DISCREPANCIES BETWEEN CHILDBEARING EXPECTATIONS AND THE PERCEPTION OF THE ACTUAL EXPERIENCE OF THE MATURE PRIMIPARA

by

Margaret Gander

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DISCREPANCIES BETWEEN CHILDBEARING EXPECTATIONS AND THE PERCEPTION OF THE ACTUAL EXPERIENCE OF THE MATURE PRIMIPARA

by

MARGARET GANDER

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

ABSTRACT

A number of studies suggest that the mature primipara has high expectations of herself in the mothering role. She also may have anxieties about the physiological and psychosocial consequences of childbearing. Little is known, however, about the childbearing experience of mature primiparas or of the congruence between their expectations and perceptions of the experience. How well a woman's childbearing expectations match her perception of the experience has been reported to have impact on her ability to view childbearing as a positive experience and her ability to take on the mothering role.

The purpose of this study was to explore and describe the childbearing experience of the mature primipara, with specific focus on maternal childbearing expectations and on discrepancies between expectations and the perceived experience of this population.

The study sample consisted of nine primiparas who ranged in age from 35 to 42 years. Data were gathered through unstructured interviews conducted between two and six months following the birth of the baby. A qualitative, grounded theory approach was used in the collection and analysis of data. Childbearing as a bittersweet experience was identified as the core category, that is, the theme central to the experience of delayed childbearing. Childbearing as a bittersweet experience was identified as the perception held by mature primiparous women that there were more negative aspects to their childbearing experience than they had expected, and that these negative aspects offset the positive aspects or gratifications of childbirth they had anticipated. For all women in the study, the experience was less positive than anticipated. Antecedents, or factors that seemed to contribute to the perception of childbirth as a bittersweet experience, action/interaction strategies and intervening conditions that modulated the experience, and consequences of the negative aspects of the experience were identified as they related to the core category. The consequences for these subjects of holding bittersweet perceptions ranged from postpartum depression, to feelings of loss of control, disappointment, dissatisfaction, anger, and guilt. The findings suggest that the type and quality of health care offered to the mature primipara should be examined. Prenatal preparation and postpartum services tailored to the needs of the mature primipara would do much to improve the childbearing experience of this age group and would help to ensure that their childbearing expectations are realistic.

ACKNOWLEDGEMENTS

This thesis is dedicated in loving memory of V. N. Round whose encouragement and unfailing love provided me with the courage to pursue my dream. Thank you Dad!

To my family, thank you for your patience and understanding throughout this project. I know that a lot of sacrifices have been made along the way and I thank you for not trading me in for a new mother.

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CHAPTER I

Statement of the Problem

This descriptive study was designed to explore and describe the childbearing experience of mature primiparous women. Using a grounded theory methodology, childbearing expectations, perception of the actual experience, and discrepancy between expectations and perception were examined.

Background to the Study

Pregnancy and the birth of a child are events that typically evoke images of happiness and fulfilment. However, personal observations during postnatal visits to primiparous women in their thirties suggested that this group of women tended to have more difficulties in postpartum adjustment than younger women. It seemed that these women expressed feelings of isolation, loneliness, and frustration to a greater extent than their younger counterparts. Consultation with colleagues indicated that similar observations had been made by other health care professionals regarding postpartum adjustment in this age group. This phenomenon was particularly evocative because these women, for the most part, had decided to delay childbearing until they felt better prepared for motherhood; they were well educated and well read, had supportive marital relationships, and were financially secure. Many of them had experience with skilled, responsible, and prestigious occupations.

According to Strauss and Corbin (1990), professional experience such as the above observation of mature primiparous women may be a source of theoretical sensitivity: "The

more professional experience, the richer the knowledge base and insight available to draw upon in the research" (Strauss & Corbin, 1990, p.42). Theoretical sensitivity, as derived from clinical experience, enables the researcher to formulate theory that is faithful to the reality of the phenomena under study (Strauss & Corbin, 1990). The clinical observations of postpartum adjustment in the older primipara provided sensitivity to a departure from the typical perception of motherhood. Through this sensitivity, it was recognized that older primiparas are a unique population and that their experience should be examined to provide a more complete and comprehensive view of women's response to pregnancy and childbirth.

Delayed Childbearing

A review of the literature conveyed some confusion about what constitutes delayed childbearing. As result of varying definitions of delayed or postponed childbearing, comparison of the findings of one study with another is problematic. Some authors have selected an arbitrary age, after which the primipara is considered elderly. Bloom (1984) identified four definitions of delayed childbearing: 1) the period of time which married women avoid childbirth; 2) the avoidance of childbirth by post-pubescent women; 3) the age at which currently married or ever-married women bear their first child; and 4) the tendency of one group or cohort of women to initiate childbearing at a later age than another group or cohort of women.

From a medical perspective, a primipara over the age of 35 years has been considered "high risk" (Morrison, 1975). Women in this age group have been reported to

be at risk for a number of physiological problems during the perinatal period. These include infertility, pregnancy complications, longer labors, and increased use of medical interventions during delivery. Their infants have been shown to be at increased risk for major chromosomal anomalies, a risk that increases with the age of the mother. Some studies have demonstrated that the mature primipara is at risk for a difficult adjustment to the parenting role. Thus it was anticipated that risks associated with delayed childbearing would be central to women's expectations and perceptions of their experience.

For the purposes of this study, therefore, primiparas thirty-five years of age or older were considered to have delayed childbearing. This definition has the added advantage that it does not rely on the time of marriage or the age at which the woman reached puberty.

Significance of the Study

The importance of understanding the childbearing experience of women who delay childbearing is underlined by the increasing numbers of women who fall into this category. An increased tendency for women of "the 80's" to postpone childbearing is well documented in the literature (Baldwin & Nord, 1984; DeVore, 1983; Pickens, 1982; Ventura, 1982; Woods, 1978). Baldwin and Nord (1984) reported that first births among women aged 30 to 35 more than tripled from 1970 to 1982. Wilkie (1981) reported a childless rate of 60 percent among professional women at the age of 28. In Canada, in 1983, 2.6 percent of all first time births were among women 35 years and older, as

compared to 1973, when only 1.5 per cent of live births occurred in this age group. This represents a 68 percent increase in the past eleven years in the number of women who postponed childbearing until at least their 35th birthday (Winslow, 1987).

One of the reasons for this increase in age at first birth is that those who were born during the baby boom are just now having children (Pebley, 1981). Baldwin and Nord (1984) and Pebley (1981) suggested that the fact that these older parents have had to work harder and wait longer for financial security may very well be a factor in delayed childbearing. Women also have many more options open to them which compete with childbearing and couples have control over the initiation of childbearing with the availability of reliable methods of contraception (Baldwin & Nord, 1984; Hofferth, 1984; Pebley, 1981). Employment outside the home has become more acceptable (Pebley, 1981), so that women now expect to work until they retire with only brief interruptions for childbearing.

A review of the literature revealed a paucity of research regarding the childbearing experience of the older primiparous woman. What did emerge from the review was a fairly clear profile of the older primipara. Women who delay childbearing are generally well established professionally and secure economically (Hofferth, 1984). Women delay childbearing to complete a "preparental" agenda which includes career, education, personal growth, and economic security (Mansfield, 1986). This profile closely matched clinical observations.

Education has been associated with both the delay of marriage and childbearing (Baldwin & Nord, 1984). A greater investment in education has given women the

opportunity to acquire better paying, more prestigious jobs (Baldwin & Nord, 1984). Education may impart new values, change aspirations, and create new skills which motivate the individual to try other options before settling into parenthood. Wilkie (1981) reports that the proportion of women having first births at older ages increases directly with schooling so that over 80 percent of first births to women with four or more years of college are at age 25 or older, and 20 percent are at age 30 or older.

Bloom (1984) summarized the following individual, demographic, economic, and social factors which he found to be associated with delayed childbearing: lower total fertility, longer intervals between births, greater marital stability, greater health risks related to pregnancy, higher wages, higher probabilities of working, employment in higher - status occupations, greater asset accumulation, more consumption of luxury items, costlier child care and education for children, and increased geographic mobility.

It is evident from this profile that the older primiparous woman has many unique characteristics that may result in a childbearing experience that differs substantially from that of younger women. Older primiparous women are for the most part a well read and well educated group and they tend to be keenly aware of the risks that accompany delayed childbearing. This raises questions about the expectations which this group of women might have regarding their childbearing experience and how their actual experience might differ from their expectations. It also raises questions regarding the consequences for the mature primipara should there be discrepancies between her expectations and her perception of her childbearing experience.

A review of the literature thus confirmed a trend toward postponing childbearing

and a profile was developed which closely compared to that which had been observed in clinical practice. It also established that these women may be physiologically and psycho-emotionally at risk, and that their expectations and childbirth experience may differ from that of other childbearing women. Little research was found that described the experience of women who delayed childbearing, and none was reported on the congruence between expectations and perception of the birth experience among mature primiparas.

Statement of Purpose

The purpose of this study, therefore, was to explore and describe the childbearing experience of the mature primipara, with specific focus on maternal childbearing expectations as well as the discrepancies between the expectations and the perceived experience of this population.

Research Questions

The following research questions guided the study:

a) What is the childbearing experience of the mature primiparous woman?

b) What are the expectations that mature primiparous women have for their childbearing experience?

c) To what extent are the expectations of mature primiparous women and their perception of their actual experience congruent?

d) What are the consequences for mature primiparous women should discrepancies exist between childbearing expectations and the perception of the actual experience?

In the following chapter, literature that pertains to delayed childbearing is explored to identify guidelines for approaching the phenomena and to provide a general organizational framework for the study.

CHAPTER II

Review of the Literature

Strauss and Corbin (1990) suggest that exploring technical literature stimulates theoretical sensitivity by providing concepts and relationships that can be examined against actual data. They define technical literature as reports of research studies and theoretical or philosophical papers characteristic of professional and disciplinary writing. It is not the intent of the researcher who is using grounded theory methodology to enter the field with a complete list of concepts and relationships, but rather to be aware of those that appear to be significant and to bring them to the field to see whether they apply to the situation that is being studied and what form they take there (Strauss & Corbin, 1990).

A review of technical literature therefore was undertaken to stimulate theoretical sensitivity. Some key concepts and relationships associated with delayed childbearing were identified. This review focuses on maternal physiological and emotional risks associated with delayed childbearing, physiological risks to the infant, and ability to take on the parenting role. As well, the impact of these factors on the expectations of women who delay childbearing until after age thirty-five and on the perceptions they have of their childbearing experience are examined.

Maternal Physiological Risks

Many physiological concerns associated with delayed childbearing were reported in the literature. These included maternal hypertension, maternal diabetes, placenta previa, placenta abruptio, postpartum hemorrhage, longer labor, and increased incidence of

forceps delivery (DeVore, 1983; Merlin, 1987; Morrison, 1975; Woods, 1987). Daniels and Weingarten (1979) reported that the risk of early spontaneous abortion and fetal loss increase with maternal age as does the likelihood of toxemia and hemorrhage. The risk of death in childbirth rises slowly in the early thirties and steeply after age thirty-five (Daniels & Weingarten, 1979).

An increased probability of cesarian delivery has been reported among older first time mothers. Older women are more likely to have uterine fibroids which are associated with miscarriage and cesarian birth (Daniels & Weingarten, 1979; Kitzinger, 1982; Merlin, 1987). Daniels and Weingarten (1979) suggested that the slight increase in dysfunctional labor and complications of delivery may be iatrogenic in that obstetricians may treat their older patients more cautiously than younger women during pregnancy, labor, and delivery. Daniels and Weingarten (1979) reported, for example, that "women 35 years and over were five times more likely than younger women to be delivered by cesarian section, even though in two out of three cases the indications for a cesarian delivery were doubtful" (p.16). There is some evidence that heavy sedation is often administered to the older patient, increasing the chance of a dysfunctional labor and of cesarian delivery (Daniels & Weingarten, 1979; Mansfield, 1986). Studies reported by Mansfield and Cohn (1986) suggested a 25 percent higher obstetrical risk for older women. However, these statistics indicated only an increased probability for delivery by cesarian section. Physicians may prefer cesarian deliveries for older women to safeguard the baby or to avoid anticipated complications (Mansfield, 1986; Mansfield & Cohn, 1986). Morrison (1975) conducted a five year review of births to primigravidas (1968-

1972). The control group, made up of a random selection of primigravidas under 35 years, had a three percent incidence of lower segment cesarian sections compared with a incidence of 31 percent for the experimental group, which was comprised of primiparas who were 35 years or older.

Knowledge of these childbearing risks and the perception of herself as "at risk" would conceivably have impact on the expectations which the over thirty-five year old woman might have regarding her own childbearing experience.

Risks to the Infant

The physiological risks to the mother are further complicated by increased risks to the infant. The incidence of fraternal twinning reportedly peaks among women 35 to 39 years of age (Baldwin & Nord, 1984; Daniels & Weingarten, 1979). Multiple births are associated with a higher incidence of birthing complications. Daniels and Weingarten (1979) noted that infant death rates decrease and remain fairly constant for women in their 20s and 30s and then rise again for women over the age of 40. However, when indicators of medical risk were considered, the rise in infant deaths was associated to a larger extent with social class than with age.

Women over 35 years have an increased chance of giving birth to a child with congenital anomalies (Baldwin & Nord, 1984; Daniels & Weingarten, 1979; Kitzinger, 1982; Merlin, 1987; Woods, 1987). The chances of having a child with Down's Syndrome rises from 1 in 1000 at age thirty to 1 in 100 at age forty (Merlin, 1987). In addition, advanced paternal age has been implicated as an independent causal factor in fresh gene

mutation that produces a number of dominantly inherited disorders including Down's syndrome (Baldwin & Nord, 1984; Daniels & Weingarten, 1979).

Women who delay childbearing tend to be well read and aware. The perception that increased risks are involved in childbearing over the age of thirty-five might well cause them concern regarding the health and well being of their infant.

The Impact of Maternal Health Status on Pregnancy/Fetal Outcome

The above studies indicated that there are physiological risks to both mother and infant as result of delaying childbearing. However, some studies demonstrated that it is the health status of the woman that is the most important factor in predicting good obstetrical and fetal outcome for older mothers (Baldwin & Nord, 1984: DeVore, 1983; Woods, 1987). Daniels and Weingarten (1979) pointed out that age is an inexact measure of physical health and well-being. There are numerous factors involved which make it difficult to distinguish the role of general health from that of age. These factors include the number and spacing of previous pregnancies, mother's genetic disposition, medical history, hygiene, nutrition, obstetrical care, as well as socioeconomic circumstances.

Although statistics show that older mothers have a slight increase in numbers of stillbirths, premature births, and low birth weight babies, the impact of controlling for previous medical conditions or inadequate nutrition on these statistics is unclear (DeVore, 1983). Kirz, Dorchester, and Freeman (1985) and Mansfield (1986) agreed that the contribution of maternal age is decreased considerably when certain confounding variables are controlled in studies.

Mansfield (1986) conducted a review of studies concerning pregnancy outcomes. In one study, the slow second-stage labor observed in the over - 35 age group was entirely accounted for by the excessive amounts of sedatives given to these women. In another study, the increased rate of fetal deaths disappeared entirely when women with elevated blood pressure were removed from the study group.

Daniels and Weingarten (1979) suggested that some complications exist which are not essentially related to a pregnancy. Many more deaths occur from all causes to people in their 40s than to those in their 20s. Superimposed medical conditions may compound the usual risks faced in pregnancy. Therefore, it is often difficult to distinguish the role of general health from that of age. For example, diabetes multiplies fourfold the risk of toxemia of pregnancy, as well as the frequency and severity of infection, the probability of delivery by cesarian section, and the likelihood of postpartum hemorrhage.

Mansfield (1986) stated that studies which involve older mothers do not consider the following: 1) older women tend to have more chronic diseases which are known to predict pregnancy complications; 2) the "special" care afforded to these older women can result in iatrogenically-induced complications; 3) the cohorts of older primiparas have frequently been involuntarily childless and thus have been a self-selected group of complication prone older women; and 4) the older sample has often included high parity births. The latter may have been unplanned pregnancies to women of lower socio-economic status, a scenario that is predictive of complications of pregnancy.

Mansfield (1986) concluded that there is little concrete evidence to support the drastic morphological changes at age thirty-five that would be required to produce a major

decrease in reproductive efficiency. Kirz, Dorchester and Freeman (1985) suggested, in fact, that because women who postpone childbearing are generally well informed and well educated, they are likely to monitor their health and adopt healthy lifestyle practices, thus enhancing pregnancy outcome.

It is difficult to reach any conclusions regarding the impact of age on reproductive efficiency and pregnancy outcome based on the review of the literature. For the purposes of this study, it was important to determine how the women themselves perceive childbearing after age thirty-five, and whether they perceive themselves to be at increased risk because of age.

Infertility

Menkin (1985) defined infertility as reduced ability to conceive and bear a live child. Factors such as sexually transmitted disease, pelvic inflammatory disease, and the use of intrauterine devices have been associated with secondary infertility and may be more prevalent in the older population simply because of more years of exposure to sexual activity (Menkin, 1985). Daniels and Weingarten (1979) agreed that infection, endometriosis, and fibroid cysts are the leading causes of infertility in women, however, women who use the intrauterine device or oral contraception do not appear to suffer long term infertility problems which are directly traceable to their previous method of contraception.

A great deal of controversy exists regarding the relationship between fertility and age. Hendershot, Mosher, and Pratt (1982) concluded that women who postpone child-

bearing until they are in their thirties do face an increased risk that they will not be able to conceive. In contrast, Bongaarts (1982) did not accept what he considered to be a gross overestimation of the true magnitude of permanent infertility, as well as its increase with age in the general population.

Wood (1987), after studying the controversy, concluded that fertility declines with age "to some extent" (p.22). However, Baldwin and Nord (1984) proposed that there should be no problem conceiving if the woman is in good health and free from fertility impairments which can occur at any age.

Daniels and Weingarten (1979) pointed to a new problem which occurs in couples who have been effectively contraceptive throughout most of their adult lives. These couples often find it difficult to break the contraceptive habit and make a conscientious decision to become pregnant. Therefore, the experience of making a decision to bear a child and possible difficulties in becoming pregnant were explored in the present study.

Motivation for Pregnancy

Lederman (1984) indicated that the motivation for pregnancy may not be "motherhood" but rather the fear of becoming too old to have children; the fear of missing a major female experience. Many investigators concluded that women may plan a pregnancy for fear of waiting beyond their "biological boundary" (DeVore, 1983; Kitzinger, 1982; Mansfield & Cohn, 1986; Woods, 1987).

Flapan (1969, p.408) suggested that the motivation for pregnancy is associated with an awareness of the "social expectations of childbearing and the disapprobation of

childlessness". Childless couples can be made to feel guilty, selfish, and inadequate (DeVore, 1983; Flapan, 1969; Houghton & Houghton, 1984; McBride, 1973).

How a woman views her own mother is important to the childbearing decision (Breen, 1975; Flapan, 1969; Lederman, 1984; McBride, 1973; Mercer, 1985; Rubin, 1984). Women may choose the traditional role of homemaker and childrearer (Boulton, 1983; Kitzinger, 1982), or, may choose "to seek personal identity outside of the traditional role" (Killien, 1987, P.121). Swanson-Kauffman (1987) expressed concern that motherhood may be seen by some women as less desirable than the pursuit of a career. Those who choose motherhood may be seen as having "sold themselves short to a role stereotype that legitimizes the social inferiority of women" (Kitzinger, 1982, p.92,). Conflict arises because women of the 80s are encouraged to "have it all" (Killien, 1987, P.121).

Baldwin and Nord (1984) described new attitudes among both women and men concerning marriage, the family, and women in the work force. These attitudes, as well as changing sexual and childbearing norms, have had an impact on the timing of first births. Killien (1987) examined the relationship between career commitment and childbearing intentions and behaviors of professional women. The women who were ambivalent about ultimate parenthood goals were those with the highest career commitment. For these women, "the childbearing decision could become overbearing and could interfere with other goals" (Killien, 1987, p.130).

Fear of producing a baby with chromosomal anomaly may have been a reason to ignore the call for motherhood at one time. However, Roghmann and Doherty (1983)

found that "25 percent of 35-39 year olds and 12.8 percent of 40-45 year olds indicated an increased willingness to have children if they were reassured that their baby had none of the birth defects detectable by amniocentesis" (p.760).

Impact of Maternal Illness on Pregnancy Outcome

Mercer (1977) noted that maternal illness during pregnancy or birth may affect a woman's self-esteem and be a drain on energy that would otherwise be available for mothering. Kitzinger (1982) maintained that some of the risks are complicated by anxiety conveyed to the patient because of "too much doctoring" (p.82). Mansfield and Cohn (1986) claimed that older mothers-to-be not only "share the concerns of their younger counterparts, but experience additional stress from believing that, because of their advanced age, both they and their babies are at high risk" (p.137). This stress can in itself "predispose the expectant mother to various pregnancy and birth complications" (Mansfield & Cohn, 1986, p. 146). Galloway (1976) described the anxiety caused by the diagnosis of a "high risk pregnancy". She suggested that a woman may have difficulty accepting herself as a high-risk mother, and may have fears regarding the outcome of the pregnancy and the normalcy of her child.

Improved techniques of prenatal diagnosis can detect fetal abnormalities, so that decisions can be made early in the pregnancy regarding the outcome. However, even with amniocentesis, the elderly primipara may have concerns regarding the health and welfare of her baby (Kitzinger, 1982; Mansfield & Cohn, 1986).

Gratification, Role Attainment, and Self Esteem

Mercer (1985) studied maternal role attainment among women who were grouped according to age: 15-19 years (n=66); 20-29 years (n=138); and 30-42 years (n=90). All had delivered their first normal live-born infant at 37 or more weeks gestation. Mercer measured self-image, role strain, time of internalization of the maternal role, as well as challenges or demands on the woman's talents and resources. Measurements were made at one month, four months, eight months, and twelve months following the birth of the baby. Mercer (1985) reported that the women over 30 years of age scored significantly less positively in the category "gratification in the maternal role" than either of the younger groups at each test period. The most frequently mentioned challenge was that of not having any personal time. Feelings of incompetency were reported more often by the over-thirty group than by the teenage group at one month and again at twelve months. Mercer (1984) found that the older mother was more adaptable and her maternal behaviour more positive when handling irritating child behaviour than the younger groups.

Motherhood did not enhance self-concept in the majority of women in the study. In fact, 64 percent of the sample experienced a decrease in total positive self-concept (Mercer, 1986). Mercer reported, however, that "motherhood appeared to cause greater internal change and decreased adaptability" (p. 31) in the 30+ group. These women experienced a 51.8 percent decrease in personality integration and a 67.8 percent decrease in self-concept at eight months post-delivery. Mercer (1986) concluded that the older woman is able to achieve competency in maternal behavior, but the intrapersonal price appears to be higher than for younger women.

