Women's perceptions of midlife mothering during perimenopause: The impact on health and well-being through life's transitions.

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WOMEN'S PERCEPTIONS OF MIDLIFE MOTHERING DURING PERIMENOPAUSE: THE IMPACT ON HEALTH AND WELL-BEING THROUGH LIFE'S TRANSITIONS

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Abstract

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The aim of this research was to understand women's perceptions of their health as they mothered young children while simultaneously transitioning to menopause. This inquiry was inspired by the growing demographics for 'older first-time mothers', which create a unique phenomenon in which the developmental transition to motherhood is followed closely or overlapped by the biological transition to menopause/ perimenopause. A gap in knowledge about the unique experiences of first time mothers aged forty and older during perimenopause, invited study.

The researcher conducted a hermeneutic, phenomenological interpretation of the lived experiences of the older first-time mothers who participated in this study. This was accomplished through two in-depth interviews with thirteen women aged 39-47 when they achieved motherhood, and 45-56 years old at the time of the interviews. Gadamer's (1975/2004b) philosophical underpinnings guided this study, and meaning was mutually negotiated through participative dialogue with the participants and simultaneously with the text. Van Manen's (1990) six methodological themes guided ongoing construction and analysis of data.

The findings led to an historical and contextual understanding of women's experiences during this time of overlapping transitions, and four main themes emerged: *Achieving First-Time Motherhood at Midlife, Intensive Mothering, Out of Sync,* and *Perimenopause as a State of Uncertainty.* Despite a negative appraisal of perimenopause, an uncertain temporality, projection of the life span, and value of health as precious enabled the women to transform uncertainty into opportunities for health promotion.

The findings from this inquiry contribute new knowledge for nurses and other health care providers about the meaning of health and mothering for older first time mothers during perimenopause. Findings from this study which have captured women's experiences enable health care providers to refocus or recalibrate the frameworks and norms traditionally applied to first- time midlife mothers, and improve the care they provide for women during perimenopause.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed .....

Date 18 June 2010

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed .....

Date 18 June 2010

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Date 18 June 2010

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Funding for the study

This study was made possible when, in 2003, the University of Wales, Swansea, School of Health Science offered a sponsorship to me for a period of 5 years of study in the doctoral program, which I accepted. Financial support for the study was also obtained from faculty research grants in 2005, 2006 and 2007 from The University of New England in Portland Maine where I am employed as an assistant professor. These funds were used to purchase recording and transcription equipment, secretarial time for the transcription of audiotapes from the interviews, books, paper and other office supplies. Additionally, some of the money was used to support doctoral supervision meetings in the UK, Canada, and the United States. A third source of funding was a research grant in 2007 from Sigma Theta Tau, Chapter-at-large Kappa Zeta.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

The aim of this research was to understand women's perceptions of their health as they mothered young children while simultaneously transitioning to menopause. I began this study with two questions: How did women aged 40 years and older who were experiencing perimenopausal symptoms and mothering young children perceive and report their own health, and how did these women's perceptions of their health affect their experiences as mothers of young children? The specific questions guiding this research were derived from the aim of the study, and were supported by concepts related to women's health, midlife women's health, delayed childbirth, mothering, motherhood, midlife motherhood, perimenopause, menopause, and transition theory. This inquiry was inspired by the growing demographics for older first time mothers which create a unique phenomenon in which the developmental transition to motherhood is followed closely or overlapped by the biological transition to menopause, referred to as perimenopause.

Women are having children at an older age than any time in the past fifty years (Hall, 1999). Between 1970 and 1990, the proportion of first births in the United States increased more than 100% among women aged 30-39 years, and 50% among women aged 40-44 years (Tough *et al.*, 2002). Since 1990, the birth rate for women aged 35-39 has increased nearly 50%, 70% for women aged 40-44, and tripled for women aged 45-49 (Martin *et al.*, 2009). The number of births in 2006 to women aged 40-44 years old was a record high for the United States. Of particular interest to the current study is the increase in *first* births to women aged 35 years and older which has increased from 1 out of 100 first births in 1970, to 1 out of 12 in 2006 (Mathews & Hamilton, 2009). This trend is not limited to the United States; similar increases have been noted in England and Wales, where the number of live births has reached its highest level since 1972. Between 2007 and 2008, the largest increase

in fertility rates in any age group was for women aged 40 and older. Over the last decade in England and Wales, there has been a 50% increase in live births for women aged 40 and older (ONS, 2009). Canada reported greater number of births in 2007 for all age groups, but particularly among mothers aged 30-34; in fact 49% of total births were to women aged 30-44 years old (Statistics Canada, 2009).

For the purposes of this study, mothering was viewed as a powerful social construct centered on the "activities involved in nurturing and caring for children in which women engage to ensure the growth of their children" (Frances-Connolly, 1998, p.149). Transitions like pregnancy, motherhood and menopause can "lead to heightened vulnerability", and for women experiencing multiple transitions, there will be "interrelations and connections" (Meleis *et al.*, 2000, p.18) between their experiences. These concepts provide a framework in which to situate this study, since older first-time mothers face an additional transition soon after their initiation to motherhood. Most women (95%) experience the transition to menopause, referred to by most health professionals as *perimenopause,* between ages 39 and 51, with a median age of 47.5 years (Dickerson, 2001). Due to much confusion among both professionals and the public regarding terminology and understanding of the time surrounding the transition to menopause, it was critical to establish which definition of perimenopause would be adopted for this study. Therefore, perimenopause was defined as "the transitional time of 6 years or more immediately prior to natural menopause when changes begin, and includes 1 year after menopause" (NAMS, 2006, p.5). Natural menopause occurs at an average age of 51 years, and is "the final menstrual period, confirmed after 12 consecutive months without a period or when both the ovaries are removed or permanently damaged" (NAMS, 2006, p.5). Transitions like motherhood and menopause, which occur during a woman's lifespan "involve individual change or adaptation... [and] they contribute to psychosocial development or have developmental potential" (Mercer *et al.*, 1989, p.2).

