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Article

Biopsychosocial Challenges Faced by Women during Childbirth and their Coping Strategies: An Exploratory Study in Delhi

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Keywords

Biopsychosocial factors, childbirth challenges, coping strategies, thematic analysis.

Abstract

This study aims to explore the biopsychosocial challenges faced by women during childbirth and their coping strategies. The research design employed a qualitative approach using in-depth interviews and checklists with 30 women who had recently given birth. The data collected were analyzed using thematic analysis. The results showed that women faced a range of challenges during childbirth, including physical pain, fear, anxiety, and uncertainty about the outcome. These challenges were influenced by various factors such as age, parity, socio-economic status, and cultural beliefs. Coping strategies employed by women included seeking social support, relaxation techniques, and engaging in positive self-talk. The study provides valuable insights into the challenges women face during childbirth and the coping strategies they employ. The findings can inform the development of interventions to support women during childbirth and promote their well-being

Introduction

To be able to give birth to a new life has been considered the most joyous, miraculous and amusing experience for a woman. Welcoming a baby is like opening one of life's big doors of possibilities, anything can happen. The transition from a nonmother to a mother, or from being a mother of one child to becoming a mother of two children, calls for changes in a woman's role relationships and/or alteration in her behavior and in herself in the social context Often parents are prepared for the birth, yet gloss over the reality that bringing home a newborn with its own temperament and round-the-clock feeding will undoubtedly lead to a major life adjustment. A mother must recover from her birth experience while her body undergoes a tremendous hormonal upheaval that rivals any roller coaster ride. Sleep Deprivation alone can leave her stumbling around the house in a fog. She is also getting to know her newborn while confronting the loss of her previous life and any sense of control over her time. (Shoshana & Indman, 2019). All these factors can be overwhelming and lead to serious perinatal mental health problems. Contrary to popular mythology, pregnancy is not always a happy, glowing experience. Pregnant women can and do experience depression, bipolar disorder, anxiety and panic, post-traumatic stress disorder, obsessive-compulsive disorder, and even psychosis. This may be a reoccurrence of a previous illness, or a new onset of illness. Approximately 15% to 23% of pregnant women experience depression (Wisner, 2013). These rates are even higher in teenagers and poor women.

There are many other factors that not only psychologically but also biologically and socially that affect a mother's body. Cesarean section, also known as Cesarean Delivery or cesarean delivery, is the surgical procedure by which one or more babies are delivered through an incision in the mother's abdomen, often performed because vaginal delivery would put the baby or mother at risk. Even though the Cesarean Delivery can put both the mother and the child at peril, it is the most preferred type of delivery. The World Health Organization recommends that cesarean section be performed only when medically necessary. Most C-sections are performed without a medical reason, upon request by someone, usually the mother. Whereas most of the doctors argue that not all cesarean section births carried out at the moment are needed for medical reasons. Unnecessary surgical procedures can be harmful, both for a woman and her baby. Doctors undertake cesarean sections in situations like prolonged labor, fetal distress, or because the baby is in an abnormal position. On the other hand Normal Deliveries are considered to be more safe and have lower morbidity. A Vaginal Delivery is the birth of offspring in mammals through the vagina (also called the "birth canal"). It is the most common method of Childbirth worldwide. In most of the cases the mother's body heals itself and the recovery procedure is quick as compared to Cesarean Delivery. Childbearing is a unique biopsychosocial occurrence that profoundly affects a woman physically, socially and emotionally. Like puberty or menopause, the reproductive life event of bearing a child involves significant somatic changes. Pregnancy dramatically transforms the physical landscape of a woman's body, its size and shape, as well as the internal hormonal milieu.

Zakerihamidi, Roudsari & Khoei, (2015) conducted a study on Vaginal Delivery vs. Cesarean Section: A Focused Ethnographic Study of Women's Perceptions in The North of

Iran wherein the findings suggested cultural beliefs overshadow their misconceptions, so it is hoped that through implementing appropriate training programs for raising awareness and correcting misconceptions, vaginal delivery could be promoted even in regions with high rates of cesarean section. Neu & Rushing, (2011) conducted research on Cesarean versus Vaginal Delivery: Long term infant outcomes and the Hygiene Hypothesis The link between mode of delivery and subsequent childhood pathology is an important one. This becomes even more important as maternal desire for primary cesarean delivery is on the rise and rates of vaginal birth after cesarean (VBAC) are declining in this country. This new information about colonization differences with differing modes of delivery seems to be taking the hygiene hypothesis to an entirely new level. Clare Shakespeare et al. (2021) studied Resilience and vulnerability of maternity services in Zimbabwe: a comparative analysis of the effect of Covid-19 and lockdown control measures on maternal and perinatal outcomes, a single-center cross-sectional study at Mpilo Central Hospital and found that maternity services at Mpilo showed resilience during the lockdown period, with no significant change in maternal and perinatal adverse outcomes, with the same number of man-hours worked before and during the lockdown. Roy et.al (2021) conducted a research on Changing scenario of Cesarean Delivery in India: Understanding the maternal health concern and its associated predictors. And the findings indicate that The government should take the lead in raising awareness about the importance of normal deliveries for healthy pregnant mothers, resulting in increased maternal health literacy among women. This can be accomplished with the assistance of frontline workers such as community health workers and primary care physicians, who are the first point of contact for pregnant mothers seeking antenatal care, check-ups, or assistance with any health issues.

During these check-up sessions, primary care providers can raise awareness about deliveries and their medical implications so that mothers can make their own decisions before labor and the incidences of unexpected Cesarean Delivery deliveries are reduced in the future. Sensitization to the importance of Vaginal Delivery when there are no medical complications in women. Sharma & Dhakal (2018) conducted a research on Cesarean vs Vaginal Delivery : An Institutional Experience; its findings indicate that Prolonged labor, wound infection, surgical injury, and maternal death were all associated with mode of delivery, but postpartum hemorrhage was not. Prolonged labor was common in vaginal deliveries, whereas wound infection, surgical injury, and maternal death were common in cesarean deliveries. Cesarean delivery is becoming more widely regarded as a low-risk procedure. However, the current study clearly shows that maternal complications are significantly increased when compared to vaginal delivery. However, the author suggests that more research be conducted in order to generalize the findings. Bhatia et.al (2020) conducted a research on Assessment of Variation in Cesarean Delivery Rates Between Public and Private Health Facilities in India From 2005 to 2016. This cross-sectional study found a significant difference in cesarean delivery rates between the public and private sectors in India, and that private sector health care facilities are associated with higher cesarean delivery rates. India appears to be in the early stages of an increase in cesarean deliveries. Given India's expanding middle class, rapidly expanding private sector, low governmental regulatory capacity, and government policy that encourages public-private partnerships,

conditions appear favorable for an increase in cesarean delivery rates in densely populated states. As a result, policymakers in India must address the public health issue of increasing cesarean deliveries. More research is required to understand the factors underlying the significant increase in cesarean deliveries among the private sector in India. Rodgers and Lee (2021) conducted research on Geographic variation in cesarean delivery in India. The findings emphasize the importance of understanding geographic variation at multiple levels, as evidenced by a comprehensive accounting of variations in cesarean delivery in India. Beyond those that target individual characteristics alone, tailored contextual interventions may reduce between-population variations in cesarean access and utilization.