In a number of studies, higher socioeconomic status and level of education tended to be associated with more positive maternal behaviour, but were negatively associated with gratification in the mothering role. The higher the socioeconomic status, the more adaptable the maternal behaviour and the more positive the approach to handling irritating child behaviour (Mercer, 1986). Boulton (1983) found that middle-class women not only saw motherhood as exclusive responsibility for children, but felt that motherhood inhibited their personal freedom and autonomy so that their identity as individuals was replaced by an identity as mothers. Boulton (1983) also found that middle class women from professional and higher secretarial occupations were more likely to assess themselves as discontented with having children, and that women with previous experience with skilled, responsible, and prestigious occupations were much more critical of their situation than women who lacked this experience.

Russell (1974) reported that highly educated parents experience more of a crisis during transition to parenthood and enjoy the parenting role less than parents with less education. DeVore (1983) referred to the "baby shock" experienced by older first time parents. Kitzinger (1982) suggested that women in their thirties have a "heightened awareness of problems and are perhaps taking the whole experience seriously as a commitment and responsibility" (p.104). These problems, according to Kitzinger (1982), include feeling utterly incompetent and anxious; feeling socially isolated and drained of strength; watching her "well-ordered life turn into chaos"; experiencing major conflict between motherhood and career goals; losing independence, freedom and prestige. McBride (1973) suggested that many of the frustrations, anxieties, and dilemmas of being

a mother are due to the notion that a baby is supposed to be a woman's ultimate fulfilment. As Boulton (1983) stated, "a sense of meaning and purpose does not come automatically or inevitably in motherhood" (p.119). Mercer (1981) observed that older women often move from well-established routines to the very unpredictable context created by an infant, and have higher expectations for themselves as mothers. As result, early transition into the role can be hampered.

Decreased personality integration among older first-time mothers was also recognized by Pickens (1983). Five career-oriented women who had recently delivered healthy infants were interviewed at 13 to 26 days postpartum and again at 16 to 17 weeks postpartum (Pickens, 1983). The investigator was able to identify six different clusters of behaviour that these women used to help them in identity reformulation. The following "cognitive processes" were identified.

1. **Reviewing**. This was a defining of selves in the past. It served to anchor the women at a time when they were not certain who they were.
2. **Projecting**. This was a defining for themselves what it might be like in the maternal role or how it would be for them in combining the maternal and career roles. This gave them a sense of the ideal and therefore a goal to attain.
3. **Planning**. This was an attempt to coordinate the present with the future so as to construct a more manageable situation. These women had been planners and organizers and used these skills in an attempt to maintain control.
4. **Cost accounting**. This was a process of considering the costs and rewards of mothering. At initial interviews there were more costs than rewards. This tended

to reverse itself at the second interview.

5. **Weighing**. This was the considering of the demand placed on oneself by two things which are both good and which exist simultaneously. This presented a "no-win" situation as they tried to choose one role over the other. The question was whether they could successfully combine the two.

6. **Assessing**. This process involved appraisal of knowledge and performance in the mothering role. These women initially assessed themselves as being less than adequate mothers. They tended to seek out evidence that they were achieving in their new job (much like the performance appraisal at work or the increment based on merit). There was a need to care for their infants correctly (Pickens, 1983, p.142).

Pickens concluded that the women were experiencing an "identity crisis" and, in order to restore a state of equilibrium, they used these six cognitive processes. However, by four months the women seemed to view themselves more positively in the maternal role. They had all returned to the work force. Their boundaries of self were formulating again.

In a study conducted by Frankel (1982), older parents planned for their child, used support groups extensively, were more accepting of the parenting role, and had less conflict regarding balancing their career and parenting roles. They may have the psychological advantage of having come to grips with their own identity and, therefore, be better equipped to handle childbearing (DeVore, 1983).

DeVore (1983) and Frankel (1982) pointed to a number of disadvantages to being

an older first-time mother. Older women have less energy to cope with the demands of caring for a child. They may become more aware of their age and may be taken for the child's grandparent. Older women lack the freedom to space their children, lack a close relationship with grandparents, and have been accused of being overly anxious about their children, lavishing on them too much love and attention (Frankel, 1982).

Indeed, Fox (1982) suggested that because of a scarcity of children (fewer children per family), there may be a loading of importance on each child. McBride (1973) agrees that there is a tremendous pressure to view the baby as exceptional, special, and out-of-the-ordinary.

Role Strain

When the older woman takes on the role of mother, it is often in addition to her existing multiple roles of wife, daughter, employee, and co-worker. Hirsch and Rapkin (1986) suggested that such multiple roles can cause role overload, interrole conflict, and role strain. On the other hand, multiple roles can result in personal growth, greater coping flexibility, and increased autonomy. Hirsch and Rapkin (1986) claimed that what seems to be relevant is the perceived quality of the role and the response of the social network members. In addition, Hirsch and Rapkin (1986) reported that spousal support is critical if women are to manage multiple roles.

Menkin (1985) examined the demographics of delayed childbearing. She found that "postponing childbearing increases the duration of simultaneous responsibility" of women "to young children and elderly parents" (p.48). These women have an unusually

high dose of responsibility (Menkin, 1985). Menkin (1985) suggested that because of better health care, the length of time that an older person experiences a disability and requires assistance has been lengthened. The burden on adult children has increased and these children may themselves be older when this obligation begins. Women have taken on increased responsibility in the work place yet still tend to take primary responsibility for child and household care. They have the responsibility in many cases of being primary caregivers to elderly relatives, their own offspring, and their husbands. Postponing childbearing increases the duration of simultaneous responsibility to young children and elderly parents, possibly creating overload when added to career or job demands.

Baldwin and Nord (1984) reported that older working mothers are the least likely to rely on grandparents or other relatives to provide child care, and therefore are more likely to rely on day-care facilities. The responsibility for provision of child care remains with the individual family and primarily with the mother. Baldwin and Nord (1984) explained that older parents may have to cope simultaneously with the costs of parents' nursing homes and children's college expenses and may never be able to call on their own parents for support or guidance regarding childrearing.

Support and Perinatal Satisfaction

The benefits of marital support through the perinatal period are well documented (Brown, 1986). Marital support contributes to overall satisfaction with pregnancy and less stress for both partners. It is a predictor of the woman's psychological adaptation during the perinatal period, and is associated with a lower incidence of perinatal depression.

Women who receive marital support are the calmest group in the hospital, experiencing fewer complications. Marital support is associated with men's more positive approach to fathering. The closer the marital relationship, the more likely the male is to experience the pregnancy vicariously, establishing an attachment relationship with the fetus before birth.

Tietzen and Bradley (1985) found that spousal support was more closely related to women's psychosocial adjustment than was support from other network members. In their study, it was found that network support was associated with negative attitudes toward pregnancy. Women who reported increased levels of satisfaction with the support received from their network members at three months postpartum also experienced increased levels of stress.

Majewski (1987) studied the role of social support in assisting women to adjust to the maternal role. Where the spouse was identified as most supportive, the mother of the newborn had less difficulty in making the transition to motherhood, compared to the group who identified non-immediate family members as most supportive. Mothers who attended a support group had significantly more difficulty with the transition to parenthood than those who did not.

Marital support among delayed childbearers has not been well researched. When Mercer (1986) examined predictors of maternal role attainment at one year post-birth, none of the support variables which she looked at (size of network, and emotional, informational, and physical support) were found to predict maternal role attainment. Marital support among women who delay childbearing was considered important to

examine in this study because of indications that marital support influences perceptions of the childbearing experience.

Impact of Childbearing on the Marital Relationship

Boulton (1983), McBride (1983), Kitzinger (1982), and Humenick and Bugen (1987) reported conflict arising in the marital relationship regarding expected parental roles and responsibilities. Boulton (1983) found that among the middle class women, children were, in fact, seen as a threat to a sense of sharing and equality between husband and wife. Children were seen to disrupt activities and to impose demands on the mother that were not experienced by the father (Boulton, 1983).

McBride (1983) studied the differences in women's and men's thinking about parent-child interactions using attribution theory. She demonstrated that men and women have quite different perspectives which could lead to regular disagreement regarding childrearing. This was supported in a study by Humenick and Bugen (1987) that indicated middle class fathers and mothers differ "not only in initial parenting roles, but also in how closely their expected role coincides with the one they actually adopt during their infant's first weeks" (p.38). Middle class husbands tend to see their main responsibility as outside the home, as breadwinners, and they are often caught up in their own career success (Kitzinger, 1982). This leaves the new mother isolated, intellectually frustrated, and resentful (Kitzinger, 1982). She is placed in the difficult position of being financially dependent after having been a major wage earner (DeVore, 1983; Kitzinger, 1982; Lederman, 1984). Since women in the over thirty-five group tend to have careers, these

considerations may be problematic for this group. In addition, Mercer (1981) found that the older primipara often has trouble maintaining her relationship with her husband because she is particularly bothered by her postpartum body image.

Baldwin and Nord (1984) suggested that perhaps couples who have delayed their first birth for a long time after marriage experience less disruption after having planned for the birth. On the other hand, many of these couples find themselves juggling the demands of children and careers. They have high expectations of themselves and their children. Frustration or dissatisfaction could set in as they realize that they cannot manage everything equally well. In many cases couples work opposite shifts to assure that at least one parent will always be home when the children are (Baldwin & Nord, 1984). The effects of such arrangements on the children, the marriage, and the well-being of the family unit have not been researched.

Expectations for Labor and Delivery

Studies that examine the relationship between childbearing expectations and the perception of the birth experience have tended to focus on the labor and delivery experience. Clark (1975) explored women's perception of childbirth based on their expectations for the birth experience. She found that women who did not have accurate expectations of the sensations of labor, and who did not have the support of a "significant other" during labor, had a distressing labor, felt negative about the experience, and stated that they were unwilling to have another child. Clark (1975) reported that when labor is complicated by physiological conditions not under the control of the woman, a negative

attitude toward labor is one possible outcome. Since the literature review indicated that a number of physiological risks are associated with delayed childbearing, it appeared that there might be a greater chance for such negative attitudes within this age group of childbearing women.

Although none specifically have examined the expectations of the older primipara, the findings of this group of studies are suggestive of areas that might have importance for the elderly primiparas. Levy and McGee (1975) examined the relationship between expectations and subjective outcomes in childbirth. Sixty primigravidas responded to a questionnaire before and after labor and delivery. Levy and McGee (1975) found that women who rated childbirth favorably also indicated that childbirth was better than they had expected. In contrast, women who evaluated labor and delivery as unfavorable tended to report that the experience was worse than expected. These findings raise questions about the expectations that the mature primigravida might have regarding labor and delivery, given that this group tends to be aware of the risks involved in delaying childbearing after the age of thirty-five.

Stolte (1987) looked at the aspects of labor and delivery which women described as being different from, or the same as, their expectations. During an interview which took place twenty-four to seventy-two hours postpartum, seventy women were asked to rate how similar their birth experience was to their expectations, and to compare and contrast the event with their expectations. She found that 73 percent of the subjects had experiences in labor and delivery that differed in some way from what they expected. Stolte (1987) observed that the primipara has no previous experience on which to base

her expectations, therefore hearsay or what she has been told in prenatal classes forms the basis for her expectations.

Morcos, Snart and Harley (1989) examined the perceived importance of, and expectations concerning, a variety of specific aspects of antepartum, intrapartum, and immediate postpartum care in a sample of prospective parents. Their study revealed that the majority of parents have desires in areas concerning the childbearing experience which they consider important but which they feel will not be accommodated. Morcos, Snart, and Harley (1989) expressed concern that such discrepancy could produce stress or apprehension in parents. They recommended that consideration be given to the potential psychological effects when patient expectations do not concur with what actually happens.

Recently, attention has focused on development of instruments to measure expectations and perception of childbirth. Hodnett and Simmons-Tropea (1987), developed the Labour Agentry Scale to measure women's expectations and experience of control during labor and delivery and have tested the instrument in a number of studies. The Childbirth Expectations Questionnaire (CEQ) developed by Beaton and Gupton (1990) is a more comprehensive instrument that incorporates four major categories or subscales: pain/coping, partner/coach support, intervention, and nursing support. Beaton and Gupton interviewed eleven women in their third trimester of pregnancy to determine their expectations for childbirth. Based on content analysis of the interviews and on a review of relevant literature, items were generated for use in the CEQ. The emergence, through factor analysis, of the subscales provides some indication of the complexity of maternal expectations for the birth experience (Gupton, Beaton, Sloan, & Bramadat, 1991).

Bramadat (1990) used the CEQ to measure expectations of childbirth in a convenience sample of 102 primiparas experiencing different types of labor. Perceptions of childbirth and satisfaction with the birth experience also were measured. Women whose experience was better than anticipated were more likely to be satisfied with childbirth than those whose experience was worse than expected ($p<.001$). The work of these research teams has contributed to an increased understanding of women's expectations and their experience of labor and delivery.

Failed Expectations

Sandelowski (1984) described an emerging diagnosis, "failed expectations", which occurs when there is a gap between childbearing expectations and reality. "Failed expectations" tends to be expressed as feelings of guilt, anger, depression, loss, and overall disappointment and dissatisfaction. Mercer (1985) concurred with this view, adding that unmet or "failed" expectations may have a long-term impact on adaptation to motherhood and on later mothering behaviors.

Mercer (1981) reported that the elderly primipara has expectations for herself in the maternal role that can hamper early transition into the role. There is an expectation that a sense of meaning and purpose will automatically or inevitably accompany motherhood (Boulton, 1983). McBride (1973) discussed expectations surrounding motherhood, based on the notion that a baby is a woman's ultimate fulfilment. Many of the frustrations, anxieties, and dilemmas of being a mother result from the realization that these expectations are not realistic.

Summary

The review of the literature raised questions regarding the expectations mature primiparas have for their childbearing experience, the discrepancies which might exist between their expectations and actual experience, and the consequences of these discrepancies should they exist. Most authors focused on expectations for labor and delivery. It seems likely, however, that expectations for childbearing extend beyond the actual birth. The mature primipara may have expectations about many aspects of childbearing including timing of conception, ability to conceive a "normal" child, availability of family and network support, and balancing career and childbearing. Childbearing expectations and the congruency of expectations with the childbearing experience have not been explored in a broad context which would define childbearing as a process beginning with the planning of the pregnancy and continuing into the postpartum period. Since the congruency of expectations with the perceived childbearing experience may have significant impact on how the childbearing experience is viewed by the mature primipara, and on her ability to take on the mothering role, it is imperative that we gain an understanding of this phenomenon.

In the following chapter, the methodology and research design which were used to address research questions are presented.

CHAPTER III

Methodology

Grounded Theory

In this study, the childbearing experience of the mature primipara was explored and described with specific focus on maternal expectations, and on the discrepancies between childbearing expectations and the perceived experience. The methodology of grounded theory was utilized. Grounded theory is "the discovery of theory from data" (Glaser & Strauss, 1967, p.1). It is a process through which theory is "discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (Strauss & Corbin, 1990, p.23). In using this form of qualitative research, there is an express commitment to viewing events, norms, actions, and values from the point of view of the people who are being studied (Bryman, 1988).

Stern (1980) recommends the use of grounded theory in investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation. Qualitative methods are appropriately used to gain an understanding about a phenomenon of which little is known; to gain new insight into things about which quite a bit is known; to furnish details that cannot be captured with quantitative methods; and to uncover the nature of a person's experiences with a phenomenon (Strauss & Corbin, 1990). Although a number of research studies have focused on delayed childbearing, little is known about the expectations that the mature primipara might have regarding her childbearing experience or about the consequences should discrepancies exist between her expectations and her perception of her actual experience. Since studies that examined childbearing

expectations have not focused on the mature primipara and have not tended to include expectations surrounding conception, pregnancy, and parenting, this remains a phenomenon about which little is known. In this study, the phenomenon of delayed childbearing was examined from the perspective of the subject, in an attempt to capture details of the personal experience that would not have been possible using a quantitative research methodology. Given the focus of this study, grounded theory was selected as the most suitable methodology to employ. A flexible and open ended design was used, in which the phenomenon was approached without proposed hypotheses or predefined variables.

Theoretical sensitivity. "Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to the data, the capacity to understand, and the capability to separate the pertinent from that which isn't" (Strauss & Corbin, 1990, p. 42). The degree of theoretical sensitivity with which the researcher entered the study was enhanced through personal experience with the phenomenon being studied, as well as through a review of relevant technical literature. It is necessary to be aware of researcher biases and assumptions throughout the research process. Strauss and Corbin (1990) stated that the researcher must maintain a balance between science and creativity. In order to accomplish this, they must periodically step back and ask "Does what I think I see fit the reality of the data?". The researcher must maintain an attitude of scepticism toward any theoretical explanations and categories brought to the research study until they are supported by the data and must follow the research procedures.

Constant comparative analysis. "Constant comparative analysis" (Glaser & Strauss, 1967) was employed. Comparative analysis is a general method used to establish the relevance of categories.

In this study, the first three interviews were transcribed and then analyzed to discover similarities and differences in the data, through the process of open coding (Strauss & Corbin, 1990), that is, data were broken down by sentences or sometimes paragraphs and labelled so that each concept could be identified for comparison. Initially a large number of concepts were identified. Like concepts were then grouped together into categories and examined to determine the general properties of each category. Categories are simply coded data which seem to cluster together (Stern, 1980). Incoming data from subsequent interviews were compared against emerging categories. Interview questions became more focused as an emerging category required further exploration or validation. For example, the researcher noted that the subjects expressed a fierce love for their infants which was almost frightening to them. This feeling was explored in greater depth in subsequent interviews.

As data collection continued, the properties of and variations within each category were noted and linkages between categories were sought. Stern (1980) refers to this process as reduction. It is the seeking out of "some higher order of category, some umbrella under which all these categories fit" (Stern, 1980). The "core category" is the category which accounts for most of the variation in the data and helps to integrate other categories. In grounded theory, the identification of a core category, the further refinement of categories and the establishment of their relationships to the core category, lay the

foundation for the development of a theory which will explain the phenomenon under study.

The core category that was identified in this study is "delayed childbearing: a bittersweet experience". As linkages emerged, categories collapsed and formed more general categories. Strauss and Corbin (1990) refer to this as axial coding, the development of main categories. Axial coding takes the data, which were pulled apart during open coding, and puts it back together in different ways by making connections between categories and subcategories. Questions are asked which provide dimensions to the categories. Data were collected until the researcher was satisfied that no new information was being received that further explained that particular category. Stern (1980) refers to this process as saturation of the categories. The core category and its related components are discussed in Chapters 4 and 5.

Memo writing. Memo writing is a continuous process that allows the researcher to keep records of emerging hypotheses, analytic schemes, hunches and abstractions. In this study, the computer was used as a means to store memos. A notebook was also helpful when insight would occur at times when the computer was not readily accessible. These memos, which represented the written forms of the researcher's abstract thinking about data, were organized to provide guidelines to writing up the study.

Theoretical sampling. Theoretical sampling, as described by Glaser and Strauss (1967), is the process of data collection which uses joint collection, coding, and analysis of data, with all three operations being done together as much as possible. In grounded theory, two criteria are used for sample selection: theoretical purpose, and relevance,

which means that the researcher makes decisions based on the emerging data as to where next to collect data and from whom. The term "proven theoretical relevance" indicates that certain concepts are deemed significant because they are repeatedly present or notably absent when comparing incidents or they have earned the status of categories (Strauss & Corbin, 1990).

Theoretical sampling was used to enable the researcher to further develop emerging categories when deemed theoretically purposive and relevant. For example, in this study, the researcher wanted to know how the expectations and the perceptions of the childbearing experience might vary in the absence of marital support, therefore, an unmarried subject was interviewed. The researcher wondered how infertility might affect expectations and the perceptions of the childbearing experience, thus two subjects who had been treated for infertility were interviewed. An instance of twins and two of miscarriage were also sampled. The grounded theory method dictates sampling on the basis of the evolving theoretical relevance of concepts.

Strauss and Corbin (1990) suggested that "as your theory evolves, you can incorporate seemingly relevant elements of previous theories, but only as they prove themselves to be pertinent to the data gathered in your study" (p.50). This aspect of the grounded theory approach will be evident in the final chapter where the findings of this study are compared and contrasted with those from other relevant studies.

Validity and Reliability

There has been much discussion regarding the issues of validity and reliability

for qualitative methods. These terms do not seem to readily fit this methodology and alternate ones have been proposed which are felt to be more appropriate.

Credibility. Lincoln and Guba (1985) suggest that credibility rather than internal validity in the qualitative sense be the criterion against which the truth value of qualitative research be evaluated. According to Sandelowski (1986) a qualitative study is credible:

1) when it presents such faithful descriptions and interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions and interpretations as their own.

2) when others can recognize the experience when confronted with it after having only read about it in the study.

Lincoln and Guba (1985) suggest five major techniques that make it more likely that credible findings and interpretations will be produced. These are as follows:

1) The probability that findings and interpretations based upon them will be found to be more credible if the inquirer is able to demonstrate a prolonged period of engagement (to learn the context, to minimize distortions and to build trust), to provide evidence of persistent observation (for the sake of identifying and assessing salient factors and crucial atypical happenings), and to triangulate, by using different sources, methods, and sometimes multiple investigators.

2) Peer debriefing or exploring aspects of the inquiry with a "disinterested" peer is recommended providing the debriefing does not provide so much criticism or influence as to be damaging to the inquiry or the inquirer.

3) Negative case analysis is the process of refining a hypothesis until it accounts for

all known cases without exception in order to eliminate all "outliers".

4) Referential adequacy refers to the storage of some portion of the raw data in archives for later recall and comparison.

5) Member checks involves providing to the members from whom the data were originally obtained, the investigator's reconstructions for testing.

In addition to these techniques, Sandelowski (1986) added that credibility is enhanced when the researcher focuses on how they influenced and were influenced by a subject. This prevents the researcher from becoming so enmeshed with subjects that they have difficulty separating their own experiences from those of their subject.

In this study, the above strategies were implemented in several ways:

1) The in-depth interviews, for example, allowed an opportunity for considerable exposure to the phenomenon.

2) Care was taken to assure accurate transcription of the taped interviews.

3) The researcher submitted examples of coding to her advisor to confirm their appropriateness.

4) Consultation with colleagues provided opportunities for exploration of aspects of the study with a "disinterested peer".

5) When examining the data, every attempt was made to consider negative cases and to construct "umbrella" hypotheses such that the majority cases could be included. It was first thought, for example, that all of the subjects who had delivered by cesarian section held negative perceptions of their experience. It was soon discovered, however, that there were a number of subjects who wished that they

had a cesarian section instead of the type of delivery which they had experienced. This lead the researcher to the hypothesis that it was not the type of the delivery but rather the perception of loss of control which precipitated the negative perceptions.

6) No raw data will be saved for further recall since one of the ethical considerations of the study is to destroy raw data once the study is complete.

