor and delivery; 3) sibling reaction; 4) spouse and/or family support; and 5) ability to perform future maternal tasks.

Section 2: Early Postpartum

Data from the second interview illuminated the psychological and social dynamics that took place during the early period after delivery (2 to 7 days). It was noted that the women under study did not differ in their reactions to this period from what is described in the literature as normal reactions. However, they communicated some concerns that were specific to their situation as living in two different cultures. The key categories that conceptualized the above

phase were: 1) recovery from labor and delivery; and 2) conflict between two systems of birth: old and modern.

Recovery from Labor and Delivery

Participants expressed a typical recovery reaction from the fast, unpredicted events of labor and delivery. This was demonstrated in three concepts that evolved from coding of data: mixed feelings; redefinition of self; and sense of gratitude.

Mixed Feelings. This concept encompassed feelings of excitement, shock, surprise, disbelief, relief, and gratefulness which constituted the theme of recovery from labor as displayed by participants. Shock and disbelief at the pace of the labor act and the unpredictability of the process dominated the earliest reactions and were expressed more frequently by primiparous mothers than multiparous ones. Later reactions were composed of relief and gratitude, and were more communicated by multiparae than primiparae. The following excerpts from interviews present examples of the reactions.

> "...it was O.K., at least it was not too long. I mean the last part went so fast...the nurses couldn't believe it,...I was 5 cm dilated on admission, then I became 10 cm after an hour!!...they couldn't catch up with me, they had to deliver me in bed in the labor room...God...she (the baby) was fast..." (Subject #4)

> "...my labor was 36-40 hours long, this was long and exhausting. I had a lot of pain, and I resisted the epidural shot because I was frightened after all I heard about it from the other women...but then the pain was getting so bad that I could not take it any longer. They were about to schedule me for a Cesarean section because the baby's head was way too high and I did not have much energy left...I decided to take the epidural and give myself a little more time...then all of a sudden, the baby's head dropped down, and I surprisingly had a vaginal delivery...I could not believe that this would happen!!!" (Subject #14)

> "...I was so relieved after the delivery was over...I tell you, I never expected it to be that fast and easy..." (Subject #6)

> "I am O.K...everything is fine...it all happened so quickly, it was natural. I did not have any hard time, thank God...I went to the hospital at 12:00 noon, I delivered at 4:00 in the afternoon, it was fast, everything went normal..." (Subject #2)

From the above responses it was noted that the participants concentrated on the process rather than the self performance. Except for one woman, none of the women were involved in evaluating their participation in the process. While this might be perceived as congruent with the women's role during labor and delivery, as being dependent and less in control of the situation (Meleis & Sorrell, 1981), it is contradicted by other behaviors where women took active roles in decision-making during this experience. For example, of all the women who were given the option of epidural anesthetic, only one (#6) accepted it without hesitance. The others decided to refuse it or to make it their last choice. One explanation of this response might be that these women are in a transient period in their relocation in a new culture. They have not retained their old behaviors any longer (not being completely passive or dependent) but they have not fully assimilated the new behaviors into their system of conduct. This was found to occur repeatedly in many other situations and became a theme in the adaptation to postpartum as will be explained more later.

Redefinition of self. Redefinition of self constituted another body of psychological and social work during the early period following delivery. For primiparae this period marked an evolution of a new aspect of self and a discovery of a new identity. In addition, an element of cost-benefit appraisal was a dominant theme in primiparae's reaction more than in multiparae's. On the other hand, multiparae expressed a sense of expansion of boundaries and establishment of a real

family that is made up of more than a father, mother and one child.

> "...going through the labor pains made me think about a lot of things...I thought about myself before I got married, and I asked myself, why did I have to do that to me, what for?...but now, I am saying it was worth it, just to look at this cream pie (looking at her baby)..." (Subject #4)

> "...I feel like I did something very great...sometimes I cannot believe that I do have a baby, I look at her and I go, is this mine?...it is still hard to believe...(laughing) sometimes I get tired and frustrated, especially when she cries...I cry too, then I laugh at myself. I look at her and I have this feeling that she is worth my hard work and frustrations..." (Subject #9)

> "...I feel good, I mean I feel like we are becoming a real family, when I got married I thought I made a family until I had my first baby when I really felt that I had my small family...now, it feels even more and more like a real family...this makes me feel that I am expanding my emotions, my whole self...hmmm, it is funny sometimes that I worry about not having enough love for one more member to the family..." (Subject #6)

> "...I feel bigger, it is as if I was a little tiny thing and now I am as large as the whole world...with my first baby, I felt a change in my life, but I never felt like I do now...I have always felt like I had only one child, this was nothing for me, now I feel like we are a real family..." (Subject #5)

One multiparous mother (#5) experienced a revival of unresolved issues related to establishing self identity and boundaries. This happened under certain conditions that were specific to this mother, such as young age, being married to a husband who is 20 years older, living in the same household with the husband's family, and being the youngest member of the family. This mother expressed that she always felt as being a small part of a big family, and that she has never felt that she had a marital life with her husband, she always felt shy to act as a wife with him, because her actions were always monitored by the members of the big family. With the arrival of the second baby, this mother began to rethink about strategies to establish her nuclear family

and marital life. One of these strategies was to move to a separate place in another neighborhood.

Sense of gratitude. Sense of gratitude was experienced by mothers and was associated with the psychological relief from the long suspension of pregnancy; the unpredictability of labor; and the shock of delivery. All of the women in the study were gratified to have a natural vaginal delivery, especially those women who at some stage in their labor became eligible for a Cesarean section, but they had a vaginal delivery unexpectedly.

> "I am happy to have a baby, I feel very special, like I have a gift from God...it is something very precious, not just anyone can have it, therefore, I will do my best to take care of it..." (Subject #9)

> "...I was scared that it will go forever, especially the last part...it really felt like it was going to go forever, but thank God it did not..." (Subject #4)

Physical wellness was another aspect of gratitude. Multiparae were more satisfied with their physical well being than primiparae. The former also reported that they experienced a better physical adjustment in comparison to their adjustment when they were first time mothers.

Two levels of gratitude were discovered through comparing and contrasting responses and behaviors of participants, each level emerged under a different set of conditions. This included: complete gratitude and incomplete gratitude. It should be realized that some women experienced both levels of gratitude at different points along the process.

Complete gratitude was expressed by all participants because labor and delivery were completed safely and mother and infant were healthy and well. Feeling of complete gratitude were intensified under the

conditions when adverse situations were expected to happen during or after labor but they surprisingly did not occur, or when there were heightened feelings of worries and anxiety due to uncertainties about pregnancy, labor and delivery, or infant's condition. H (Subject #11) represented a category of women who shared one or more of the above conditions. She was a second time expectant mother who had an eye disease (cataract) in the family which she learned after she became pregnant, was transmitted genetically. Her first child had the disease and had been treated medically. Throughout her pregnancy, H constantly worried about the baby having a cataract. At the end of pregnancy, when she was 10 days overdue, and she expressed that the delay happened because she was too frightened to deliver and face the fact that the baby had the disease. H had a prolonged labor and was scheduled for a Cesarean section delivery one-half hour before she delivered her baby vaginally. After going through all the above events, H's first intensified reaction to labor was thankfulness and complete gratitude, especially after neonatal eye testing was done on the baby, and she was told that the baby was free of cataract.

Incomplete gratitude was experienced under the following conditions: failed expectations of a highly competent and skillful performance of health care professionals, unexpected loss of body integrity, and dissatisfaction with infant's sex.

There were some interactions between the first two conditions (performance of health care professionals and loss of body integrity) and both were strong predictors of incomplete gratitude. The following slices of data illustrate these relationships.

> "...I did not feel comfortable when they (nurses and physicians) got so excited and confused as they watched the baby's head coming through...it was as if it was a surprise for them. I think they could not predict what was going to happen, they waited too long probably...then they had to run back and forth when it happened!!...I did not like that..." (Subject #2)

The researcher: "Did you have an episiotomy?"

> "No, I wish I did, but no, I did not, unfortunately, I got cut by the baby's head instead (shaking head unpleasantly) and they had to repair it, then I had to stay under observation in the delivery room for one more hour before they transferred me to the floor..." (Subject #2)

> "...but too bad, I got a third degree tear and that is what is bothering me now...it is just so sore and the pain killer is not working...I feel kind of helpless. I cannot move easily, I walk very slowly and I cannot even sit down to nurse the baby..." (Subject #4)

The third condition, dissatisfaction with infant's sex, occurred most frequently with incomplete gratitude and produced some important consequences to the postpartum adaptation. Dissatisfaction was expressed only in the cases in which the infant was female. Of those mothers who delivered female infants, only one mother was greatly satisfied with the baby's gender, two others did not express any specific feelings, whereas the remaining three were greatly dissatisfied.

The degree of dissatisfaction varied with the variation in parity; second and third time mothers expressed more dissatisfaction with a female infant than first time mothers, and the dissatisfaction was reinforced by the extended family. It was interesting to note that the one mother who was satisfied with a female baby was a second time mother who delivered a male baby in her first pregnancy.

> "...I knew I will have a girl, although I was hoping for a boy, and I think my mother-in-law hoped for a grandson too, but...I always shopped at the girls corner, I always enjoyed looking at their small dresses...anyways, when I was told that it was a baby girl, I

> looked at my mother-in-law and told her that next time it will be a boy...she laughed and said that she was just happy that I was safe and the baby was healthy, but I guess I will have to try again and this time, I really want a boy..." (Subject #4)
>
> "I mean I am happy that it is a beautiful, healthy baby, but I did not expect it to be a girl...it was so different this time...the kind of pains and the fast delivery made me think that I will have a boy...I was surprised to know it was a girl...but anyway I am glad she is healthy..." (Subject #5)

The following comparisons and contrasting were made to elicit the various conditions under which dissatisfaction with baby's sex occurred and the consequences which it produced. G (Subject #5) who was a second time mother, was psychologically prepared for a baby boy because she had a baby girl in her first pregnancy. This was reinforced by the family's expectation of a baby boy and also by G's awareness that her husband's ex-wife had given him a boy. When G had a baby girl for the second time, she responded with a failed expectation and incomplete gratitude. This was indicated by her questioning the clues based on which she believed that she would have a boy. Among these clues were her experience of a different pregnancy, faster and tougher labor and a smaller sized baby than the previous one. The failure of these clues added to G's negative reaction.