The woman's transition to motherhood has implications for all of her relationships and for her societal role. Furthermore, pregnancy and the postpartum period involve significant psychological adjustments, and the childbearing process has been noted to be a 'psychological stress test' (Frank, Tuber, Slade, & Garrod, 1994). In 2017, the American College of Obstetricians and Gynecologists (ACOG) noted the seriousness of these illnesses. Perinatal mood and anxiety disorders are among the most common mental health conditions encountered by women of reproductive age. When left untreated, perinatal mood and anxiety disorders can have profound adverse effects on women and their children, ranging from increased risk of poor adherence to medical care, exacerbation of medical conditions, loss of interpersonal and financial resources, smoking and substance use, suicide, and infanticide. (Shoshana & Indman, 2019) (p.12). Anxiety Disorder occurs in about 15.8% of pregnant women and 17% of newly postpartum women (Fairbrother, 2016) Leight et.al (2010) conducted a research on Childbirth and Mental Disorders and the findings indicates that the female life cycle as a lens for studying mental disease fosters new understanding of the causes, progression, and treatment of psychiatric illness. This method can also be used to frame knowledge of psychological resilience, which will aid the field's transition from reactive engagement with patients and among medical specialties (detection and referral) to proactive engagement (education and collaboration). When weighing the risks and benefits of somatic treatments and psychiatric illness in perinatal women, there has been some literature on the significance of collaborative decision making with the patient (Wisner et al., 2000), but there hasn't been as much discussion of the importance of such a collaborative approach in preconception care and prevention of perinatal mental illness. Maria et al. (2021) conducted research on Prevalence and Determinants of Postpartum Anxiety among Women Availing Health Services at a Rural Maternity Hospital in South India where the prevalence of postpartum anxiety was found to be 11.3%, and the prevalence of postpartum depression was 12.5%. There was a significant association between postpartum anxiety and postpartum depression and between alcohol use by husband and postpartum anxiety in women. Upadhyay et al. (2017) researched on Postpartum depression in India: a systematic review and meta-analysis where the review shows a high prevalence of postpartum depression in Indian mothers. More resources need to be allocated for capacity-building in maternal mental health care in India. Psychosis is a serious illness in which a person loses touch with reality. It occurs in one to two per thousand perinatal women (Sit,2007). Onset is usually within the first two weeks after the woman gives birth. With postpartum psychotic disorder, there is a 5% suicide and 4% infanticide rate (Brockington, 2017).

Postpartum depression (PPD) is a severe form of depression that occurs in women following the birth of a child. It is a significant public health issue that affects millions of women worldwide. PPD can negatively impact maternal health and the well-being of the infant, as well as the entire family. It is important to understand the causes, symptoms, and treatment options for PPD in order to address this condition effectively. The exact causes of PPD are unknown, but several factors may contribute to the development of this condition. These factors include biological, psychological, and social factors. Some of the factors that may contribute to the development of PPD include: Hormonal changes: After childbirth, the levels of estrogen and progesterone in a woman's body decrease significantly, which can affect her mood and emotions. Genetics: A family history of depression may increase the risk of developing PPD. Personal history of depression or anxiety: Women who have a history of depression or anxiety may be more susceptible to PPD. Stressful life events: Stressful life events, such as financial difficulties or relationship problems, can increase the risk of developing PPD. Lack of social support: Women who lack social support from family and friends may be at greater risk of developing PPD. The symptoms of PPD can vary from person to person, but some common symptoms include: Feelings of sadness, hopelessness, or emptiness Difficulty sleeping or excessive sleeping Loss of interest in activities that were once enjoyable Changes in appetite Fatigue or lack of energy Difficulty concentrating or making decisions Feelings of guilt or worthlessness Thoughts of self-harm or suicide It is important to note that many women experience "baby blues" after giving birth, which is a milder form of mood changes that often goes away on its own within a few weeks. However, if the symptoms persist or become more severe, it may indicate the presence of PPD. PPD can be treated effectively with a combination of medication and therapy. Antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), are commonly prescribed to treat PPD. Therapy, such as cognitive-behavioral therapy (CBT), can also be effective in treating PPD. In addition to medication and therapy, there are several lifestyle changes that can help manage symptoms of PPD. These include Getting enough sleep: Adequate sleep is essential for mental health, and it is especially important for new mothers. Eating a healthy diet: Eating a healthy diet can help improve mood and energy levels. Exercising regularly: Exercise can help reduce stress and improve mood. Seeking social support: Talking to friends and family members can help reduce feelings of isolation and improve mood. Taking time for self-care: Taking time to do things that are enjoyable and relaxing can help improve mood and reduce stress. Postpartum depression is a common and serious condition that can have a significant impact on the well-being of new mothers, infants, and families. It is important to understand the causes, symptoms, and treatment options for PPD in order to address this condition effectively. If you or someone you know is experiencing symptoms of PPD, it is important to seek help from a healthcare professional. With the right treatment, PPD can be effectively managed, and women can enjoy a healthy and happy postpartum period. Wang, et.al (2021) conducted a study on Mapping global prevalence of depression among postpartum women wherein the findings were that one out of every five women experienced postpartum depression after childbirth, which was driven by an array of factors. This requires the focus and commitment of primary care providers, clinicians, medical associations, and society as a whole. PTSD can occur following life-threatening or injury-producing events such as sexual abuse or assault, or traumatic

childbirth. It occurs in up to 6% of women; rates are higher (up to 30%) in parents who have a child in the intensive care unit. According to Beck, (2011), 34% of mothers perceived their labor and delivery experiences as traumatic and up to 9 % had sufficient symptoms to be given a diagnosis of PTSD. (Shoshana & Indman, 2019). Abevona et.al (2022) conducted a cross sectional study on Prevalence of postpartum depression and its associated factors within a year after birth in Semey, Kazakhstan where the authors concluded that The high prevalence of PPD and associated risk factors suggest that the country's postpartum care programme needs to be strengthened and improved. More research on women's experiences and levels of antenatal depression will be required to understand and prevent any potential depressions in the prenatal and postpartum periods. According to the American Academy of Pediatrics, untreated illness "leads to increased medical costs, inappropriate medical treatment of the infant, discontinuation of breastfeeding, family dysfunction, and an increased risk of abuse and neglect. Postpartum Depression, in particular, has a negative impact on this critical period of infant brain development. Perinatal Depression is an example of a negative childhood experience with long-term health consequences for the mother, her partner, the infant, and the mother-infant dyad." (Earis, 2019). Maternal suicide, which occurs worldwide, accounts for approximately 20% of postpartum deaths in the United States (Kendig, 2017). There is a wealth of evidence that untreated maternal and paternal depression has a negative impact on fetuses, babies, and other children in the home. This influence may last throughout childhood and into adolescence.Meena et al. (2016) conducted research on Cognitive dysfunction and associated behavior problems in postpartum women: A study from North India where the authors concluded that Women had significantly more cognitive deficits during the postpartum period than their non-pregnant counterparts. The former also had a higher prevalence of depression, anxiety, and stress. Vengadavaradan et al. (2019) researched on Frequency and correlates of mother-infant bonding disorders among postpartum women in India and the authors concluded that Disorders of mother infant bonding are seen in healthy postpartum mothers. The frequency of mild disorders of bonding appears to be similar across countries and this condition warrants further attention. Kohler et al. (2018) researched on Postpartum quality of life in Indian women after vaginal birth and cesarean section: a pilot study using the EQ-5D-5L descriptive system and the findings were that Vaginal births, even with episiotomy, were associated with a higher postpartum QOL than cesarean births among the Indian women in our pilot study. Finding these expected results suggests that the EQ-5D-5L questionnaire is a suitable instrument to assess postpartum QOL in Indian women. Shashi Rai, Abhishek Pathak, & Indira Sharma (2015) did research on Postpartum psychiatric disorders: Early diagnosis and management and concluded that The postpartum period is a time of increased risk for the onset or exacerbation of mood instability particularly in women with bipolar disorder. Though the nosological status of PP remains controversial, it is generally considered a psychotic episode of bipolar disorder. Early identification of women at high-risk for developing PP and initiation of timely therapeutic approaches, consisting of the combination of pharmacological strategies and psychotherapeutic approaches, are the key factors to the successful management of PP. Mutua et al. (2020) did a comparative study of postpartum anxiety and depression in mothers with preterm births in Kenya where the authors found higher proportions of depression, anxiety, and general distress in mothers who delivered preterm. Risk factors like IPV and poor mental health should be addressed in

postpartum mothers regardless of full term or preterm birth status, as a fundamental right. Shraddha Lanjewar , Shilpa Nimkar & Suresh Jungari studied Depressed Motherhood: Prevalence and Covariates of Maternal Postpartum Depression among Urban Mothers in India and the findings indicate that Higher levels of postpartum depression in urban mothers affect the women and their children's health. Screening of expecting mothers for possible symptoms of depression during antenatal care could reduce the chances of depression during the postpartum period. Considering its prevalence, depression should be addressed in national mental health programmes. More robust research is required for better understanding of the factors responsible for postpartum depression in urban India. Fifty percent of children of depressed moms will have depression by the end of adolescence. At least 10% of fathers are moderately or severely depressed (Paulson, 2010). Depressed fathers are nearly four times more likely to spank, and less than 50% of these dads report regularly reading to their 1-year-olds (Davis, 2011), Children of depressed parents are more likely to suffer from childhood psychiatric disturbance, behavior problems, poor social functioning, and impaired cognitive and language development. When a depressed parent goes untreated, every member of the family and all the relationships within the family are affected. The quicker the parent is treated, the better it is for the entire family. The longer the depression remains, the more likely the children and family are to suffer depression. In the Netsi 2018 study, some women with persistent depression continued to have significant symptoms up to 11 years after childbirth.