However, the transition to menopause has also been associated with an increase in physical as well as psychological symptoms, and has even been labeled a time of "instability and unpredictability" (Hudson, 2001, p.33). The changing demographics for women who delay motherhood until midlife led me to question the effect these overlapping developmental transitions might have on women's experiences as mothers and on their health as they navigate this experience.

Northrup (2001, p.108) advises women to assess their total health at this point in their life, and make every effort to "restore or build... health", yet Walker and Wilging (2000) point out a dichotomy in women's health that focuses either on reproductive health issues, or women's health outside the boundaries of reproduction, thereby neglecting the intersection of the two. While there is a growing body of research available to health care professionals on the social construct of motherhood, there is a scarcity of literature on older first time mothers, particularly women aged forty and older, and there is even less from the perspective of women themselves. Similarly, women's experiences of menopause have been addressed in the literature (Walter, 2000; George, 2002; Matarese, 2005; Hall *et al.*, 2007) yet little is known about the meaning of women's experiences as they transition to menopause. Following a thorough search through the literature, I was unable to locate the unique experiences of older first time mothers simultaneously transitioning to menopause, and it is this gap in knowledge about women's health which invited study.

For many years, health has been conceptualized on a continuum (Neuman, 2002), with illness at the opposite end. A person's health fluctuates within a normal range dependent in part on satisfactory or unsatisfactory adjustments to environmental stressors. Stressors may be intrapersonal, interpersonal, or extra-personal, and may have a positive or negative outcome. Phenomenological research requires that the

integrated whole be explored (Carpenter, 2003a), so for the purposes of this inquiry, I utilized Roy and Andrews (1991) conceptualization of health along with illness as coexistent dimensions of a person's total life experience. In the Roy Adaptation Model (Roy & Andrew, 1991, p.21) health is defined as:

> *a state and a process of being and becoming integrated and a whole person. It is a reflection of adaptation, that is, the interaction of the person and the environment.*

Asking women about their perceptions of health during these life transitions created an opportunity for them to reflect on the meaning of their experiences in a holistic way. Nurses are interested in bridging the body, mind and spiritual connection when caring for clients, and promoting healthy behaviors. There is timely significance to this study, fueled by a critical need to gain knowledge about the health and mothering experiences for this expanding cohort of women. It is this neglected intersection of women's development which became the locus for this study, the findings from which will contribute new knowledge about the health, well-being, and experiences of older first time mothers during a time of overlapping developmental transitions.

The research approach for this study was qualitative, adopting the philosophies and constructs of hermeneutic phenomenology, specifically those of Gadamer (2001, 1975/2004b, 1976/2004a, 2006) and van Manen (1990). I will describe how my own ontological and epistemological views concurred with those of Gadamer and van Manen, and how these influenced my choice of a constructivist paradigm to frame and support this study. Gadamer's (1975/2004b, 1976/2004a) principles for hermeneutic understanding were used to guide the entirety of this study, and as a result, meaning was mutually negotiated through participative dialogue with the participants, and simultaneously with the text. Gadamer's hermeneutic constructs of prejudice or pre-understanding, the hermeneutic circle, dialogue, horizon, fusion of horizons, play, buoyancy and projection provided the basis for interpretation.

Interpretation (understanding) always occurs through the fusion of horizons of the interpreter and the interpreted, and both are taken up into a higher form of understanding. Gadamer (1976/2004a) insists that it is through language that one comes to understand, and that this can be achieved through genuine conversation. During this inquiry, it was through listening, conversation, and the reading of the text that understanding occurred (Gadamer, 2001). Additionally, van Manen's (1990) six activities to guide researchers through a hermeneutic phenomenological human science study were employed, and these guided the ongoing construction and analysis of data. Van Manen's assertions that common understandings can be reached through dialogue and conversation are in harmony with Gadamer's philosophical underpinnings, so his work also provided a framework for discourse with the participants as well as with the text. Gadamer (1976/2004a) also believed that the researcher plays an active role, and the interpretation should include the interpreter's own language, not just that of the text. I believe I played a critical role in conversations with the women, and in the construction and interpretation of data. Therefore, I made a decision to use the first person to represent my presence in this study (Wolcott, 1990) while at the same time recognizing that the women's experiences in the context of their lives provided the expert knowledge for this work.

Researcher's Presence

The background for this study was linked with my professional experiences as a nurse for 27 years. During this time I cared for childbearing women and their infants during pregnancy, labour, birth, and postpartum. Toward the end of my clinical career, I shifted my focus of care to women in a private gynecological practice. It was in this setting that I developed a keen interest in the experiences of women transitioning to menopause, and my graduate research conducted during that time examined women's decision making experiences about hormone therapy during the postmenopausal period (Morgan, 2001). That research provided illumination into this

period in a woman's life, and revealed it to be a uniquely individual experience which some women view as a normal natural event, and others find more challenging. It was during this MSc study that I became aware of unique issues that mothers with young children might face during this time. One woman described a rage that felt overwhelming to her at times and affected her relationships with her husband and children. This new understanding expanded my horizon on women's health, and eventually led to the proposal for this current body of work.

I became curious about the experiences of women whose transition to menopause follows closely upon their initiation into motherhood. How would women describe their health, and what effect would their health have on their capacity to mother young children? During the first year of this project, I reflected on my own notions of mothering and perimenopause in an effort to gain insights into my own pre-understandings and history. I discovered that these have been constructed from my personal and professional experiences, my access to other health professionals, and exist within the situated context of my middle class second generation, Italian-American background. My own decisions to have children at ages 27 and 30 were shaped by a combination of life circumstances and feminist ideology. As a *baby boomer* growing up in the United States during the 1950s and 60s, I felt empowered to make choices about my education, career, relationships, and my own fertility that were not available to previous generations of women in my family. My mother graduated from high school but did not attend college; she did not work outside the home until the last of her four children started elementary school. Though my father was traditionally the financial provider for the family, our circumstances reversed suddenly when he suffered from congestive heart failure at the age of 46, and was thrust into medical disability. Mother initiated a full-time career at that time, and I

only include these details because I believe this cast a strong influence on my views of what women could accomplish, and this awareness affected my own decisions about my future. I made a decision to attend college, got married, established a career, divorced and then remarried before choosing motherhood. Unlike the women who participated in this study, I did not experience perimenopausal symptoms during any of the first twelve years of my sons' lives, but did experience some health problems which affected my abilities to mother in the short term. However, during the course of my doctoral work, I did experience perimenopausal symptoms and eventually menopause prior to the completion of this study.