7) The subjects will be given the opportunity to consider the findings presented in this study. They will each be given an executive summary of the study for this purpose.

Fittingness. Fittingness is the term used by Lincoln and Guba (1985) to refer to the criterion against which the applicability of qualitative research be evaluated. A study meets the criterion of fittingness when its findings can "fit" into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences (Sandelowski, 1986). Lincoln and Guba (1985) discussed the establishment of transferability rather than the establishment of external validity in qualitative research. However, the researcher must provide the data base which makes transferability judgements possible on the part of potential appliers. The findings of this study have not yet been tested outside the study situation. The researcher attempted to provide the detail required so that transferability judgments can be made by future researchers.

Auditability. Auditability is a criterion of rigor that relates to the consistency of qualitative findings. According to Sandelowski (1986), a study and its findings are

auditable when another researcher can clearly follow the "decision trail" used by the investigator in the study and when another researcher could arrive at the same or similar, rather than contradictory, conclusions given the data, perspective, and situation of the researcher in the study.

In this study, the advisor was provided with copies of each interview transcript and examples of coding, so that decisions could be traced. In addition, considerable detail is included in Chapter 4, so that readers also will have the opportunity to follow the "decision trail".

Confirmability. Neutrality refers to the freedom from bias in the research process and product. In qualitative research, confirmability is suggested as the criterion of neutrality. Confirmability is achieved when auditability, truth value, and applicability are established (Sandelowski, 1986).

Participants were told at the onset of the interview that the researcher was only interested in their expectations and experiences and that there were no correct responses to the questions posed. The interview guide was loosely structured and questions were phrased in an open-ended manner so that participants could introduce topics which were relevant to their experience. The researcher responded in an open ended way to the topics introduced by the participants to eliminate possible hypothesis guessing on the part of the participant.

Organizational Framework

Lincoln and Guba (1985) commented on the use of a framework at the onset of

a grounded theory study. The researcher "does not always begin empty-handed (and certainly not empty-headed!)" (Lincoln & Guba, 1985, p.209). They recognized that theory grounded in an earlier investigation may be available to the researcher, as well as tacit knowledge that is germane to the phenomenon being studied. The researcher must be careful that the framework used is appropriate for "the now-being-investigated context". The design at the onset can only be described in "broad-brush process strokes" and as the inquiry proceeds the elements of the design become more and more clear and explicable (Lincoln & Guba, 1985). No hypotheses were put forward at the onset of this study. The framework was used as an organizational tool which was meant to provide some direction without committing the researcher to a set of variables and hypotheses.

The paradigm developed by Flapan (1969) was used to assist the researcher in developing the themes to be explored in the study. Flapan developed the framework to assist in establishing a better understanding of childbearing motivations and conflicts. Flapan arrived at the paradigm through the content analysis of statements elicited from 82 women who ranged in age from 20 to 41 years. Thirty-two of the subjects were postponing or avoiding childbearing. Women were asked to recall thoughts and feelings about "having and not having children", pregnancy, labor and childbirth, and being a mother, "when you were a little girl, as you were growing up, and more recently". In addition, each subject was asked to formulate a series of questions directed at herself and then to answer a tape-recorded playback of these questions.

The paradigm was chosen as an organizational framework for this study for the following reasons:

1) It is loosely formulated and open. This feature fit well with the grounded theory methodology.

2) The paradigm shows that a multiplicity of meanings and anticipations may be associated with conception, pregnancy, childbirth, motherhood, and childrearing. Use of this paradigm captured the idea of childbearing as a process that begins prior to conception and unfolds well into the postpartum period. Since the literature review revealed that the childbearing expectations of the mature gravida extend to such things as the timing of conception, the ability to conceive a normal child, the availability of family and network supports, and the ability to balance career and childbearing, the paradigm appeared to fit well with the focus of this study.

3) The paradigm provided a reasonable link with the concept "failed expectations" introduced by Sandelowski (1984) in that it incorporates the notion that a variety of anticipations and expectations are held surrounding childbearing, and that when conflict is experienced around the anticipations and expectations, problems with conception, pregnancy, childbirth, and childrearing can arise.

4) The paradigm introduced the idea that childbearing expectations can change over time. It was of particular interest to this study to consider how childbearing expectations might change over time for those who postpone childbearing. Did changes in expectations allow for the decision to bear a child after having postponed this event until after the thirty-fifth birthday?

5) The paradigm shows that the decision to bear children can be understood in the

context of the woman's appraisal of her current life situation and the changes, biological, personal, and interpersonal, which she expects childbearing to bring about. The expectations that the mature primipara holds regarding these components of her childbearing experience were considered extremely important to explore. The profile of the mature primipara that was developed through the literature review suggests that this population is well established professionally and economically secure. They are well read and well educated. For them, childbearing will likely be perceived as eliciting quite dramatic biological, personal, and interpersonal changes. It was anticipated that their expectations of the impact that these changes would have on their lives might be quite different from the expectations of a younger less well-established population.

Definition of Terms

Mature primipara. For the purposes of this study, a woman who was thirty-five years old and over, having her first child, was considered to be a mature primipara.

Delayed childbearing. A primipara who is thirty-five years of age or older was considered to have delayed childbearing.

Childbearing. Childbearing was broadly defined to include the planning of the pregnancy through to and including the postpartum period.

Childbearing Expectation. The term childbearing expectation in this study refers to the participant's report of her anticipated experience with planning her pregnancy, as well as pregnancy, labor and delivery, postpartum recovery, and motherhood.

Discrepancy. Discrepancy refers to the differences between the participant's expectations or anticipated experience with childbearing and her perception of the actual experience.

Study Design

Sample. The sample for this study was obtained from the population of all women who have delayed childbearing until the age of thirty-five years or older. Both married and unmarried women were included. To be included in the study, women had to be:

1) female
2) thirty-five years of age or older
3) primiparous
4) good command of the English language since the ability of the subject to describe her experience in a clear and articulate manner was paramount to the success of the study
5) living within the Boundary Health Unit catchment area
6) able to be contacted for the purpose of setting up an interview, ie. have a mailing address and telephone.

Setting. The study took place in an urban community in south-west British Columbia. Interviews were set up at a time and place which was convenient to the participant. In all cases, in-depth interviews took place in the participant's home.

Time frame. The study was retrospective. No limit was placed on the time elapsed since the birth of the baby. The age of the infant at the time of the interview ranged from

two to six months old.

Instruments. An unstructured interview guide was used which was composed of a loose collection of themes to be explored during the interviews (Appendix A). The framework developed by Flapan (1969) served as a beginning guideline to the areas to be explored with the respondents. A pilot interview was conducted with a mature primipara to determine the suitability of the interview guide. The approach advocated by Bryman (1988) was used that is, the person being interviewed was allowed to ramble since this would reveal something about the interviewee's concerns. The researcher provided minimal guidelines and allowed considerable latitude for the interviewee. Interviews were tape recorded and fully transcribed. Some questions or foci were omitted or were supplemented as analytical sensitivity increased. Strauss and Corbin (1990) refer to this as "theoretical sampling on site".

Demographic information was obtained from the participants at the beginning of the interview (Appendix A). These data were used to describe the sample obtained for the interviews.

Procedure

Approval was gained to access study participants through a local Health Unit (Appendix B). The researcher made a brief presentation of the research proposal to Community Health Nurses in three sub-offices of the Health Unit. Community Health Nurses agreed that when they encountered women who met the study criteria, during regular community health nursing contact, they would ask their permission to release to

the researcher their name and telephone number (Appendix C).

All potential participants were sent a letter of introduction outlining the purpose and the nature of the study (Appendix D). The letter indicated that the researcher would contact the prospective respondent by telephone to further explain the study, answer any questions, and set up a mutually convenient time to interview should they be willing to participate. A telephone conversation followed the mailing of the letter by two weeks to allow time for the potential subject to consider her participation in the study (Appendix D). During the telephone conversation, the prospective participant was provided with the opportunity to ask questions with regard to the study. An interview was set up at a time and place convenient to the participant.

Ethical Considerations

The research proposal was submitted to the Ethical Review Committee of the School of Nursing, University of Manitoba for the purpose of ethical approval prior to commencing the study. (Appendix E).

During the initial interview, the consent form (Appendix F) was reviewed and completed by the participant. Participants were told that they could refuse to answer any questions they wished and could withdraw from the study at any time. Participants were offered a summary of the study once it was completed. The researcher was sensitive to the needs of postpartum subjects and structured the interview so as not to tax or tire interviewees. Interviews were set up at a time and place that was convenient to the participant.

Data collected during interviews have been held in the strictest confidence. Tape recordings and transcripts prepared by the researcher were identified by a code number only. Subject names were kept separate from tape recordings, transcripts, and memos and were accessible only to the researcher. The transcripts were accessible only to the researcher and her advisor. No identifying details or names were used in any publications or reports. At the end of the study all tapes were erased.

In the following chapter, the findings of the study are presented, using an organizational framework, the categories and subcategories that emerged through the use of the grounded theory approach.

CHAPTER IV

Findings

Constant comparative analysis resulted in the emergence of a core category, delayed childbearing as a bittersweet experience. As concepts were identified, associations with the core category were mapped (Appendix G) using Strauss and Corbin's (1990) paradigm model. Antecedents or factors that set the stage for the mature primipara's response to childbearing were identified. Among the antecedents that were central to women's experience were their expectations and perceptions for childbearing. In some cases, an incongruency resulted between the woman's expectations and her perception of what actually occurred. This incongruency often brought negative consequences which caused various levels of distress. Intervening conditions had a positive or negative impact on the mature primipara's experience of childbearing. As well, women were found to have engaged in behavior (action/interaction strategies) served to mitigate the negative aspects of delayed childbearing.

In this chapter, findings are presented in five sections. In the first four sections, findings are presented as they relate to each stage of the childbearing process, from planning the pregnancy through to and including the postpartum period. In Section 5, women's evaluation of their experience and the advice they would give to other mature primiparas are reported. Integration of the core category with the related concepts will be discussed further in Chapter 5.

SECTION I - The Preconceptual Period: Making the Decision

Expectations

Among the most pertinent antecedents that influenced the decision for delayed childbearing were the expectations and perceptions of the women and the expectations they perceived were held by their partner, families and friends.

Personal expectations. Both positive and negative meanings or values were attached to childbearing.

1) **Gratification.** Most women wanted to have a child and expected major rewards or gratification:

> I needed to share...to teach...some of the things...my values...my morals... I needed to have something other than my husband. Something that's kind of mine...I can look and say this is what I made...I wanted to share my life with some one other than my husband (003).

> I think we thought it would make our lives more full (007).

> I don't know where that emotion comes from but you feel that you need that. It's just the inherent ability that we have and I wanted to know what that experience would be like...(008).

> I knew I wanted a child. It wasn't well formed like how many children I wanted but I always knew I wanted a child. I guess I sensed that it would make me feel more complete...a sense of importance...of being vitally linked with some one (009).

2) **Childlessness.** Two participants said that they had never expected to have children:

> I never had any strong maternal instincts ...it didn't figure into my plans at all (004).

Another had an extremely negative attitude toward the whole childbearing process. She believed that the only conversation that mothers could have involved their children:

> I have never met a good kid in my life. I don't know why but I never really thought that I wanted kids in my life (005).

3) **Infertility.** Women also identified personal expectations about their ability to conceive and bear children. One participant described the problem which she had experienced with amenorrhea. Because of this medical problem, she had not had a menstrual period for five years. Since this woman did not wish to have children, she did not perceive that this problem prevented her from realizing her childbearing expectation. For other women, expectations that they would have children drove them to unusual lengths to overcome infertility. One woman, for example, had expected to become pregnant right after marriage at an early age. Infertility acted as a barrier to her realizing this expectation: "Not in all my dreams did I ever think that it would be as hard as it was." The consequences of this discrepancy between childbearing expectations and her perceived experience was extremely negative:

> I think it's been hard because it was six or seven years before I got pregnant the first time. In between all that I was going for the different tests and it really put a strain on everything (007).

As a result, this woman experienced depression and self-blame. She also went through extraordinary hardships which were at times life threatening in order to realize her childbearing expectation. She experienced four ectopic pregnancies over five years. At one point her fallopian tube ruptured and she almost died. Still she did not give up. She enrolled in the in vitro fertilization program which involved travelling thirty-five miles to the clinic twice each day and a large financial commitment. Her commitment to childbearing was evident in her attempt to normalize the whole procedure: "It's a really neat procedure and you don't realize how many women are going through it."

For another woman, the discrepancy between her expectation to conceive and her perceived experience of infertility resulted in very negative consequences including feelings of worthlessness, isolation, and depression. Infertility caused friction in her marital relationship. Both she and her husband wanted children but she felt that they were "in different places and at different times". This woman expressed great dissatisfaction in the medical management of her case. Lack of information or misinformation increased her level of stress. Her husband accused her of over reacting when she would burst into tears at the news of another failed conception.

Friends were perceived as being insensitive to the impact that infertility was having in her life. When testing seemed to indicate that the infertility was "her fault", she felt that she was useless, had time on her hands, did not belong. She asked, "what good am I?" For this woman, self-concept was closely tied to her expectations for parenthood.

Similar responses were identified with women who experienced a miscarriage. One of the participants had expected to conceive at a particular time in her life when she and her husband both felt "ready". However, a miscarriage prevented this from happening. The result of this discrepancy between her expectation and her perceived experience was that both she and her husband were devastated. The miscarriage was seen as a hurdle to her fulfilling her life plan.

> One thing was my miscarriage. I never counted on that happening. Because you think all you have to do is get pregnant and then you will have this wonderful child but it doesn't always work that way.... So it was difficult for both of us and I think it was sort of a healing process and I needed to get pregnant immediately to do that (003).

Miscarriage acted as a barrier to conception on time for another participant. Miscarriage was perceived to have been the reason for the dissolution of the relationship which she had with her partner at the time:

> So that was very very difficult for us. More difficult for him actually because he's very emotional and he just couldn't imagine going through it again and he was really apprehensive about having a child after that.

> He kept thinking if I had one miscarriage it would happen over and over again. And he couldn't deal with that so it was hard on him (008).

This miscarriage also put great pressure on her to become pregnant again within her perceived time frame. Her business partner, who is a woman younger than she, was perceived as not understanding her need to become pregnant:

> I don't think there is ever a good time (for childbearing) especially in business. It could have been later but I couldn't wait until later. She (her business partner) knew that was the issue and she's ten years younger than I am so I think it's hard on her because she's younger and she doesn't understand maybe the need or the time frame...(008).

When one woman believed that she had suffered a miscarriage, she describes "an emotional roller coaster". She and her husband had begun to accept the pregnancy and, when they believed that it had ended, they found themselves going through the whole process of deciding whether or not to have children all over again. Another had a miscarriage following infertility treatment. This event tended to evoke increased support from her husband in that he realized that a pregnancy was possible.

Impact of partner, family and friends on expectations

1) **Being "in sync"**. The majority of participants agreed that they had been satisfied with their lifestyle prior to conception. Most participants mentioned spontaneity, travel, and financial freedom. The participants

entered into a marital relationship or partnership bringing with them certain expectations regarding childbearing. Some were fortunate to have a partner who was "in sync", who had congruous life plans. For others "getting in sync" did not occur immediately, but rather occurred at any number of different points within the childbearing process. The following are examples of congruent life plans.

One woman and her husband both wanted to have one child. "I've always thought that one would be enough for both of us...and my husband feels the same way...thank goodness we both think the same."

Another subject and her husband did not want to have children. She said about her relationship with her husband:

> It's a really great relationship we have. And because of that we never really thought that we needed a family to disrupt anything with this relationship." (005).

Other participants entered their relationships with expectations about childbearing which were incongruous with their partners' expectations. These couples were not "in sync" prior to conception. When there was a lack of congruency there were often negative consequences:

> One subject stated: "I kind of would have liked to have had one baby before it was too late...but you know...if the other partner doesn't want to...." (001).

This participant felt disappointed that she probably wouldn't have a child. She describes "an emptiness". Instead of childbearing, their plan was "to

work to an early retirement ...living a nice lifestyle."

Another woman said about childbearing:

> I guess I was attracted to kids and I always thought that I would want them....I wasn't in a serious relationship so I just didn't think that everything was going to come together so that I could have kids. (006)

Her husband was inclined against having a family, but not a hundred per cent opposed. She described the situation as "a seesaw" because neither could make a commitment to having children or not having children:

> It was like I was at the stage where I would be thinking no we're getting too old I don't want the hassles let's just keep on the way we're doing and my husband would say maybe we should think about having kids and then I would raise the issue I would be more ready...I think there was safety in the other person not. I could think about it knowing that my partner isn't really interested right now (006).

In this case, incongruency regarding childbearing created great turmoil for the participant and lead mixed feelings which formed the basis for a bittersweet perception of the experience.

2) **Support.** The family was felt to offer support to most of the participants regardless of their expectations about having children. Support was identified as an intervening condition in the paradigm model, that is, as a factor that mitigated or otherwise had an impact on the experience of delayed childbearing. Only one participant described any pressure from a family member regarding the couple's childbearing reality and this was not

perceived by the participant to have influenced the couple's attitude toward having children.

3) **Independence**. In one situation, the parents fostered independence which was quite against their cultural norm regarding women's role in society. They encouraged the participant to attend university so that she could gain high level employment. This participant talked about how her mother always put her children first and this gave her a basis from which she would operate as a parent.

4) **Competition**. One participant discussed the competition she felt with her sister who gave her a standard of behavior which she always felt she had to surpass. The sister had a wonderful daughter who idolized the participant and caused her at times to re-examine her own lack of desire to parent. Interaction with nieces and nephews created an increased desire to have children for one participant.

Friends and co-workers, on the other hand, seemed to have very little influence on childbearing expectations. One participant had noted a trend among her career-oriented friends to delay childbearing. This helped to validate her own life plan. Another subject who clearly had no desire for children, felt very left out when women gathered socially and discussed their children. She admitted that she had pretended to be interested in their children all these years so she would not appear to be rude. This validated her desire to be childless. Friends of one of the participants encouraged

her, in a teasing sort of way, to go against her culture and have a baby, married or not. Although this was never acted upon, their support nurtured her strong desire for a child.

Society/Culture and childbearing expectations. The expectations of society\culture regarding women and childbearing also tended to influence childbearing expectations, depending on how participants viewed the expectations of society/culture. At times the subjects's personal expectations regarding childbearing were not in concert with perceived societal/cultural expectations.

1) **Reason for being.** For some women, parenthood was seen as the inevitable female reason for living. They recognized the role of society in conditioning women to be mothers. " I think it's just expected that you are going to grow up, get married, and have kids. I didn't really think about the why" (007). Some participants expressed a keen awareness of the traditional lifestyle and two verbalized the cliche "living happily ever after with the white picket fence" (001, 003). One woman seemed to sense society's disapproval of the fact that she had no desire for children and looked for reasons to validate not wanting children:

> ...you know people are quite shocked at a situation like ours where we are so compatible and yet we don't want kids. They think that's very strange....It must have had something to do with the way that we were brought up" (005).

2) **Options.** Even so, the majority of participants wanted to ensure independence before marriage and childbearing. They believed that society

had given them the freedom to choose the lifestyle that suited them and that options to a traditional lifestyle were available:

> I always thought that I would have a child but I had no desire to do it when I was younger....I think that the reason that I didn't get married and didn't have children was the reverse expectation...of being a baby boomer and being that perfect age group and having the advantage of being able to be single and be more independent and have a career so I think it actually was the reverse of that. For me I was allowed to do so much more that I delayed that, in fact I think that I delayed relationships and everything thinking I've got all this freedom. I'm going to do this and this and this (008).

Some of the women had set down very concrete life plans with very concrete goals:

> ...it was almost like I had planned my life in that I wanted to finish an education. I didn't want to get married before I was twenty-five and that's actually the way it happened (003).

There was a perception for some that both options were open and that motherhood and a career could be combined:

> "I guess I always hoped to have it all. I didn't see it as an either or" (006).

Others felt pressure to find employment before raising a family, even though they were not committed to a career:

> I said to myself I need to work in my field a little while before I get pregnant. If not I'll have thrown away ten years of trying to find myself....Pregnancy would have been an easy

> out for me at that time because it was a scary thing for me to do (009).

According to one participant's cultural values, childbearing was not to occur until after marriage. The influence of this cultural taboo was felt so strongly that she waited to find a partner despite her overwhelming desire for a child. For another subject, however, the influence of culture\society in this regard was not perceived to act as a deterrent so that she felt that she had the freedom to plan a pregnancy outside of marriage. It was evident that all women were aware of societal/cultural expectations and that they felt varying degrees of pressure on their decision making around delayed childbearing.

Childhood fantasies and childbearing expectations. Childhood fantasies did not seem to consciously influence childbearing expectations of women in this study. The majority of the participants did not recall any fantasies or dreams about having children when they were growing up, other than saying that they thought that they would like to have children some day. One participant said that as she was growing up she wanted to be like her mother. She remembered "playing house as a lot of little girls do" as did one other participant. Another subject stated that she wanted a child so that she could give him/her the opportunity to do the things that she did not get to do as a child.

The variety of personal meanings that women attached to having children, preconceptually, influenced their expectations for their experience and for themselves in the mothering role.

Perceptions

The passage of time and childbearing expectations. Women's perception of the passage of time converged with their expectations for childbearing. All participants made reference to timing, the passage of time, or running out of time. The passage of time was identified as a strong motivating factor for pregnancy. A number of circumstances, which have already been presented, prevented "conception on time". These included miscarriage, infertility, and finding a suitable partner. In addition, the passage of time brought forth the following issues.

1) **Increased childbearing risks.** Participants were aware that the passage of time increased the risks involved in childbearing:

> I have no experience having babies but what I have heard is that if you are past the age of 35 it is difficult to get pregnant and to have babies (002).

> I certainly was aware of some of the information being in the field of mental retardation. Some of the statistics about Down's Syndrome and this sort of thing (006).

> My major concern was that we were dealing with old eggs -really ripe... (004).

This awareness of risks created anxiety in the subjects and was considered to be an antecedent to the core category.

2) **Lifestyle disenchantment.** The passage of time also seemed to cause some of the subjects to become disenchanted with the lifestyle in which they had previously found satisfaction:

> You say I've travelled the world and now what?
> Do I do it again? (006).

> After a while you got sick of going out for dinners and everything. It's like there was no meaning (007).

3) **Missing the female experience**. The passage of time caused subjects to recognize that they were nearing the end point to their ability to bear children:

> I was very conscious of the biological clock ticking that was certainly a part of it for me making that decision. I didn't want it to go by without making a clear decision. I didn't want it just to stay in limbo and then to realize it's too late to make a decision (006).

> I was perfectly content. And I don't think I had really thought seriously about time clocks as they say until just a few years ago. Maybe when I turned 35 or 36 (008).