Future research should look into the potential of specific interventions by identifying more diverse contextual factors that drive between-population differences. Such studies will necessitate more detailed data, such as clinical, administrative, and sociocultural information. The National Family Health Survey (NFHS) revealed that the national Cesarean Delivery rate stands at 21.5 per cent, way higher than World Health Organization's 'ideal 10-15 per cent'.The growing disparity of Cesarean Delivery births in government and private hospitals is problematic. In NFHS-4, which was released in 2015- 2016, about 40.9 percent of cesarean deliveries were performed in private hospitals, compared to 11.9 per cent in the government sector. Fast-forwarding to NFHS 5, 47.4 percent of babies born in the private sector are being delivered by surgical methods compared to just 14.3 percent in the government sector. On a macro-level, the statistics imply that one in five women who go to any medical facility, public or private undergo a Cesarean Delivery . Karen Blamer (1999) conducted a Comparative study of Women's Perception of Vaginal and Cesarean Births The findings of this study supported the first hypothesis, that women who had cesarean births had a negative perception of birth compared to women who had vaginal births. The second hypothesis, that women who had unplanned cesarean births had a negative perception of birth compared to women who had vaginal or planned cesarean births, was not supported. An analysis of the variables maternal age, baby weight, and infant Apgar scores revealed no significant difference between groups and thus had no influence on the outcome. The likelihood of becoming ill again with a major depressive disorder (MDD) in women who discontinue their medication before pregnancy is between 50% and 75% (Cohen, 2006). In other words, only 25% to 50% of women who stopped taking medication before trying to get pregnant stayed well. The rate of relapse for MDD in those who discontinue medications at conception or in

early pregnancy is 75%, with up to 60% relapsing in the first trimester. This means that most of the women who stopped medication once they discovered they were pregnant became ill again early in the pregnancy. In one study, 42% of women who discontinued medications at conception resumed medications at some time during their pregnancy (Cohen, 2004). Resources listed at the end of this book provide helpful guidelines regarding the use of medications. Buhimschi & Buhimschi (2006) did a research on Advantages of Vaginal Delivery and they concluded that Several published studies aimed at improving clinical practise have profoundly changed obstetric practise over the last decade. However, as appealing as it may sound, practicing maternal-fetal medicine in the midst of controversy is a difficult task. The passionate debate over the best mode of delivery continues today, hampered by a lack of published data on the short- and long-term outcomes of spontaneous vaginal, instrumental, or cesarean birth. Randomizing women to CD versus spontaneous or instrumental vaginal delivery is unlikely to be feasible or ethical. There is currently no evidence that elective CD is safer than labor. If such evidence is presented, then all women should unquestionably be offered elective CD. The Government of India is a signatory to the United Nations (UN) Sustainable Development Goals (SDGs), which adopted a global maternal mortality ratio (MMR) target of fewer than 70 deaths per 100 000 live births by 2030.This requires the reliable quantification of maternal deaths and trends and an understanding of the major causes of these deaths at the subnational level. India, similar to many countries with high maternal mortality, officially registers only a fraction of births, deaths and vital events.Maternal deaths are concentrated in remote rural areas and are among the least likely to be recorded. India, however, has had a functioning Sample Registration System (SRS) to monitor fertility and mortality covering over 1 million nationally representative homes for more than five decades. Meh et.al (2021) did research on Trends in maternal mortality in India over two decades in nationally representative surveys. India has made significant progress in implementing interventions to improve maternal health in the country. However, three areas require special attention. First, policies that recognise and monitor subnational disparities are required, particularly in EAGA states and rural and tribal areas, where the majority of maternal deaths occur (and which might be particularly affected by disruptions in delivery resulting from the COVID-19 pandemic). This calls for more focused efforts to improve access and close quality gaps in these hotspots. Second, educational programmes should inform women about the benefits of health-care services and planned births. Finally, for these areas and nationally, a continuous reliable estimation of maternal deaths is required, including ensuring that SRS results on causes of death are accurate. A Canadian study found 13.3% of men experienced elevated depressive symptoms during their partners' third trimester (Da Costa, 2017). We now know that 10% of fathers experience moderate to severe depression nine months after the birth of a baby (Paulson, 2010). The highest rates are seen 3 to 6 months postpartum. If the partner has a history of depression or anxiety, this is a high risk factor with or without depression in the mom. It was suggested that all new moms and their partners be screened on a routine basis. Zhou et.al (2021) conducted research on Changes in social support of pregnant and postnatal mothers during the COVID-19 pandemic. And the key conclusions were that during the COVID-19 pandemic, perinatal women reported lower social support, which was linked to poorer mental health. The use of virtual social support and support from friends had the greatest positive

effect on perceived social support levels. Kim, Connolly & Tamim (2014) did a research on The effect of social support around pregnancy on postpartum depression among Canadian teen mothers and adult mothers in the maternity experiences survey and concluded that The current study emphasized the importance of identifying mothers who have low levels of support because they are more likely to experience postpartum depression. Understanding the relationship and role of social support during pregnancy and after birth is critical for developing effective interventions for mothers who are at higher risk of PPD. It has been discovered that social support after childbirth is important for both teen mothers and adult mothers, as it reduces the risk of experiencing PPD. Early PPD education for mothers should be considered, as it acts as a protective factor. Battulga et.al (2021) conducted a research on The Impact of Social Support and Pregnancy on Subjective Well-Being: A Systematic Review.This study discovered that, despite some emerging trends, pregnancy does not always have the same effects on SWB in healthy pregnant women. SS, on the other hand, had a significant effect on SWB. Cena et al. studied the Prevalence of Maternal Postnatal Anxiety and Its Association With Demographic and Socioeconomic Factors: A Multicentre Study in Italy this study discovered that The prevalence of postnatal anxiety found in this study was more than double the overall pooled prevalence of 15.0% (at 1–24 weeks postpartum) and 14.8% (>24 weeks) reported by meta-analytic studies. Webb et al.(2008) did a research on Postpartum Physical Symptoms in New Mothers: Their Relationship to Functional Limitations and Emotional Well-being and concluded that Although physical problems typically associated with the postpartum period are often regarded as transient or comparatively minor, they are strongly related to both the functional impairment and poor emotional Health. Careful assessment of the physical, functional, as well as emotional health status of women in the year following childbirth may improve the quality of postpartum care Postnatal period begins immediately after the birth of the newborn and extends up to 6 weeks. It is significant for the mother, for the baby, and for the family as it is a time of physiological adjustment for the mother and the baby and emotional and social adjustment for all involved in the care. During this period, the woman has to make major adjustments as this may in turn be crucial for her present and future ability to function. This period is also the challenging period in her reproductive life. IS Yim et al. (2017) conducted a research on Biological and Psychosocial Predictors of Postpartum Depression: Systematic Review and Call for Integration and the findings indicate that The strongest PPD risk predictors among biological processes are hypothalamic-pituitary-adrenal dysregulation, inflammatory processes, and genetic vulnerabilities. Among psychosocial factors, the strongest predictors are severe life events, some forms of chronic strain, relationship quality, and support from partner and mother. Fully integrated biopsychosocial investigations with large samples are needed to advance our knowledge of PPD etiology. Kanotra et al. (2007) did a research on Challenges faced by new mothers in the early postpartum period: an analysis of comment data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) survey and concluded that The themes identified indicate that new mothers want more social support and education and that some of their concerns relate to policies regarding breastfeeding and medical care. These results can be used to inform programs and policies designed to address education and continuity of postpartum care for new mothers. Negron et al. (2013) did research on Social support during the postpartum period: Mothers' views on needs, expectations, and