G's response was shared by the family members; her sister-in-law (husband's sister) was angry and tearful, her husband was neutral (indifferent) and her other sister-in-law (the wife of the husband's brother) was not happy about the attention that G received from her husband, because after all she (G) gave him just a girl!

How is G similar/different from the other women in the study? The data indicated that the task of bringing a boy to the family was a shared valued by the women in the study. Those who were similar to G in

terms of parity and baby's gender displayed similar reactions. For example E (Subject #20) was disappointed because she failed to gain her husband's approval when she gave him a second baby girl. She was also frustrated because this outcome made her a candidate for a third pregnancy, for which she did not have a desire. On the other hand, S (Subject #6) was delighted to have a baby girl in her second pregnancy because she had a baby boy in her first one. While this reaction might seem different from the above ones, the fact that this mother fulfilled her goals by bringing a boy in the previous pregnancy, makes her reaction to a baby girl in the second pregnancy legitimate and congruent.

What are the consequences of dissatisfaction with baby's gender? Consequences ranged from mere disappointment at failed expectations to constant frustration, feeling of inadequacy, guilt and self doubts; such reactions were behind the decision of working toward repeating the pregnancy again. Variables of religion and country of origin did not account for any variations in this observation. Actual steps toward reaching an unfulfilled goal by repeating the pregnancy over and over again was a dominant task for the majority of mothers who were dissatisfied with their infant's gender. One primiparous mother stated that she will have to get pregnant as soon as she feels rested; she also said that she wished her first baby were a boy to relieve her of the burden of fulfilling a task, so she can be more relaxed in her second pregnancy. Also, a multiparous mother experienced great restlessness and expressed an intense urgency to get pregnant again. She stopped breast feeding at 4 weeks postpartum to stop the effect of lactation on ovulation and to enhance prompt conception. This mother actually became

pregnant for the third time, when her second baby was 2 months old. All the above behaviors (strategies/techniques) had an adverse influence on the maternal and infant adaptation to early and late postpartum. Conditions such as low education, young age, lack of control over one's life, being a part of an unsupportive, competitive social network predicted the above set of consequences. However, these conditions evolved from individual cases in the study; generalization to other situations is limited, also whether or not there are other confounding conditions that could have led to the same situation needs to be further explored.

Conflicts Between Two Systems of Birth

Pregnancy did not mark significant conflicts between the old and the modern systems of birth for women under this study. However, labor, delivery, and postpartum were periods of increased tensions between the two systems. Evidence from data analysis revealed themes of pull and push between two poles, each of which represented one of the two different systems. Women were involved in a re-evaluation of the old beliefs and practices that used to guide the actions during birth and postpartum. Also, they constantly compared and contrasted such beliefs and practices with the new ones. Finally, they challenged the whole traditional system, discovered flaws in it, and sometimes rejected it.

Rejection of the old system was motivated partly by the desire of the women to be liberated from rules and traditions in general and partly by the absence of the older generation who usually acted as a protective regulator of the liberation process. A third motivation was

the unpracticality of the old rules in the new situation after relocation. In other words, according to the women, the traditional rules may have worked under certain conditions; when such conditions changed under the impact of relocation these rules became a burden to follow because they lost their shared meaning.

On the other hand, the modern system had not provided an alternative set of rules that fits the cultural background of the women and encompassed the present social changes in their life situations. Conflicts originated in birth being defined according to the traditional system but managed according to the modern one.

The following two categories, re-appraisal of the old system, and perception of the new system reflect the core of analysis as introduced in the above overview.

Reappraisal of the old system. As mentioned above, re-appraisal of the old system was done through several operations such as comparing and contrasting, testing and challenging, discovering of flaws, losing faith and giving up.

> "...I like it here better...things are easier and faster...while back home, things are slow and you have to follow too many rules and principles...I think babies grow faster here too...look at my baby, I never saw a baby opening his eyes in the first few days after he is born...back home it never happened...all I saw was baby's wrapped in so many layers, nobody could see them...they should not go out for fear of cold, and they should not be bathed later than 6:00 in the morning when windows and doors are still closed...even the mother herself has to be in bed for 40 days doing nothing but eating and feeding the baby, and she has to eat the same special dishes everyday for 40 days!!..." (Subject #5)

> "...I don't really follow any of these rules, I eat everything and anything, I go everywhere, I am not stuck in bed...I do the dishes, I clean the place and I cook...nothing happened to me..." (Subject #5)

> "...I don't really know much about what women should do after they have their baby...I wrapped my baby more heavily when he was real

> little, but not any more...that is about it...my mother makes soups and chickens for me, but I also eat everything else..." (Subject #14)

The researcher: "When do you think you will go out?"

> "...whenever, it does not really matter, whenever I feel ready...I think I will feel sick if I stay home for 40 days..." (Subject #2)

The above responses reflected the major theme of the re-appraisal behaviors of participants. Such themes were generalizable to the whole sample. However, some evidence from data gave a clue to some propositions that could illustrate some degrees of variations and relate them to possible correlates. For example, women gave up most of their postpartum traditional beliefs, but they were still complying with those beliefs around food and eating.

> "Soup is a must..." (Subject #4)

> "Milk, chicken, nutritious food is generally important..." (Subject #6)

> "...good food is very important...eggs, yogurt, meats, fruits, chicken soup...soups are important to relief tummy aches and increase milk flow..." (Subject #9)

Another area of compliance with old practices was the one of baby care, and protection.

> "...actually, I am not going out soon not for my own sake, but for the baby's sake...I want to make sure that he is strong enough to go out...maybe it is still cold for him out there..." (Subject #2)

> "...Oh, you know that I still do like home, I give the baby olive oil bath every morning after the warm water bath..." (Subject #5)

In addition, women who had a member of the older generation (mother or a mother-in-law) were more compliant with the old practices than the ones who did not. This contributed to some variations in the late postpartum adjustment as will be elaborated in Section 3.

Perception of the modern system. Perception of the modern system included aspects of compliance with the health care program and satisfaction with its quality. Women demonstrated a range of compliance and satisfaction behaviors that varied in degree and quality according to the phases of the pregnancy and birth process, and also according to the specific aspects of health care.

For example, women demonstrated more compliance with the health care routine during pregnancy more so than during labor and delivery, and their compliance dropped even more during early and late postpartum. Behaviors of compliance included maintaining punctuality of the antenatal visits, following instructions of the health care providers, and seeking information.

It was also observed that women demonstrated varying degrees of compliance with the different medical technologies and procedures. For example, in the area of monitoring, only one participant (5.5%) perceived fetal and uterine monitoring during labor as important, 83% expressed no specific reaction to this technique, while 11.5% perceived it as unnecessary and as hindering the interpersonal interaction between them and the health care attendants.

The procedure of epidural anesthesia was another area which marked variation in compliance, including: complete compliance, complete non-compliance and a mid-range in between. Of the six women who were given the option to use epidural, only one accepted it without resistance or hesitance, two completely refused it, and three decided to keep it as a last choice. In addition, of all the women who actually used epidural anesthesia, only one perceived it as very effective in blocking pain during first and second stages of labor.

Conditions under which satisfaction/no satisfaction responses occurred were not clear in the data, however, conditions that influenced the decision to comply or not comply with the above procedure are listed below. Complete compliance occurred under the following conditions: 1) mother was related to a member from the medical profession (physician's wife); 2) learning about the procedure before hand from health care providers; and 3) having no previous bad experience with the procedure or having no previous experience at all. On the other hand, conditions under which compliance failed included: 1) knowing little or no information about the procedure; 2) learning about a long-term side effect (backache) of epidural from other women's experiences; and 3) having a strong disbelief in the effectiveness of the procedure.

As for the satisfaction with the health care, data revealed a general tendency by participants to be open to the new concepts of health care in the western system. There was also a general theme of satisfaction with the quality of health care that was highest during pregnancy, then declined with the progression to labor and delivery, and reached the lowest level during early and late postpartum.

> "The nurses were so wonderful, they listened to me, they were always there when I needed them, especially the nurses in labor and delivery room, they were very supportive and kind...you should see that nurse who gave me her hand to hold on to every time I had the contractions, she really knew how to calm me down and help me take the pains by talking to me..." (Subject #16)

> "...in the first day, the nurses checked on me frequently and offered help whenever I needed...in the second day, nobody really cared, even when I needed water I had to go to the desk to ask for it...the thing is, I don't believe that they were busy...they were talking to one another in the station when I went to ask for my pain medicine..." (Subject #2)

> "...the nurses in the labor and delivery room were good, they were more sensitive than the ones on the floor, at least some of

> them...I don't know, the ones on the floor were not very friendly, also, I did not think that they checked me as often as they really should...I liked the night nurse though, she is more caring..." (Subject #4)
>
> ""...I could not believe it when I called for help with the baby and the nurse said to me that she was supposed to take care of me only, not the baby, and if I needed help with the baby I should call somebody from the nursery!!" (Subject #18)
>
> "...the nurses seemed to not want to be bothered, they spent a few minutes with me and then disappeared, most of my calls were not answered before ½-1 hour, when I had cramps. I kept asking for my pill more than an hour before they finally gave it to me...they seemed too busy and always far away from the patients..." (Subject #9)

The areas of professional performance by nurses, nurse midwives, and physicians received various levels of satisfaction that differed according to the specific area of performance. For example, higher levels of satisfaction were reported in the areas of communication, teaching, providing of knowledge, and showing sensitivity and supportive behaviors, than in the areas of technical skills (physical examination, diagnoses, manual intervention, treatment decisions), knowledge and experience in the field.