During the years I worked as a nurse with pregnant women and post partum mothers, my experiences with older first-time mothers were limited, but very positive, and I witnessed first-hand the joy and happiness expressed by women who achieved motherhood later in life. I did not believe I harbored any preconceived notions or prejudices about older women who became mothers, though I did acquire some professional knowledge over the years which contributed to my pre-understandings about the experiences of women who come to pregnancy at an older age. I knew that women over 35 were referred to as *elderly primiparas,* or were considered at *advanced maternal age* by their providers, and were consequently at risk for complications. I believed at the outset of this study that women older than 35 were at greater risk for conceiving a child with a genetic disorder, and were at higher risk for pregnancy complications. Women over 35 are routinely offered genetic counseling, testing, including amniocentesis, and diagnostic ultrasounds as part of a standard of care for older pregnant women in the United States. In my role as assistant professor in a nursing programmeme, I taught student nurses that older women usually had an increased need for induction of labour, and a higher risk for a caesarean birth. In my

role as Chair of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) in Maine for the past three years, I have had opportunities to read and discuss women's health issues, attend conferences, and participate in meetings and conversations with nurse leaders in the state as well as nationally. All of these opportunities to learn or discuss the older woman's pregnancy and birth were framed in a context of greater risk to the woman and foetus.

My work in an outpatient gynaecology office created many opportunities to care for women transitioning to menopause and beyond. As noted earlier in this chapter, I observed the various changes women experienced during this time and the unique responses of each woman. I was aware that each woman's response to the biological, and psychosocial changes of the transition also have cultural and relationship components, and that these all influence her emotional adjustment (AWHONN, 2001). My graduate research (Morgan, 2001) clarified that a medicalised model of viewing menopause has been criticised by women, nurses and other health care providers for its negative point of view (Rostosky & Travis, 1996; Rousseau, 1998; Lyons & Griffin, 2002; Im, 2007) as well as for its reductionist paradigm (MacPherson, 1995; Rostosky & Travis, 1996; Ulacia *et al.*, 1999). Most mid-life women aged 40-65 describe themselves as healthy (Woods, 1996), and I became aware of a newer model of menopause which emerged out of this view in which menopause is considered a normal and natural process (Northrup, 1994, 2001; Rostosky & Travis, 1996). In this new paradigm, the years surrounding the menopause are viewed as a "transition that involves some positive and some negative aspects... but both would be considered necessary and ultimately desirable" (Rostosky & Travis, 1996, p.303). It is with these pre-understandings that I engaged in this study.

The study was conducted in the northeast section of the United States, which is called New England. Participants were recruited through women's and children's health care offices in the states of Maine and New Hampshire, and via personal and professional contacts throughout four states in New England. Women were given a choice of locations for their interviews, and a variety of locations were used, including their homes, church space, university conference rooms, and participant's offices. Having introduced the reader to the research aims, research approach, my interest and pre-understanding of the topic under study and the research setting, I now orientate the reader to the organisation of the thesis.

Organisation of the Thesis

Chapter two begins with a section on timing of the literature review, and includes a discussion of the ambiguity present in the literature about when to conduct a literature review in a phenomenological/qualitative study, as well as my arguments for doing an initial literature review. I follow this discussion with a review of the search criteria and databases used during the review of the literature. The chapter includes a review of the literature on mothering, delayed motherhood, the experiences of older mothers, transition to motherhood, perimenopause, menopause, and midlife women's health.

Chapter three describes my rationale for using a qualitative hermeneutic phenomenological perspective as the framework to guide this study. I present an argument to support the use of a constructivist paradigm to frame and support it, and describe the growth of phenomenology as a philosophy. My reasons for adopting the philosophical underpinnings of Gadamer, and the methodological themes of van Manen to guide this research, rather than those of Husserl or Heidegger will be defended. Gadamer's (1975/2004b) principles for hermeneutic understanding were used to guide the entirety of this study, and as a result, meaning was mutually

negotiated through a participative dialogue with the women, and simultaneously with the text. Gadamer's hermeneutic constructs of prejudice or pre-understanding, traditions, the hermeneutic circle, dialogue, horizon, fusion of horizons, play, buoyancy and projection as a framework for interpretation (understanding) will be discussed. Van Manen's (1990) methodological themes were used as a guide for data analysis and interpretation, and I will articulate the compatibility of van Manen's concepts with Gadamer's philosophical underpinnings. The specifics about how I gained access to participants, data construction methods, data management and ethical considerations will be shared. Finally, I will make an argument for rigour, by outlining the criteria used to establish the trustworthiness and authenticity of the findings and the study as a whole. Ultimately, readers will have to judge for themselves if this study represents what van Manen (1990, p.58) refers to as a "possible human experience".

Chapter four introduces the reader to the thirteen women who participated in this study, and presents the demographics of the final sample. I chose to craft a summary on each of the thirteen women who were living their lives as older first-time mothers as well as women transitioning to menopause. Remaining true to hermeneutic inquiry requires the reader to have an understanding of the history and context of each woman's life, from which her discourse about mothering and perimenopause emerged. While I chose to write the summaries from my own perspective in this chapter, each woman's story will be forthcoming in subsequent chapters, in her own words on the phenomenon of interest as told to another mid-life woman. I adapted this approach from one used by Patricia Munhall (1994) in A Phenomenological Study of Menopause in which the researcher introduced the women who participated in her study to the reader. After a brief summary of each woman, the voices of the

women prevailed, and Munhall (1994, p.121) wove "a tapestry of the experiences of menopause from the 'stories' of ten midlife women living the menopause transition".