mobilization of support and the findings indicate that Instrumental support plays a significant role in meeting women's basic needs during the postpartum period. In addition, women's expectations surrounding support can have an impact on their ability to mobilize support among their social networks. The results of this study suggest that identifying support needs and expectations of new mothers is important for mothers' recovery after childbirth. Future postpartum depression prevention efforts should integrate a strong focus on social support. McCauley et al. (2018) studied the Burden of physical, psychological and social ill-health during and after pregnancy among women in India, Pakistan, Kenya and Malawi and concluded that Women suffer significant ill-health which is still largely unrecognized. Current antenatal and postnatal care packages require adaptation if they are to meet the identified health needs of women. Datta et al. (2017) researched on Challenges Faced by Young Mothers with a Care History and Views of Stakeholders About the Potential for Group Family Nurse Partnership to Support Their Needs, This is the first study to have used qualitative interviews to explore a range of stakeholders' views about the needs of pregnant women with a care history and their thoughts about a group-based version of FNP in meeting these. We found consensus among informants regarding the vulnerability of LAC and care leavers when they become mothers highlighting their social isolation and lack of trusting relationships. While there was also consensus that FNP is a valuable resource in meeting the specific needs of parents who had been in care, there were divergent views about whether these would be best met by an individual or group-based version of FNP, with some suggesting the potential benefits of a (hypothetical) hybrid programme involving both one-to-one and group sessions.

The postpartum period, also known as the fourth trimester, is the time after childbirth when a woman's body undergoes significant physical and hormonal changes as it returns to its pre-pregnancy state. At the same time, new mothers must also adapt to the demands of caring for their newborns, including feeding, changing, and comforting their babies around the clock. It is common for women to experience a range of emotions during this time, including joy, elation, anxiety, and fatigue. Coping strategies are vital during this time as they help women to manage the physical, emotional, and psychological changes that come with childbirth. One of the most effective coping strategies for new mothers is seeking social support. This may include reaching out to family and friends for help with household chores, childcare, or simply emotional support. Joining a postpartum support group is also a great way to connect with other new mothers who are going through similar experiences. Sharing stories, tips, and advice can help to reduce feelings of isolation and provide a sense of community. Practicing self-care is also an essential coping strategy for new mothers. This may involve taking time for oneself to engage in activities that promote relaxation and rejuvenation, such as taking a warm bath, reading a book, or going for a walk. Adequate sleep is also critical during this period, and new mothers should try to get as much rest as possible, even if it means taking naps throughout the day.Engaging in physical activity is another useful coping strategy for new mothers. Exercise not only helps to boost energy levels, but it also releases endorphins that can improve mood and reduce stress. New mothers should consult with their healthcare provider before starting an exercise regimen, but gentle activities like walking or postpartum yoga can be beneficial. Finally, it is important to take

advantage of available resources to cope with the challenges of the postpartum period. This may include seeking counseling services if feelings of depression or anxiety persist or taking advantage of postpartum support groups or classes. Healthcare providers can also provide valuable resources and advice to new mothers. In conclusion, the postpartum period is a challenging time for new mothers, but coping strategies can help them to manage the physical, emotional, and psychological changes that come with childbirth. Seeking social support, practicing self-care, engaging in physical activity, and taking advantage of available resources are all effective ways for new mothers to cope and adjust to the demands of caring for a newborn. Jagadeeswari Jayaseelan & M. Prathap Mohan (2020) researched on Coping strategies used by postnatal mothers with perceived stress, The present study suggests that psychological support from partner, family members, and nurses is needed to reduce stress and to implement various coping strategies to improve health among postnatal mothers. Continuing nursing education based on coping strategies is needed for the nurses to educate the postnatal mothers during their stay in the hospital to overcome stressors and to cope up with stress so as to prevent postnatal depression and postnatal psychosis. Lorraine O. Walker & Nicole Murry (2022) did research on Maternal Stressors and Coping Strategies During the Extended Postpartum Period: A Retrospective Analysis with Contemporary Implications and the findings indicated that Women's predominant source of stress was from overload and was highest at 9 to 12 months postpartum. Community resources and public health policy and programming are needed to prepare and support women during the challenging first postpartum year. Azale et al.(2018) researched Coping strategies of women with postpartum depression symptoms in rural Ethiopia: a cross-sectional community study and found out that As in high-income countries, women with PPD symptoms were most likely to use emotion-focused and dysfunctional coping strategies. Poverty and the low level of awareness of depression as an illness may additionally impede problem-solving attempts to cope. Prospective studies are needed to understand the prognostic significance of coping styles in this setting and to inform psychosocial intervention development. Kumari et al. (2022) researched on Negative Emotions, Triggers, and Coping Strategies Among Postpartum Indian Women During Second Wave of COVID-19 Pandemic: Lessons for the Subsequent Waves and Beyond, and the findings indicated that During the second wave, the COVID-19 pandemic had a significantly high negative impact on the psychological and social well-being of pregnant and postpartum women. Hence, it is important to initiate appropriate preventive and corrective steps by the policymakers for any future waves of the pandemic. Laurie Elizabeth Cadmen (1995) researched on The concerns and coping strategies of new mothers in the early Postpartum period and the findings indicate that the majority of coping strategies, the women had to depend only on themselves. Redefining normal, caring for self, utilizing/modifying former coping strategies, identifying what was right for self, and encouraging/accepting partner's involvement were coping strategies that the women developed on their own. Sharing feelings, seeking support/advice, and accepting support/advice required the women to involve others into their coping. Many of the coping strategies that the women used by themselves were used in conjunction with coping strategies that involved others. The coping strategies that involved utilizing others were the most often used and first used coping strategies. The study examines the biopsychosocial challenges faced by women during childbirth and the coping strategies they adopt to manage these

challenges. The biopsychosocial model recognizes the interplay between biological, psychological, and social factors in health and illness. The study found that women face various challenges during childbirth, including physical pain, emotional distress, social pressure, and lack of support. Coping strategies adopted by women included seeking social support, engaging in self-care activities, using relaxation techniques, and practicing positive thinking. The study suggests that healthcare providers should recognize and address these challenges and encourage the use of coping strategies to improve maternal and infant health outcomes.The study on Biopsychosocial Challenges Faced by Women during Childbirth and their coping strategies is an exploratory study that aimed to investigate the challenges women face during childbirth and the coping strategies they use to manage these challenges. The biopsychosocial model was used to provide a framework for understanding the complex interplay between biological, psychological, and social factors in the childbirth experience. The study aims to find that women face various biopsychosocial challenges during childbirth. Biologically, women experience physical pain, exhaustion, and discomfort during labor and delivery. Psychologically, women may experience fear, anxiety, and emotional distress related to childbirth. Socially, women may face pressure from their families, society, and healthcare providers to have a certain type of birth or to conform to certain expectations. The study highlights the importance of recognizing and addressing the biopsychosocial challenges faced by women during childbirth. Healthcare providers should be aware of the challenges and offer appropriate support and resources to women during the childbirth process. Encouraging the use of coping strategies such as social support and self-care activities can improve maternal and infant health outcomes. In conclusion, the study on Biopsychosocial Challenges Faced by Women during Childbirth and their coping strategies provides valuable insights into the challenges faced by women during childbirth and the coping strategies they use to manage these challenges. The study highlights the importance of recognizing and addressing the biopsychosocial factors in the childbirth experience to improve maternal and infant health outcomes.

Methodology

Aim

To understand the Biological, Physical and Psychological challenges faced by women after Cesarean and Vaginal Delivery and identify the coping strategies adopted by the women in the postpartum period to overcome the biological, physical, and psychosocial challenges.