4) **Readiness to conceive**. The passage of time was the signal for some participants that they were ready to conceive:

> I don't know how to describe how I felt...I just knew it was time. I wanted to share my life with some one other than my husband. I knew I was ready and it was a point of he will come to me when he is ready (003).

One subject recognized that she had a full life and that a child now would not take away from that. She was ready to give to some one without feeling that she was missing out on anything, "It was the right thing to do now".

5) **Changing childbearing expectations**. The passage of time caused some

participants to re-examine their childbearing expectations:

> We started to talk and say well my time is starting to run out and we should decide whether or not we want kids (004).

This participant had stated earlier that they had no desire for children. Another subject had been extremely negative about the whole childbearing process. However, she stated:

> And then as you get older you know your mind changes and I might have in my own mind thought a little bit more about gosh I'm getting a little older and if I was going to have kids I should do something about it (005).

The passage of time seemed to be a critical factor in ultimately influencing the actions/interactions of those subjects in the study who had never expected to have children or those who had expected to have children but whose partners did not share their childbearing expectations. Two behaviors identified were: 1) weighting, which is the process of considering the pros and cons to childbearing, and 2) taking chances, which is the failure to consistently practise effective birth control methods.

Actions/Interactions in Preconceptual Period

Weighting. Those subjects who had not expected to have children or whose partner did not share their childbearing expectation, engaged in a process of examining the pros and cons to childbearing and the impact it would have on their lifestyle. Lifestyle appraisal was seen to be an antecedent to the core category since it was not found to

assist the subjects in making the childbearing decision and lead to negative perceptions for those who were unable to make a conscious decision to parent.

One couple gave consideration to their advancing age and their financial situation, "...we went and bought a house and were strapped with these big mortgage payments". However, these were being weighted against a sense of unfulfillment, of missing out, of having no purpose to their life.

One subject, who did not desire children, started thinking more about having children, and what she might regret if she did not have a child. This subject started to give consideration to parenting, "...if I had a child I would love it. I would be the best mom I could be but I would never know that side of my husband." She began wondering what her husband's thoughts might be on the subject. She even talked to her physician about the risks involved if she were to become pregnant. Her doctor did not see it as a problem, however the subject admitted that she didn't really ask enough questions since she "hadn't really planned on getting pregnant."

For another subject, this weighting process was very stressful and resulted in marital tension. Factors which were considered included having the patience to parent effectively, how parenting might effect their lifestyle, and the risks involved related to age. This couple enjoyed a comfortable lifestyle, financial freedom, and the freedom also to take part in interesting activities. But "is that all there is" was the question asked. The subject was keenly aware of the "biological clock ticking" and she felt the need for making a clear decision. She says about making this decision, "A lot of responsibility you know...knowing that this decision would affect us for the rest of our lives so it wasn't

something that we could renege on once it was made".

For some of the subjects, childbearing was part of a carefully laid out life plan. Certain goals needed to be accomplished before a pregnancy would be considered (education, career, finding a suitable partner, certain life experiences). In some cases, life circumstances acted as a barrier to childbearing expectations (infertility, miscarriage). For others, pregnancy was never an expectation or, at least, not one that was shared with their partner until time started to "run out" and they were forced to re-examine their lifestyle and the weighting process was begun.

Taking chances. For those couples with incongruent childbearing expectations and for those who had not expected to have children, the final decision regarding whether or not to parent was an extremely difficult one to make. Many of the couples began to engage in the behavior "taking chances". This is the failure of the couple to consistently practise reliable birth control methods. Those who became pregnant after "taking chances" had difficulty in accepting the reality of pregnancy.

One subject was told by her doctor to quit smoking or quit taking birth control pills. She chose to quit taking birth control pills and did not adopt a new method despite the fact that she and her partner shared inconsistent childbearing expectations. "I guess it was about a year and a half afterwards (when conception occurred)...so I guess that there's a time when the pill stays with you..."

Another subject used no birth control at all, even though her husband clearly did not share her desire for children and despite her awareness of the risks involved in childbearing at her age. She believed that she would not get pregnant right away because

of her age.

About birth control, one subject prefaced her comments by saying that she's a really reliable person. She admitted to becoming "sloppy about precautions". This was within her husband's level of awareness .

> It was sort of like he didn't think I could get pregnant and I didn't because for six months I hadn't really done any precautions and I never got pregnant so we just sort of thought like we'd talk about it looks like we can't get pregnant because of not even doing any precautions. And yet in the back of my mind I thought yes but I could get pregnant. You never know (005).

For another woman, the test came when it was time for her to have her IUD replaced. This couple had not made a clear decision regarding childbearing. She says:

> If we want to consider having kids let's use this as a marker. So we kind of used it as a marker and we said okay we won't use another IUD and then we panicked and couldn't go without any control. So we used condoms for a while and then decided not to use those...We hated the condom. It was really what it was. It was out of frustration so we said let's not continue with these. And I think quite frankly in the back of my mind I really questioned whether I could become pregnant being thirty-nine and spending my whole life wanting to avoid pregnancy (006).

Regardless of their original childbearing expectations or whether there were congruent expectations, the passage of time appeared as a most significant factor for this study group.

SECTION II - Women's Experience of Pregnancy

All of the participants in the study talked about their reactions upon receiving the news that they were pregnant and how they were able to accept and incorporate

pregnancy into their life plans. Some of the women had very definite expectations about what pregnancy would be like for them. Others brought with them few preconceived notions about pregnancy. In all cases, their perception of pregnancy was different from their expectations. The incongruency between pregnancy expectations and the perceived reality of pregnancy was identified as an intervening variable that contributed to how women perceived their childbirth experience, that is, why it was perceived as a bittersweet experience.

Expectations For Pregnancy

Of the study participants, two did not want or expect to become pregnant. Subject 004 had not really considered pregnancy at all and so had no real expectations regarding her experience. On the other hand, subject 005 had very negative expectations regarding what pregnancy would be like for her:

> ...I wasn't looking forward to being pregnant. All pregnant women get sick, at least that's what I thought. And they all get gross looking. Most women that I see are really big ...big in the face...I mean big all over. Sure people say that pregnant women are beautiful, at least this is what I've heard, but I've never thought that many pregnant women were beautiful.... That might have something to do with never having a desire to be pregnant (005).

Three subjects had a strong desire for a child, and were "in sync" with their husbands in this respect. Two of these women expected that pregnancy would be an extremely positive experience for them:

> I thought being pregnant would be wonderful. I wouldn't be sick and I would just carry this baby around for 9 months and all of a sudden I would give birth and it would be

> great...I thought it was going to wonderful. When you start thinking you're going to be a typical model pregnancy. You're going to still have your figure. All you're going to have is this little ball in front. And summer is going to be wonderful because you can sit out in the sun and nothing is going to bother you. You're still going to be dainty looking (003).

The third subject of this group (009) had not formulated many expectations regarding pregnancy. Although she too wanted a child, she was afraid to expect that it would happen for her because of problems with infertility and miscarriage.

> I guess when you're going through infertility treatment you don't get too attached to things. You didn't want to plan. We used to talk about names...all sorts of silly things...silly names...and joke and then after a while I didn't want to talk about it any more. I didn't want to be around children, babies, pregnant women. Even going through a toy department was difficult...so you try not to think about it too much. That's probably what happened. It wasn't well formulated about what pregnancy would be like before I got pregnant (009).

The remaining four participants indicated that they wanted a child but none of them were in sync with their partners. Three participants from this group had really not thought too much about pregnancy and had no expectations regarding what pregnancy would be like for them. Subject (008) said about pregnancy, "Well I didn't imagine it at all. I had no preconceived notion about it at all. I really didn't. I just did it."

The fourth woman had very positive expectations regarding what pregnancy would be like for her. She thought that everything would be easy since her mother had eleven children without any problems.

Perceptions of Pregnancy

For this group of women, perception of their pregnancy did not match their expectations. Those who had the most positive expectations regarding pregnancy perceived their experience to be most negative. The women who had expected pregnancy to be negative, perceived it to be a most positive experience. Finally, those participants who had no expectations regarding pregnancy, all perceived their experience to be positive. Gaps between the expectations for the experience of pregnancy and the perceived experience contributed to negative perceptions of childbearing.

Three subjects who expected pregnancy to be a positive experience had a negative perception of their experience. The following passage is an example of negative perceptions of the experience of pregnancy:

> It was a difficult pregnancy in that in the first three months I was very sick. I was to the point where I was becoming dehydrated...was so sick. But you carry on I mean I was still happy that I was pregnant...and I guess the worst time for me was the last month. I started to retain a lot of fluid around my seventh month...and they were wondering ...I was borderline diabetic. I could control it with just diet. But I still retained water and my ankles were just huge. I felt uncomfortable. I couldn't sleep properly because I couldn't move. My legs hurt because I was carrying so much weight. He was quite a big baby so I was quite uncomfortable .... I started feeling fat and towards the end I started feeling not pregnant but fat. And you look at other women who are a little slender and you're self conscious of yourself in a lot of ways (003).

Subject 002 had expected an easy pregnancy but she experienced premature labor and found the experience to be very frightening for her. She had read about normal pregnancy and was not prepared for this eventuality. On the other hand, subject 005 had

expected pregnancy to very negative and for her the experience was most positive:

> ...But I didn't look pregnant. I didn't until I was about 7 months. You know how you can wear clothes that don't make you look pregnant, that are baggy. So I only gained weight around my tummy....And I was very lucky because my pregnancy was so good. I was never nauseated at all. I wasn't sick. I didn't get all clumsy and overweight. I had a really good pregnancy and that's a good thing because I probably couldn't have coped (005).

The remaining subjects had no preconceived notions about pregnancy and all of them found pregnancy to be a positive experience:

> And I found it a fascinating process to go through. It was just thrilling for me...I enjoyed pregnancy...and I had never given it a thought before then. It was always having the children that I thought of rather than the actual pregnancy. I do a lot of reading so I had my trusty guide and I just enjoyed watching it all develop and feeling it all develop and experiencing the changes you know (006).

> During my pregnancy, my husband took pictures of me in all those places where we had visited. Always a sense of pride...not shame that I looked so big. He always made me feel so beautiful...What was inside was such a treasure for us...(009).

For three out of the four participants who developed pregnancy complications, negative perceptions of the experience were linked with medical concerns encountered during the pregnancy. Complications included premature labor and delivery at twenty-seven weeks (002), borderline gestational diabetes (003), edema (003), and pregnancy with twins (007). The last of these was not necessarily a complication, but was treated as such by the physician who imposed a number of restrictions on the participant to safeguard the pregnancy. Subject (004), who experienced pregnancy induced hypertension, had no expectations regarding pregnancy and, even though she encountered some

difficulties, perceived pregnancy to be a positive experience.

Intervening Conditions

Accepting the reality of pregnancy. The readiness with which women and their partners were able to accept the pregnancy had an impact on how they perceived their pregnancy. A number of factors were associated with the subject's ability to accept the pregnancy. These included: the fit between childbearing expectations and the reality of pregnancy, the ability of the partner to "get in sync", the reassurance that baby would be healthy, and support from friends and family.

Congruence with expectations. News of conception was met with a variety of reactions which varied according to the subject's childbearing expectations. For those who failed to conceive on time because they had experienced a miscarriage, the news that they were pregnant was met with excitement but also the fear that a miscarriage might happen again and their expectations not be realized.

For those who had not expected to have children or who had a partner who did not share their childbearing expectations, shock and disbelief were typical reactions. This reality did not match their expectation regarding childbearing. The following is an example of this type of reaction:

> So I got the test and I didn't tell anyone, just got the test and I remember feeling so shocked that I had to sit down, it was like I was going to faint...I wanted to take out my contact lenses and clean them to make sure I was seeing it right. I kept turning it to the light. No its just clear. I tried to talk myself into it. Anyway it was definitely pink...I was just devastated like I was feeling in a way that I wished I could turn back the clock you know... like if someone just

> told you you have cancer or something. And yet as you look back on it you wonder how you could have ever been so devastated but at the time I was so shocked (005).

Three of the subjects felt that the pregnancy had happened "all of a sudden". None of these subjects had made a conscious decision to parent but had engaged in "taking chances". Subject 006 states:

> That was again a really difficult time. We both went into shock. Whoa! I think because it happened so quickly. We didn't have time to adjust to the fact that it could happen. It happened too quick...I guess the way I look at it is that we just hadn't got used to the idea that the possibility now could become real. There just wasn't enough time to accept the possibility. And so I think we both went into shock over it. I was worried about how my husband would accept it (006).

Those subjects who had not expected to parent had other plans regarding how their adult life would unfold. Early retirement, financial security, travel, freedom were incongruent with pregnancy. These couples needed to reframe their expectations in order to incorporate childbearing:

> My whole life...we had planned...our retirement, our travel, our second home here...I guess everything is all set now, organized, our financial all organized, and then all of a sudden this happens and its like starting from scratch. I mean its all gone. Its like all your plans are gone. I just got this job. I had only been working at it for a year, a most fantastic job and what's going to happen there and all these sorts of thing as going through your mind. And I just couldn't believe it and I must admit that I wasn't totally happy (005).

> ...and it was kind of we had focused on being 55 or whatever and its like thinking of your retirement age and all of a sudden you're turning into a middle aged parent...(001).

Assurance that the baby was healthy. All of the subjects were aware that certain risks to the infant were associated with delayed childbearing, and all required proof that the child was whole as part of accepting the pregnancy. None of the subjects, regardless of their desire for a baby, thought that they would continue with a pregnancy if the results of the amniocentesis were not favorable. As a result, in the initial weeks of pregnancy excitement was tempered with anxiety. This situation contributed to a mixed response to pregnancy--these weeks were bittersweet as the subjects awaited the results of the testing procedure. About amniocentesis, subject 001 said:

> We kind of talked it all over...and we decided to go ahead with it...as long as it would be physically okay...the baby...Cause I can't really see well I don't know if it would make any difference but sort of being older and working and sort of having to work and raising a handicapped child is pretty difficult I think for someone who is able to stay at home (001).

For those subjects who had experienced a miscarriage, fetal monitoring was particularly difficult:

> I guess at around nine or ten weeks they wanted me to go for ultrasound and I dreaded that day. I did not want to go. It was the hardest thing for me.I was really scared. Going in there you know you don't get an opportunity to see the monitor right away...they keep you looking away. I kept saying how does it look and they would say fine fine. They said that the first time you know and then I guess they were looking for the heart and so finally I came right out and said is there a heart beat...They said oh yes yes yes. Well then that was fine. That was a very hard time (003).

Getting "in sync" with partner. As discussed in section one, "getting in sync" is the formation of congruent lifestyle expectations between partners. For some participants, congruency regarding childbearing expectations was evident prior to conception but, for

others, "getting in sync" did not occur until the news of the pregnancy or much later. Failure for the couple to "get in sync" had negative consequences for the participant.

Subject 006 had wanted a child but she and her husband were not "in sync". His negative reaction made it difficult for the participant to accept the pregnancy. She said:

> Well I think it would be fair to say when we found out that my husband thought of all the negative things. Like what if I don't like this kid? you know if I don't want to live with this person for the next 18 years. Maybe I just won't like him. And maybe I won't be a good father, I won't have the patience, and its going to interfere and that's not going to make a good situation.... And so I think my reaction would have been quite different if his reaction had been "oh that's great" or something because I think I would have been more excited, more positive about it. Oh it was very stressful. Because basically throughout the pregnancy he had ambivalence about it so which I guess in retrospect was really unfortunate because as he would say "if only I knew then what I know now"(006).

Subject 002 had a strong desire for a child, a desire which was not shared by her husband. About the news of the pregnancy she said:

> He didn't like the idea... because we were having a trip. And he thought it would spoil our holiday. And he said why don't you have an abortion...and then maybe next time...But I'm too scared...I would never do something like that (002).

The fact that this couple failed to reach congruency regarding childbearing not only affected how the woman experienced childbearing, it almost destroyed their relationship. For subject 008, congruency did not occur with her partner. For her, accepting the pregnancy also involved accepting the fairness of raising a child without a father:

> I started to feel responsible and I started to feel really guilty

> because I thought is this fair to the baby? Is it fair to do this...a child without a father...especially when he was not around when he was deciding that he was not going to be involved. I suppose then I was feeling very badly but it was a fleeting moment. By then I already decided that I had wanted it for so long it wasn't something that I would do (008).

The two participants who were "in sync" with their partners in not wanting children found congruency with their partners almost immediately upon discovering that they were pregnant. Subject 005 had the greatest difficulty sharing the news of the pregnancy with her husband. This may have been associated with the difficulty she was having in accepting the pregnancy. She related the details of telling her husband:

> ...he went over and he sat on the bed and he turned white as a ghost and he actually had a smile from ear to ear and when I saw that smile that was really all I needed and he laughed. He just thought it was hilarious. He didn't turn somersaults but he did laugh.... And its a funny thing that I never knew how he would react. I was really surprised and that was like a big relief cause I hadn't told him for two weeks. It's a good thing that you have 9 months to adjust to having this baby because it took me a good 6 months to feel really excited about having this baby (005).

Support from family and friends. All subjects received support from their family and friends. For those who had not expected to parent, comments like "you'll make good parents" validated their decision to proceed with the pregnancy. Surprise and shock were typical reactions of friends and family. "I think a lot of people's mouths dropped open actually." (001)

Action/Interaction Strategies during Pregnancy

Mature primiparas engaged in action/interaction strategies that provided evidence

of and assisted in their acceptance of the pregnancy. These included presenting the pregnancy, complying with the rules of pregnancy, and preparing for delivery.

Presenting the pregnancy. Accepting the pregnancy and presenting the pregnancy to others were closely linked. Those who had difficulty with acceptance seemed to delay the process of presenting the pregnancy. Most subjects waited until the results of the amniocentesis before telling friends and family. For subject 009, who had experienced a miscarriage, presenting the pregnancy did not occur until an ultrasound showed a heartbeat:

> The first time we were high as kites and we told everybody. I think that 200 people knew. I miscarried at about 6-7 weeks, so all these people had to find out. It was hard. With this one we were scared..so we told very few people. He was happy but we weren't going to get ourselves elated until we saw the heart beat on the screen. Then we relaxed a bit...then we could tell everyone...but we didn't put out a banner or anything. A lot of the pregnancy I was scared (009).

Subject 005 waited to present the pregnancy until she was five or six months pregnant. She had held very negative views on childbearing and saw the pregnancy as threatening her career as well as her relationship with her husband.

Complying with the "rules of pregnancy". All of the participants knew the "rules of pregnancy" regarding diet, alcohol consumption, and cigarette smoking. Some found these "rules" more difficult to follow than others. For example subject 001 had to make many adjustments to her normal routine:

> ...I didn't eat junk food I skipped that kind of stuff...I'm a coke addict but I changed to diet coke...just one glass a day ...and I drank all that milk...and I tried to you know how you're supposed to eat so many portions and I tried to

> follow that ...I'm not used to eating a lot ...we used to skip dinner and just have a sandwich or crackers for dinner and you just couldn't do that sort of thing...so you always had to plan dinners...and make sure you were eating all those little snacks...I maybe didn't do that good a job ...I only gained 21 pounds...so maybe I wasn't eating all that well (001).

Following the "rules" was a means of maintaining control over the pregnancy. Maintaining control, in turn, was identified as an action/interaction strategy women used to mitigate or cope with negative aspects of their experience.

Preparing for delivery. The majority of the subjects attended prenatal classes. The focus seemed to be on preparation for labor and delivery, rather than learning about nutrition or exercise during pregnancy:

> And why she said this is that because of age, we knew nutrition and so forth and a lot of our friends who were in their thirty's and went through that found it was boring. We went just one day. It dealt with a lot of concerns that we had and that was labor and delivery. I didn't care about nutrition. I knew what I could and couldn't eat (003) .

The need to feel prepared for labor and delivery was a strategy designed to assist the subjects to maintain control over their experience. Acquiring knowledge and attending classes was seen as a means for paving the way to success, or for ensuring involvement of their partner:

> And we went to prenatal classes and that really put him as the significant person in this ordeal. You know it was like I had read books throughout my pregnancy, read books but he never read anything and he's a real book reader. He reads a lot. I would tease, I would say well I guess you think that I'm going to be the real knowledgeable one in this. I'm going to do everything. And he would say oh no, I'm going to do crash reading (005).

For subject 006, attendance at prenatal classes raised anxiety. Her husband had not yet accepted the pregnancy. For him, being present at the classes was confirmation of the pregnancy and this was uncomfortable for both of them.

SECTION III - Experience of Labor and Delivery

Expectations for Labor and Delivery

The main response women had toward labor and delivery was one of fear. Many participants expressed a fear of the unknown, as well as a fear of the pain which they thought would be involved during labor and delivery. Two of the participants said that they would prefer to have a cesarian delivery than suffer through a vaginal birth:

> ...I think that was the worst part of the whole thing...what I thought it would be like...over the years being my age I'd gone through the different groups and I'd heard all about morning sickness, 36 hours of labor and all this...(001).

> I was okay with it...the c-section. They had started talking about it earlier on...you are so small...with your back problems and your age along with this and that, you'll probably have 40% chance of surgery. I've had surgery before...I can deal with post-op...but I didn't know what giving birth was like and I was frightened to death of it. I was more frightened of labor and delivery than of a c-section (009).

Subject 005 compared her expectations for the experience to that of having cancer:

> Fear of the unknown...when you've never gone through it and you don't know what your delivery is going to be...It's like some one telling you that you have cancer and you are going to die and you don't know when you're going to die...or how you're going to die...(005).

Subject (005) also feared the indignities involved in labor and delivery,

> "I wasn't looking forward to putting myself in that position...legs wide open and exposing myself to every person who pops their head in."

Perceptions of Labor and Delivery

All nine participants found that their labor and delivery experience was far more difficult than they had ever anticipated. The failure of their expectations to match the perception of their experience contributed to their perception of childbirth as a negative experience and to their perception of childbearing as a bittersweet experience. Those who had attended prenatal classes felt that they were left unprepared to deal with their experience. A number of themes were associated with the participants' perceptions of their experience. These included sense of control, support from their labor coach, pain management, doctoring, and the perception that there was a danger to the infant.

Intervening Conditions Affecting Perception of Labor and Delivery

Sense of control. All but one of the subjects experienced some type of complication during labor and delivery. Techniques for pain management practised in prenatal classes and birth plans were discarded when medical interventions were required. Table 1 indicates the complications and the medical interventions which were experienced by the subjects in the study.