Chapter five through to eight present my hermeneutic interpretation of the lived experiences of the older first-time mothers who participated in this study. Throughout chapters five, six, seven and eight, I have crafted a fusion of both conversations with the participants, and dialogue with the text to create a written interpretation of the participants' lived experiences as midlife mothers, and as women transitioning to menopause. The findings are introduced with one main conceptual theme per chapter, and these are supported by *categories* (Graneheim & Lundman, 2004), the term used henceforth to represent what other researchers may refer to as sub-themes. The theme of chapter 5 *Achieving First-Time Motherhood at Midlife* explores the women's journeys to motherhood, and articulates the meaning of the women's experiences as they sought to achieve motherhood for the first time at age 39 and beyond. This theme is supported by six categories, which most clearly represent the shared voices of the women. As each category unfolds, the voices of women whose experiences were unique to those of the others will also be heard. These findings are critical in establishing the situated context for the text which follows in chapters six, seven and eight.

Chapter six focuses primarily on the meaning of midlife mothering for the participants, their perceptions of their health, and how perimenopause affected their mothering abilities. The theme *Intensive Mothering* is used conceptually to convey the overarching experience of the women as being concentrated and dynamic, filled with joy, yet challenging, advantageous, but not without disadvantages. This theme is authenticated by six categories which provide substance and support to the concept of midlife mothering as an intense experience.

Chapter seven presents the theme *Out of Sync,* which represents the women's achievement of motherhood at a time in their lives which did not uniformly synchronize with other women, friends and family's experiences of parenthood. As a result, they lacked a sufficient support network and experienced inadequate social support in their everyday lives as midlife women and older first-time mothers.

Chapter eight continues the conversations begun in chapters six and seven by delving further into the women's perceptions of their health as they transitioned to menopause. The theme *Perimenopause as a State of Uncertainty* is used conceptually to convey the transition to menopause as one replete with ambiguity, lacking familiarity, support and educational preparedness. This theme is authenticated by six categories which provide substance and support for the theme. My intent is to illuminate for the reader the interconnectedness among these four chapters as a vehicle for understanding the complexity of the women's experiences as midlife mothers who were simultaneously transitioning to menopause.

The final chapter nine presents a summary and discussion of the findings in light of the aim and research questions which guided the study, as well as the implications for nursing and other health care providers' practice, policy and education. The rigour and relevance of the study are discussed. Limitations of the study are presented and finally recommendations for further research are proposed.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter, I discuss the ambiguity present in the literature about when to conduct a literature review in a phenomenological/qualitative study, as well as my arguments for doing an initial literature review. I follow this discussion with a review of the search criteria and databases used during the review of the literature. The chapter continues with a review of the literature which is organised thematically by the following topics: mothering, delayed motherhood, the experiences of older mothers, transition to motherhood, perimenopause, menopause, and midlife women's health. I provide an in-depth critical appraisal of three particular bodies of work which I felt were most influential on my own work. While there is a body of research available to health care professionals on the social construction of motherhood, there is a scarcity of literature on older first time mothers, particularly women aged forty and older, and there is even less from the perspective of women themselves. Similarly, women's experiences of menopause have been addressed in the literature in recent years, yet little is known about the meaning of women's experiences as they *transition* to menopause. Following a thorough search, the unique experiences of older first time mothers simultaneously transitioning to menopause was not visible in the literature, and it is this gap in knowledge about women's health which invited study. The chapter concludes with a summary of the review.

Timing of the Review

There are conflicting recommendations about when to do a literature review as part of a phenomenological (qualitative) study. Carpenter (2003a) advises an initial cursory review only, to confirm a need for the study, and guide the researcher's choice of methodology. She recommends a more complete review of the literature after data analysis in order to avoid

preconceived ideas and bias. Taylor and Bogdan (1998) concur that the researcher will have a better idea of which literature will be relevant after some preliminary research is completed. They stress the importance of uncovering gaps in current knowledge on the subject. Munhall (2007c) suggests that researchers read any literature that becomes available as it may facilitate meaning and understanding during the interviews. However, Munhall (2007c) cautions researchers to avoid literature which focuses on the experiences of others as it may influence a researcher to stray from the genuineness of her own participants' stories. Only after the study progresses, and discourse is established, should the researcher introduce topics from the literature for consideration and reaction by participants. Similar advantages and disadvantages to reviewing the literature at various points in the research are addressed by Patton (1990, p.163) who suggests that an ongoing literature review may permit "...a creative interplay among the processes of data collection, literature review, and researcher introspection".

Adapting these suggestions to my own research, I conducted an initial literature review at the onset of the current study, to confirm that this was an area of research that needed further development. Concepts that were explored included: mothering, delayed motherhood, the experiences of older mothers, transition to motherhood, perimenopause, menopause, and midlife women's health. Throughout the progression of the study I periodically conducted further searches to update the literature review with respect to these original topics. I uncovered critical findings and discovered what was problematic (Schram, 2003) or missing in the literature, relative to my inquiry, in an attempt to situate my research within a broader context (Wolcott, 2001). I provided a critical review of the literature, with an in-depth critical appraisal of three particular bodies of work which I felt were most influential on my own work. Further engagement with the literature is presented in chapters five, six, seven and eight in the context of study findings. This led to discovery of new and relevant literature

which was initially not considered, as well as discussion of findings with what is already known and has been disseminated in both the professional and lay literature. In addition, a discussion of the literature relevant to the philosophical underpinnings of hermeneutic phenomenology and other methodological positions or decisions can be found in chapter three.