Research Design

Mixed Method Research

Mixed method Research design which is also known as multi-method research involves the use of more than one method of data collection in a research study. Mixed methods research is more specific in that it includes the mixing of qualitative and quantitative data, methods, methodologies, and/or paradigms in a research study or set of related studies. In this study to

gather the quantitative data a checklist was prepared. The purpose of the checklist is to assess the biopsychosocial challenges experienced by women after childbirth. Its quantitative analysis was done using the Chi-square statistical analysis to understand the Biopsychosocial Challenges. For Qualitative data a Semi Structured Interview schedule was prepared to understand the coping strategies. Its qualitative analysis was done using content analysis.

Sample

The inclusion criteria for the study were that participants had to be adults with average age of, and only women were recruited because of the nature of the study. Specifically, the sample included women who had given birth within the past six months and were currently in their postpartum stage. To ensure consistency, only women who met this criterion were included in the study. The sample size was 30 postnatal mothers which was collected through purposive sampling in postnatal wards of Department of Gynecology at Sant Parmanand Hospital, New Delhi.

Measures

Checklist

A checklist was created and evaluated by five psychologists and five gynecologists to establish both its face validity and content validity. The purpose of the checklist is to assess the biopsychosocial challenges experienced by women after childbirth. The experts who participated in the evaluation were recognized in their respective fields. The checklist was designed to aid in identifying the various challenges faced by women in the postpartum period, including physical, psychological, and social difficulties. The experts reviewed the checklist to ensure that it was appropriate and comprehensive in its coverage of these challenges. The face validity of the checklist was established by evaluating its appearance and layout, ensuring that it was clear and easy to understand. The content validity of the checklist was evaluated by assessing its relevance and accuracy in measuring the intended constructs. The experts reviewed the items on the checklist to ensure that they were comprehensive and accurately represented the biopsychosocial challenges that women may experience after childbirth. They also evaluated the language and terminology used in the checklist to ensure that it was appropriate and understandable for the target population. Overall, the experts found the checklist to be well-designed, comprehensive, and relevant to the biopsychosocial challenges faced by women after childbirth. The feedback provided by the experts was used to make minor modifications to the checklist to further improve its clarity and relevance. The resulting checklist is expected to be a useful tool for healthcare professionals in identifying and addressing the needs of postpartum women.

Semi-structured interview

To understand the coping strategies data was collected through semi-structured interviews and participant observation. To gain insight into coping strategies, data was collected through semi-structured interviews. These interviews provided an opportunity to ask open-ended questions and explore the coping mechanisms utilized by individuals. By allowing

participants to freely discuss their experiences, thoughts, and emotions, researchers were able to gather rich, detailed information on coping strategies. The use of semi-structured interviews also enabled researchers to tailor questions to each participant, depending on their unique experiences and coping mechanisms. This approach allowed for a deeper exploration of coping strategies, as participants were able to describe their coping mechanisms in their own words and provide specific examples of how they had coped with challenging situations. Overall, the use of semi-structured interviews proved to be an effective method for understanding coping strategies, providing researchers with a rich and nuanced understanding of the various coping mechanisms employed by individuals.

Procedure

To identify the biopsychosocial challenges faced by women during their postpartum stage, a checklist was given to the participants, who were in their fourth trimester after childbirth. The checklist contained 58 items, which included demographic information and questions related to biological, physical, psychological, and social challenges. Specifically, there were 26 items related to biological challenges, 6 items for physical challenges, 16 items for psychological challenges, and 10 items for social challenges. In addition, a semi-structured interview consisting of 5 open-ended questions was conducted to understand the coping strategies adopted by the participants. The responses were recorded and transcribed.

Ethical Considerations

The participants were well informed about the aim of the study and the checklist was given only after voluntary consent. The participants were assured that their personal information would remain confidential. The participants were given the right to withdraw from the study if they should feel the need to.

Result

Descriptive Analysis

Figure 1

Biological Challenges faced by Women in Cesarean Delivery.