In summary, the experience of birth and the early period of postpartum was described in two categories, recovery from labor and delivery; and conflict between two systems of birth. Recovery from labor and delivery was described by a number of sub-concepts including: mixed feelings, redefinition of self, and sense of gratitude. Two levels of gratitude evolved from the analysis, complete and incomplete, each of which evolved under specific conditions.

Conflict between two systems of birth was the other category, and included the following concepts: 1) re-evaluation of the old system and 2) perception of the modern system.

Section 3: Late Postpartum

An Overview

The period of late postpartum is defined in this study as extending from the end of the first week after delivery until the end of the sixth week. The core category that described the women's experience of this period was that of postpartum strain. The latter defined the stressors derived from the physical and psychological changes as well as the role demands.

In addition, the relocation transition added some dimensions to the above situation. For example, a great deal of postpartum strain was directly related to combining two systems of birth through late pregnancy to late postpartum. The majority of women complied with both systems during pregnancy. They did that by following the traditional notion of pregnancy as being a normal process, but also attending the antenatal visits offered by the new system more strictly than they used to do, or would have done with the antenatal visits in their original countries. Some women stated that attending antenatal visits replaced the support that would otherwise be provided by their extended families, such as providing assurance, guidance and a reference for answering questions. Birth and early postpartum, on the other hand, marked a high conflict between the above two systems (as explained previously); however, women were more inclined to give up their old practices and be protected by the more advanced practices of the new system. Finally, in late postpartum these women hit the border of high risk status being left with no system to follow. This was due partially to losing their faith in the old practices, being viewed as impractical rules that were difficult to follow under the new conditions of relocation, and

partially due to the lack of an alternative system to follow.

Postpartum strain was a state manifested by the majority of participants (78%); the other 22% did not actually experience strain due to some protective conditions (will be explained shortly). However, they were distressed by the idea that they will have to face such a strain in the near future when conditions will change.

Types of Postpartum Strain

The following sub-concepts evolved to define the parameters of postpartum strain: a) bodily fatigue and psychological drain; b) maternal role strain; and c) marital stress. This is discussed in the following section and summarized in Table 5.

Bodily fatigue and emotional drain. Bodily fatigue was reported by all participants with the exception of two (#9 and 20). Fatigue took various forms not all of which were reported by each and every subject in the study and included: weight loss, decrease or cessation of breast milk, limited rest, interrupted night sleep, and physical tiredness.

Emotional drain was also experienced in a wide scale ranging from just a sense of boredom and isolation to a pending emotional explosion. The middle range included experiences such as perception of slowing down of pace and freezing of events, accumulated tension or uptightness, and unexplained feelings of being down. The majority of participants (61%) were in the middle range; 22% in the low range; and 17% in the high range (pending emotional explosion). Conditions under which low range of drain occurred included one or more of the following: a) having a reliable support system; b) having a satisfying spousal support; c) being a mother for the third time; and/or d) being in the host country

Table 5

Summary of Postpartum Strain as Experienced by Arab Immigrant Women at Six Weeks Postpartum

Type of Postpartum Strain	Indicators
(1) Bodily fatigue and Emotional drain	weight loss, decrease or cessation of breast milk, limited rest, interrupted night sleep, and physical tiredness; sense of boredom, perception of slowing down of pace and freezing of events, accumulated tension or uptightness, unexplained feelings of being down, and feeling of a pending emotional explosion
(2) Maternal role strain	feelings of inadequacy and incompetence in performing the role tasks, perceived increase in pressures and responsibilities, self doubts and constant need for approval, appraisal of self as a mother, grief over previous life periods, and worry about the coming motherhood experiences
(3) Marital stress	perceived increase in family demands and decrease in amount of time for marital life, dissatisfaction with marital interaction, self doubts about the ability to manage marital life, perception of power imbalance among partners, and dissatisfaction with spousal support

for a temporary stay that was coming to an end shortly after the completion of the six weeks postpartum. Conditions under which high range of drain or pending emotional explosion occurred included one or more of the following: a) being a mother for the second time; b) having an unreliable support system; c) having an unsatisfying spousal support (with the exception of one participant); and d) previous child was a boy.

It is interesting to examine the manner in which women in this study expressed their emotional experiences in late postpartum. For example, terms like blues, depression, anxiety, or bothersome were not used to communicate emotional difficulties. Instead, words like chest tightness, boredom, isolation, loss of interest to talk to any body, and feeling like crying were used.

> "...sometimes I felt so bored that I could throw myself out of the window" (Subject #5)

> "...I have not really felt sad, but sometimes my chest feels tight, I don't feel like talking to anybody, I just want to be by myself..." (Subject #2)

> "...I cannot believe that it has been only 6 weeks since delivery. I mean it feels a lot longer than that...it has been a heavy period to carry..." (Subject #15)

One interpretation of the above observations might be that the women's perception of their postpartum is part of their definition of childbearing and motherhood as one of their important roles in life which should bring a sense of fulfillment and pride rather than be bothersome. The latter term is not fully accepted as a part of motherhood experience in the Arab culture (Meleis & Sorrell, 1981). Mercer, et al. (1982) supported this interpretation. The researchers reported that unlike participants representing white Americans, those

coming from other ethnic backgrounds could not fully accept the phrase 'bothersome' as part of maternal role.

Another interpretation might be based on the notion that the Arab culture is oriented toward the social perspective more than the psychological one. Everything in this culture is described as a part of context, using indirect, non-salient expressions (Lipson & Meleis, 1983). Women in this study described their physical and emotional strain by explaining that they were extremely busy, they carried many responsibilities, and were tired, then added some stronger contextual clues "...the big boy is driving me crazy...", "...everything is fine, but..."

Maternal role strain. Maternal role strain was indicated by various forms of behaviors such as feelings of inadequacy and incompetency in performing the role tasks, perceived increase in pressures due to expansion of responsibilities; self doubts and constant need for approval, appraisal of self as a mother and actively seeking of approval, grief over previous life periods, and worry about the coming motherhood experiences.

> "...sometimes I have the feeling that I am not a good mother...I think I am too young...sometimes I worry that I am not doing the right things as a mother, I always have the feeling that other mothers who are older than me are doing better, this makes me feel guilty because I am not doing the correct things for my children..." (Subject #5)

> "...sometimes I just wish I had my mother around, just to talk to her...maybe ask her about the things that I need to know about, especially those things that I find hard to decide about...after all, she got the experience..." (Subject #2)

> "...if I were back home, things might have been a little different...for one thing, at least I would not have to fix meals, lay and lift the table for the first few days...at least somebody would have taken care of my older son...all these responsibilities would have been taken off my shoulder!!" (Subject #6)

"...I am just worked out...too much to do, and nothing is getting done...I am trying not to be 100% perfect, but still, I cannot catch up..." (Subject #13)

"...I could not believe that after only one week of delivery I carried everything out as if I had not had a baby...I mean, I cook, clean, do laundry and dishes, carry the garbage, take my son to school...and everything else plus the baby!!! No wonder I am just worn out..." (Subject #11)

"...I think I feel stronger now than in the first few days after delivery...at least I am not sore any more...but things are getting heavier, I am up on my toes all the time, I feel more up-tight than before..." (Subject #18)

Origins of Maternal Role Strain

Feelings of inadequacy were due to perceived inability to meet the infant's needs, especially in relation to feeding. Primparous mothers reported more difficulties in reading infant behaviors and learning about its needs. Mothers who complained of cessation of breast milk experienced more intense feelings of inadequacy.

In addition, there were other origins of strain that included: alterations in the sibling behaviors and demands; increased responsibilities and pressures; breaking of one's previous life routine including cutting down of one's time, space, freedom and privacy; increased social isolation; decreased or absence of informational and moral support resources; and insufficient spousal support.

Marital stress. Marital stress was more frequently reported by families that received a second or third child than those receiving their first child. The stress mostly resulted from the maternal strain under the increased family demands and the decreased amount of time and energy for marital life.

One mother (#2) said that she was concerned about having no time to spend with her husband, however, she pointed out that her husband did

not complain about it. On the other hand, another mother (#11) reported that her husband complained that the arrival of the second child made her more involved in her mothering duties and left her no time for her wife duties. A third mother (#5) stated that the arrival of her second child revived some of the marital conflicts which she had previously and which evolved around inequality of power between her and her husband.

The postpartum marital stress occurred in marriages which already had some instabilities prior to the arrival of any children, with the exception of one case (#20) where the arrival of the second child improved the marital and family relationship.

Aspects of marital stress from the women's perspective included: dissatisfaction with marital interaction, self doubts about the ability to manage marital life and family affairs, perception of power imbalance among the partners, and dissatisfaction with spousal support.

Dimensions of Postpartum Strain

Through comparing and contrasting of responses and their corresponding conditions, two dimensions of strain surfaced: range and subjective perception of timing of strain.

Range

Range is used to describe the degree of strain which was determined in this study by the number of stressors as derived from the three sub-concepts of postpartum strain discussed previously (bodily fatigue and emotional drain, maternal role strain, and marital stress). Three degrees of postpartum strain were identified: 1) a high degree-strain which included stressors coming from the three areas of postpartum

strain; 2) an average degree-strain which included stressors coming only from two areas, namely: bodily fatigue and emotional drain, and maternal role strain; and 3) low degree-strain which included stressors coming solely from one area, that is, maternal role strain (actual or anticipated). A summary of the three degrees of strain and the corresponding conditions is presented in Table 6 below. It is noted from the table that the factors of social support, type of social network, and spousal support are associated with the degree of experienced postpartum strain at six weeks postpartum. The additional factors of parity and previous marital conflicts are also noted.

Subjective Perception of Timing of Strain

Subjective perception describes the subject's experience of strain from a time frame of reference. There were two classes of perception in terms of time: actually experienced postpartum strain, and shortly anticipated postpartum strain.