Table 1

Complications and Medical Interventions

Subject	Complications
001	cesarian birth for fetal distress general anesthetic
002	premature labor and delivery at 26 weeks
003	vacuum extraction for CPD epidural
004	cesarian birth fetal distress, breech, PIH spinal block
006	forceps for CPD, manual pushing back of the cervix oxytocin, no analgesic
007	forceps, vacuum extraction oxytocin, spinal block
008	high forceps for failure to progress epidural
009	cesarian birth epidural

Subject (002) experienced a premature labor and delivery, so that her experience was quite different from her expectations. She did not know what was happening to her, or whether her baby, who weighed only 900 grams, would survive:

> When did you start contracting she asked me because I was already having so much pain and I said no I'm not having the baby it's too early. But I went straight into the delivery room and the doctor examined me. I said I want to go to the toilet and the midwife said oh no we don't want to have a baby in the toilet and she gave me a bedpan and the doctor was examining me and it just went out everything and I was still holding it I don't want the baby to go out because I knew it was too early.I have to go back. It was everything and I said what's that I didn't push it or anything and I feel all the pain is gone. And I didn't even move I didn't want to see what happened either. I just closed my eyes and I could hear them...(002).

Some women felt that they had not had an opportunity to prepare themselves emotionally for the labor because they found themselves in a situation which was different from what they had expected. Birth plans, which were to have afforded a sense of control, were of little value:

> So I was hoping to have a nice natural childbirth. That's what I was anticipating. But that was before the blood pressure problem. I wanted little or no medical intervention. I had wanted to stay home as long as possible, but it just didn't work out that way (004).

Subject 006 did not fully dilate so that her cervix had to be manually pushed back by the physician. This was done without any communication with the subject and without any pain medication:

> I realized after. He may have said something but I didn't feel that it was directed at me. Because I can remember saying "what are you doing!" ...and I said you're hurting me...and that was the worst part for me. I felt totally out of control that these things were happening to me... (006).

Pain management. Within the participants' perceptions of their labor and delivery experience, pain management and sense of control were found to be closely linked. An example of this is given by subject 003 when she discussed how their birth plan assisted in helping her to maintain a sense of control over her pain:

> Subject: I really think you have to have a game plan otherwise I could have easily become hysterical in there with my pain.
> Researcher: It helped you to maintain control?
> Subject: It certainly did. I could vaguely hear my husband say "well I think that it's time for you to give her something and what can we give her". And it was okay because he knew that I had come to that level that we had spoken about (003).

All of the subjects found that their experience of pain during labor was far greater than they had expected. Subject 005, who actually experienced no complications and who had likely held the worst expectations for labor and delivery, shared her perception of the experience:

> No one tells you a lot of things. No one tells you about delivery. They tell you about the breathing and all this but no one ever tells you how painful it is and what a horror it is. It has got to be, and I bet every mom will tell you this, that has got to be the most...I shouldn't say the worst because that would be negative...but its got to be the most difficult time in their entire lives to have to go through (005).

Subject 003 had expected that she would be "a brave enough soldier to deal with the pain" of labor and found that she could not. She required an epidural:

> The epidural was starting to wear off. That's when I said I feel this pain I don't want to feel this pain like give me something because I was so afraid of the pain... I did not expect the labor or delivery to turn out the way they did. But I thought I would be able to cope with it. I would endure and I couldn't...the pain was too great (003).

The majority of subjects found that the techniques learned in prenatal classes for pain management were of little or no value:

> And I was trying everything I'd learned in the prenatal classes. For me they just made it worse...every position with every pain and I thought oh this is harder. The only thing that I found that worked for me which was basically that I would become catatonic. I just literally couldn't move and I just closed my eyes and I was just kind of getting into myself and that worked (006).

Two of the subjects (004) (006) likened their experience to dying and going to heaven:

> I had had no pain medication by that point. They were coming every minute just non-stop and the baby's not moving and my body was just involuntarily pushing. It was really difficult... at that point I thought I was going to heaven. I thought that I was dying (006).

Two of the subjects (006, 007) who delivered vaginally wished that they had had a cesarian birth:

> I expected I'd go in and be in labor for a few hours and have the babies. I thought it was going to be a normal labor. I thought there was going to be pain and everything but I didn't expect that it was going to last over a few days and nothing worked. I expected that the epidurals would work...I mean after such a good pregnancy I wished they had just given me a C-section and got it over with....It was just a lot longer and worse than what I thought (007).

Support from labor coach. Eight of the nine subjects had expected support from their labor coach during the labor and delivery process. The coach attended prenatal

classes and worked with the subject to develop a birth plan. The majority of the participants found the support from their coach to be invaluable:

> I guess he was so tired that he quit breathing and I grabbed him by the shirt and I pulled him down and I said start breathing...because I would look at his face I would concentrate on his eyes and he would breathe with me. So he would regulate my breathing also. But he was tired. I needed him so that I think that if he weren't there I would have gone to pieces...(003).

Only subject 004 did not find the presence of her labor coach to be helpful:

> You know they say how important it is to have your mate there with you for support. When this all started I really felt sorry for him. There was nothing he could do. I'm in agony and I didn't want to hold his hand, I mean I was throwing up and I thought why does he have to look at all of this. At that point I was really unaware of how many people were around me (004).

Doctoring. The physician who cared for the subjects during their perinatal experience played an important role in setting up expectations for the subjects and in determining how the subjects perceived their experience. Some doctors were entirely prescriptive while others were willing to discuss birth plans with their patient and to take into account the patient's wishes. The attitude of the physician toward the mature gravida was particularly important in determining how the subject perceived the experience, therefore, "doctoring" was identified as an intervening condition in the study.

One woman's doctor claimed that her difficulties arose because she had a weak placenta because of her age. Another's physician suggested prior to the onset of labor, that because of her age, she would be a candidate for a cesarian birth. A completely different attitude was conveyed to the subject who developed pregnancy induced

hypertension (PIH). Her doctor maintained that pre-eclampsia often occurs with first pregnancies and that with subsequent pregnancies there may be no concerns of this nature, that is, PIH was not age-related.

Some of the women felt that there was a problem communicating with their physician. The failure of the physician to prepare their patient for procedures and to give adequate explanations lead to misunderstandings, stress, and fear. Subject 002 was told that she was going to have a big baby. This frightened her "because I am so small and I don't want a big baby. So all the time I don't eat too much. I don't want a big baby to get bigger."

Subject 001 had not been prepared for the likelihood of an early admission:

> The doctor said oh I guess we'll have to bring this baby out early... and I thought he meant that in a few days I would go in...but he meant that day...so I almost died. I had to go to the hospital right from the doctor's office...(001).

Providing the patient with explanations and some input into decision - making was felt to be important because it allowed the patient to retain a sense of control over her body and the overall process. Subject 004 and her partner were given a full explanation of the risks related to PIH, to the fact that there was fresh meconium in the amniotic fluid, and to the fact that the baby was breech. They were given a few moments of privacy to decide how they wanted to proceed. The physician who cared for subject 007, on the other hand, gave her no input into the decisions regarding induction or the use of a spinal block. These procedures were instituted on the basis of the fact that he wanted to safeguard her twins rather than on any medical complications.

The differences in physician approach can be clearly seen when the experience of

subject 003 is compared to that of subject 006. Both required the assistance of forceps or suction during delivery:

> I really felt he was pulled out rather than pushed out because he would say push but I was really just trying to keep up with the force of the pull...That scared me because I felt that I had to keep up with this because he's being pulled out (006).

> She said I'm just putting this on his head but don't worry it will just assist you. When you push I will pull. So in my mind I thought this is good, now I don't have to do all this work by myself (003).

Those subjects who had a female physician appeared to have been given more anticipatory guidance, more input into decision making, and to have been treated with more empathy than those subjects who were cared for by a male physician:

> And I think it really helped me to have a female doctor. I don't care what anybody says, you could have a wonderful male doctor who delivers children but he'll never know what you're going through. Because she (her doctor) gave birth and had a cesarian and had a traumatic time with her first. So she knows exactly what you're going through. She was very calm and monotone through the whole thing and she would encourage me and when I would get a little ornery she would say you're making progress and I would say no I'm not you're lying to me she would be very calm and say yes come on now. So it was good. It was important to have someone like that there (003).

The comments made by subject 003 can be contrasted to the opinions that subjects 001 and 009 held about their physicians:

> The doctor wasn't there...they usually come in at the last minute and take their bows...it was she (the nurse) who decided that something was wrong (001).

> I thought maybe I caved into the doctor...because he wasn't my regular doctor and I think now that he was just trying

to make it easier for himself (009).

Perceived threat to the infant. The awareness of risks to the infant had created anxiety in the early weeks of pregnancy, and all of the subjects had agreed to continue their pregnancies on the basis that their baby would be healthy and whole. When medical complications posed a threat to the infant during labor and delivery, these expectations were also threatened. An example is given by subject 006 when she learned that the physician was about to use forceps to assist the delivery:

> ...he said we've got to get him out...and they were going to use forceps...and that by the way was my dread. Of all the things, again because of my field I've worked with so many people who are mentally handicapped because they had forceps in their birth history and now granted I realize that that doesn't necessarily relate, but in my mind it did (006).

Action/Interaction Strategies during Labor and Delivery

The majority of participants developed strategies which they hoped would prepare them for the experience. These included attending prenatal classes, developing a birth plan, and securing the support of a labor coach, in most cases, their husband. Strategies were identified which were aimed at maintaining control of an unknown and frightening experience. Women prepared for their experience using the tools which had worked for them in the past, studying, reading, planning, and organizing.

Attending prenatal classes. Eight of the participants attended prenatal classes in order to prepare themselves for the labor and delivery experience:

> She focused on delivery, explaining what delivery was, what was going to happen and how you can make it easier for yourself. Just going through breathing techniques and

> positions and then she went through some of the complications that you might be faced with and the sort of decisions before you went to the hospital so that you have a birth plan (008).

Subject 006 could not imagine what to expect, and prenatal classes failed to enlighten her:

> I honestly had a hard time visualizing at all what to expect and I know that one of the most frustrating things for me in the prenatal classes was trying to visualize what the heck was this contraction going to be. I just couldn't fathom in my mind what that was going to be. I just couldn't conceive...I can still remember the words "Just consider a grapefruit coming through your vagina". It's like I can't!! I honestly just couldn't visualize what it would all be about (006).

Developing a birth plan. Eight of the participants developed a birth plan which included the timing of the trip to the hospital, the type of pain management which would be acceptable to them, and support from their labor coach. The labor coach was expected to provide support and encouragement to the subject during labor and delivery. The labor coach participated in developing the birth plan, and was to be the patient's advocate. The birth plan was designed to help the subject maintain control over an unknown and frightening situation:

> I thought I could cope with the pain. Even one of the questionnaires said would you consider taking this type of drug ...and I said I would wait until the very end (003).

> We both were of the same opinion. We weren't going to have heroics. I was going to just play it by ear. If I thought things were going fine but if I felt that some pain relief would help then I was going to ask for it (006).

Minimizing discrepancies. The perceived experience of labor and delivery was

different from the expectations in every case. These women attempted to minimize the discrepancies between their expectations and their perceived experience by using a number of strategies. Only subject 005 experienced a labor and delivery without complications and without analgesic. Even though she found the experience to be more difficult than she had ever expected, she felt proud of her performance:

> I wanted to do it perfectly. I wanted to get an A in it. I never thought about it that way. And I wanted everyone to know I got an A in it, especially my husband. I wanted him to know about it. And it even felt like... well my pregnancy... people say I had a textbook pregnancy, a textbook delivery, and so I wanted a textbook baby (005).

Five of the subjects expressed the idea that even though the labor and delivery experience did not proceed as expected, they were satisfied that at least their baby was healthy. They were able to say that without medical intervention, this outcome might have been otherwise.

Subject 009, on the other hand, worried that she had "caved in" to the doctor because she did not insist on a trial of labor:

> It was probably the right decision in a way, otherwise the doctor might not have come back until the next night to check. It would have been when it was convenient for him I'm sure. In retrospect, it would have been a very long labor...the head was high...a forceps delivery probably...he didn't need that. I didn't need that. It might have been a distressed birth. For all the little problems we had that first week, the baby didn't have an extra one (009).

Subject 006 had been subjected to medical interventions during the labor and delivery for which she was unprepared and which left her feeling out of control. However when she spoke to the physician the next day, she was more able to understand the

urgency of the situation and to rationalize why it had to happen as it did:

> I didn't know what was happening at the time. But what was explained to me by the doctor is he had to get him out. It was basically the point of no return...so that's why the forceps were being used. And it was the next day when the obstetrician came back and told us that it was, as he described it, the kind of situation that gives him grey hair. It was that nip and tuck and he said," I couldn't have used any more force. I used as much force as I could and it was just enough to get him out" (006).

A number of women sought out whatever positive aspects of their experience that they could find. Subject 001 felt that her experience could have been worse. She could have been in labor much longer before the cesarian birth. Subject 004 had a taste of labor before her cesarian birth and she was satisfied that she had not missed anything by not experiencing a "natural childbirth". Subject 006 was the only one who experienced medical interventions without analgesic. For her the positive aspect was how the pain was gone as soon as the baby was delivered:

> I think one of the things I remember most is how it all ended as soon as he was out. That was the most powerful experience. Being in that much pain and to be going through that much trauma and then literally the second he was out it was over. It was like a completely different world. It was wonderful and I will never at least I hope that I will never forget that moment. It was just kind of like an incredible experience (006).

Three of the women experienced some difficulty in minimizing the discrepancy between their expectations and their perceived experience of labor and delivery in the early postpartum period. Subject 002 experienced a premature labor and delivery. She was unable to minimize the discrepancies because not only did she feel that she had been

careless during her pregnancy but she also did not know whether her baby would survive:

> I feel guilty. I was careless. I was so scared that there might be some abnormalities some complications because she was so small. And I said it's my fault. Because I didn't take care of her like that (002).

Both subject 008 and 009 talked about feelings of failure during and immediately following their experience. Both of these women had healthy babies. Subject 009 had experienced a cesarian birth because of a failure to dilate. Subject 008 had experienced a high forceps delivery for cephalo-pelvic disproportion and failure to progress:

> The feeling of why is this so hard. And after it was over I guess philosophically I had a hard time with the whole process of why do you get pregnant and why is it so difficult and why would you get pregnant and the baby not be able to come out. And I've talked about it among women and we've just sort of come up with the philosophy that well a lot of us just wouldn't have had babies if it weren't for modern medicine... But I did find that difficult. And you want to go through it as naturally as possible. I mean women have done this for centuries. How did they do it? You wonder about that. And you feel like a failure. (008).

Subject 009 received counselling from the head nurse on the maternity unit to help her to come to terms with her feelings of failure following delivery:

> The girl beside me...they were making such a big deal about her delivery...this nine pound baby vaginally...and I couldn't deliver a six pounder. It really upset me. And some of the nurses...this didn't help...some of the nurses even came in and said stuff and I felt like I didn't fulfil my "womanly" part like I didn't do it right (009).

The perception of labor and delivery for every subject was that it was far worse than expected. Those who had difficulty minimizing the discrepancies experienced

feelings of failure.

SECTION IV - Experience of Motherhood

Expectations for Motherhood

Subjects entered into motherhood with an array of expectations about how this experience might unfold for them. Satisfaction with parenthood did not automatically come to those who had initially expected to parent and who were congruent with their partner regarding childbearing expectations. All participants, regardless of their desire to parent or their expectations regarding motherhood, required a period of time to form attachments to the baby and to incorporate the baby into their lives. Once subjects had dedicated themselves to motherhood, the majority had to begin to separate from their infants in order to return to their careers.

The majority of subjects held high expectations for their experience with motherhood. High expectations contributed to women's perception of their experience as bittersweet because, in the majority of cases, the perceived reality of their experience was incongruent with their expectations.

Expected lifestyle changes. Women differed greatly in their expectations of the impact pregnancy would have on their lifestyle. Participants 004 and 005 had never expected to parent. Participant 004 had never given childbearing much thought and had no preconceived notions regarding what lifestyle changes might occur as result.

Participant 005 had completely negative expectations regarding how childbearing would change her lifestyle:

> I thought that it would change our lifestyle dramatically. I think that the older you are the more aware you are of the commitment of having children. And I knew that if I was going to have a child, it would be a lifetime commitment. For the rest of my life. I'm 37. For the next 20 years anyway...oh well for life. So its obviously going to drastically affect your lifestyle. I just wasn't ready for it...(005).

One woman (002) had never discussed childbearing or expectations regarding lifestyle changes with her husband. Another (006) and her husband did not reach congruency prior to the birth of the baby. Expectations regarding lifestyle changes from this husband's perspective were completely negative. Women who wanted to parent, and who were in sync with their husbands, believed that changes to their lifestyle would be minimal:

> I knew it would tie us down a little bit. But we just thought that it would enhance it. There would be someone else to show all this wonderful stuff to...we'd take him back to all these places we'd seen (009).

The remaining women, who wanted to parent but were not in sync with their partners prior to conception, shared the belief that lifestyle changes would be minimal:

> I didn't think it was going to do much and I still don't. I resigned myself to the fact that it would alter it drastically for the first six months. I faced that and definitely for the first three months I said I don't expect to do anything and then I said over the next few months I should be able to do a bit more. I definitely said that after six months I don't expect it to change my lifestyle a lot... (008).

Expectations for the child. Some of the participants had a very definite picture in

their mind about how the baby would look. Because of amniocentesis, a number of the subjects knew the sex of the baby:

> I knew that it would be a boy and that it would have dark hair and blue eyes (003).

Some of the women held expectations concerning the type of relationship that they would have with their child:

> I think most of the thoughts I had were about a child not a baby. Like when they're about a year or two or three and that process. The relationship that you have with them...the friendship. I have a nephew and I think I've looked at that relationship and thought about having a baby in that sense (008).

Women tended to have fairly high expectations for their children. Some who had sons seemed to emphasize the importance of their being involved in sports activities. Subjects also emphasized the importance of their child attending university and of "making something of himself". Their children were expected to develop rather sterling qualities:

> I want him to have a wonderful sense of self esteem which I don't think I had as I was growing up...a sense of self worth...self love (009).

> I would like him to be a leader not a follower cause I think that is a clue to a lot of things. How confident you are in yourself. And I want him to be that. I want him to be able to say no or I don't like that. And I think it's from my mom ...don't be afraid to do this or that and if you make a mistake never be afraid to walk into a room with your head held high. Never be ashamed of anything (003).

Expectations for themselves as parents. In considering how they would parent their child, the majority of participants reflected back on the way that they were parented.

Some hoped to imitate aspects of the way that they were parented. Others hoped to correct some of the mistakes which they felt their own parents had made:

> I'm thinking when he's older...if he's in the park over there saying something that he's not supposed to that I will go out there and just grab him by the ear...so maybe I'll be the one who's too strict...my husband is a real neat freak... that's not strict exactly but he's going to make sure that he doesn't mess things up....Because of the things I wasn't shown...I'm going to teach him how to cook... have him cook in the kitchen with me. I think he should learn things (001).

Subjects generally had high expectations for themselves in the parent role as is shown in the following example:

> Well, I think I will instill in her a lot of the things that I have learned through the years. Confidence, positiveness, giving, sharing, and good listener. All those kinds of things. Making her feel special, and for her to love herself....I'm hoping not to spoil this child because I'm only going to have this one child...(005).

Subject 008 suggested that as an older mother she wanted to do the job "correctly:

> You tend to over do it. You tend to want to know everything. You want to make sure that you are doing the job right. You want to get all the information you can...but I also don't want to be one of those mothers that pushes their child and you know that you read about all that too "my child is only a year old and already he's doing this" (008).

Perception of the Experience of Motherhood

Women provided a detailed account of their perception of motherhood. They described their initial reaction to their baby, what it was like to return home with a newborn infant, the support they received, and their perceptions of breastfeeding.

Initial reactions to the baby. Women who had medical interventions were reluctant to hold the baby following delivery:

> I was quite aware but I just didn't want to hold her because of all the apparatus around me and I knew I wasn't really as alert as I thought I was but my husband was there and he held her (004).

Most of the participants expressed disbelief that this baby was theirs:

> I wondered on the way out of the hospital is anyone going to ask if this really is my baby. Do I look like this is my baby? As if someone was going to walk up and say "excuse me miss but is this your baby?" (008).

Many expressed the idea that they did not immediately feel a connection, a bond with their baby:

> I was in disbelief - I think this whole thing was in disbelief. I knew she was, I mean she's the spitting image of my husband. She was even at birth. You knew right away who her dad was. I feel a whole lot closer to her now. But it's quite a concept. I was interested in her... looking at her hands and feet - to learn about what she was like. But I didn't feel any immediate bond (004).

Subject 003 found a remedy to the pain and exhaustion which followed labor and delivery:

> You should have seen me the days after. My eyes, well you couldn't even see my eyes. I was so bloated and swollen. I was very very tired. But its funny, when they give you the baby, your energy seems to come back. You just perk up. When I would hold him I just perked up (003).

Some of the subjects became quite emotional during the interview as they recounted their birth experience:

> Well I guess it felt unreal. I felt that it wasn't happening. I just couldn't believe that this was our little fellow. And with my husband crying....I can't believe how choked up I get when I think about it even now (subject broke down and began to cry as she recollected the birth experience) (006).

For subject 002, initial reactions to the babe included tears but not of joy. She expressed feelings of guilt and concern because of her early delivery and her baby's unknown prognosis:

> And I went home it was not a home it was a camper van. That is the worst thing I have ever experienced in my life...going home without your baby and you are in a foreign country. I am just glad that my husband is there with me. I just go to the trailer park and I am crying and crying and I sit on the floor and I am crying and crying. I just want to sleep and not wake up at all but my husband said we have the baby you should be strong (002).

Subject 009 found the first few days in the hospital to be quite upsetting:

> I was overwhelmed by a lot of feelings...love...I think I attach pretty quickly...inadequacy. For a few days I was very confused about what was expected of me and what wasn't. After the surgery I hardly had him the first day, I didn't know what was expected of me. I tried to start breast feeding right away, but I was kind of bewildered and a little depressed funnily enough (009).

Initial reactions to and feelings for the baby were not what was expected by the majority of subjects and can be seen as contributing to their mixed perception of the experience as bittersweet.

Perceived realities of coming home with the baby. The first few weeks home with the baby were found to be overwhelming and exhausting for the majority of the participants. This reality did not match their expectation of motherhood. The subjects

commented that it felt very strange to have a baby in the home and to be his\her mother. The following passages express the emotional turmoil experienced in the first weeks home:

> When I brought that child home, the feeling...it was the weirdest feeling when I walked out of that hospital and came here and had that little baby...walked through the door...it was. It was a weird feeling. It was like my whole life... stepping into a new chapter of my life. It was like I didn't even know my home. You know when you've gone on a holiday and you've been away a long time and you come home and you feel strange. Well that's how it felt and I had just been away for two days (005).

> All of a sudden there's this little baby here. The first night we had the monitor on - full blast - and she made one little noise and I jumped out of bed. I thought it was good to start her in her own crib right, but I ran down the hall so fast I thought my heart was going to jump out ...it was pounding so hard. I still wasn't moving around so good (004).