Search Criteria & Databases

A literature search was conducted using the Cumulative Index of Nursing and Allied Health Literature (CINAHL), EBSCO HOST, Proquest Nursing and Allied Health Source, (Proquest) and PsychInfo. All peer-reviewed journals were considered, with no limitations placed on years as I was aware of some classic work on mothering which I wanted to include. Keywords used were *delayed motherhood, mothers, mothering after 35, old & mothers, mothers & 35, parenting, perimenopause, midlife mothers, mid-life health, pregnancy after 35, women's health, & transitions.* Reference pages from the work of other researchers and authors were also mined for additional articles and research reports related to the topic. Searches included unpublished works, as well as published dissertations, and all searches were limited to those written in English. What follows is a literature review of the concepts which provided a framework for this study.

Mothering

Although the focus of this study was not on the concept of maternal role *attainment* or *becoming* a mother, I felt it was important to review the classic work on mothering which began in the mid-twentieth century. This seminal work initiated an examination of the subjective experiences of women and mothers which were previously unexplored in the literature, yet are critical to the work of nurses and other health care providers. Rubin (1984, p.vii) stated in her book Maternal Identity and the

Maternal Experience that "the judgments that make for the art in professional practice are based in good measure on how much is understood of the woman's subjective experience of a situation at a give time". Understanding women's subjective experiences is paramount for nurses and other health care providers, yet women's psychological experiences as they transitioned to motherhood were not described until the 1940's and 1950's. Rubin's seminal work on maternal behavior and identity in the 1960's is well known to nurses, and still taught in nursing curricula today. Rubin (1967, p.243) first defined the concept of *maternal identity* as the end point in maternal role attainment; it was at this point that mothers "had a sense of being in their roles". Rubin (1984) went on to describe the 'maternal tasks' and other subjective experiences which emerged from her qualitative inquiry with women.

Oakley's (1974) work with mothers began in Britain in 1974 with women aged 19-32; she focused on the experiences of parenthood through the eyes of women. Oakley (1974) conducted a qualitative study which included six months of observations at a London hospital, from which she selected her sample. She completed four interviews each with a total of fifty-five predominantly middle class, married women at 26 and 34 weeks of pregnancy, and then 5 and 20 weeks post partum. Her purpose was to obtain views of parenthood through the eyes of women, and demonstrate that motherhood "is not only an event of importance to the individual woman, but a moment in the history of *all* women" (Oakley, 1974, p.1). Oakley discovered that women had misconceptions about what motherhood would be like, and they wished they had been more realistically prepared for what the role required. Oakley (1974) challenged the social and historical image of motherhood at that time when she described three false assumptions which contribute to what she called the myth of motherhood: (i) all women need to be mothers; (ii) all mothers need their

children; and (iii) all children need their mothers. She attributed the first false assumption to the socialization of women to the mother role, which was backed up by a cultural expectation and emphasis on the role of mother for women. Oakley (1974) initiated a discussion which was culturally relevant in the 1970's that a woman's rejection of motherhood was viewed by society as an equal rejection of womanhood. Oakley debunked the assumption that all women possess maternal instinct, and argued against the belief at the time that abortion invited guilt because it was in conflict with women's instinctive maternal feelings. The researcher expressed the greatest disregard for the third assumption about motherhood which was that children need their biological mothers, rather than substitute caretakers. Oakley (1974) asserted that the myth of motherhood was really a political statement, designed to keep women subservient, and disguised to prevent fathers from assuming their paternal responsibilities. Oakley (1979, p.1) later described the moment that a woman becomes a mother as the first time she "...first confronts the full reality of what it means to be a woman in our society" and continued to point out that motherhood was a "crisis in the life of a woman, [and] a point of no return".

Ruddick (1989) sought to illuminate a discourse on maternal thinking during a time when she and other mothers she knew were trying to determine how to be *good enough* mothers. Ruddick (1989, p.40) described a mother as "a person who takes on responsibility for children's lives and for whom providing child care is a significant part of her or his working life". Her intentional use of the male pronoun invites discussion of her belief that either sex is capable of doing the work required of the maternal role. Ruddick (1989) portrayed the responsibilities of doing a mother's work as preserving a child's life, nurturing emotional and intellectual development, and promoting social acceptability.

Further work on maternal behavior, and maternal role attainment was accomplished by Mercer (1986, 1995, 2004) who expanded earlier concepts of Rubin's work (1967, 1984). Mercer (1995) also utilized concepts from transition theory to help clarify a woman's developmental process in becoming a mother. This led to the concept of pregnancy as a 'marker event' in a woman's life, one which upsets the status quo, and is capable of creating uncertainty and a sense of vulnerability in a women's life. Mercer (1995, p.1) defined mothering as "...the maternal behavior learned in interaction with a particular child, beginning in the process of achieving a maternal role identity and continuing to evolve throughout the child's development". Based on the cumulative work of other researchers, Mercer (2004, p.231) revised her earlier theory of Maternal Role Attainment and renamed it 'Becoming a Mother' to capture the "dynamic transformation and evolvement of the woman's persona...and the continued expansion of the self as a mother". Mercer (2004) recognised the lag in health care and social support systems which have not addressed the needs of women who represent a broader range of mothering experiences, such as adoptive and single mothers.

Frances-Connolly (1998, p.149) described mothering as a powerful social construct centered around the "activities involved in nurturing and caring for children in which women engage to ensure the growth of their children". The author believed that while there may not be an explicit consensus on what constitutes an appropriate mother, women spend a lifetime striving for perfection, trying to meet the elusive ideal image of the perfect mother. This idea of mothering is elaborated further by Hays (1996, p.3), who maintains that the American "...public ideology of appropriate child rearing has urged mothers to stay at home with their children, thereby ostensibly maintaining consistency in women's nurturing and selfless behavior". In spite of this

standard for motherhood, women choose to juggle both a career and the demands of mothering, which is supported by the growing number of women who are mothering young children and also present in the American workforce. Fifty-seven percent of women who gave birth to their first child during the late 1990's and in 2000 in the United States worked full time during their pregnancy, and this represents an increase of 40% from the 1960's (U.S. Census Bureau, 2009). Women are returning to the workforce shortly after childbirth, as evidenced by the fact that 56.4% of mothers who had infants less than one year old were present in the workforce in 2008. These numbers correspond to a broader statistic of 59.5% for women aged 16 and older who participated in the labor force in the United States in 2008 (U.S. Dept. of Labor, 2009).