One variable was found to predict either one of the above classifications that is, the availability of social support which had the following characteristics:

- Source of support: mother's own family (most commonly, own mother)
- Duration of support: a period that covers late pregnancy and first 3-4 months postpartum
- Quality of support: emotional, physical, informational and moral support that is organized around postpartum needs

Thus, women who had their own mothers coming from the home country exclusively to attend birth and postpartum were more likely to only

Table 6

Degrees of Postpartum Strain at Six Weeks and the Associated Conditions to Each Degree

Degree	Contents	Conditions
High	Bodily fatigue and emotional drain, maternal role strain, and marital stress	Multiparous status Presence of marital conflicts prior to childbearing Low spousal support Stressful social network
Average	Bodily fatigue and emotional drain, and maternal role strain	Multiparous status Low social support Low spousal support
Low	Maternal role strain	Primiparous status High social support High spousal support Supportive social network

anticipate postpartum difficulties or actually experience just a low degree strain contrary to those mothers who did not. Also, the former group of mothers displayed signs of full recovery from birth and expressed higher degrees of emotional well-being than the latter group.

This proposition was not validated in one condition; that is when the support person became acutely ill upon arrival to the U.S. In that case, postpartum strain was intensified by the physical and psychological burden of the sick visitor (Subject #18).

To summarize the section on late postpartum, this period demonstrated features of strain involving, bodily fatigue and emotional drain, maternal role strain and marital conflicts. The variables of parity, social support, type of social network and spousal support were found to influence the degree of strain and its time frame perception by the women.

PART III: Integration of Two Transitions

Relationship Between Relocation Transition and Postpartum Transition

In this part of the study findings the question of 'to what extent do the changes related to the relocation event contribute to the course of postpartum and the amount and quality of concerns associated with it?' will be examined.

The study findings in Part I demonstrated that the relocation transition encompassed a number of other transitions and yielded the following consequences: Changes in social roles, along with shifts in social status and goals in life; changes in social life style, including modes of social interaction, levels of social relationships, perception of time, and type and amount of responsibilities; and finally, changes

in social support and social network including decrease in amount and quality of support, and radical or partial change in social networks.

The data analysis provided evidence that these changes of relocation, by interacting with the physiological and psychological changes of postpartum, added new dimensions to the women's perception of the course of their postpartum period, and unfolded additional concerns beyond those typically experienced in pregnancy. These dimensions and concerns will be described.

The New Dimensions of Postpartum Course

As presented in the study findings (Part II, Section 2), the course of early postpartum was described by a number of concepts, among which were: incomplete gratitude and conflicts between two systems of birth. According to the data analysis, part of the women's incomplete gratitude was a direct result of their failed expectations of the health care professionals' skills and techniques. Thus, conditions as perineal lacerations, postpartum fever and postpartum urinary tract infection (subjects # 2, 5, and 9) were interpreted as failure of modern techniques and inadequacy of skills. Also, these conditions were perceived by subjects as unnecessary and unexpected discomforts of a normal delivery that could have been avoided. The women's failed expectations of the modern, high technology care activated their reappraisal of the new health care system as a reliable source of help.

> "...from my experience with physicians here, I realize that they are not very competent...I used to listen to them and take their words for granted, but not anymore...I ask questions. I read medical books in the library. I just learned not to depend completely on the physician. I have to be part of the treatment plan...". (Subject #11)

The concept pertaining to conflicts between two systems of birth was another theme which described the course of early postpartum period. Conflicts between two systems of birth were direct consequences of the women's exposure to a different body of beliefs and practices around postpartum and their tendency to become liberated from the old rules and rituals under the new conditions after migration. Both types of change were associated with the relocation event.

The data did not provide enough evidence on how the conflicts between two systems of birth could influence postpartum adjustment of women under study. However, it is suggested that these conflicts did not encourage the women's early postpartum recovery since they gave up most of their traditional protective health beliefs during this period of vulnerability. Also, it is proposed that these conflicts might influence the women to seek the help of the modern system of care.

The course of the late postpartum period was described primarily by the concept of postpartum strain (Part II, Section 3). Three degrees of strain were defined: high, average, and low; also two levels of time perception of strain were identified: actual strain and anticipated strain. High-degree strain included bodily fatigue and emotional drain, maternal role strain, and marital stress. Average-degree strain included bodily fatigue and emotional drain, and maternal role strain. Low-degree strain included maternal role strain only.

The degree of postpartum strain and its time perception by the subjects (i.e., actually experiencing strain, or anticipating experiencing strain in the near future) were influenced by a number of variables, some of which were migration-related, such as the type of social network structure and the amount and quality of social support.

Thus, women who described their social network as supportive, received the highest level of support and were most satisfied with its quality, and as a result, their postpartum strain was either in anticipation rather than actual level or only a low-degree of strain. Whereas, women who described their social network as competitive, superficial or unreliable, received the lowest level of support and were least satisfied with its quality, and in turn experienced actual, and high-degree strain.

The Postpartum Concerns

Postpartum concerns as communicated by participants reflected normal postpartum tasks in combination with the relocation related expansion of role expectations, increase of life responsibilities, and the decrease in the adapting resources of the women. Some of these changes were related to becoming a parent, but many were associated with the social and environmental changes of relocation as well.

For example, a group of concerns was organized around anticipated difficulties on coming home. These difficulties differed among first time and second time mothers. Areas of difficulties from first time mothers included self care, care of the baby, and understanding its clues and needs (# 4, 9, 14); whereas difficulties anticipated by second time mothers included handling the older sibling (#1, 2, 6, 11, 17, 18), facing increased demands after the arrival of the second or third child (#1, 2, 11, 17), and adjusting to interrupted marital relationship (#2, 11). While these concerns are documented as normal expectations of the early weeks of postpartum period (Shereshefsky & Yarrow, 1973; Leifer, 1977; Russell, 1974; Entwisle & Doering, 1981), they are considered new

concerns for Arab immigrant women if compared to the postpartum concerns of the Arab non-immigrant women, which are composed mainly of worrying about return of body figure to normal and concern about the baby's health and well-being (ElSayed, 1984), fear of physical vulnerability and evil eye (Morsy, 1982), and anticipating difficulties by working mothers upon returning back to work and carrying mothering duties (ElSayed, 1984).

It is also worth noting that these concerns were perceived by subjects of this study as occurring specifically because of the relocation situation. For example, a second-time mother expressed her worries about coming home by saying:

> "...my biggest concerns is that I will have to be on my own, I won't have the privilege of having the family around to take care of me and the baby like what happened in my last pregnancy...I'll do my best...I hope my husband will help; he is supportive and everything, but he loses his patience very easily and very early...I am afraid that he will give up before I am ready" (Subject #11)

Another example was the problem of handling sibling behavior; mothers interpreted this as originating from the lack of extended family members who could take care of the sibling and be attentive to his/her needs while the mother is busy with the new baby. Also, two mothers stated that the absence of their children's cousins added to the children's boredom and isolation and made them more demanding and frustrated (Subjects #2, 6). In addition, the problems of marital relationships were viewed by subjects as resulting from the isolation from the extended family. The extended family was considered to be a mediator between the couple and as a source of moral support and help in case marital problems occur.

"...with your family around, you never get stuck with your

> problems, at least they give feedback that helps the husband appreciate his wife, even with the simple things like praising me about my good cooking, my efficient family finance, or my way of raising my son...these appraisals make me feel good about myself; they raise my self-esteem; they tell me that I am on the right track..." (Subject #11).
>
> "...whenever I had problems with my husband, like any married couple does, the family played a role in easing our difficulties and making problems more manageable...here sometimes I have the feeling that I don't know if I am doing the right thing..." (Subject #20).

Another group of concerns has resulted from disruption of the support system, especially female support. Women who had some members from their own families (usually own mother) coming from the home country to attend the birth and postpartum event reported feelings of worry, fear, and anxiety about facing the demands of the maternal role and other responsibilities on their own after the departure of their mothers (#9, 14, 20). Another group of women found it difficult to rely on the available support which was provided either by their husband or some female members from the husband's family (#6, 11, 13). It is noteworthy that women who had their own families as well as their husband's (#4, 12, 14) relied more on their husband's families for help and support. This happened partly because the husband's family was closer geographically than the wife's family. However, it is also suggested that the traditional role of the grandmother (from the mothers side) changes under the conditions of relocation. For example, one of the women (#4) stated that she relied on her mother-in-law's help because her own mother worked full-time and could not be available except for a few visits.

In summary, the interaction between the relocation changes and postpartum course and concerns was evident from data analysis. In

some instances the interaction between these two variables was possible to isolate from the other variables, however, in some other instances the relationship between the variables was confounded by other conditions that were normal part of the postpartum experience.

CHAPTER 5

DISCUSSION

The theoretical scheme developed in this study explains how people carry out the tasks of a certain event in their lives under the influence of another event that occurs simultaneously. The case of Arab immigrant women who were having their pregnancy and birth experience after migrating to the United States was the particular problem under study. The basic questions were: 1) What is the relocation experience like for the Arab immigrant women? 2) What is the postpartum period like for the Arab immigrant women? What concerns and difficulties do these women face as they go through the postpartum period? What resources do these women have during their early transition to postpartum? 3) To what extent does the relocation transition of the Arab women influence the course of postpartum period and amount and quality of concerns associated with it?

The core category referred to as 'successive unsettled transition's provided one way of understanding the course of one event (the relocation) by illuminating the processes and consequences which then became the contextual conditions under which the tasks of the other event (postpartum) were undertaken. The theoretical model was developed by organizing the categories from both events around the core category of successive unsettled transitions in order to examine the distinct ways in which the changes associated with relocation influenced the meaning, tasks, and concerns of postpartum for the group of women under study.

The following discussion will be focused on summarizing the model around the research questions, then verifying the delineated concepts by comparing and contrasting them with results from other relevant studies.

Research Question 1: What is the relocation experience like for the Arab women who migrated to the United States?