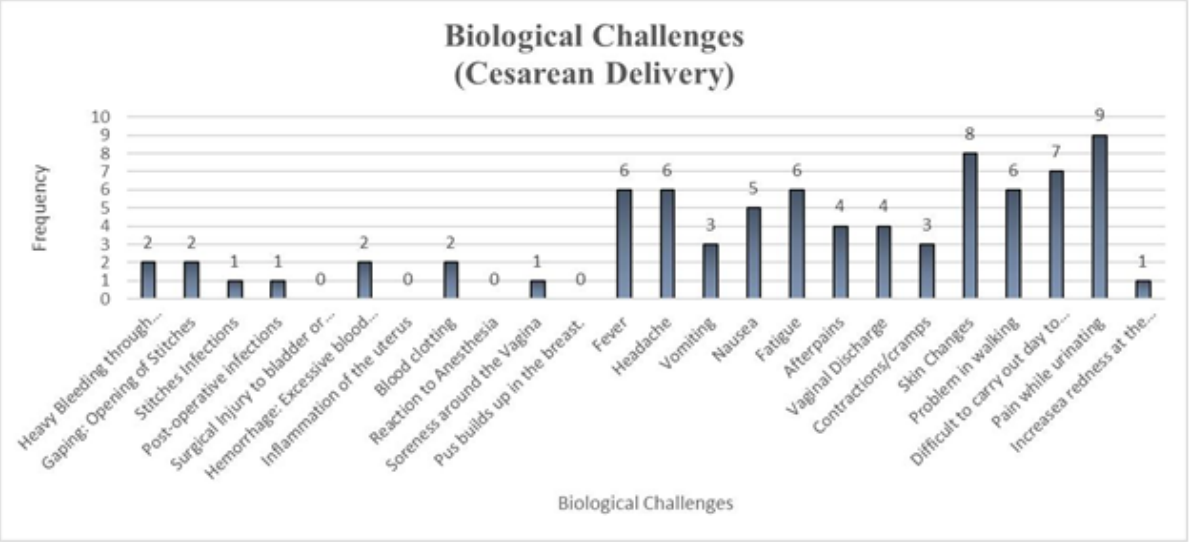

Figure 2

Physical Challenges faced by women during Cesarean Delivery

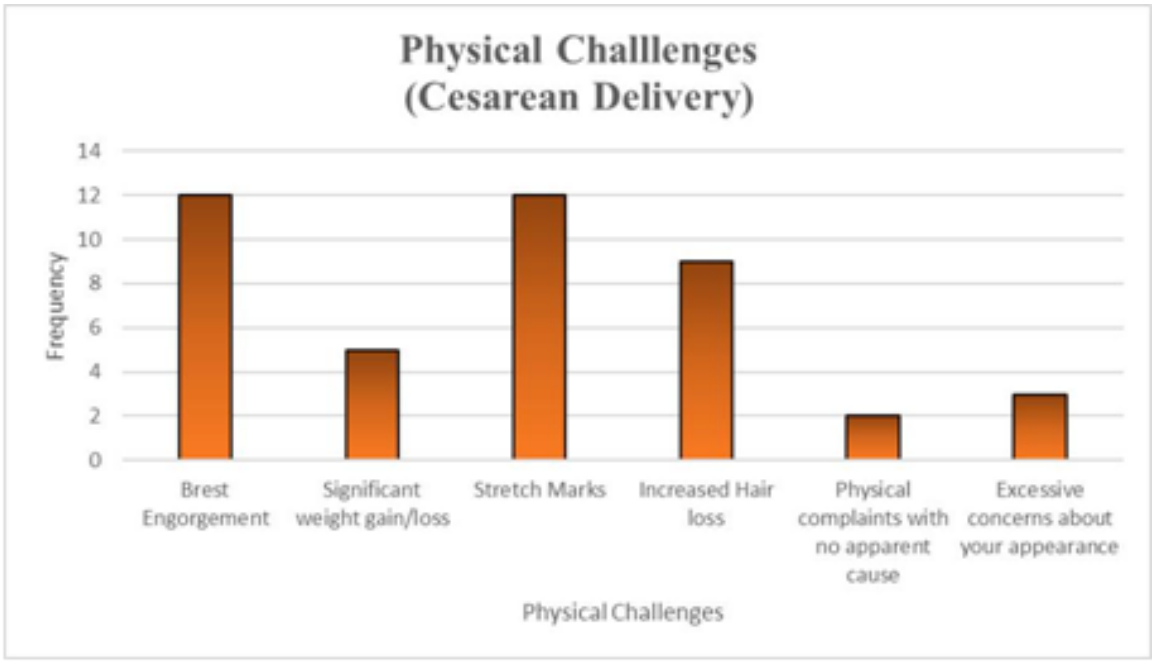

Figure 3

Psychological Challenges faced by women during Cesarean Delivery

Figure 4

Social Challenges faced by women during Cesarean Delivery

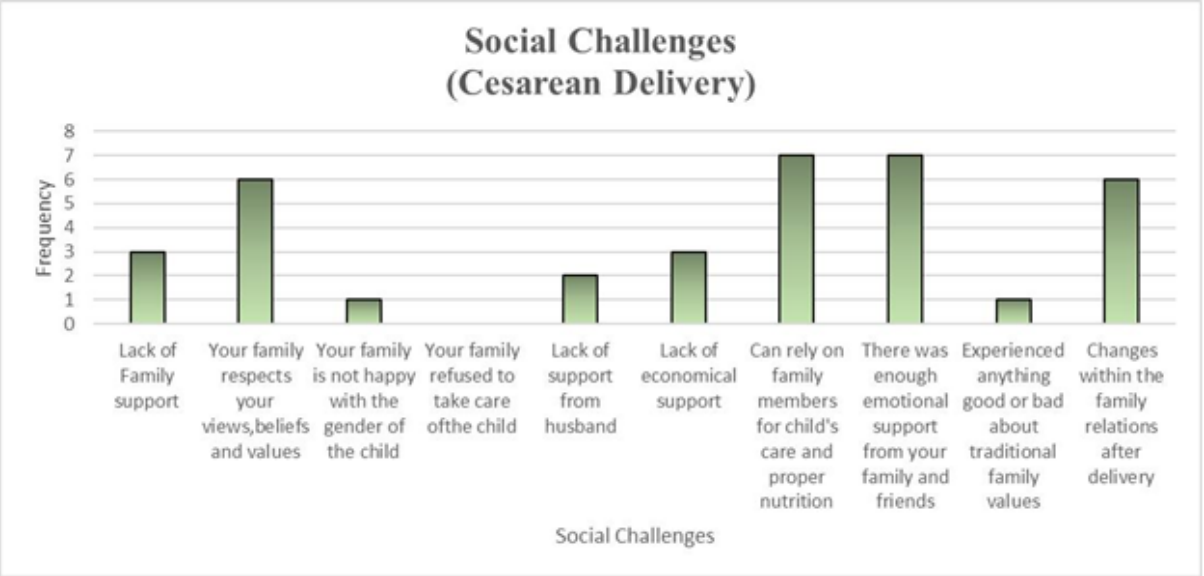

Figure 5

Biological Challenges faced by Women in Vaginal Delivery

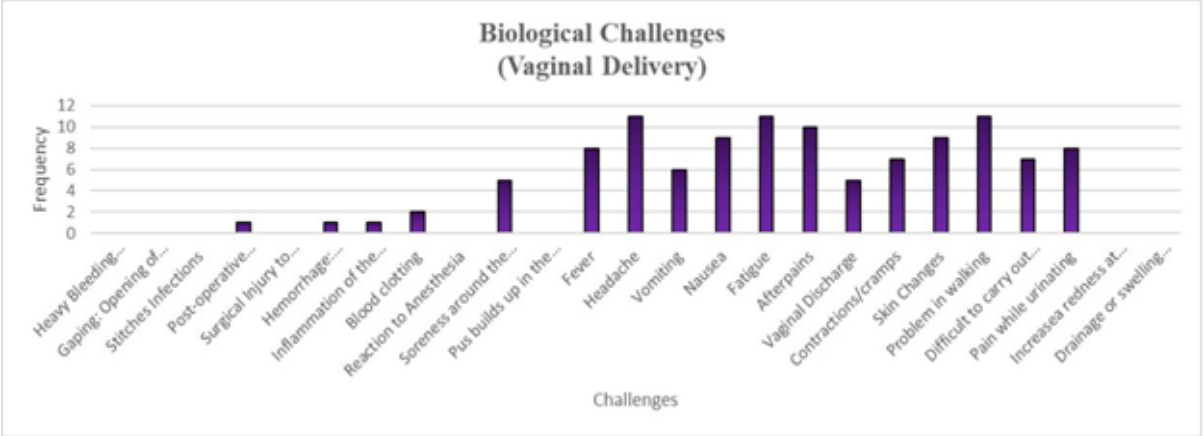

Figure 6

Physical Challenges faced by Women in Vaginal Delivery

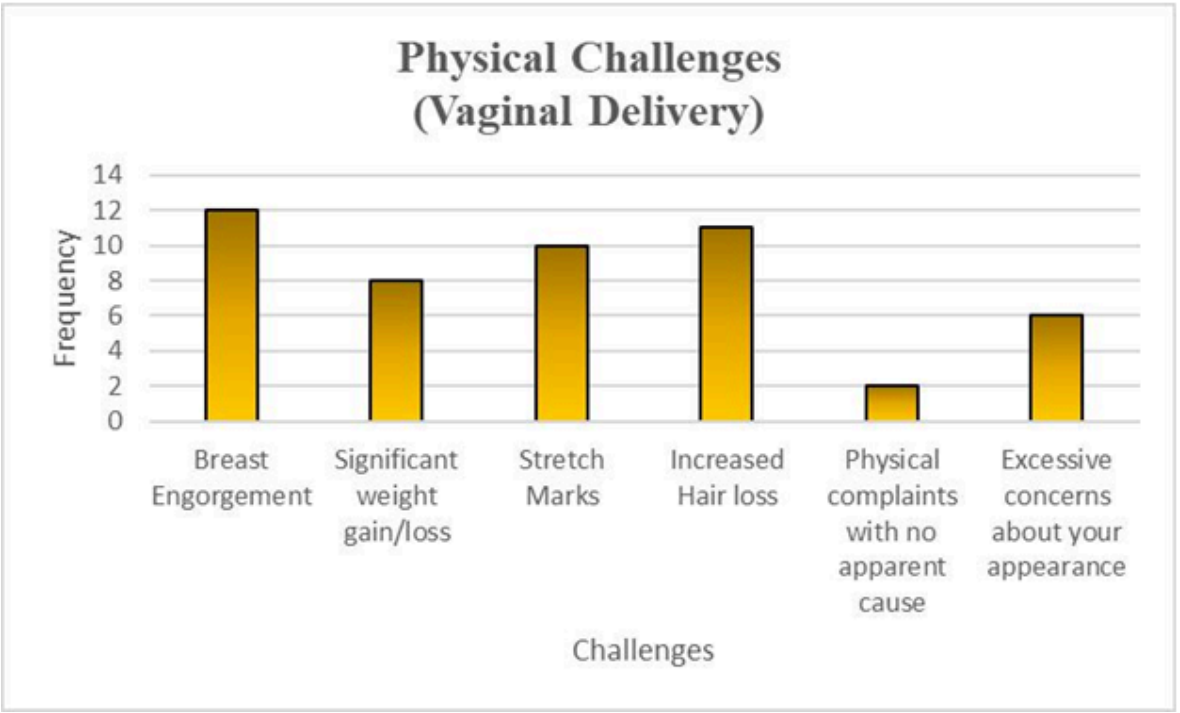

Figure 7

Psychological Challenges faced by Women in Vaginal Delivery

Figure 8

Social Challenegs faced by women in Vgainal Delivery

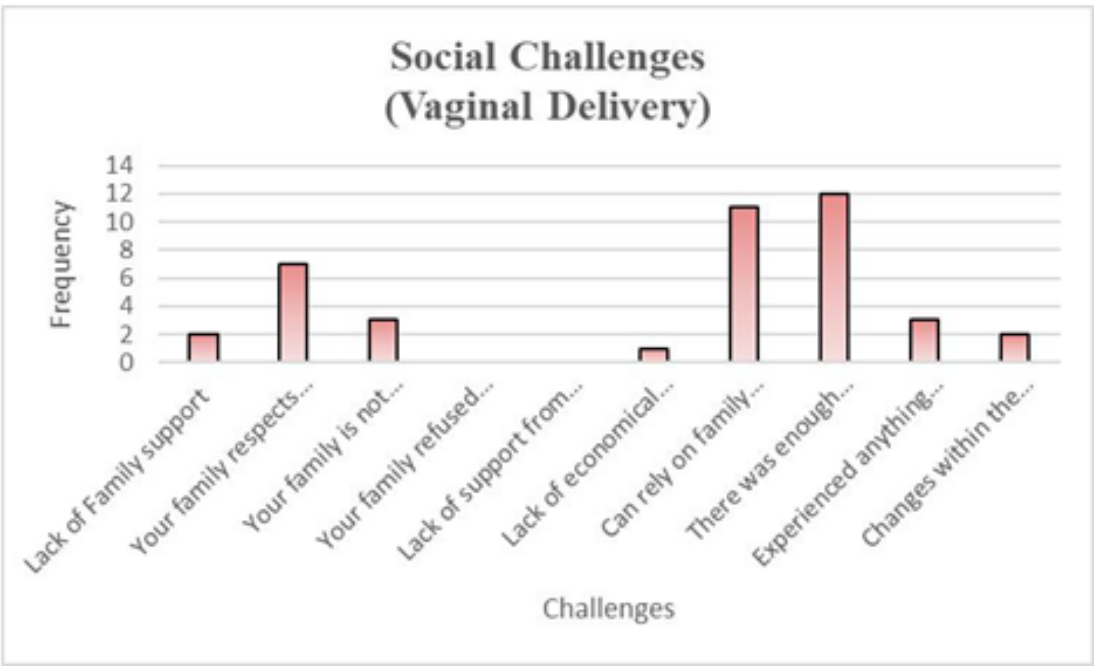

Table 1

Observed frequency of biological, physical, and psychosocial challenges

Observed	Vaginal Delivery	Cesarean Delivery	Total
Biological Challenges	112	79	191
Physical Challenges	49	43	92
Psychological Challenges	84	62	146
Social Challenges	41	36	77
Total	286	220	506

Table 2

Expected frequency of biological, physical and psychosocial challenges

Expected	Vaginal Delivery	Cesarean Delivery	Total
Biological Challenges	108	83	191
Physical Challenges	52	40	92
Psychological Challenges	83	63	146
Social Challenges	44	33	77
Total	286	220	506

Table 3

Test Statistics of biological, physical and psychosocial challenges

Test Statistics	Vaginal Delivery	Cesarean Delivery
Biological Challenges	0.14	0.19
Physical Challenges	0.17	0.075
Psychological Challenges	0.01	0.01
Social Challenges	0.2	0.27

Table 4

Test Statistics - Chi-square test

Significance Level	0.05
Degree of freedom	3
Test Statistics	1.14
p value	76.74%
Critical value	7.8147

Table 4

Qualitative Analysis

Categories	Codes	Responses
Emotional and Physical Restoration	Sharing feelings Redefining normal Caring for self	"After giving birth, I began to challenge many stereotypes and redefine what is considered normal. I prioritized self-care and incorporated positive practices, such as meditation and yoga, into my daily routine to benefit both myself and my baby."
Breastfeeding	Seeking support and advice Accepting support and advice	“Breastfeeding was something that was the most challenging part during postpartum but my mother-in-law supported me a lot in this and made me aware about the process. I even seek advice from the nursing staff of the hospital. I shared my feelings with my family about this with my mother which helped me a lot.”

Balancing Roles	No defined role Equal concern for infant Support	“My partner supported me throughout the journey. He is very caring and loving. He never defined particular roles for me, instead he initiated the conversation with the hospital about how to manage the after care of the baby and the mother. I also identified what is right for me and the baby.”
Developing relationship with the infant	Quality time with the child Support from therapist Support from healthcare professionals	“For the baby blues I coped up by spending more time with my child. Initially I felt like I didn't want to carry the baby but slowly with the support of hospital staff and the therapist the blues faded away.”
Unsupportive attitudes and actions of others	Love and care for child Constant support from partner Family support	"Although lacking support can be a challenge, my constant love and care towards my child, along with the positive support I received from my partner, helped me to cope with the situation."

Table 5

Frequency distribution of content analysis

Categories	Frequency	Percentage

Emotional and Physical Restoration	10/15	66.6%
Breastfeeding	12/15	80%
Balancing Roles	8/15	53%
Developing Relationship with the baby	9/15	60%
Unsupportive attitudes/actions of others	4/15	26.6%

Discussion