> I think I was so bagged when I came home that the first few weeks are just a blur. After that kind of labor and everything I was just... I had to go back the following week for a D & C because I was bleeding quite heavily and they realized that they didn't get everything out. It's all sort of a blur (007).

> I remember too denying the discomfort that I felt from my episiotomy. I had no idea that it was going to hurt so much and I think for the while after we were home that I was just running on adrenalin (006).

Perceptions of breastfeeding. Seven of the subjects started out breastfeeding their infants. Six of the subjects were still breastfeeding at the time of the interview. Subject 007 expressed disappointment in the fact that she was unable to maintain breastfeeding:

> I breast fed for about a week. But how can you breastfeed when they tell you you're supposed to get lots of rest and

> you're supposed to eat properly. Even now I don't eat properly. It's just too busy. And at the beginning there was no way. I was breastfeeding almost 24 hours a day between the two of them. I wasn't getting a lot of sleep so my milk wasn't coming in properly. I thought I just can't do this any more. Not just for me but for them (007).

Two of the subjects (004,008) had difficulty with the whole concept of breastfeeding:

> Well at first I thought it would be...well breastfeeding seemed so strange, as a single person you don't associate your breasts with nurturing a child (004).

The participants who breastfed had done extensive reading and consultation in order to prepare themselves for the task. Despite this preparation, some of the participants found breastfeeding to be quite difficult:

> However it was very hard at first... He was on supplements from the beginning which made it difficult because he got nipple confusion. My nipples got sore because he wasn't latching on properly. His mouth was so small. I wanted to do it so much because I had the cesarian so I wasn't able to give birth. So I really wanted it to work. In hospital I would try for an hour to get him on...he wouldn't even be eating...just trying...finally I would be in tears. I would call for the nurse. At one point I had four nurse and a doctor in the room. I burst into tears. I said the baby is going to starve to death...what am I going to do? (009).

In addition, for at least one subject, the experience was less gratifying than anticipated:

> I have mixed feelings about this breastfeeding. Again I think you can really get into that...you feel like there's supposed to be this feeling that you get...this emotion...this bonding...and to me it feels more like a function. It doesn't feel like an emotion. I mean I am thrilled, I am happy that I can do this for him but its not...that thing where...I don't know whether I just fantasized that it should be more than

> it is or whether books or whatever literature that I've read has made it that way...has made me feel that like I said...this bonding. I feel that there is a bond there no matter even if I didn't breastfeed (008).

Common negative perceptions. The majority of subjects believed that no amount of readiness training could have prepared them for the experience of motherhood. This was something that you have to experience in order to understand. "Except you don't prepare yourself. For everything I read and heard that it was going to be a lot of work, it didn't prepare me" (007). Negative perceptions were unexpected and lead to the perception of motherhood as a bittersweet experience. The following are some of the common negative perceptions which were identified by the subjects:

1) Lack of sleep.

> And my biggest concern after I delivered the baby, because you don't get any sleep for the five to eight days, whatever, is I need sleep...and for the first week, I don't even remember it. It was like a nightmare. It was like a dream...no nightmare because I never got any sleep. It was just crazy. For me not to get any sleep...it was like I really didn't even know what was going on. (005).

2) Having no time for yourself.

> I found that I could have breakfast or I could have a shower but I could never have both on the same day. My friend is the same age as me and had her first baby about 3 months before I had mine and we'd talk - this was before my baby was born -and she'd say I haven't done a thing all day and I'd think come on, it can't be that difficult to make a cup of coffee or well I just couldn't believe and looking back now, I'm not even sure why I couldn't do those things, but it just seemed that every second that was free you had to do something and I had no idea of the time that would be involved. (004).

3) Worries about the baby's wellbeing.

> Because even now...they're supposed to cry to let you know when they are hungry or not knowing what kind of a cry it was...okay was this a hunger cry? was it because they were wet? or what? Just not knowing. Them not being able to tell you what's wrong. (007).

4) Feeling cooped up and isolated.

> I would say to my husband, I'm bored I can't stand just sitting around here. I need some kind of stimulation besides watching TV. I mean I was so sore I couldn't even really go for walks. But I was ready to go to work. And I kept saying I'm bored here, I'm bored and I resent the fact there you are at work having conversations with people and here I sit. (003).

5) Having to set new priorities.

> I'm not as organized. When he's awake I just don't want to stick him in a chair. I want to make sure he gets adequate play, adequate loving...otherwise I feel very guilty. I think he really needs the playtime. He has a lot of learning to do and so I think it's really important to work with him. He's the priority. Often, I haven't even got supper started when my husband gets home but that's okay...we're flexible. I think that's part of being older...we're flexible about things like that. (009).

6) Worries about parenting. The majority of subjects were concerned about how they would handle their child as he/she became a teenager. Drugs, AIDS, peer pressure, and manipulation were key issues:

> It's scary right now having kids. I look at all the teenagers out there and I wonder what it's going to be like when they're 13 or 14 years old. With AIDS and everything. I don't like to think ahead like that (007).

Some of the participants worried about their age in terms of parenting their growing child:

> I'm worried as he grows up will I have the energy to cope with him. We've started going to fitness classes and my husband joined the spa to try to keep our selves in good condition. I think overall we've become more aware of our health since the baby has joined us. I worry about the isolation. My family and my husband's family live away from here and I wonder if the baby will ever get to know his grandparents in any way at all... We've even talked about having a second baby and what that might be like. I wonder what it would be like for him to be an only child with older parents (006).

> Actually its funny because I thought about that tonight. I thought I wonder how I'm going to feel when I'm fifty and he wants to get roller blades. I was watching a TV commercial and I was wondering how I'm going to feel. But then I'm forty and I would put them on today so why wouldn't I put them on when I was fifty? That's my attitude. I mean I'm active, physically active. So hopefully as long as everything is still working I'll be able to do that. I hope that I still have the energy. I will work hard to have the energy (008).

> It might be harder because I've heard that children don't want an older mother, when they were in school, because they think that their classmates will say that they are their grandmother, but I don't think I look like a grandmother (002).

Common positive perceptions. Two features of motherhood were identified which assisted the subjects in folding the child into their lives. Both of these features were based on the passage of time. As the infant became more mature he/she began to interact with the subject and in addition the infant became more predictable so that the subject could take back a little of the control which had been lost.

1) Maternal-child interaction. Subjects felt increased satisfaction with motherhood as their infant began to react and interact with them:

> I find it quite a routine...feed and bath and change and that's really all it

> is. There's the emotional but I think really in the first few weeks...in the beginning, I was confused and I thought is this all there is and then you start to get feedback from them. As soon as they start looking at you and you start getting something coming back to you, then you realize that all this is for a reason. (008).

2) Infant predictability. When the infant began to sleep through the night and subjects felt more rested, motherhood became far more enjoyable. Some subjects were willing to contend with daytime crying providing that the baby slept through the night:

> ... I'm two months into it and its getting easier and easier. Now that she's sleeping through the night, I just feel I'm in heaven. It's just like "no sweat". I don't care if she's cranky in the day, babies have to cry but she's just great. (005).

Most subjects found that increased infant predictability gave them the ability to venture out to visit friends and the shopping malls. One exception to this observation was subject 009, who felt more isolated as the baby got a little older:

> He screams trying to get him into his outdoor clothes and I just want him to be happy...so I just don't go. Just even taking him out for a walk...I know the fresh air would be good...but I can't deal with the screaming...so I just think...forget it. I won't go. So we get stuck... Some things are a lot harder than I envisioned (009).

Subject 008 found that the lack of infant predictability was very difficult for her:

> Every day is a new day and when he wakes up you don't know. He may be the best baby that day and you just think oh maybe he's going to be that way from now on and you really know that he's not but the next day may be good again (008).

Intervening Conditions

Support. All of the subjects had supportive help when they brought their infants home. Support was extremely important to the new mother in helping her to cope in the early weeks postpartum. However, support did not offset the perception of the postpartum period as a bittersweet experience. Seven of the subjects had their mother come to stay with them while they recovered. Other family members as well as friends and neighbors were mentioned as supports. Three of the subjects mentioned the Public Health Nurse as being helpful during the early postpartum period:

> I think the hardest thing in the first month, well I was really lucky to have my mom come. She came for a couple of weeks and my sister. I don't know how any woman can go through this and have no help after. You have got to have that help after (005).

Some of the subjects found that there were too many visitors and that this sometimes added to their stress. Subject 008, although she appreciated the help she received, found that she did not really begin to attach to her infant until she was alone with him:

> I think it was after the first couple of weeks, after we had been alone for a while. I think I was sort of overwhelmed at first by visitors and people. My mother stayed with me so we were never alone. After we were alone I felt that we started connecting or I felt more...maybe because I felt more responsible or I was closer to him...maybe because we could do what we wanted (008).

Subject 005 had expected that she would lose many of her friends after having the baby. She found that she actually regained friendships through the process:

> Everyone wants to drop over and see you. You get phone calls. I never knew people did that. I never knew it was

> such a big deal. I couldn't believe that these people were so overwhelmed at this baby of mine. Why should they? I mean I could see me being overwhelmed or my husband, but why are all these people calling and sending flowers. I mean I had flowers all over that table and there. I couldn't believe it. I mean why were all these people so excited for me? This is what shocked me. You see I guess I really never really got that excited when anyone had a kid (005).

Dedicating to baby. All of the participants discussed the intensity of the love which they felt for their infants. For some participants this emotion was almost frightening. The following passages illustrate "dedicating to the baby":

> I can't get enough of this little boy. The love that I have for this little boy I can't put into words. I mean I would throw myself in front of a train for him. It's just unconditional love. It's something that a person just can't explain (003).

> The passion. The depth of feeling that I have for him which I never dreamt I could feel for anyone. Its different from anything you might feel for a lover or a husband. A passion after going through this experience which I would never have understood even if someone had explained it to me (006).

> How it scares you. How it... I don't think I've ever felt like that. It's just like an extension of yourself. It's very hard to describe. It shocked me because I didn't realize how deep it was or how emotional I was about it...(008).

This dedication occurred in all cases regardless of what initial childbearing expectations had been and regardless of whether perceptions of the childbearing experience were positive or negative to date. All of the women were quite possessive of their infants and to some extent they became the directors of infant care. This possessiveness interfered with the marital relationship when fathers wanted to be involved, but were criticized because they were not handling the baby "correctly".

> He gets mad at me because I boss him around. He says I do. It's like "tip the bottle up higher" or "burp him now" because he will take his time and he'll sort of play with him and the way they used to spit up all the time it was "come on get the burp out of him or he'll get gas." It's probably because I think I know better because I'm around them all day and he's not (007).

Although the subjects dedicated themselves to their infants, many of them realized the importance of including their husbands in infant care. They "sat on their hands" while dad performed the necessary tasks and in some cases tried to make it a cooperative venture:

> I don't like to boss him around. We are both new to this. But I was a little nervous. He may not have the experience with babysitting and I may have read the books before he did. But I read that if you criticize too much they are going to get frightened or fed up and say to ****! with you. Sometimes I would get like "he's not holding him the way I would" and he would fuss. So sometimes I would say little things but I've tried to let him find his own way (009).

Perceived changes in the marital relationship. Seven of the participants perceived that their partners were supportive of them following the birth of the baby. In these cases, partners were willing to help with infant care as well as with household tasks. However, marital support did not totally offset the perception of childbearing as a bittersweet experience. Subject 002 did not receive this type of assistance. However, she seemed content to care for her infant without her husband's help:

> I just want to be with my baby. I am so happy taking care of her, sometimes I get tired, but it doesn't matter because soon she will grow up very fast and I have to help her right now especially when I have to take her out and I take her to the Mall only the two of us sometimes I don't even want my husband (002).

Some of the subjects perceived negative changes in their relationships with their husbands. They were unable to spend as much time with their husbands as they had prior to the birth of the baby:

> At times my husband will say to me "We need some time to be alone to be close"...because you don't... you don't make time for that and we're both guilty of that. Now you're listening for sounds, making sure the formula is made, that this is here that his clothes are washed and he has enough sleepers...your time isn't your own any more...you almost have to make time for yourselves (003).

Some husbands felt that they were cheated on the amount of attention that they were receiving from their wives:

> I should have thought of these things before. What I hadn't anticipated was how much time I would have to be away from my husband. We used to on the weekends have nice breakfasts and have coffee and get caught up on the week and maybe go for a walk on the beach especially at the very beginning. When I wasn't moving around too well, I mean we never for the first six weeks, we never sat down together for a meal. There was just no time. It was like she was psychic - as soon as she could smell food on the table she would cry.I think it bothered both of us. And I think even now he feels that he's cheated on his time. It's got better, but I think he still feels it (004).

Couples were now taking on new roles as "mommy" and "daddy", and this was found to change the nature of their relationship:

> The baby is kind of number one right now. I think we still feel affectionate toward each other, but I think we express more of our affection to the baby...sort of channelled through him...normally you go to bed and hug and kiss and so when he goes to bed, I'm feeding the baby and by the time I come to bed he is sound asleep...so that we don't get that late night hug and kiss kind of thing. I don't think it bothers my husband...I don't think he is jealous or anything...he talks about me being a good mommy to the

> baby and I think that is very much what he wants...(009).

Subjects 005 and 006 identified positive changes in their marital relationships:

> I think before we seemed often to have divergent goals ...going off in our own ways. Since we've had the baby I think that our relationship has become much more solid. I think that we are actually much more in tune with each other (006).

Changes in self-concept. Motherhood brought with it a number of changes in self-concept. Three of the subjects referred to their body image. Subject 005 was determined not to look "gross" after being pregnant and was proud that she could fit into her jeans. Subject 007 on the other hand felt quite depressed about the fact that she had no time to exercise and that she still had inches to lose:

> My clothes don't fit that depresses me. My hair is falling out that depresses me. I didn't expect that (007).

Subject 009 was not as concerned about losing weight as she was about her grey hair:

> I'm used to carrying a lot of weight...I know it's not good for me but my body image well I don't get too hung up on it. But I did get my hair dyed today (laughter) ...so I don't look like I'm 50...so I don't look like I'm the grandmother which I've gotten a number of times..."Are you babysitting?" "Are you his grandmother?" "Is that your biological child?" I was very grey - so I decided to get the dye job (009).

Separating from the baby - returning to work. Seven of the participants were going to be returning to work following their maternity leave. All of these subjects expected that it would be very difficult to leave their infants:

> It's going to be really hard to let go of him. Only because little things, like the way he cries and now I listen for that

> certain cry when he's going to go into that transition, where he's going to stop breathing because he's going to get hysterical. I can hear that and I don't know whether some one else is going to give him that attention. Will they be there for him all the time. So that's really hard. I mean he's my little boy. It's hard to even think about it (003).

They realized, however, that they would not be totally satisfied at home raising a child:

> Well that's another thing that worried me about being pregnant is that I knew I wasn't the type of person, or at least this is the way I had always pegged myself, not being a mother who would stay at home looking after children.I just assumed that I would be back at work as soon as I could (005).

Subject 003 felt that working outside the home would be easier than staying at home raising a child:

> Well I think you have different distractions. And I think you have different stimuli. You have conversations. You have adult conversations. I think that being home with a child is very demanding. You can't just say "No I can't do that for you right now because I'm busy myself... that job will have to wait until I have time to do it." ...you just do it. I mean if he wets his pants or whatever I can't say you just sit there and wait for a while. It's uncomfortable for him so you do it. And also you can't sit down and talk about current affairs when you have children. And I need that. I need that extra stimuli (003).

The participants found ways to make the separation from their infants less difficult. Three of the subjects were going to be using a family member to provide child care. Subject 005 was going to hire a live-in nanny so that the baby would have continuity in her life instead of a number of different daycare workers. Subject 006 did some research into the best way to integrate working part time with raising her child:

> I think its going to be very difficult for me. I have just hired a woman to provide daycare for him. I am going to go back to work part time and you know I did a bit of research, talked with some friends about how to do this you know whether to go back so many days a week or part days and I have come to the conclusion that there would just be too much of a pull to work part days so I've decided against that option (006).

Subjects 001 and 005 seemed to be preparing themselves for the time when they would return to work by leaving their child with a sitter to see how everyone would manage:

> ...maybe I've already sort of got it so that he's going to be independent. Almost like maybe its that I know I'm going to leave him at some point that its...I've already conditioned myself that if I go out now ...maybe subconsciously I've tried to put him in another place...because I know I'm going to be away from him when I go back to work that the odd time when I'm away from him...for an hour or two I sort of think the same way (001).

Feelings of guilt about leaving their child were expressed as well as the need to spend as much quality time with the baby as possible while at home:

> Well I guess to me as I said I'll be going back to work in March...so that I would dedicate that whole time to the baby...basically because...well you're not ignoring him but you are basically depriving him a little bit going back to work and not being home...(001).

Two of the subjects (002, 009) were not going to be working outside the home. Subject 009 felt that her baby was too important to be brought up by a series of day care workers:

> This business of waiting so long and trying so hard...just to "stick him in daycare" and some one else be that special, special person to him...I think that's ...I don't like that. At least one of us should be that special person...We both

> should be...but at least one of us. A daycare worker is not going to be there in 3-4 years. It won't be the same person. For one thing he has to develop that special trusting relationship and that's so important and I understand that now (009).

Action/Interaction Strategies

One of the ways in which women tried to resolve their conflicting perceptions of childbearing was by looking back over their experience, identifying the advantages of delayed childbearing.

Advantages to delayed childbearing. The majority of participants felt that there were certain advantages to being an "older" first time mother. The fact that they had been able to travel and experience life was to their advantage. They did not resent the demands placed on them by their infant as they might have if they were younger. They felt that if they had parented at an earlier age they would not have the financial security which they were now able to enjoy. The participants believed that they were more aware of their infants' needs, better informed, and more adaptable because they were older parents:

> The one advantage is that I wouldn't have wanted to do this at 20. If this had happened to me at 20 I don't think I could have done it. Because I think that I would have been frustrated and impatient and felt ripped off from a lot of experiences. Like if it had happened and even I think if you planned it...because I knew what I was getting into and it's difficult but I'm also not feeling like I'm missing anything. I've had good jobs and careers and I've done a lot of travelling and I've got great friends that we have good relationships that when they phone I can go "I can't talk to you" and don't phone them back for 4 days and they're not angry at me. So I think all those things are important and I didn't have any of those things when I was 20. And after 2 months if I were 20 I don't think that I would have been

a very happy woman. I don't think so (008).

Subject 003 did not believe that age in itself would give her a parenting advantage. For her it is more a question of maturity:

> I don't know if age makes you a better parent. I think your economics, your control, a lot of things play a big role. How you feel about yourself. Having a job where you don't have to worry about where my mortgage payment is going to come from or when I'm going to get my next cheque to buy baby food. I mean that's a big weight off somebody's shoulder. I don't know if that's age or not. I don't think it is. I think there are women out there that are in their late thirties's who are on welfare and have to budget themselves. I'm not saying I'm better than they are. I'm just saying that its easier for me. I think you need to be ready to have children because...Because in your mind you think that you are going to have this ideal child and when its time to go to bed it will go to bed and it won't cry and it won't do this and it won't do that and its not like that at all. So unless you are mentally prepared to deal with these things then I don't think people should have children. It's difficult...it is difficult (003).

Consequences of Negative Perceptions of Motherhood

Women experienced depression and feelings of guilt associated with their negative perceptions of motherhood.

Depression. Three participants felt that they had experienced postpartum depression to some degree following the birth of their baby:

> I'm not a person to be depressed but I have been depressed. I've noticed a few days when I wasn't actually depressed but lethargic and I know it's related to a type of depression ...feeling overwhelmed and not quite sure if I can do it any more (006).

Feelings of guilt. Subjects sometimes found that motherhood made it difficult for

them to satisfy their own needs:

> Sometimes when I do things for myself, I feel sometimes I think that if they jeopardize him in some way it just doesn't feel right...doesn't feel good. If we go to the mall and he is so miserable...it just doesn't feel right (009).

SECTION V - Evaluation and Advice to Others

In the interviews women discussed their satisfaction with the childbearing experience. They also provided suggestions for ways in which other mature primiparas might be helped to cope with delayed childbearing. In this section, women's overall satisfaction with the experience and their advice to other women in a similar situation are summarized.

Overall Satisfaction with their Childbearing Experience

Two of the nine subjects were left with a fairly negative perception of their childbearing experience. Although subject 002 had had a strong desire to have a child, her experience with a premature labor and delivery was so discrepant from her expectations that she states that she would never want to go through it again:

> I am so happy but there's always in my mind wondering, thinking, will she grow up normal like any other baby...I know it might not happen any more if I have another pregnancy, maybe it won't be like this one. It was different, I was travelling at the time, but my experience scares me so much that I said that's enough. At least I have one...at least I experienced it (002).

Subject 007 had gone through great hardship to become pregnant because both she and her husband expected that children would enhance their lives. The following passage

indicates the difficulty which she is having in accepting her perceived childbearing experience:

> I think I just feel cooped up sometimes and that's what gets me teary eyed or I will worry if I'm feeding them properly... I feel like I'm not a good mother sometimes because I don't bath them everyday. They don't get their hair brushed everyday. Some days I don't have time to do everything right. You're always taught okay you should give them baths every day and do their hair and do this and do that or read them stories or play with them a lot...That's why I feel bad sometimes... I think I would give anything to get rid of them. But then I feel bad when I have thoughts like that I shouldn't feel like that. That's what gets me upset...I live for my husband getting home at night though. I'm such an organized person all the time and it's so hard when you have babies that you can't really organize. They do what they want when they want. You have to learn to live with it... I guess it's never what you expect. It's never the same (007).

Subjects 005 and 006 on the other hand perceived their experience to be more positive than expected. Subject 006 had not expected to have children because her husband and she did not share congruent childbearing expectations. She found the experience to be far more rewarding than she had ever expected. Subject 005 had started out expecting childbearing to be totally negative:

> I think this has had a positive affect on me. I don't think there is anything wrong with having a child over 35. I used to. I would say if I don't have kids by the time I'm 30, that's it. But there is something to be said for having children later on and I'm glad we did. I wouldn't change this now for anything. I'm very excited about this baby. She has become a huge part of our lives and so we have to change our whole life. Change is what keeps you going.... It has been a ways easier than I ever thought. I thank my lucky stars. I think I expected the worst. Maybe that's why it seemed so good (005).

For subjects 001, 003, 004, 008, and 009, the childbearing experience was "bittersweet". These subjects were totally dedicated to their infants but there were far more negative perceptions than they had expected. Subject 001 seemed to indicate resignation rather than satisfaction:

> I have to do some packing and hauling around but its better than staying home. I've sort of resigned myself to the fact that where I go he goes (001).

Subject 003 had a very concrete life plan which included childbearing at a time when she and her husband felt "ready":

> I don't know if its everything you thought. It's just a feeling that you can't explain and you can never think... you can think of what it would feel like but it's something more....So its a feeling that you can't describe it. You can imagine, oh I'm going to feel like this or that, feel so happy. But it's different (003).