Findings from the study indicated that the participants represented various degrees of successive unsettled transitions in the course of relocating to the new environment according to their demographic and migration characteristics. These included: age at migration, marital status at migration, level of education, occupational background, reason for migration, and duration and type of stay in the host country. The degree of successive unsettled transitions was defined by the magnitude of the changes associated with the relocation event and the degree of psychological and social adjustment as reflected by the extent to which the participants experienced what was called 'ambivalent adjustment' and 'feeling out of place'. Thus migrant women who were young in age, less educated, and newly married, tended to face an extensive range of transitions upon their relocation in the new country. Also, those women who migrated because of war in their home lands experienced less ambivalent adjustment in the new society because they accepted the fact that they lost their place in their original countries. Whereas women who migrated at an older age, had a higher level of education, established their marital and occupational lives before migration, and migrated because of other reasons than war, tended to face a less extensive range of transitions after their relocation, and to experience more ambivalent adjustment due to their belief that they have the option of returning to their original countries. Thus it appears that the

stressors associated with the initial phase of relocation are more readily accommodated by older women with more resources; however, their ultimate adjustment is more ambivalent.

The role of demographic and migration variables in shaping the course and outcome of the relocation experience is documented in the literature (Hull, 1979; Kats, 1982; Evans, 1984). The above findings about the initial phase of relocation were also supported by results from other studies on women immigrants. For example, Mirdal (1984) studied Turkish immigrant women in Denmark and found that these women face an extensive range of stressors in their relocation and have difficulties in managing these stressors successfully. Smith (1980) on the other hand, found that Portuguese immigrant women in the United States did not perceive their relocation as stressful and were more competent in managing the difficulties of the uprootedness. These differences seemed to occur because factors of young age, low education, low level of occupation, and lack of social resources were more prominent among the Turkish women than the Portugese women. However, factors related to the non-acceptance of the Turkish women by the host country, their poor employment conditions, and their isolation from other Turkish communities were also identified as other confounding variables.

One of the distinct features common to the Arab women's experience of relocation was that these women were unable to reach a complete and stable adjustment to the new environment, as indicated by the experience of 'ambivalent adjustment' which was often accompanied by recurrent 'feeling out of place'. The state of becoming completely adjusted to the new environment was described as having the following domains:

'feeling at home'; 'feeling less alien'; beginning to feel that the surroundings belong to one's self and no longer remind one of strangeness; having friends; becoming familiar with social customs, mores, and cultural outlooks similar to those of the host country (Sarwer-Foner et al., 1970, p. 465). Findings from this study suggested that the women's inability to reach complete adjustment might be related to the other conditions, in addition to those conditions described previously. For example, the women's length of stay in the United States was found to extend between just below one year to six years. This period was described in the literature as a critical phase of the transition to the new environment during which the old behaviors are reappraised for better compatibility with the new context. Consequently, this phase is characterized by intensified instability and increased conflicts (Sluzki, 1976; Brink & Saunders, 1976) as found in this study. How this phase relates to subsequent adjustment needs to be tested by comparing groups of Arab immigrants with longer durations of stay.

Also, the cultural and social properties of the Arab women should not be overlooked as forces that may contribute to the experience of ambivalent adjustment. It is noted that Arabs tend to link more to the past (than the future) and grieve on it in appraising their present and future*. This is expected to account for the magnitude of their ambivalence about their life situation under relocation or under many other circumstances.

However, the fact that the women in this study were immigrant and

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*Discussion of study findings with Dr. Afaf I. Meleis, Ph.D., 1986

pregnant in the meantime provides another plausable explanation for the ambivalent adjustment. Pregnancy is a transition by itself which can add to the amount and quality of the relocation stressors and can also revive any unresolved aspects of the adaptation to its course. Support from the literature for this explanation is extremely limited since none of the migration studies included pregnancy as a variable that might influence the adaptation to migration changes. However, data from this study provided evidence where pregnancy either disturbed or enhanced the women's adaptation to their successive relocation transitions. Some women stated that they felt unstable again and their plans were interrupted when they became pregnant; others said that the pregnancy gave them something to think about and look for, and this helped them to cope with their lives after relocation. Further investigation is needed to validate these observations.

Research Question 2: <u>What is the postpartum period like for the Arab immigrant women? What concerns and difficulties do these women face as they go through the postpartum period? What resources do these women have during their transition to postpartum?</u>

First, what is the postpartum like for the Arab immigrant women? Results revealed that Arab women had a postpartum experience that shared most of the common features of postpartum as described in the literature. For example, the concepts of mixed feelings, sense of gratitude, and redefinition of self as themes of recovery from labor and delivery in this study were consistent with the empirical findings of the common psychological reaction of the recovery process following delivery. Robinson and Moss (1980), Liefer (1977), and Grossman (1980) found that the recovery process brought mixed feelings of elation,

anxiety, worry and depression. The mother's redefinition of her self in relation to her infant and significant others was another psychological component of normal postpartum reactions reported by other studies (Rubin, 1960, 1972, 1983; Mercer, 1980; Robson & Moss, 1970).

The conflict between two systems of birth, the old and modern, was one of the distinct aspects of postpartum experience of the Arab immigrant women. The incomplete satisfaction with the health care of the modern system and the discovery of flaws in the old system added to the degree of conflicts. Moreover, the failed expectation of a high quality care by the modern system contributed to the women's sense of incomplete gratitude with the experience of early postpartum. Studies that examined the effect of being born and raised in one culture and experiencing pregnancy and birth in a different culture reported similar findings. For example, Stern et al. (1980) found the Pilipino-American women raised with non-Western models of childbearing experienced stress during pregnancy when receiving Western obstetrical health care due to the difference in cultural beliefs and practices of childbearing (e.g., beliefs about diet, medication, and activity). The adherence by women to their old practices, as dictated by their own mothers, added to the magnitude of conflicts.

Secondly, what concerns and difficulties do these women face as they go through the postpartum period? It was revealed by the findings that the women's concerns resulted from the interaction among postpartum physiological and psychological processes, the cultural values of the Arab women, and the relocation changes. Early postpartum concerns included the following: anticipating difficulties of self care and infant's care upon leaving the hospital and coming home; worry, fear,

and anxiety of facing the demands of maternal role and other responsibilities on one's own; worry about the ability to conceive in the near future (for those who were not satisfied with the baby's sex); and concern over handling the sibling's reaction to the arrival of the new baby. Late postpartum concerns included bodily fatigue and emotional drain, maternal role strain, and difficulty of handling the sibling's behavior, and marital stress. The bodily fatigue and emotional drain reached a climax at 4-6 weeks after delivery. The marital stress was found to occur more prominently in families who had problems with marital relationship prior to the arrival of children. Also, more marital stress was reported by families who had their second or third child than couples having their first baby.

Findings from other studies suggest that women's anxiety about self care and baby care and the other maternal role demands are an inherent part of puerperium, and are contributed to by the intensified fatigue, discomfort, and loss of control over body functions (Rubin, 1961, 1983; Mercer, 1981; Gruis, 1977; Strang et al., 1985). It is also emphasized by many researchers that fatigue accumulates and gets intensified from the first few days postpartum to the first 2-3 months. Liefer (1977, 1980) reported that fatigue reached a peak-point at one month postpartum, and that fatigue contributed to the women's emotional distress and feelings of inadequacy. Mercer et al. (1982) also identified fatigue as one of the dominant characteristics of the women's physical condition at one month postpartum.

In the case of the Arab women, fatigue and emotional distress may be potentially compounded by those concerns that are unique to these women such as the dissatisfaction with the baby's sex and worrying about

the task of repeating the pregnancy in a short period.

Entwisle and Doering (1981), Miller and Sollie (1980), and Grossman (1980) supported the findings of this study on marital stress during postpartum. Entwisle and Doering (1981) found that couples who had weak, unstable marital relationship before they had their first infant tended to face more disruption in their relationship after the baby's arrival than couples who had stronger marital relationship around the same time. Miller and Sollie (1980) reported that mothers and fathers experienced an increase in their personal stress and a drop in their personal well- being from pregnancy to the first month after deliver, and from then to the eighth month postpartum. Also, the variation in the degree of marital stress among the first time and second time parents found in this study was consistent with Grossman's (1980) results which indicated that marital disruption and disenchantment were higher among multiparous mothers than primiparous.

Results from the few studies that described puerperium among Arab non-immigrant women provide some useful comparisons. Although these studies represented only one Arab country (Egypt) and did not address postpartum concerns as their major question (except for one study), the results did include the core postpartum concerns among these women. For example, Govearts and Patino (1981) and Morsy (1982) found that physical weakness and vulnerability of mother and infant were the primary concerns during the first few weeks after delivery among Egyptian mothers. Also, concerns about infant's well-being especially in relation to health and feeding were reported. However, it was noted that the mother was the center of attention rather than the baby

(Govearts & Patino, 1981). More recently, ElSayed (1984) found the following as major concerns of Egyptian women during 2-4 weeks postpartum: a) worry about returning of body figure to pre-pregnant state; b) anxiety about competency in carrying mothering duties especially in relation to maintaining successful breast feeding; and c) working mothers anticipated difficulties in combining maternal role responsibilities, job/career demands, and household duties.

Comparison of concerns by immigrant and non-immigrant women revealed a great deal of similarities among the two groups, also the concerns reported by both groups are consistent with results from literature as mentioned above. Taken together, this suggests that most of these concerns are normal components of puerperium as a physiological, hormonal, and psychological process. The consistency among the results adds to the scope of postpartum as a universal experience.

However, it is also noted that there is more consistency in concerns among the Arab immigrant women (as provided by this study) and the American women (as provided by literature). For example, like American women, Arab immigrant women reported fatigue, psychological distress, maternal role strain, and disruption in marital relationship; none of which concerns were shared by the Arab non-immigrant. This is an example of the possible effect of the migration changes on perceptions of pregnancy. In addition, social isolation, boredom, difficulty handling sibling behavior, and worry about producing a male offspring stand as unique concerns to the Arab immigrant women in this study.