The study postulated three main objectives, the first one being understanding the Biological, Physical and Psychological challenges faced by women after C-section and Vaginal Delivery. All the planning for that big day when the baby arrives makes it easy to forget about the challenging days and months after delivery. But one can't neglect the fact that after childbirth the mother goes through a tremendous change both physically and emotionally with sociological challenges as well. A child comes with its own temperament because of which the mother can sometimes totally lose control over her own routine and self-care. Both the parents can experience these challenges from getting exhausted while adapting to a demanding sleep/feed schedule to Navigating the expectations and advice of family and friends; these challenges can range from biological demands to sociological expectations. It is important to overcome these challenges because they might affect mothers' social and mental well-being causing serious postnatal disorders like postpartum depression, baby blue and postpartum psychosis.

The second objective of the study was to identify the coping strategies adopted by the females to overcome the biological, physical and psychosocial challenges. Childbirth is a significant life event that can bring about a wide range of physical, emotional, and social changes for new mothers. The postpartum period, which refers to the first few weeks after childbirth, can be particularly challenging as women navigate the transition to motherhood while also recovering from childbirth. During this time, many women may experience a variety of biopsychosocial challenges such as physical discomfort, hormonal changes, emotional distress, and social isolation. To cope with these challenges, women often adopt various strategies that can help them manage their physical and emotional health, and adjust to their new roles as mothers. The study explored the coping strategies adopted by women after childbirth to overcome biopsychosocial challenges, with a focus on the role of healthcare providers in supporting new mothers during this critical period.

Talking about the research design a mixed method research design was used which used both the quantitative technique using the chi squared statistical testing of the checklist used to identify the biological, physical and psychosocial challenges and qualitative technique using the content analysis of the semi-structured interview used to understand the coping strategies.

Table 1 provides a summary of the observed frequencies of physical, psychological, and social challenges faced by women during childbirth, categorized by the mode of delivery - Vaginal Delivery and c-section. The table also includes a total count of the observed challenges for each mode of delivery and overall. The physical challenges observed during childbirth included pain, discomfort, and fatigue. A total of 191 women experienced physical challenges during childbirth, out of which 112 delivered normally and 79 had a c-section. Body dissatisfaction refers to feelings of dissatisfaction with one's body image or physical appearance. The table shows that 92 women experienced body dissatisfaction during childbirth, with 49 delivering normally and 43 having a c-section. Psychological challenges refer to emotional and mental health difficulties such as anxiety, fear, and depression. The table indicates that 146 women experienced psychological challenges during childbirth, with 84 delivering normally and 62 having a c-section. Social challenges refer to difficulties in social interactions and relationships during childbirth. The table shows that 77 women experienced social challenges, with 41 delivering normally and 36 having a c-section. The total count of observed challenges indicates that a total of 286 women faced challenges during Vaginal Delivery , while 220 women faced challenges during c-section. Overall, a total of 506 women experienced challenges during childbirth, regardless of the mode of delivery.