Subject 008 had expected to parent and was raising her child as a single parent. She talks about her perception of the "control factor":

> Being pregnant was definitely one of the most incredible experiences of my life and the most humbling. Having a baby is very humbling. And for women of my age and lifestyle I don't think we know very much about that. I don't think we've ever had to succumb to things...to let go. We've had a very big control factor in our lives and been able to do what we want and be where we want and be who we want and just the fact that I can be here and be a single mother and for it not to be a taboo sort of thing says a lot for it. I think I'm fortunate to be doing what I'm doing when I'm doing it (008).

Subject 009 had experienced infertility treatment. She and her husband shared congruent childbearing expectations. She described how difficult mothering can be:

> Until you go through it you don't really understand. I know

> how much love and effort it takes to even half way feel that he's getting what he needs. I can understand what it takes to be a mother...it is not an easy thing...it's wonderful but it is very taxing. You've got to want it to do it right (009).

In summary, the majority of participants did not find childbearing to be a totally gratifying experience. The higher the expectations of motherhood the greater the discrepancy between expectations and the perceived reality.

Women's Advice to Others

Looking back over the experience, some subjects had advice to give to others based on what they felt they had learned. Subject 006 advises that if a couple is in the process of making the decision to parent then there is room for a positive decision:

> It doesn't seem like the kind of decision that you can make rationally you know weighing the pros and cons. It's one that when it happens it happens naturally (006).

Two of the women, 008 and 005, wished that they had been in their early thirties when they delivered their first babies. Subject 005 thought that if she had started earlier she might have had time to have a second baby. Subject 008 believed that she might have had an easier experience if she had been younger having her first baby:

> ...I would say have a baby when you are 32-35 because 40 is really getting there. I think I would have had an easier experience when I was 32-33. I would never have done it in my 20's but I think early 30's would have been ideal. I think that's just physically and mentally. I think the difficulty with the birthing experience was related to age also to the experience that I had with a difficulty in pregnancy. If you go back and compare, the experience might have been the same at either age. Every woman is so different (008).

Subject 008 advised against reading too much literature:

> It's almost like a couple of books are good and then it starts to get overwhelming. I think you get neurotic (008).

Subject 005 advised that people do change and although she started out with such a negative perception about motherhood, she now has a totally new outlook on life and has a new sense of excitement about her life now that she is a mother. Subject 002 felt that it was her ignorance that caused her premature labor and delivery. She read books but did not read about abnormal occurrences. She had no idea that babies could be born so early and because of this she did not take proper care of herself.

In the next chapter these findings will be discussed in relation to the organizational framework and to other research in the area. In Chapter five further integration of the concepts identified with the core category also is provided. Some direction for future research and for changes to nursing practice are discussed.

CHAPTER V

Discussion of Findings

The purpose of this study was to explore and describe the childbearing expectations of the mature primipara in relation to her perception of her experience. Expectations and perceptions were explored in a broad context that defined childbearing as a process beginning with the planning of the pregnancy and continuing into the postpartum period. Qualitative analysis of the data using grounded theory methodology resulted in the emergence of a core category, delayed childbearing as a bittersweet experience (Appendix G). The core category and associated categories will be discussed in this chapter, within the framework of the paradigm model of Strauss and Corbin (1990). Discussion will focus first on the childbearing expectations of the mature gravida and the discrepancies between her expectations and the perceived reality of her experience. The findings of the study will be compared and contrasted to research which has been conducted in this area. The findings then will be considered in relation to the organizational framework and the limitations of the study identified. Finally, recommendations for future research and for nursing practice will be presented.

Delayed Childbearing as a Bittersweet Experience

Delayed childbearing as a bittersweet experience emerged as the core category or main theme around which all other categories can be integrated. Childbearing as a bittersweet experience was identified as being central to the experience of delayed childbearing as described by the subjects in this study.

The phenomenon of delayed childbearing as a bittersweet experience was identified as the perception held by mature primiparous women that there were more negative aspects to their childbearing experience than they had expected and that these factors offset, and at times overshadowed, the positive aspects of childbearing. Discrepancies existed between their childbearing expectations and their perception of the actual experience which they were unable to minimize. This perception was still evident at the time of the interview. The perception of childbearing as a bittersweet experience was most evident through labor and delivery and again through the early weeks at home with the baby. In the postpartum period, this perception tended to decrease as the baby became more predictable and began to interact with the subject.

Antecedents. Delayed childbearing as a bittersweet experience was preceded by a number of variables that resulted from the interactive effects of age and childbearing. These can be broadly subsumed under the categories of "expectations" and "perceptions" and were evident during all phases of the childbearing experience. An overview of the major findings during each phase of childbearing and the interaction between expectations and perceptions will be discussed.

From a review of the literature, it appeared that women wait to bear children until they are over the age of thirty-five as part of a life plan. This was not found to be true for many of the women who participated in this study. Four factors which impeded childbearing at an earlier age and therefore contributed to delayed childbearing were: infertility, miscarriage, lack of willing partner, and no expectation to bear children. Factors such as satisfaction with current lifestyle, expectations of the experience, and

congruency with their partner did not ultimately influence the mature primipara's decision to parent.

Expectations surrounding the ability to conceive and to carry an infant to term were antecedents which lead to the perception of childbearing as a bittersweet experience. Two of the nine subjects in the study were being treated for infertility so that they failed to conceive within their expected time frame. Two of the subjects had experienced a miscarriage which caused them great emotional turmoil and created worries of repeated failure at the news of a subsequent pregnancy. The remaining subjects had difficulty believing that they could become pregnant when they tested their fertility. Pregnancy for them was a bittersweet experience as they attempted to accept a reality different from the expectation that they would not bear children.

Daniels and Weingarten (1979) found that couples who have been effectively contraceptive throughout most of their adult lives find it difficult to break the contraceptive habit and make a conscious decision to become pregnant. Six out of the nine subjects interviewed in this study did not make a conscious decision to parent. They, in fact, started taking chances with the birth control method which they used. Their expectation was that becoming pregnant at their age would be at least difficult if not impossible.

Motivation for pregnancy was seen as an antecedent to the perception of childbearing as a bittersweet experience since it was found to be the pressure created by the passage of time which was the most important pregnancy-motivating factor for women in this study. The passage of time exerted tremendous pressure on women of this age

group who feared that they would miss the experience of childbearing. It was the perception of passage of time, the "ticking of their biological clock", which led the majority of women to contemplate childbearing. The decision to parent was not always made after careful consideration in which the benefits outweighed the costs. A number of these women did not believe that they could conceive since their fertility had never been tested. They "took chances" with their birth control method when they found that they could not make a rational childbearing decision. This finding is consistent with Lederman's (1984) suggestion that the motivation for pregnancy may not be "motherhood" but rather "fear" of becoming too old to have children; fear of missing a major female experience. Many researchers discuss the fact that women may plan a pregnancy for fear of waiting beyond their "biological boundary" (Mansfield and Cohn, 1986; DeVore, 1983; Kitzinger, 1982; Woods, 1987). This was found to be the case for the women interviewed in this study. Women were aware of the "ticking of their biological clock" and, for the majority, this signalled changes in attitudes and behaviors around childbearing.

The mature primiparas perception of risks associated with delayed childbearing also was identified as an antecedent that contributed to women's perception of childbearing as a bittersweet experience. Because the population of women who delay childbearing tend to be well read and aware, it was not surprising to find that all of the subjects in the study were knowledgeable about the risks involved in delayed childbearing. Many examples of maternal physiological risks to the mature primigravida were documented in the literature. These risks include an increased incidence of delivery

by cesarian section. This risk became a reality for four out of the nine subjects interviewed. None of the subjects who delivered by cesarian section were in poor health, even though the health status of the woman has been mentioned as an important factor in predicting good obstetrical outcome. None of the factors mentioned by Daniels and Weingarten (1979), which include the number and spacing of previous pregnancies, mother's genetic disposition, medical history, hygiene, nutrition, obstetrical care, as well as socioeconomic circumstances, could be implicated. Three of the nine subjects interviewed required the use of forceps or suction to assist them in delivery. Again, no predisposing factors seemed evident.

Awareness of risks may have acted as an antecedent to the perception of childbearing as a bittersweet experience by creating anxiety in the subjects. According to Mansfield and Cohn (1986), anxiety in itself could "predispose the expectant mother to various pregnancy and birth complications" (Mansfield & Cohn, 1986, p. 146). Levy and McGee (1975) studied the relationship between expectation and perceived reality of childbirth within the framework of Janis's theory of psychological stress. The "work of worry" is discussed as being necessary so that the individual is better able to understand and control the adversities of the stress episode by her rehearsal of events. However, extreme worry and denial of danger result in poor outcomes. In all cases, the participants in this study held negative expectations of the labor and delivery experience, and in all cases they perceived that the experience was far worse than expected. It is possible that high anxiety rendered these women unable to cope adequately. Consideration must also be given to Clark's (1975) suggestion that when labor is complicated by

pathophysiological conditions not under the control of the woman, as was the case for eight out of nine participants in this study, it is likely that the outcome will be a negative attitude toward labor.

Participants also were aware that certain risks to the infant were associated with childbearing over the age of thirty-five. The risk with which they were most familiar was that of giving birth to a child with congenital anomalies. This risk was well documented in the literature (Woods, 1987; Kitzinger, 1982; Baldwin & Nord, 1984; Daniels & Weingarten, 1979; Merlin, 1987). Women underwent amniocentesis as a guarantee against this occurrence and none would have continued with the pregnancy if the results of the tests had indicated any concerns. This fear was a condition which resulted in the initial weeks of the pregnancy being bittersweet in which negative overshadowed positive, as the subjects awaited the results of the testing procedure. It also created fear during labor and delivery, when complications were perceived to threaten the wellbeing of the infant.

The major theme associated with expectations for labor and delivery was fear, in particular, fear of the unknown. In all cases, their perception of the labor and delivery experience was that it was worse than expected. Eight of the nine developed complications and/or required medical intervention. One of the more intriguing findings of this study was that female physicians were better received by this group because they were found to be more empathetic, less prescriptive, and more likely to allow the patient to the maintain control during labor and delivery.

The desire for a baby and the positive expectations around childbearing did not mean satisfaction with parenting during the postpartum period. This group set high

expectations for the baby and for themselves in the parent role. They expected childbearing to bring only minor disruptions to their lifestyle. All had supportive help during the early postpartum period from their family. All of the women felt that no amount of readiness training could have helped to prepare them for motherhood. Breastfeeding was found to be more difficult and for some it was not as satisfying as expected. Both positive and negative changes to the marital relationship occurred following the birth of the baby. The subject became the "coordinator of infant care" which caused some amount of conflict in the marital relationship, as the father attempted to participate in infant care.

Forming attachments to the baby took longer than expected. The instant bond which the subjects had expected did not occur. Dedication to the baby occurred in all cases regardless of the woman's perceptions of her childbearing experience. In the early postpartum period, all of the women held negative perceptions of motherhood. These perceptions of motherhood tended to become more positive with the passage of time as the baby became more predictable and began to interact with the caregiver.

Women worried about a number of issues surrounding being older parents. They were more aware of their age and wondered if they would have the energy to cope with their children as teenagers. Those who would be separating from their baby because they were returning to work used strategies to minimize the difficulties they expected. None of these subjects expected that such separation would be easy. The guilt which they felt concerning returning to their careers helped to contribute to the perception of their experience as one in which negative factors offset positive outcomes.

This study supports Mercer's (1985) findings regarding gratification in the maternal role. The most frequently mentioned challenge of not having or finding any personal time (Mercer, 1985), was confirmed by the subjects interviewed in this study. Another challenge, the inability to master role skills, with a resulting feeling of incompetence, also reported by Mercer (1985), was validated by the majority of women in the present study. In a number of previous studies reviewed, higher socioeconomic status and level of education were associated with more positive maternal behaviour, but were negatively associated with gratification in the mothering role. This also was demonstrated in this study. These subjects took their role as mother extremely seriously and wanted to do the job correctly, and yet gratification did not come with the mothering role. The work of Russell (1974), DeVore (1983), Kitzinger (1982), McBride (1973), and Boulton (1983) is supported in this study, in that all of the subjects had difficulty in making the transition to parenthood. Those with the most positive expectations had the most negative perceptions of motherhood.

Overall, many similarities were found between the findings of this study and those reported by Pickens (1983). Pickens interviewed five career-oriented primiparas with demographic backgrounds similar to those of the mature primipara. Many of the conditions which predispose the mature primipara to the perception of childbearing as a bittersweet experience have previously been identified, for example, in the report by Pickens (1983). These are as follows:

a. Career was an important part of the identity of the subjects.

b. Subjects felt competent and confident in their careers.

c. A number of the subjects were feeling less than satisfied with their careers prior to becoming pregnant.

d. One of the major aspects of identity was "independence".

e. After the women had cared for a "totally dependent other" for several weeks, they became aware that their independent functioning had been affected.

f. Subjects held high expectations for themselves in the mothering role.

g. Subjects were concerned for their child's psychic well-being and had high expectations for their infant.

h. Initially, the cost of motherhood considering such things as personal time, rest and sleep, ability to organize were perceived to outweigh the rewards.

i. With the passage of time, the number of perceived rewards increased, possibly due to the baby becoming more responsive, and sleeping through the night.

j. The choice to return to work had already been made in most cases. None of the subjects however expected that returning to work would be easy.

k. Initially, subjects assessed themselves as being less than adequate as mothers.

Intervening conditions. Intervening conditions in this study are the conditions which either facilitated or impeded the mature primipara's attempts to cope with delayed childbearing. Several intervening conditions were identified. Discussion will focus on three of these conditions: support, doctoring, and dedicating to the baby. These factors

will be discussed in relation to the findings of this study and to other research in the area of delayed childbearing.

1) **Support.** The support of family and friends was evident in all cases in this study. This support was physical as well as emotional. Presence of support assisted the subjects in accepting the reality of pregnancy and was found to be extremely important to the mother's ability to cope with her infant in the early postpartum period.

Contrary to the findings of Baldwin and Nord (1984), this study demonstrated the important role that parents play in supporting the mature primipara. In all but one case, the subject's mother provided care for her and for the baby in the early postpartum period. A number of grandparents would be providing child care when the subject returned to work.

However support from family and friends did not appear to mitigate the perception of childbearing as a bittersweet experience. This is congruent with the findings reported by Mercer (1986), who examined predictors of maternal role attainment at one year post birth. None of the support variables which she considered (size of network and emotional, informational, and physical support) were found to predict maternal role attainment (Mercer, 1986). Support could not be used in this study to predict ease of maternal role attainment or the positive perception of the childbearing experience.

Marital support was not found to moderate the childbearing perceptions held by the participants. In this study, marital support was present in all but two

cases. Support was both emotional and physical. Husbands were involved in performing household duties prior to conception. They were involved in attending prenatal classes, and in the design of the birth plan. They supported their wives during labor and delivery and were involved in infant care following the birth. Even in the cases where partners were not expecting to parent, the support was demonstrated. Couples who were "in sync", whether both expecting to parent or both expecting not to parent, remained "in sync" after the news of the pregnancy. The birth of the infant was found to disrupt the marital relationship to some degree. For example many subjects did not have as much time as previously to spend with their husbands. The nature of the relationship was found to change as the subject and her husband took on new roles as "mommy" and "daddy". In all cases the new mothers took on the role of "coordinator of infant care" and often were found to criticize their partners for not providing care to the infant "correctly". The "coordinator" role was not documented in the literature reviewed. Neither of the participants who lacked marital support had positive perceptions of their childbearing experience. However, marital support also was not sufficient to predict that the subject would hold positive perceptions of her childbearing experience.

2) **Doctoring.** Kitzinger (1982) maintains that some of the physiological maternal risks are complicated by anxiety conveyed to the patient because of "too much doctoring" (p.82). "Doctoring" was found to influence the perceptions of a number of the participants in the study regarding their childbearing experience. The

attitude of the physician toward the mature gravida was particularly important in determining how the subject perceived her experience. The failure of the physician to prepare the subject for procedures and to give adequate explanations led to misunderstandings, stress, and fear. It was found that those subjects who had female physicians were allowed to maintain control of their childbearing experience to a far greater extent than those who had male physicians. Male physicians were described as more prescriptive, less communicative, and less empathetic than their female counterparts.

3) **"Dedicating to the baby"**. This intervening condition was not addressed in the literature reviewed. This dedication could be seen as an antecedent to the view of childbearing as a bittersweet experience since it existed even without gratification in the maternal role. It existed amid negative perceptions of the childbearing experience. The depth of emotion which the subjects felt for their infants was unexpected by then.

Action/interaction strategies. Action/interaction strategies are directed at managing, handling, carrying out, or responding to a phenomenon. Mature primiparas used several strategies to cope with delayed childbearing. In the preconceptual or decision-making phase, they tried "weighting", considering the pros and cons to childbearing, but found this process did not assist them in making a decision of this nature. Many of the subjects "took chances" with their birth control method, testing their fertility rather than planning a pregnancy. The phenomenon of "taking chances" was not found to have been documented in the literature. It is often assumed that those who delay childbearing plan

their pregnancy once they have achieved certain life goals. This study demonstrates that such planning does not always occur and that the decision to become pregnant could not be rationally made using the decision-making skills which had worked for this group in past. For this reason, those who became pregnant after "taking chances" had some difficulty in accepting the reality of pregnancy. The consequences for these women were feelings of emotional turmoil when they faced the childbearing decision. The news of pregnancy was met with feelings of shock and disbelief when they discovered that the childbearing decision had been made for them.

The reality of pregnancy was difficult to accept for the women who became pregnant after "taking chances". In order to accept the reality of pregnancy, women needed reassurance that their infant would be healthy. They also needed to reframe their lifestyle expectations to include childbearing. Behavior which was taken as an indicator of acceptance of pregnancy included presenting the pregnancy to family and friends, following the rules of pregnancy, and attending prenatal classes. Attending prenatal classes, designing a birth plan, and securing the support of a labor coach were strategies used to help women prepare for the labor and delivery experience. These strategies were designed to help them to maintain control over an experience for which they held negative expectations.

Mature primiparas used a number of strategies to help them to minimize the negative aspects of their experience. Planning, studying, and organizing were the tools with which they were familiar. However, their past performance in educational and professional endeavours was not a guarantee of success in the unpredictable context of

childbearing. It was their ability to let go of the control factor which had dominated for most of their adult lives which was paramount to their perception of their childbearing experience. None of the strategies used by these women were perceived as effective in helping them cope with their experience. Their attendance at prenatal classes was not found to be helpful to them during their labor and delivery experience. Subjects attempted to accent the positive aspects of their labor and delivery experience even though in every case the experience was far worse than expected. For the women in this study, part of the process of minimizing the trauma of labor and delivery was celebrating the fact that their baby was healthy and that without medical intervention, this might have been otherwise. Their first night's sleep, their interaction with the baby, their ability to resume some former activities like shopping at the mall were all acclaimed as positive aspects of their experience. Three women had trouble minimizing the negative aspects of their experience and the consequences for them were feelings of failure and guilt following their experience.

Women also attempted to maintain control over their childbearing experience. They did extensive reading and attended prenatal classes in order to prepare themselves for childbearing. Such preparation had worked for them in the past and should have paved the way for a successful experience. They planned and organized in order to do the best possible job of childbearing. However, their experiences were such that these strategies were not found to be helpful. Attendance at prenatal classes was not sufficient for a positive labor and delivery experience. Loss of control resulted when unforeseeable circumstances presented themselves.

When faced with mixed perceptions of their experience, mature primiparas analyzed their experience, examining themselves in their new role. This reflective awareness was directed at coming to terms with the discrepancies which existed between their expectations and their perception of the experience. They were able to see many of the advantages as well as the disadvantages of delayed childbearing. Many of the disadvantages to postponing childbearing which were reported by Frankel (1982) and DeVore (1983), were also addressed by the women who took part in this study. Disadvantages included not having the energy to cope with their child, particularly when they became a teenager; an increased awareness of their age; and difficulty in spacing children.

Many of the advantages which these subjects felt to be associated with delayed childbearing were not discussed in the literature. Subjects felt that the fact that they had been able to travel and experience life was to their advantage. They did not resent the demands placed on them by their infant as they might have if they were younger. They felt that if they had parented at an earlier age, they would not have the financial security which they were now able to enjoy. The participants believed that they were more aware of their infants' needs, better informed, and more adaptable because they were older parents.

Consequences. Mature primiparas experienced several negative consequences of delayed childbearing. The majority of participants in this study held bittersweet perceptions of their childbearing experience in that the negative perceptions countered, and at times, overshadowed the positive aspects of the experience. The consequences of

holding bittersweet perceptions reported by these women ranged from postpartum depression, in three cases, to feelings of loss of control, disappointment, dissatisfaction, anger, and guilt. This study therefore adds support to the contribution of Sandelowski (1984) that 'failed expectations' may have negative psychoemotional consequences. Mercer (1985) supports Sandelowski, adding that unmet or "failed expectations" may have a long-term impact on adaptation to motherhood and on later mothering behavior. The finding of negative consequences that contributed to a bittersweet perception of childbearing therefore should be noted with some concern.

In summary, mature primiparas in this study held high expectations for their childbearing experience. They expected few lifestyle changes as result of parenting and believed that their lives would be enhanced through childbearing. They held high expectations for themselves as parents as well as for their children. These high expectations for the childbearing experience can be seen as an antecedent to the perception of childbearing as a bittersweet experience since in all cases the perceived reality of their experience was incongruent with their expectations. Women who had the most positive expectations regarding pregnancy had the most negative perceptions about their experience. Those who had negative expectations or no expectations perceived their experience to be positive. The strategies which they had used successfully in the past did not help them in the new and unpredictable context of childbearing. The women all stated that no amount of readiness training could have prepared them for their experience. These findings should be carefully noted, because discrepancy between expectations and the perceived childbearing experience, or "failed expectations" (Sandelowski, 1984) has been

reported to have significant impact on how childbirth is viewed by primiparas and on their ability to take on the mothering role (Mercer, 1985).

The Relationship of the Findings to the Organizational Framework

The organizational framework which guided the interviews was derived from a paradigm developed by Flapan (1969). This framework was selected because it explores the expectations and ambivalence that women hold regarding childbearing. Childbearing is defined in the paradigm in a broad context as was the case in this study. In practice, the choice of this paradigm was found to provide an excellent fit with the phenomenon being investigated in this study for the following reasons:

1) The loose and open formulation of the paradigm fit well with the grounded theory methodology in that it provided an organizational framework without committing the researcher to set hypotheses and variables. It therefore facilitated an unstructured exploration of the phenomenon.