More important, due to the fact that Arab immigrant women are not aware that their concerns are similar to the concerns of the American women during this critical period, they tend to attribute these concerns mostly to the migration event instead of considering them as part of the normal postpartum process. This is expected to add to their distress and increase their sense of being deprived.

Thirdly, what resources do these women have during their transition to postpartum? Based on the study findings, women relied on two types of resources, social and medical. The social resources consisted of social support that was provided by different social networks composed of either kin or non-kin members. This included members from the spouse's family, from the women's own family, or female friends, both native and non-native. The medical resources consisted of the maternity health care program provided by the American health care system. Although women were not completely satisfied with the Western care, they tended to rely heavily on their prenatal visits and showed a high level of compliance especially during pregnancy. Thus it seems that these women, under the disruption of their original support system, considered the health care providers as a substitute for the support and advice that are normally offered by the kin-support under the non-migration condition. Some women stated that they felt secure being taken care of by qualified health care providers and knowing that the hospital was well equipped to take care of them and their babies in case emergency occurred. To women in this study, this type of support compensated for the absence of the extended family. This is expected to double the significance of the role of the health care providers for these women.

On the other hand, there was some indication from the data that although the relocation had some disruptive effect on the social support system of the Arab women, pregnancy seemed to have an integrating influence on the women's support. For instance, under the condition of pregnancy the women's extended family resources were mobilized despite the long distance. It is noteworthy that the women did not receive the same attention from their families to help them cope with the relocation transition. This illustrates the differences in the definition of each transition (relocation and postpartum) by these women's culture. It is clear that pregnancy and postpartum are considered more critical than other experiences or the expectations to provide support for pregnancy are more clearly established than for relocation.

Research Question 3: To what extent does the relocation transition of the Arab women influence the course of postpartum period and the amount and quality of concerns associated with it?

As presented in Chapter Four, relocation had significant consequences to pregnancy and postpartum in a number of ways: the problem was basically one of facing conflicts between two systems of values and beliefs around this period, combined with the lack of a frame of reference, and imbalance between demands and resources. In other words, women in this study demonstrated considerable tension between their traditional system of birth and the modern system. Moreover, the majority of cases marked absence of a familiar frame of reference, lack of meaningful external feedback to validate actions and deficient physical and emotional support. This resulted in physical strain, feelings of inadequacy, self-doubts in assuming maternal role, and active seeking of approval of actions by the women.

Virden (1981) found that feedback received from mother's significant others contributed to external validation of maternal role behaviors. External validation was suggested to influence maternal role adequacy during the early weeks postpartum to an equal or greater degree than internal validation. Thus, mothers whose ethnic origins represented a minority in the American society displayed higher levels of anxiety in carrying out maternal role tasks due to the absence of feedback from family and friends or due to incongruence between the role expectation in two different cultural models.

The imbalance between demands and the available resources was another aspect of the relationship between relocation transition and postpartum. One of the consequences of relocation according to this study was the deficient social support and/or the defective social network. This finding is consistent with other findings related to changes in social network after migration among Arab immigrants. For example, compared to a normative American sample, an Arab-American immigrant parent group (N=85) were lower in social network and social support variables on the Norbeck Social Support Questionnaire (May, 1985). It was also pointed out that the Arab immigrant parent group had a high proportion of their network members living outside the United States; this proportion significantly varied according to the duration of stay in the United States, with parents whose duration of stay ranged between 0 to 9 years having significantly less proportion of their network members in the United States than those whose stay extended for over 10 years (May, 1985). In this study, the content and structure of the social network were found to be indicators for degree of postpartum strain; those women whose social network was composed of their own

families, especially their own mothers, received the most satisfying support and consequently displayed the least degree of postpartum strain; whereas, women whose social network was composed mainly of their husband's family members received the least satisfying support and displayed the highest degree of postpartum strain.

One explanation for the above results may be based on the type of support provided by each of the above networks and whether or not this support could meet the specific needs of postpartum. Findings indicated that women whose network was made of their husband's family members received financial, physical and informational help, but not emotional or moral support which were received by mothers whose social network was made of their own family members. Moreover, social networks made of husband's family members were perceived by women as stressful, unreliable and competitive rather than supportive.

Analysis of how social support works to influence the interplay between postpartum demands and measures of adjustment to postpartum revealed that the structure of network determined how support is given and received (Cronenwett, 1981, 1984; Gosha et al., 1986). Cronenwett (1981) found that women at six weeks postpartum perceived support provided by an all-women support group as more valuable over the support provided by a mixed support group. Also, Cronenwett (1984) reported that emotional and instrumental support were significantly related to higher postpartum self evaluation by mothers at six weeks after delivery, while information and appraisal support were not. It was also found that a greater percentage of relatives from both partners families were associated with positive postpartum outcome for men but not for women.

One type of support was not rigorously tested by analysis of data in this study, that is, the spousal support. This is due to the difficulty to isolate the spouse's support from the other types of support in the case of the study sample. For example, in some instances subjects combined a supportive social network (their own family) and a supportive spouse in their social support system. On one hand it could be conceived that the spouse's support was enhanced by the presence of the wife's family members; on the other hand, the wife's sense of support by the presence of her own family could be expected to contribute to satisfaction with the husband's support. In addition, other subjects combined either absent social network or an unsatisfactory network with an unsupportive spouse. This gave no opportunity to test the spouse's unsupportiveness separately. Further research is needed to examine the questions of how much support is provided by spouse, how does it differ from other types of support, and under what conditions does a spouse provide or withhold support during the period of early parenthood?

Conclusion

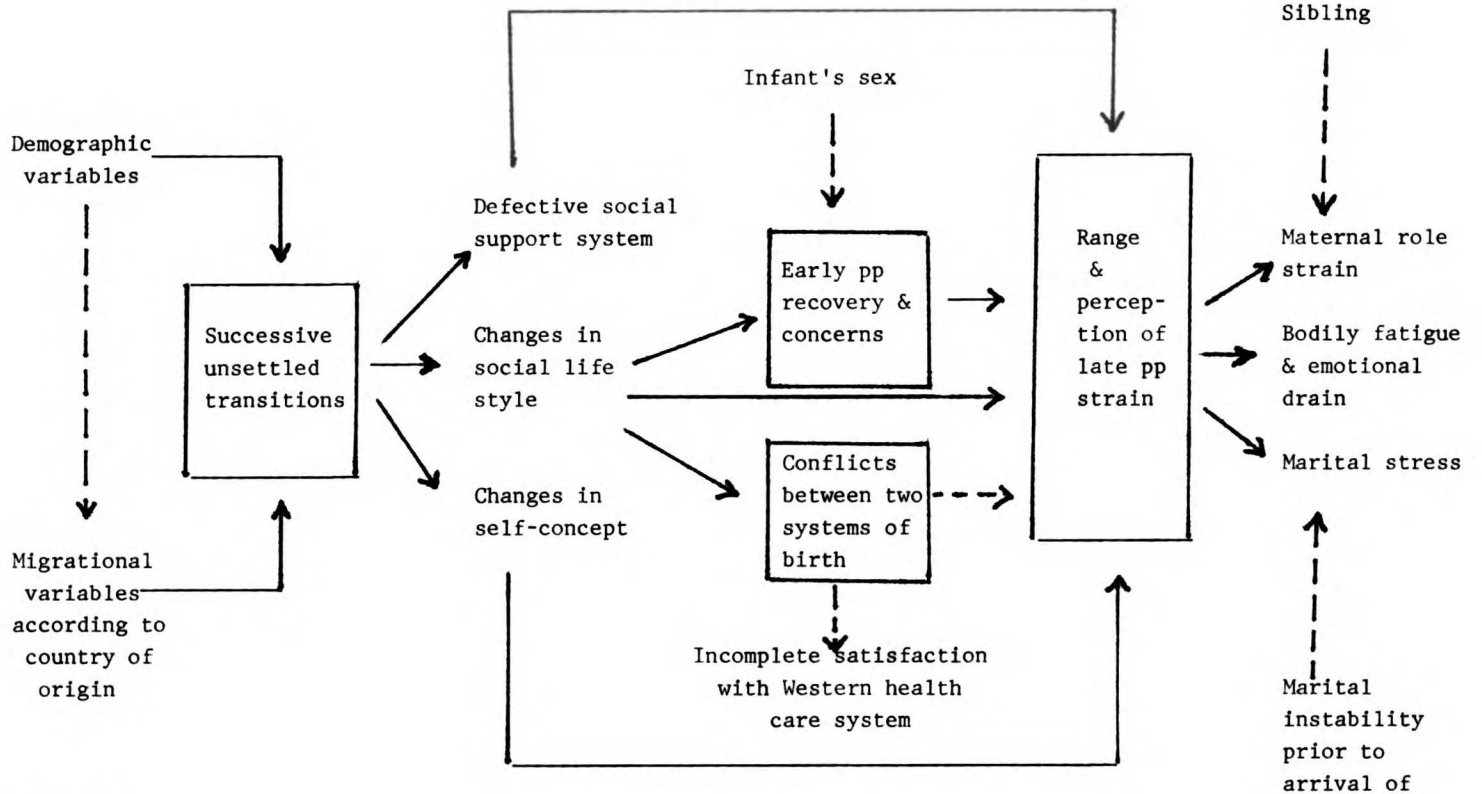
In the previous sections, the interaction of the factors of relocation and postpartum as organized by the emerged model were interpreted. The interpretation is summarized below and the model is presented in Figure 3.

Demographic and migration characteristics have emerged as an independent variables that influenced the migration experience as defined by the range of transitions involved and the magnitude of

FIGURE 3

Interaction Between Relocation Variables and Early[1] and Late[2]

Postpartum (pp) Concerns Among Arab Immigrant Women



[1]One week postpartum

[2]Four to six weeks postpartum

consequences. Ambivalent adjustment, conflict between two models of values and beliefs, and breaking of the social support system evolved as core consequences of relocation. Interaction among these consequences influenced the tasks and gratifications of postpartum.