The cultural contradiction here in the United States creates expectations for *appropriate child rearing* that interfere with a woman's commitment to a career (Hays, 1996). The first expectation is that mothers are still considered to be the primary caregivers for children, and when the mother is not available, others serve as substitutes. Second, in a child-centered world, the mother must put the child's needs first, and promote optimal developmental opportunities which includes methods that are "expert-guided, emotionally absorbing, labor-intensive and financially expensive" (Hays, 1996, p.8). Finally, the *appropriate* mother recognises the 'priceless value' of her child/children, so there should be no real question as to which is the most important job in her life. Hays (1996, p.9) presents this ideology of "intensive mothering" as particularly true for white, middle-class career women, and that it is understood as the "proper" way to mother. The problem with an established ideology like intensive mothering is that it can serve as a standard that can potentially distort both women's experiences and society's understanding of what is proper mothering.

Additionally, a dominant ideology like intensive mothering can impose expectations which if unfulfiled could lead to anger, frustration and resentment (Glenn, Chang & Forcey, 1994).

As noted in the previous chapter, women are having children at an older age, and this trend is not limited to the United States. The next section examines the literature on delayed motherhood, which provides further background on mothering to frame the current study.

Delayed Motherhood

Several studies (Winslow, 1987; Dion, 1995; Welles-Nystrom, 1997; Nelson, 2004; Benzies *et al.*, 2006) have looked at women's decisions to postpone motherhood. Feminist ideology influenced American women's decisions to postpone motherhood in a mixed methods study of fifteen women born between 1947 and 1953 (Welles-Nystrom, 1997). Women became aware of the women's movement as adolescents, and felt it had a positive impact on the choices they made to pursue careers over motherhood while they were young adults. They felt their lives were radically different from their own mothers, and that they made deliberate choices about the timing of motherhood (at age 34-41), unlike most mainstream American women. Winslow's (1987) qualitative study utilized a grounded theory methodology, and she conducted in-depth interviews with 12 primigravida women (pregnant for the first time) aged 35-44, though she does not identify the method of recruitment for her sample. Winslow identified four themes which described the women's experiences during pregnancy: *Planning for Pregnancy, Seeking Safe Passage, The Reality of Now*, and *Anticipating the Future*. Women felt there was a *right time* to have a baby, and their decisions were influenced by five factors which reflected careful planning on their part. Most important to them was having a committed relationship with the father of the baby, and second, they had concerns for decreased fertility if they

delayed any longer, as well as worries about increased risk of having a baby with Down's syndrome. Down's syndrome is the most common of the genetic trisomy disorders, and is characterized by distinct facial features and mental retardation (Olds *et al.*, 2004). The third set of factors which influenced their decisions reflected a sense of achievement, financial security, travel, material acquisitions, and an established career. The final factor was a desire for a baby, though the intensity of this desire varied. Their final consideration was that they did not want to remain childless. *Seeking Safe Passage* reflected three strategies the women employed to maintain control over their lives, and *The Reality of Now* represented the women's recognition that they were in a time of transition from their old life to one with less control and more demands on their time. *Anticipating the Future* described the actual preparations for becoming a mother. There was a sense of uncertainty about how they would balance their roles as mothers with their careers, and still make the children's needs their first priority. It is critical to note that Winslow's (1987) study included women younger than age 40, and was limited to data gathered during each woman's pregnancy.

In a mixed methods study of mostly Canadian women, Dion (1995) identified that the perceived advantages for women who delayed childbirth (into their thirties) were opportunities for personal growth and well-being, preparedness for the mothering role, and psychological readiness. Again, findings were limited to data gathered during pregnancy, and data were obtained from women referred to as 'delayers', but whose ages were primarily in their thirties, not their forties. Nelson (2004) also reported a readiness for motherhood among women aged 36-48 in a phenomenological study of seven first-time mothers in the Northeast section of the U.S., which focused on mothering experiences during the first year post partum. All

seven women were married; six were Caucasian, all had two or more years of college and all worked. Women were interviewed during the first year of motherhood only, and included women as young as thirty-six. Three of nine themes (from her dissertation, Nelson, 2003a) were discussed in the paper, including *Being Ready*, *Planned Intensity*, and *How Far We've Come*. In addition to the 'readiness' theme, the second theme revealed the intense organisation and planning older mothers engage in, a high level of demand placed on health care providers by older mothers, intense focus on the safety of their child, and a deep appreciation of their children. The third theme included reflections on women's past selves, present struggles, and thoughts about the future. Nelson's work will be addressed in more depth in the section titled *The Experiences of Older Mothers*.

I have conducted an in-depth analysis of three of the particularly influential papers (Nelson, 2003a; Benzies, 2006; Kafanelis *et al*, 2009) from the literature on the topics most relevant to my inquiry, and which informed the methodology and methods used in my study. The first is a study by Benzies *et al.* (2006, p.626) which was particularly relevant to the focus of my enquiry because it was conducted by a nurse researcher, with women aged 20-48 regarding factors which influenced their decision to become mothers. The researchers recruited a convenience sample of women aged 18-50, with and without children, in a large Western Canadian city "through word of mouth, obstetric clinics, parenting classes, and posters in public places". The final sample included 45 women aged 20-48. Benzies *et al,* (2006) were vague about what particular age described a *delayer,* though they grouped women 30-35 years and women older than 35 years in separate groups. The primary methods of data collection were focus groups with 30 women (the other 15 women participated in telephone interviews) and each group lasted 1-1.5 hours. There were six focus groups with 6-11 women in each group, and these were appropriately sized for conducting focus groups

(Morgan, 1997). Focus groups are group interviews; the interaction within the groups can provide useful insights on a subject that may not be well understood, and there is generally sharing and comparing among participants (Morgan, 1997). Participants in focus groups are usually homogeneous strangers with something in common; however, this characteristic about focus groups may not have been conducive to data collection in the Benzies *et al* (2006) study due to the potentially sensitive nature of the topic. This was exemplified when the researchers reported that one woman was referred for crisis counseling after a focus group because she shared emotionally distressing personal information. Telephone interviews were used as an additional method of data collection with the 15 women who could not attend a focus group, though I wonder if this would have been the better choice for data collection in the absence of the time and resources to conduct individual interviews. Each woman was interviewed only once which may have limited data collection. Seidman (1998) recommends using a three-interview structure, which contributes to the validity and reliability of the study. Multiple interviews provide an opportunity for relationship building, and allow time for participants to reflect on what they want to say. There is no rationale provided by Benzies *et al* (2006) to explain why women were only interviewed once.