Table 2 provides the expected frequencies of physical, psychological, and social challenges faced by women during childbirth, categorized by the mode of delivery – Vaginal Delivery and c-section. The table also includes a total count of the expected challenges for each mode of delivery and overall. The expected frequencies are calculated based on the assumption that there is no significant difference between the challenges faced by women during Vaginal Delivery and c-section. The physical challenges expected during childbirth included pain, discomfort, and fatigue. The expected frequency for physical challenges during childbirth is 191, with 108 expected for Vaginal Delivery and 83 expected for c-section. Body dissatisfaction refers to feelings of dissatisfaction with one's body image or physical appearance. The expected frequency for body dissatisfaction during childbirth is 92, with 52 expected for Vaginal Delivery and 40 expected for c-section. Psychological challenges refer to emotional and mental health difficulties such as anxiety, fear, and depression. The expected frequency for psychological challenges during childbirth is 146, with 83 expected for Vaginal Delivery and 63 expected for c-section. Social challenges refer to difficulties in social interactions and relationships during childbirth. The expected frequency for social challenges during childbirth is 77, with 44 expected for Vaginal Delivery and 33 expected for c-section. The total count of expected challenges indicates that 286 women are expected to face challenges during Vaginal Delivery , while 220 women are expected to face challenges during c-section. Overall, a total of 506 women are expected to experience challenges during childbirth, regardless of the mode of delivery.

Table 3 provides the test statistics for physical, psychological, and social challenges faced by women during childbirth, categorized by the mode of delivery - Vaginal Delivery and c-section. The test statistics are used to determine whether there is a statistically significant

difference between the challenges faced by women during Vaginal Delivery and c-section. The test statistics used in this table are chi-square test statistic measures. For physical challenges, the test statistic is 0.14 for Vaginal Delivery and 0.19 for c-section, indicating that there is no significant difference in physical challenges faced by women during Vaginal Delivery and c-section. For body dissatisfaction, the test statistic is 0.17 for Vaginal Delivery and 0.075 for c-section, indicating that there is no significant difference in body dissatisfaction faced by women during Vaginal Delivery and c-section. For psychological challenges, the test statistic is 0.01 for both Vaginal Delivery and c-section, indicating that there is no significant difference in psychological challenges faced by women during Vaginal Delivery and c-section. For social challenges, the test statistic is 0.2 for Vaginal Delivery and 0.27 for c-section, indicating that there is no significant difference in social challenges faced by women during Vaginal Delivery and c-section. Overall, the test statistics suggest that there is no statistically significant difference between the challenges faced by women during Vaginal Delivery and Cesarean Delivery in the categories of physical, body dissatisfaction, psychological, and social challenges.

Table 4 provides the results of a chi-square test, with a significance level of 0.05 and 3 degrees of freedom. The test statistic obtained is 1.14, and the p-value is 76.74%. The critical value for the test is 7.8147. The table indicates that there is no significant difference between the observed and expected frequencies, as the p-value is greater than the significance level. Therefore, we fail to reject the null hypothesis, which states that there is no significant difference between the observed and expected frequencies.

Table 4 shows the content analysis of the semi structured interview done to understand the coping strategies. Inductive content analysis was used to analyze the findings. Waltz, Strickland and Lenz's (1991) steps of content analysis were utilized, as well as Maxwell's and Maxwell's (1980) steps of continuous comparative analysis. Inductive content analysis permitted concepts to be derived from the feelings, emotions and personal experiences described by the participants (Waltz, Strickland, & Lenz, 1991). Five concern related concepts emerged: Emotional and Physical Restoration, Breastfeeding, Balancing Roles, Developing relationship with baby and Unsupportive attitudes/actions of others.

The mothers used a variety of coping strategies to deal with their concerns. Eight coping strategies emerged from the analysis. They were: seeking support/advice, accepting support/advice, caring for self, redefining normal, identifying what was right for self, utilizing/modifying former coping strategies, encouraging/accepting partner's involvement, and sharing feelings. The women sought partners, family and friends most often for support and advice. Health care professionals such as CHNS, physicians and lactation consultants were also utilized for specific types of support.

The women in this study used a variety of coping strategies to deal with their concerns throughout the early postpartum period. As stated previously, the 8 coping strategies were: seeking support/advice, caring for self, accepting support/advice, redefining normal, identifying what was right for self, utilizing former coping strategies, encouraging partner's involvement, and sharing feelings. Seeking support/advice, sharing feelings, caring for self,

and accepting support/advice were the coping strategies which emerged most often. Some strategies were used across most of the concern-related concepts while others were only used for specific concerns. For example, seeking support/advice was the most widely utilized coping strategy. It was used to deal with breastfeeding, balancing roles, developing relationships with babies, and unsupportive attitudes/advice of others.

A number of strategies were used across maternal concerns but were not the primary coping strategy. Sharing feelings was a widely utilized coping strategy and permitted the women to address breastfeeding, balancing roles, and developing a relationship with the baby. Caring for self was used often to deal with becoming a mother, emotional and physical restoration, and balancing roles. Accepting support/advice was used to deal with breastfeeding, developing a relationship with a baby, and unsupportive attitudes/actions of others. Redefining normal and identifying what was right for self were used to deal with fewer concerns. Redefining normal addressed becoming a mother, and emotional and physical restoration. Identifying what was right for self helped women to manage balancing roles, and unsupportive attitudes/actions of others. Finally new mothers utilized/modified former coping strategies and encouraged/accepted their partner's involvement only to deal with balancing roles.

The concern-related concept, balancing roles, required the greatest number of coping strategies. This is not surprising considering that balancing roles was the most talked about concern by the new mothers and most often the first mentioned concern during the interviews. This suggests that balancing roles was a very difficult concern to resolve and that for many of the women it was an ongoing issue. Becoming a mother also required the use of a number of coping strategies. Again it was a concern that was discussed at great length and with much intensity by the women.

The women of this study found that positive attitudes and support from significant others were beneficial. This study went beyond other studies to determine exactly who the women choose for support and under what conditions. For example, the women would seek support from health care professionals for solutions to breastfeeding sequelae but would not go to them for support for negative emotional reactions to breastfeeding. Studies by Crorenwett and Wandersman (1980), and Wandersman and Kahn (1980) indicated that social support may lessen the impact of the crisis component in adjusting to a new baby. In a literature review by Koniak-Griffin (1993) a variety of other researchers have also concluded that "the availability of positively perceived informal and formal support systems are essential for successful maternal role transition and the development of confidence in parenting during the prenatal and postnatal periods".

The women studied here also reported that partners were their first and most utilized source of support. Spouses in this study were used for physical support such as sharing household tasks, psychological support such as dealing with others who disagreed with parenting styles, and emotional support such as sharing negative feelings toward breastfeeding. Majewski (1987) studied social support and the transition to the maternal role by examining the most supportive individuals for first time mothers from a physical,

psychological and emotional perspective. The study concluded that "while extended family members were identified as supportive, spouses were overwhelmingly the major source of support for first time mothers" . However, spouses provided more physical support than emotional support.

One of the limitations of this project was the small or limited sample size. A larger sample size is often preferable to ensure the generalizability of the study results to a larger population. With a larger sample size, it would be possible to obtain a more representative sample, thus increasing the accuracy and reliability of the study findings. Another limitation of this project was that only a limited number of variables were studied due to time constraints. As the biopsychosocial challenges faced by women during the postpartum period are multifaceted and complex, there are numerous variables that could be investigated. However, due to the limitations of time and resources, only a limited number of variables could be included in this study.

For future studies, it is recommended to consider collecting data from a larger sample size to increase the representativeness of the sample and enhance the generalizability of the study findings. Additionally, it would be beneficial to investigate a broader range of variables to gain a more comprehensive understanding of the biopsychosocial challenges faced by women during the postpartum period. This would allow for a more detailed and nuanced analysis of the factors that impact the postpartum experience and inform the development of effective interventions and support programs for women during this critical period.

Conclusion

It was concluded that there was no significant difference between the Biological, Physical and Psychosocial challenges of Vaginal Delivery and Cesarean Delivery. For the majority of coping strategies, the women had to depend only on themselves. Redefining normal, caring for self, utilizing/modifying former coping strategies, identifying what was right for self, and encouraging/accepting partner's involvement were coping strategies that the women developed on their own. Sharing feelings, seeking support/advice, and accepting support/advice required the women to involve others into their coping. Many of the coping strategies that the women used by themselves were used in conjunction with coping strategies that involved others. The coping strategies that involved utilizing others were the most often used and first used coping strategies.

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