Of the above consequences, the breaking of social support system was found to have a more pervasive influence in relation to postpartum. Differential degrees and quality of support were provided by different types of networks, with the most satisfying support provided by a social network that had the following characteristics:

1. Being composed of the mother's own family members,
2. Small in size and low in density and competition,
3. Having the postpartum event as its main focus,
4. Providing support specific for postpartum needs.

Contributions to Nursing Research

This study is a beginning step in a relatively new area of inquiry into the interplay between postpartum and the factor of social and environmental changes due to migration.

One of the major contributions to nursing research made by this study is the description of postpartum concepts in a culture that has not been studied by previous researchers, that is the Arab culture. Also the description of migration experience of an ethnic group that has been ignored by migration literature, that is the Arab immigrants.

Another contribution to nursing research made by this study was expansion of the knowledge base on sociocultural factors that are associated with postpartum adaptation. The exploration of the influence

of the relocation factor on postpartum concerns and adaptation resources added to the understanding of postpartum as a bio-psychological and social transition which is equally influenced by contextual conditions of cultural and environmental changes as the biological, hormonal, and psychological changes.

An overall interpretation of the findings with respect to the framework developed by the study produced a number of generalizations. These generalizations are that postpartum strain can be reduced by:

1. Adequate support system
2. Presence of a frame of reference for validation of actions
3. Complete gratification in early postpartum, especially in relation to infant's sex
4. Satisfaction with the health care system

Implications for Nursing Practice

Findings from this study revealed a great deal of the issues behind the difficulty from the health care professional's side to handle the health care needs of the Arab maternity clients. From the researchers experience through the process of planning for the study, data collection, and health care consultation, it was noted that a considerable portion of these difficulties were related to the lack of knowledge about the Arab immigrant population in general, and Arab women in particular. Inaccurate perception, ambiguity about the modes of interaction, and lack of understanding of the cultural concepts controlling behaviors among the Arab clients have interfered with the process of assessing the patient's needs and planning and delivery of health care.

The study findings may be used to raise the awareness of health care professionals about differences between the Western and Arab models in concepts of childbearing and childbirth. Such an awareness may increase the understanding of the behaviors, expectations and needs of the Arab maternity clients and further facilitate the managing of their health care.

Study results revealed that Arab women are caught between two different models of practices; however, it was also demonstrated that these women are receptive to both models. This receptivity is potentially important for facilitating the integration of these women into the health care system. With some support and guidance in decision making these women can have a better orientation to the system that will enable them to use the Western resources and at the same time keep what is appropriate from their old system.

Finally, the study described the characteristic features of the migration experience of the Arab women and identified a number of factors associated with greater ranges of migration impact, such as age, reason for migration, and type of social network structure; the combination of these factors and the obstetrical condition such as parity and infants gender will provide a more adequate basis for assessing the degree of difficulty a given woman may experience in her management of the postpartum tasks.

Limitations

The aim of the design for this study was to generate hypotheses rather than test theories. The study limitations stem from the sample characteristics, longitudinal design, and reliability of data.

Selection of a variable sample was a prerequisite for using grounded theory approach for data analysis. The study sample was diverse in respect to demographic, migrational, and obstetrical characteristics. However, the sample clustered around some variations of these characteristics more than the others. For example, regarding demographic characteristics, the majority of participants were non-working mothers. As a result, the testing of the influence of this variable was limited. As for migrational characteristics, the range of stay in the United States for the whole sample was only 5 years. It is assumed that this duration of stay produces a specific set of changes associated with relocation that might differ from other ranges of duration. The expansion of the range of duration of stay might have contributed to further comparisons and more verification of the concepts. Finally, with respect to obstetrical background, the sample was dominated by multiparous mothers, the majority of whom were pregnant for the second time. Primiparous mothers constituted only 33.3% of the sample. Results showed that primiparous women had a different postpartum experience from the multiparous. Variations within each group as well as among both groups could have been maximized by including more members, especially from the primiparous group. This could provide for refinement of concepts describing each group's experience.

A longitudinal prospective design was utilized to study the two transitions of relocation and postpartum as processes. The major strength in this design was that it allowed for obtaining indepth information and provided for concurrent validation of data when previous observations by researchers were verified by further sessions of

interviewing or participant observation.

One of the limitations of this design in association with this study was the problem of mortality. Although the rate was only 11.11%, each subject was treated as representing a set of conditions, behaviors and incidences to be compared and contrasted. Therefore, the above rate is considered significant in relation to this study's method of analysis.

Reliability of data was a third limitation of this study. As mentioned in the method chapter, data collection took place in a variety of settings and surroundings. While the variation in the setting was useful in expanding the comparative analysis, surroundings (members of the extended family, sibling, or husband) might have influenced the subject's responses to the interviews. For example, the presence of mother-in-laws were perceived by the researcher as restricting real responses from subjects. Siblings were considerably distracting to the mothers involvement in the interviews.

Also the fact that the researcher was from the same culture as the participants may have encouraged what is called the 'socially' and 'culturally' acceptable responses. Finally, because all of the interviews were conducted in Arabic language to facilitate spontaneity in responding to the interviews, especially for those women who did not speak English well, some difficulties were encountered by the researcher in translating the field notes into English ensuring that the responses were communicated clearly to the English reader without altering the original meaning.

Implications for Future Research

The theoretical model developed in this study provided one way of explaining the interaction between factors of relocation and the transition of postpartum. Future research may further test this model on a different group of Arab immigrant women who display different demographic and migrational characteristics. The purpose would be further refining of concepts and verification or modification of linkages among them.

A number of factors were identified by the results of this study that appear to be potentially significant in moderating the relationship between relocation and postpartum. These factors were a mix of demographic, migrational, obstetrical, and social. This has implications for future studies focused on the factors themselves and for the design of future correlational studies. As for the factors themselves, more studies are needed to search for those factors that were not explored in this study as associated to postpartum. For example, spousal support, and other types of social network structure. As for designs of future studies, a higher level design is needed to examine the relationship among a sub-set of factors that seem to be associated, controlling for the variations in the other factors. This could be done through strict sampling criteria or using statistical technique of analysis of variance and co-variance.

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APPENDIX A

APPENDIX A

(An Arabic version of this sheet was provided)

Information about this research

This study is about how Arab women who live in the United States experience the 40-day period following delivery. By participating in this study you will be providing some information about the Arab women's beliefs and values related to childbirth and postpartum, and what is important for them to take care of themselves and their babies during this period. You will be asked questions about your labor and delivery experience and the early period following it, and the difficulties you have met by delivering your baby in a different culture. Also, you will be asked about who helped and supported you during this time. By asking these questions it is hoped that more will be known to the health care providers about the needs and concerns of the Arab American women who receive their maternity care from the American health care system.

I will be interviewing you two times, each interview will take 1-1½ hour, this will be followed by a telephone call 4-6 weeks after your baby is born for a 15 minute follow up. In the first interview, you will be asked questions related to your coming to the U.S., especially the changes that you have to face such as, roles, life style, social support system, and family life. In the second interview, I will be asking you about your health after delivery. Also, I will ask about your concerns regarding yourself and/or the baby. The third interview will be done over the phone, and it will be about how it is for you to give birth in a country that is different from your home country. My questions will be around the kinds of difficulties and rewards that you faced and who helped you, and how was that different from home. I will be meeting with you either at the hospital or at your home, whichever you prefer.

You will receive no direct benefit from participation in the research, however, as an Egyptian maternity nurse, who speaks Arabic and who took care of women like you, I will be glad to listen to your concerns and suggest resources if you need them. You are under no obligation to participate. Even if you agree to participate, if you later feel anxious or have other reasons for wanting to stop, you may discontinue your participation at any time. The answers you give will be anonymous, which means that your name will not be on the interview sheet, and no names will be used in reporting the results of the study. All information you give will be confidential. There will be no cost or inconvenience to you except the time required to complete the interview.

APPENDIX A

Information about this research (cont'd)

My name is Yousria A. ElSayed. I am a nurse who is doing this research as part of my dissertation research for a doctoral degree in nursing. I am available to answer any questions you may have about this research, and you may contact me at 666-2895. You can also contact the Committee on Human Research at the University of California, San Francisco at 666-1814. They will answer any question you might have about this study.

Thank you for your participation and your important contribution to this research.

Yousria A. ElSayed, M.S., R.N.
D.N.Sc. Candidate
School of Nursing
University of California,
San Francisco

معلومات عن هذا البحث

يقوم هذا البحث بدراسة فترة الأربعين يوماً بعد الولادة بالنسبة للمرأة العربية المهاجرة بالولايات المتحدة الأمريكية. عندما تشترك في هذا البحث، سوف تقدمين بعض المعلومات عن القيم والمعتقدات العربية حول تجربة الحمل والولادة، وعن الأشياء التي يجب على الأم أن تراعيها للعناية بنفسها وطفلها خلال الفترة التي تلي الولادة. سوف تقوم الباحثة بتوجيه بعض الأسئلة عن عملية الولادة نفسها والفترة الأولى التي تعقبها، بالتركيز على نوعية المشاكل والصعوبات التي تواجه الأمهات العربيات عندما يجتزن تجربة الحمل والولادة في بلد تختلف فيه القانون الصحي وأسلوب الرعاية الصحية للأم والطفل عما هو سائد في موطنهن الأصلي.

سوف تقوم الباحثة أيضا بتوجيه بعض الأسئلة عن نوعية ومصادر المساعدة والإرشاد التي تحصل عليها الأم خلال هذه الفترة.

والغرض من هذا البحث هو الوقوف على مشاكل واحتياجات المرأة العربية في الهجر خلال الحمل والولادة على وجه الخصوص، وذلك حتى تتمكن للهؤلاء العاملين بالحقل الصحي والمسؤولين عن صحة الأم والطفل أن يقدموا الخدمات الصحية الملائمة لها.