Women responded to questions about factors that influenced their decisions about the timing of childbearing. The interviewer was a doctoral prepared nurse with experience in conducting focus groups and was knowledgeable about childbearing. Interviews were audio-taped, transcribed verbatim, and software was used to manage the data. Analysis was ongoing with data collection, along with the reading and 'engagement' with each transcript, during which coding and themes emerged from the data. Benzies (2006, p.627) cited a reference that is more than twenty years old which defines theme as a "simple expression of what a data segment is about". I would argue that what the authors referred to as themes are actually the *meaning units*

(Graneheim & Lundman, 2004) within the text, consisting of words, phrases, sentences and paragraphs which are identified as key. These are usually noted in the margins of the transcripts. A theme is the focus or point which captures the phenomenon one is trying to understand (van Manen,1990). Themes are not objects or things. Graneheim and Lundman (2004, p.107) regard a theme as a "thread of an underlying meaning through, condensed meaning units, codes or categories, on an interpretive level". This difference in opinion about the construction of themes in the analysis process leads me to question the credibility of the following findings in the Benzies *et al,* (2006) study.

The researchers used an 'ecologic framework' of *Individual, Familial, and Societal Factors* to organize the themes and each *Factor* incorporated 3-7 themes within it. *Individual Factors* included the theme *Independence* which described the greater value that older mothers placed on their independence, achieved through "education, secure employment, and financial stability" (Benzies *et al.*, 2006, p.627). *Family Motivation, Readiness* for motherhood, *Projecting the Life Plan, The Biological Clock, Chronic Health Problems*, and a *Stable Relationship* were recurring themes which were essential to decision making by the women. *Familial Factors* included *Partner Readiness, Financial Stability,* and *Family of Origin* which represented choices that previous generations of women did not have, different parenting styles, and geographical separation from families. *Societal Factors* like *Social Acceptability of Delayed Childbearing, Divorce Rates*, and *Policy* were also critical to decision making about the timing of motherhood. What is not clear to me is whether the ecologic framework emerged from the data or whether the researchers utilized the framework to organize the data which would be a methodological flaw within the study. They do reference another author for the ecological framework

which creates suspicion around the analysis process. Benzies *et al* (2006, p.627) state that measures were taken to assure rigour in that the research team "reflected on "potential sources of bias in expressing themes", and reached consensus about final themes", but they do not elaborate on the influence their presence or bias had on the study findings. Once again there was inconsistency in identifying women who were referred to as 'delayers'; some were mid-30s and some late 30s. Benzies *et al* (2006) suggested that further research was needed from the male perspective and their influence on the timing of motherhood.

Studies which have explored reasons and factors which influence women's decisions to delay motherhood have primarily explored the experiences of women younger than age 40, and no studies were located which have specifically explored the experiences of first time mothers aged forty and over. Several of the studies presented had inconsistencies in methods of data collection and/or analysis which raise questions of authenticity. This older group of mothers represents an increasing phenomenon as evidenced by the changing demographics for women age 40 and older, yet little is known about their mothering experiences. There is only a small body of available, recent work in the last decade or so which has explored the actual experiences of older first time mothers age 35 and older, and these will be presented now.

The Experiences of Older Mothers

As noted, little research attention has been paid to the real occupation of mothering, and that which exists provides little understanding of the meaning women give to the experience of mothering (Francis-Connolly, 1998; Reece & Harkless, 1996). This is particularly true for older first-time mothers. The literature relating to older first-time mothers is focused primarily on pregnancy and childbirth after 35

years of age, and draws attention to risk factors for the mother and foetus, pregnancy and fertility issues, and complications of labour and delivery (Cunningham & Leveno,1995; Abu-Heija *et al.*, 1999; Tough *et al.*, 2002).

Several studies (Mercer,1986; Winslow,1987; Roosa,1988; Reece & Harkless, 1996; Windridge &Berryman, 1999; Nelson, 2003a, 2003b, 2004; & Carolan, 2005) have explored the mothering experiences of women who gave birth after the age of 35 years, and some of these were presented in the previous section. This research has contributed to the body of knowledge for older first-time mothers, but has been limited to focusing on women's experiences during pregnancy, early postpartum, and the first year. Mercer's seminal work in the mid-1980s was a quantitative longitudinal study that examined first-time motherhood for women in their teens up to age 42. She found older mothers (aged 30-42) were more flexible, highly integrated, and more highly educated. Older mothers reported more emotional support, fewer problems with partners, less financial stress, described mothering as 'hard' less often than younger mothers, and found 'nothing' surprised them during the first year. Major concerns revolved around balancing career and motherhood roles, and lack of time, but their biggest concern was isolation from other adults. The older mothers also "consistently reported the least gratification in the maternal role" (Mercer, 1986, p.335) compared to younger mothers.