2) The paradigm implied that a multiplicity of meanings and anticipations may be associated with conception, pregnancy, childbirth, motherhood and childrearing. This was found to be particularly pertinent to the mature primipara. The meanings and expectations associated with such issues as fertility, motivation for pregnancy, maternal physiological risks, fear of labor and delivery, ability to parent, ability to combine motherhood and career all can be seen as having an impact on the perception of the mature primipara regarding her childbearing experience.

3) The paradigm provided a better link with the concept of "failed expectations",

introduced by Sandelowski (1984), than was initially anticipated. The paradigm suggests that when conflict is experienced around childbearing expectations, problems with conception, pregnancy, childbirth, and childrearing can arise. This aspect of the paradigm was validated by the findings of this study in that the core concept that emerged (childbearing or bittersweet experience) centers around the discrepancy or conflict between the childbearing expectation and the perception of the actual experience.

4) The paradigm introduced the idea that childbearing expectations can change over time. Again this was found to be an excellent fit with the data which emerged. This study demonstrated that it is possible for changes in childbearing expectations to occur with the passage of time. Regardless of their lifestyle appraisal or regardless of the changes which they thought childbearing would bring about, the single most important factor which motivated the participants to "taking chances" was the passage of time. Even those who had negative expectations surrounding childbearing began to change their outlook with the passage of time.

5) The paradigm suggests that the decision to bear children can be understood in the context of the woman's appraisal of her current life situation and the changes, biological, personal, and interpersonal, which she expects childbearing to bring about. Again an excellent fit was found between this aspect of the paradigm and the phenomenon being studied. The subjects in this study all held expectations about the impact that childbearing would have on various facets of their lives. When trying to decide whether or not to bear children, they engaged in a

weighting process, an appraisal of their lives, trying to determine the benefits and costs of childbearing for them. For the women in this study, many of the expectations which they held regarding their childbearing experience lead to the perception of childbearing as an experience with many negative as well as positive features, that is, a bittersweet experience.

Implications for Further Research

The present study was based on interviews with a small sample who primarily were middle class urban career women. The interviewer sought out subjects with varied experiences in that some of the subjects had experienced infertility, some had experienced miscarriage, one was unmarried, and one was non-Caucasian. However, in order to develop a greater understanding of expectations and perceptions of childbearing, sampling should be expanded to include subjects from other socioeconomic groups, as well as subjects from rural or remote areas, and those from different cultures.

Women were interviewed only once in the postpartum period. A longitudinal study might tap into expectations and discrepancies after the subject had returned to work. The passage of time also might change the perceptions held by women regarding their child-bearing experience. A different research design also might include interviews with women during their pregnancy, during the immediate postpartum period, and at later intervals. A prospective longitudinal study would address one limitation of this study, that is, it's retrospective nature and would document the long term impact of postponing childbearing. It would be worthwhile to interview the husbands of these women in order to compare

and contrast their expectations and perceptions regarding childbearing with those of their partners.

More research is required in the area of "doctoring" since medical care has been demonstrated to have great impact on the expectations and perceptions of women regarding their childbearing experience. Morcos, Snart, and Harley (1989) recommend that physicians identify and discuss specific areas of concern or apprehension with their patients, providing options wherever possible and rationale where choices cannot be honored (p.8). Research into the concept "doctoring" might explore the differences in approach between male and female physicians, as well as patient preferences regarding their obstetrical care.

Prenatal classes were not found to be helpful in preparing the subjects for their labor and delivery experience or for the realities of motherhood. Stolte (1987) was surprised that women who had attended prepared childbirth classes reported more unexpected events than those who did not attend. She postulates that prepared subjects may have expected to be prepared for any eventuality, and, when they were not, were more aware of unexpected events than were unprepared or informally prepared subjects who may not have had such specific expectations (p.102). Current approaches to childbirth preparation must be explored so that more effective methods can be developed for preparing the mature gravida. Research is required to determine the best ways to provide "motherhood readiness training". Bliss-Holtz (1988) reports that interest for learning infant care is low in the prenatal period and recommends that the postpartum period be considered. However, this study demonstrates that the postpartum period is too

late to address these issues. In fact, subjects indicated that nothing could have prepared them for the realities of motherhood. Would preconceptual counselling be of any value to these women?

Implications for Practice

The researcher's interest in this topic stemmed from a clinical observation. An overall tendency toward increased difficulties in postpartum adjustment had been observed. The observation was supported by the findings of this study. Labor and delivery and the early weeks following were reported by the subjects to be extremely difficult for them. In some cases postpartum depression was reported, as well as feelings of disappointment, loss of control, dissatisfaction, anger, and guilt. Perhaps medical and nursing personnel have unrealistic expectations of this age group because they appear to be so capable. They are mature, financially secure, well read, and well educated. Perhaps professionals do not provide the same type of information and support to these women because they appear not to need it. This study demonstrates that mature primiparae can suffer serious emotional consequences because of failed expectations and that they require different approaches to what they traditionally have been offered.

Prenatal classes that provide opportunities for women to voice their fears, concerns, and expectations would be more helpful to these woman than those following a prescribed course outline. The women in this study felt that they did not need much of the basic information presented in the traditional classes. The mature gravida must be recognized as having different learning needs and requiring an approach which is more

tailored to her needs. More emphasis must be given to building confidence and providing a less prescribed approach to coping with labor and delivery. The majority of women interviewed found that the strategies that they had learned in class, and that they had expected would work, did little to help them cope with the birth experience.

The subject who had twins believed that it would have been helpful for her to have attended a twin support group so that she could have learned first hand about parenting twins. It might be helpful to provide opportunities for other mature gravida to talk with women who have recently given birth so that they can test their expectations against the perceived reality of others. The subjects seemed to suffer from information overload, yet lacked the opportunity to test what they had heard and read against the perceived realities of others. They were very determined to do the job correctly and sought "the correct" way to perform. They may have appreciated learning that a whole array of "correct ways" exists from which to choose. Women who had female physicians were more satisfied with their care than those who had male physicians. The mature gravida must realize that all physicians do not use the same approach with their patients and that they have the right to choose a physician who will provide the type of care with which they feel comfortable.

The Public Health Nurse (PHN) was mentioned by a number of subjects as having provided support to them in the postpartum period. The PHN is in the unique position of being able to care for the family in the home during the postpartum period. The PHN must make contact early in the postpartum period since that was the time which the study demonstrates to be the most difficult for new mature mothers. Support and encouragement

during the first week home could help to make a difference in women's perception of their experience. Linking these women with others in their community would also help them to form support networks. The PHN could take a lead role in facilitating the formation of such support networks.

Above all, the attitude of health care professionals toward the mature gravida must change. Increased sensitivity of physicians, childbirth educators, and hospital and community nurses who provided care to the mature gravida would have done much to improve the childbearing experience of the subjects in this study.

Limitations of the Study

Several limitations of the study are acknowledged:

1) The study was retrospective. The researcher was unable to validate the reports given by the subjects, but had to rely on the ability of the subject to accurately recall the experiences and the emotions which accompanied them.

2) The perceived realities were not explored past six months following the birth. A number of expectations which the parents held for their child as he/she grew older and for themselves as parents returning to the workforce were not explored.

3) The study cannot be replicated because of the unstructured and open approach to the research design.

4) The sample obtained for the study was not representative of the population of all persons who have postponed childbearing, so that the findings cannot be generalized to this population.

Conclusions

In conclusion, the following overview highlights the salient features which described delayed childbirth as experienced by the mature primipara. The observations made apply to the majority of women in the study.

The childbearing experience was expected to enrich the lives of these women, to satisfy their need to share and to teach some of the things about life which they had experienced. Expectations for this "female experience" were so great that these older women began to fear that they might in fact wait beyond their "biological boundary". The pressures of time clashed with situations of miscarriage, infertility, and incongruent expectations with their partners and, in some cases, with their own personal life plans. The problem-solving skills which had stood them in good stead in their lives to date did not help them in making childbearing decisions. They used "weighting", looking logically at the pros and cons to childbearing. In the end, when it seemed that no logical decision could be made, they resorted to "taking chances" with birth control. This is not unlike the behavior observed with teenagers.

These women expected that logic and past skills would pave the way to success as it had in past endeavours. They studied and went to classes to prepare themselves for the childbearing process. Above all, they wanted to be organized with birth plans and baby clothes washed and packed. They expected that because they had successfully dealt with so many of life's dilemmas, they had the skills to integrate parenting with marriage and career. They did not expect that there would be too much disruption in their lifestyle. Their expectations for themselves in the mothering role and for their children's

achievements were extremely high.

These women perceived that their childbearing experience overall was far more difficult than they had ever expected. Most of these women felt that no amount of readiness training would have prepared them for their experience. The techniques which they had successfully used in past failed them. The new skills which they had learned in prenatal classes were of little value. The situations in which they found themselves were so unpredictable and emotionally draining that their sense of control was lost. The availability of family and marital supports did not seem to mediate this feeling of loss of control.

Most of the women had a sharing relationship with their husbands. However, they experienced such a fierce and unexpected "dedication" to their infant that they found themselves having difficulty giving up child care responsibilities to their partners. Their lifestyle was thrown into chaos. The time that they had to themselves and with their husbands was suddenly gone, and their ability to organize and plan seemed no longer to exist. Breastfeeding was expected to bring great emotional satisfaction and to cement the bond between mother and infant. However, breastfeeding was perceived as a function that had none of the glamor that was anticipated. Those who had many negative perceptions of childbearing expressed feelings of guilt, disappointment, inadequacy, and depression.

Women used minimizing techniques, like celebrating the health of their infant and saying that the labor could have been worse, them cope with their negative perceptions. The passage of time was an important factor which helped participants to regain control over their lives. Many of the negative perceptions were reduced as the infant became

more predictable and began to interact with the mother.

The women were aware that there were risks involved with delayed childbearing, risks to themselves and to their infant. It is possible that this awareness created in them an increased level of anxiety, especially regarding labor and delivery. Perhaps because they appeared to be so capable, the supports that they needed were not offered. The fact that these women expected to be "correct mothers" may have set them up for failure. They expected that they were prepared for childbearing and when situations were different from what they expected, they were aware of the discrepancies. That is, the higher the expectations, the greater the discrepancy may be between expectations and the perceived reality.

As a consequence of these discrepancies, negative aspects of the experience intermingled with, and at times overshadowed, the pleasure and gratification of the childbearing experience so that childbearing was perceived as a bittersweet experience by the majority of the mature primiparous women who participated in this study.

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APPENDIX A

INSTRUMENTS

Appendix A

Interview Guide

The following are the themes to be explored with the mother. The framework adopted (Flapan 1969) will be used as a guide and will assist in providing a focus for the interviews.

1. Appraisal of her life situation prior to conception, (ie. description/feelings about herself, her spouse/partner, family, social network).
2. Explore the mother's cultural beliefs, experiences, meanings associated with childbearing (ie. hopes, dreams, desires, fantasies).
3. Changes to her life situation (as described) which she expected to take place as result of childbearing, (ie. expectations concerning biological changes, personal and interpersonal changes).
4. Compare her perceived experience with the expectations held.
5. The range of consequences if the mother's expectations and her perceived reality are widely disparate.

Demographic Data

The participant will be advised that she can omit answering any of the questions asked.

1. Age at delivery (in years)
2. Marital status
3. Education
4. Reproductive history
5. Employment history
6. Future plans regarding return to work

APPENDIX B

LETTERS REQUESTING ACCESS TO STUDY PARTICIPANTS

Date

Administrator
Public Health Nursing

I am a Graduate Student in the School of Nursing at the University of Manitoba. I have completed the course work required for the Masters Program and I am ready to begin work on my thesis. My thesis advisor is Dr. I. Bramadat, Associate Director, Coordinator Undergraduate Program, School of Nursing (474-6222).

My study will explore the childbearing expectations of the mature primigravida, who, for the purpose of my study, will include women who are thirty-five years of age or older. The study will involve meeting with women who have delayed childbearing in order that I might hear from them about their childbearing expectations and experiences. The interviews will be tape recorded and will be used to analyze the discrepancies between childbearing realities and expectations in this age group. A trend toward delayed childbearing has been identified and it is hoped that the results of this study can be used by health care workers to better understand this phenomena.

I am seeking permission to recruit women who might be interested in participating in this study through Boundary Health Unit.

Women who volunteer to take part in the study will be provided with an explanation of the nature and purpose of the study and will be required to sign a consent form. Participants may withdraw from the study at any time and may refuse to respond to any questions at any time as they wish. All information furnished to me by the participants will be held in strict confidence.

For your information, please find enclosed a copy of the interview guide which will be used during the study. I would be happy to provide to you any additional information which you might require regarding the study.

I look forward to receiving a response to my request at your earliest convenience.

Yours truly,
Margaret Gander

APPENDIX C

APPROACH TO PROSPECTIVE PARTICIPANTS

November 5,1991

To the Participant,

I am a Graduate Student in the School of Nursing at the University of Manitoba. I have also worked as a Public Health Nurse in Winnipeg for several years. One area that I am most interested in is maternal child health.

I have completed the course work required for the Masters Program and I am ready to begin work on my thesis project. My thesis advisor is Dr. I. Bramadat, Associate Director, Coordinator Undergraduate Program, School of Nursing (204-474-6222). The area that I am studying is childbearing expectations of women who were thirty-five years of age or older when they had their first baby. I am interested in talking with women in this age group so that I might hear from them first hand about their childbearing expectations and experiences. It is hoped that the results of this study can be used by health care workers to assist them in providing care for childbearing women in this age group.

The purpose of this letter is to tell you about the study and ask you to consider volunteering as a participant. I will be contacting women who meet the following criteria:

1. thirty-five years of age or older
2. having had their first baby
4. English speaking
5. living within the jurisdiction of Boundary Health Unit
6. can be contacted for the purpose of setting up an interview.

The study will consist of interviews which will last an hour to an hour and one-half. Interviews will take place at a time and place which is convenient to you. Should you become tired during the interview we can arrange to complete it at another time. Interviews will be tape recorded so that I will not miss any of the details of the conversation. All information shared with me will be held in strict confidence. All information will be locked in a safe location and only my advisors and I will have access to it. All the interviews will be identified by code number only
and no identifying details or names will be used in any publications or reports. At the end of the study all tapes will be erased.

I am required to have all participants sign a consent form. This will be given to you before our interview begins. Please read it very carefully at that time and be sure to ask any questions you may have before you sign it.

Your participation in this study is strictly voluntary and you may withdraw from it at any time. You may decline answering any questions during the interview. I will be happy to share the findings of the study with you once it is completed.

I will telephone you in about two weeks in order to answer any questions which you might have about the nature of the study and your role as a participant. Then we can arrange a suitable time for our interview should you decide to become a participant in the study.

Thank you for your time and consideration.

Margaret Gander

Telephone conversation with prospective participants

Hello. I am Margaret Gander. I am calling as a follow-up to the letter which I sent to you last week about my thesis project. Is this a convenient time for me to talk with you? (If not, set up a more convenient time to have this telephone conversation.)

Do you have any comments or questions about the study or what your role would be if you were to decide to participate?

(Answer questions and clarify any points with the prospective participant.).

If you are interested in participating, I would like to set a time and place where we could meet and begin the interview. Where and when would be a convenient for you?

Thank you for your participation. I am looking forward to meeting with you.

APPENDIX D

CONSENT FORM

Consent Form

By signing this consent form, I,_____, having met the criteria set out for this study, agree to participate in the study. The following is my understanding of the nature of the study and my role as participant therein:

1. The purpose of the thesis project is to study the childbearing expectations of women who are thirty-five years of age or older when having their first baby.

2. I have been provided with written information about the study.

3. The study is being conducted by Margaret Gander who is a Masters Student at the University of Manitoba. Her thesis advisor is Dr. I. Bramadat, Associate Director, Coordinator Undergraduate Program, School of Nursing (204-474-6222).

4. My participation in this study is purely voluntary. Participation in the study will not result in any direct benefit to me. I can withdraw from the study at any time without penalty to me. I may refuse to answer any questions asked of me during the interview.

5. All information shared during the interview will be held in strict confidence. Only the researcher and her advisor will have access to it. The information will be identified by code numbers only and all information will be kept in a safe place. No identifying information will be used in reporting the findings of this study and no one will know the names of the participants. At the end of the study, the tapes will be erased.

6. The interviews will be conducted at a time and place which is convenient to me. The interview will be about an hour to an hour and one-half in length. The interview will be tape recorded.

7. I will be provided with a copy of this consent form.

8. I can contact Margaret Gander at any time if I have questions about the study or my participation in the study.

By my signature I am indicating my willingness to participate in the study as outlined above.

Date_____

Participant_____

Researcher_____

APPENDIX E

CONTACT FROM COMMUNITY HEALTH NURSE

CONTACT FROM COMMUNITY HEALTH NURSE

The community health nurse will read the following request to release potential subjects' names during a regular postpartum contact:

Margaret Gander, a graduate nursing student, is doing a study on the childbearing expectations of women who deliver their first baby when they are thirty-five years of age or more. She would like to contact you in the next few weeks to ask you to participate in the research study. You would receive a letter of explanation prior to her contacting you. The study involves a home visit which will last one hour to one hour and a half. May I give her your name and address so that she can contact you?

Thank you.

APPENDIX F

ETHICAL REVIEW COMMITTEE APPROVAL

The University of Manitoba

SCHOOL OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#91/20

Proposal Title: "Discrepancies Between Childbearing Expectations and the Perceived Experience of the Mature Primipara."

Name and Title of Researcher(s): Margaret Gander
Master of Nursing Graduate Student
University of Manitoba School of Nursing

Date of Review: June 03, 1991.

APPROVED BY THE COMMITTEE: JUNE 03, 1991.

Comments:

Date: June 19, 1991

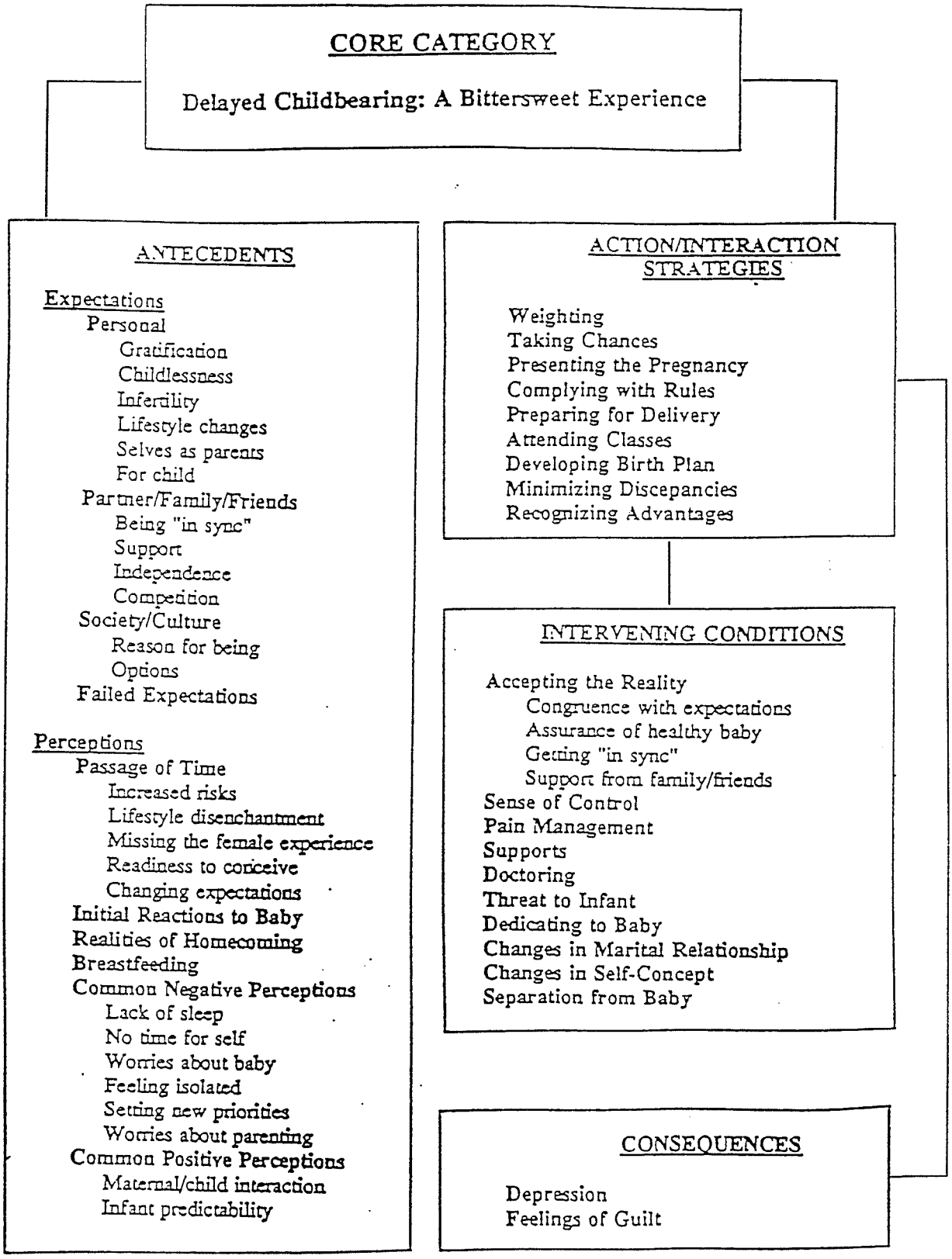
Erna J. Schilder, RN, DNS Chairperson
Associate Professor
University of Manitoba School of Nursing
Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Revised: 91/01/11/se

APPENDIX G

SCHEMATIC OF CORE CATEGORY


CORE CATEGORY
Delayed Childbearing: A Bittersweet Experience
ANTECEDENTS
Expectations
Personal
Gratification
Childlessness
Infertility
Lifestyle changes
Selves as parents
For child
Partner/Family/Friends
Being "in sync"
Support
Independence
Competition
Society/Culture
Reason for being
Options
Failed Expectations
Perceptions
Passage of Time
Increased risks
Lifestyle disenchantment
Missing the female experience
Readiness to conceive
Changing expectations
Initial Reactions to Baby
Realities of Homecoming
Breastfeeding
Common Negative Perceptions
Lack of sleep
No time for self
Worries about baby
Feeling isolated
Setting new priorities
Worries about parenting
Common Positive Perceptions
Maternal/child interaction
Infant predictability
ACTION/INTERACTION STRATEGIES
Weighting
Taking Chances
Presenting the Pregnancy
Complying with Rules
Preparing for Delivery
Attending Classes
Developing Birth Plan
Minimizing Discepancies
Recognizing Advantages
INTERVENING CONDITIONS
Accepting the Reality
Congruence with expectations
Assurance of healthy baby
Getting "in sync"
Support from family/friends
Sense of Control
Pain Management
Supports
Doctoring
Threat to Infant
Dedicating to Baby
Changes in Marital Relationship
Changes in Self-Concept
Separation from Baby
CONSEQUENCES
Depression
Feelings of Guilt