سوف تقوم الباحثة بعد مقابلتين شخصيتين معك، تستغرق كل منهما ساعة والساعة والنصف من الزمن وبين ذلك مكالمة تلفونية بعد حوالي ٤-٦ أسابيع من الولادة، وسوف تستغرق حوالي ١٥ دقيقة. ستتم المقابلة الأولى خلال الشهر الأخير من الحمل، وسوف توجه إليك أسئلة عن خبرتك في الولايات المتحدة وخاصة بالنسبة للتغيرات الاجتماعية والنفسية التي طرأت على دورك في الحياة، وطريقة معيشتك ونمط الأسرة بعد الهجرة، ومصادر العناية والمساعدة بالنسبة لك ولأسرتك. أما المقابلة الثانية فسوف تكون بعد الولادة مباشرة وسوف تقوم الباحثة بتوجيه بعض الأسئلة لك عن صحتك الجسمانية والنفسية بعد الولادة. وبين ذلك المقابلة الثالثة التي ستتم عبر المكالمة التلفونية، وأخيراً سوف تسألك الباحثة عن تقييمك للصعوبات وكذلك الإيجابيات التي صادفتك في تجربة الولادة في بلد تختلف عن وطنك الأصلي، والأشياء التي ساعدتك في تذليل الصعوبات.

سيدتي المشتركة في البحث، أود أن أوضح لك بأنه رغم اشتراكك في هذا البحث سوف لا يعود عليك بمنفعة خاصة وأكرر لك أن تعاوني أنت القائمة بهذا البحث هي طالبة دكتوراه حاصلة على بكالوريوس في التمريض - تخصص ولادة، وتتحدث باللغة العربية وبيرها أنها تتحدث إليك وتنصت إلى مشاكلك وتقدم المساعدة إذا لزم الأمر.

ورغم ذلك فليس هناك أي ضغوط عليك أن تشتركي في هذا البحث - حتى إذا اشتركت ثم شعرت برغبة في الانسحاب لأي سبب من الأسباب، يمكنك أن تفعلي ذلك في أي وقت تشائين. أحب أيضاً أن أوجه عنايتك بأن المعلومات التي سوف تقدمينها ستكون سرية للغاية، وذلك بعدم ذكر أسماء على استمارات البحث وكذلك عدم علانية أي أسماء عند نشر النتائج الخاصة بتحليل البيانات. كذلك سوف لا يطلب منك اشتراكك في البحث أي أتعاب أو تكاليف سوى الوقت الذي ستقضينه في الإجابة على الأسئلة.

وأخيراً، هذه معلومات عني الباحثة:

الاسم: سيرين أحمد السيد، حاصلة على بكالوريوس في التمريض وتقوم بهذا البحث كجزء من رسالة الدكتوراه للحصول على درجة الدكتوراه في علوم التمريض.

إذا كان لديك أي تساؤلات يمكنك الاتصال بالباحثة على الرقم التالي:
(664-2895) ٦٦٤-٢٨٩٥.

كذلك يمكنك الاتصال بالمجلس المشرف على البحوث بجامعة كاليفورنيا - سان فرانسيسكو للاستفسار. وذلك على الرقم التالي: (666-1814)
١٨١٤-٦٦٦.

شكراً على ما تحملت بالمعلومات اللازمة لإتمام هذا البحث.

سيرين أحمد السيد
طالبة دكتوراه
كلية التمريض
جامعة كاليفورنيا - سان فرانسيسكو

APPENDIX B

APPENDIX B

Interview Guide

Time 1

1. Tell me about your coming to the United States.
2. How do you find life here different from life in your country?
3. What do you like most about living in the United States? What don't you like?
4. What kind of changes did you have to face on coming to the United States?
5. How do you describe your support system here?
6. Tell me about your relationships with friends and neighbors.
7. To whom would you go for help in case you have a problem?
8. Tell me about your pregnancy.
9. What do you think people do in your country to have a healthy pregnancy?
10. How much of that do you still do after you came to the United States?
11. How do you like the care you receive during your pregnancy?
12. How do you think it will be for you as a new mother in this country? How would it be, had you been home?
13. What concerns do you have at this point of your pregnancy?

APPENDIX B (cont'd)

Interview Guide

Time 2

1. How has it been for you since the baby's birth?
2. Tell me about your labor and delivery experience.
3. Would you do everything the same way had you been home?
4. Tell me about your baby.
5. How do you feel about the postpartum care you receive?
6. Who is going to help you when you get home? Who would it be if you were in your country?
7. Do you intend to celebrate the 7th day when you go home? Would you celebrate it in your home country?
8. What other practices, rituals or rules are you planning to follow?
9. What do you think it will be like for you as a mother when you go home?
10. How much rest do you think you will be able to get?
11. In general, what are the things that you worry about going back home with the baby?
12. Would you have the same worries (concerns) if you had been in your home country?
13. How do you feel about that?
14. What do you specifically like about having your baby here?
15. What do you specifically miss about having your baby in your home country?

APPENDIX B (cont'd)

Interview Guide

Time 3

1. How have you been feeling since you left the hospital?
2. What is it like for you now being a mother? How would it be like in your home country?
3. Thinking over the last 4 weeks, what has been hard about mothering? What has been easy?
4. What are the things that worry you about this period after delivery?
5. How much rest have you been able to get since you have been home?
6. What questions or problems do you have concerning care of yourself as your body recovers from pregnancy and delivery?
7. Tell me about your baby. What is he/she doing? How do you feel about what your baby is doing?
8. Who takes care of the baby most of the time? Who would it be if you were in your country?
9. Who helps you with the household chores? Who would it be in your home country?
10. Being a mother, who can you rely on for help when you're in a bind? (financial, emergency, baby is sick)
11. Being a mother in your country, who would you rely on for help in a bind?
12. Who bolsters your morale by letting you know he/she cares about, values you?
13. Thinking over the last 4 weeks, who has been most helpful to you in your role as a mother?
14. In what way has this person been helpful to you? Was that as much help as you needed?
15. How much would you say your husband does in connection with taking care of the baby?
16. Which of the following activities would he do in connection with baby care? Changing diapers, feedings, bathing, playing, others (describe)

APPENDIX B (cont'd)

Interview Guide

Time 3

17. Do you think your husband would participate in the baby care activities had you been in your home country? Why?
18. Who besides yourself does your baby have the opportunity to see, play with?
19. In summary, what would you say are your primary concerns at this time?
20. Would you say that these concerns are different from what you would have if you had your baby in your country?
21. What are the advantages of having a baby in this country?
22. What are the disadvantages, difficulties of having a baby in this country?

APPENDIX C

APPENDIX C

Examples of More Focused Interview Questions

How have you changed your ways of communication or modified your style of interaction upon coming to the United States?

How would you describe the values of privacy, freedom, and the use of time and space in this country?

In what ways have your roles and responsibilities changed upon coming to the United States?

Being a mother (or expectant mother), how do you see your coming to the United States affecting your life?

Tell me about your relationships with your own extended family.

How do you describe your relationships with your husband's extended family?

How do you see the medical techniques here useful for pregnant women?

Are there any conflicts between what you believe you should practice during pregnancy and after delivery and what you are instructed to do by the health care givers here?

APPENDIX D

APPENDIX D

Demographic and Migrational Data

1. What is your age? _____
2. How long have you been married? _____
3. What is your highest level of education completed?
   _____ 7th grade or less
   _____ 8th grade
   _____ high school graduate
   _____ some college
   _____ college graduate
   _____ some graduate education
   _____ graduate school graduate
   _____ other (please specify) _____
4. What is your husband's highest level of education completed?
   _____ 7th grade or less
   _____ 8th grade
   _____ high school graduate
   _____ some college
   _____ college graduate
   _____ some graduate education
   _____ graduate school graduate
   _____ other (please specify) _____
5. What is your religious preference?
   _____ Catholic
   _____ Orthodox
   _____ Moslem
   _____ Other
   _____ None

APPENDIX D

Demographic and Migrational Data (cont'd)

6. What is your occupation?

_____

7. What is your husband's occupation?

_____

8. What is your yearly family income (from all sources)?

_____ less than $5,999
_____ $6,000 to $9,999
_____ $10,000 to $14,999
_____ $15,000 to $19,999
_____ $20,000 to $24,999
_____ $25,000 to $29,999
_____ $30,000 to $34,999
_____ more than $35,000

9. What is your country of origin?

_____

10. How long have you been in the United States?

_____ 1-3 years
_____ 3-5 years
_____ 5-10 years

11. How old were you when you came to the United States? _____

12. Why did you come to the United States?

_____

_____

_____

13. Are you planning to go back to your home country?

_____

14. Is this the first time for you to live abroad?

_____

APPENDIX E

APPENDIX E

OBSTETRICAL DATA

Collected by investigator from subject's chart.

_____ Age
_____ Gravida
_____ Para

EDC __ __ __ __ __ __
month day year

Delivery __ __ __ __ __ __
month day year

Weeks gestation _____

Type of labor
_____ spontaneous
_____ augmented
_____ induced

Medications in labor
Describe:

Description of labor
_____ normal
_____ prolonged 1st stage
_____ prolonged 2nd stage

Total length of labor _____

Monitoring
_____ internal
_____ external
_____ both
_____ none

Anesthesia
_____ none
_____ local
_____ pudendal
_____ epidural
_____ caudal
_____ spinal block

Delivery
_____ spontaneous
_____ low forceps
_____ mid forceps
_____ vacuum extractor

Episiotomy
_____ yes
_____ no

Complications
_____ yes Describe_____
_____
_____ no

APPENDIX E

OBSTETRICAL DATA (cont'd)

Infant's sex

_____ male

_____ female

Problems during pregnancy

_____ yes

Describe_____

_____ no

Postpartum complications

_____ yes

Describe_____

_____ no

Received obstetrical care from

_____ UCSF/Moffitt

_____ Women's Clinic/San Francisco General Hospital

FOR REFERENCE

NOT TO BE TAKEN FROM THE ROOM