Reece and Harkless (1996) used mixed methods to explore the maternal experiences of women aged 35-42, during the last trimester of pregnancy and up to three months postpartum. This study was part of a longitudinal project exploring social support and stress experienced by first-time mothers. The sample was recruited from childbirth programmes in the Boston area, and data were obtained from self-report questionnaires sent by mail. Three themes emerged which were consistent with

results from quantitative assessments of younger women's maternal experiences: *Self-Evaluation, Centrality,* and *Life Change*. Two other essential themes of *Mortality/Hastening Time*, and *Loss of Control* were found to be particularly relevant to the older mothers in their study. The first "represented perceptions of time running out, lost time, increased vulnerability to ill health or death, and worry about future parenting" (Reece & Harkless,1996, p.151-152). *Loss of Control* described the older mother's perception that she is unable to accomplish anything after many years of goal attainment, freedom and flexibility prior to motherhood. Three additional themes: *Social Support/Isolation, Fatigue/Need to Heal* and *Work/Career Issues* were thought by the authors to be common to mothers of all ages (Reece & Harkless, 1996).

Examination of the literature on the older first-time mother's experience uncovered discussion regarding the common practice among health care professionals to designate women over 35 a 'high risk' status. In a mixed methods study in the UK, Windridge and Berryman (1999) examined women's pregnancy and early post partum experiences after age 35, as part of the 'Leicester Motherhood Project'. They noted that professionals were more likely to classify women over 35 as 'high risk' despite lack of data in medical records to support this distinction, and the expectation of good outcomes. Women may believe that their age makes their infant vulnerable during labour and birth, however higher levels of concern did not have a negative effect on the overall birth experience or the women's postpartum health, and overall, older women's experiences were more positive than those of younger women.

Nelson (2003a, p.3) sought to uncover "the essential aspects of the experience of older, first-time mothering" (in order to) "provide patient-sensitive care" though she did not specifically state this as a research aim. The researcher conducted a structured

and comprehensive literature review divided into three sections: *Motherhood, Transition Theory*, and the literature on *Older Mothers*. Nelson identified a gap in the literature as she was unable to identify any qualitative studies which "focused on the lived experience of the first maternal transitional year" (Nelson, 2003a, p.84). The methodology utilized in this qualitative study was identified by Nelson as phenomenology, but 'not strictly phenomenology'; rather it was described as a human science approach that "blends both the phenomenological and hermeneutic traditions" using primary sources by van Manen (Nelson, 2003a, p.86). Nelson did not identify any specific tradition of phenomenology which guided her inquiry, cited no primary sources for any philosophical underpinnings for the study, and did not report on the epistemological and ontological beliefs which influenced her choices. This lack of a conceptual approach creates confusion and lack of methodological clarity which affects the rigour of this study and its findings.

Nelson's (2003a) study employed a purposive sample of seven English-speaking, first-time mothers aged 36-48 who resided in the Northeast section of the U.S. and who had delivered a baby within the year prior to the study. Interviews were conducted at different points during the first year of mothering in an effort to explore the experience of older first-time mothering in all its "modalities and aspects" (Nelson, 2003a, p.88). However, all of the women were married (none single), and the experiences of women who adopted and/or were in lesbian partnerships were not included, and this was not identified as a limitation of the study. The rationale for the size of the sample was reported and was adequate for a qualitative study. The sample demographics were consistent with those identified in the literature for women who delay childbirth. All seven women were married; six were Caucasian, (race of seventh participant not provided); all had two or more years of college and all

worked. Women were interviewed during the first year of motherhood only, and included women as young as thirty-six. One woman withdrew from the study before being interviewed due to family illness. Participants were interviewed in their homes (4) or place of employment (3), but the researcher did not elaborate on the setting choices or how this may have impacted on the quality of the data collected. Data were collected during two interviews with each woman; these were tape recorded, and notes were made by Nelson (2003a) following each interview. The focus of the interviews was on their daily lived experience rather than their perceptions or reflections on their experiences. Emerging themes were presented to participants for reflection during the second interview which enhanced rigour. The questions were open-ended and addressed the phenomenon of interest.

Analysis was conducted initially by identifying "essential themes inherent in the experience of older mothering that without which it would be a different phenomenon" (Nelson, 2003a, p. 93). The researcher credits van Manen (1990) with this approach, but if Nelson had used primary sources to guide the philosophical underpinnings of her study, she would have recognized that this philosophically agrees with the phenomenology of German philosopher Edmund Husserl (Koestenbaum, 1967). This study is not hermeneutic at all, as it does not recognise that there may be more than one experience or interpretation of a phenomenon. The inclusion of "personal accounts, experiential and phenomenologic studies and writings, and selected poetry were also incorporated" (Nelson, 2003a, p.94) in order to develop the text beyond the interview-based themes. Of note is another methodological weakness in that Nelson (2003a) failed to recognise further connections in her work to Husserlian phenomenology when she applied the concepts of *reduction and bracketing* in the writing of the text of her thesis. These conceptual

misnomers emerged from the initial failure early on to establish a philosophical framework for the study that would work in harmony with *selective* guidance from the work of van Manen (1990) for data analysis and the writing of the text. These issues with methodology and methods affect rigour, and put the credibility of the findings into question.

Nelson (2003a) identified nine *essential themes* : *Doctors Set the Tone, Being Ready, Confronting Age, Feeling Out-of-Step, A Bridge Apart, Planned Intensity, How Far We've Come, The Future Will Come, and The Child as both Self and Other.* There are sample extracts from the data to represent the themes and sub-themes, but the researcher has not identified which participant is speaking in the extract, which interview it refers to, and it is not always clear if the extract represents common meaning, or the exceptional point of view. This raises issues of *voice* in the writing of the text, and again affects the rigour of the study. The reader is unable to judge whether extracts selected reflect the range of women's views expressed.
Nelson (2003a) wrote anecdotes, and used poetry (her own or that of others) to express meaning of the women's experiences. She also created a 'hooked textile medium' (Nelson, 2003a) to represent the interpretation of older, first-time mothering. To support rigour, she discussed preliminary themes with the participants in her study, and stated that themes were validated by the women. Additionally, Nelson (2003a) sent two of the women participants a copy of the preliminary text and was able to obtain feedback from them confirming the accuracy of the interpretation.

The researcher refers to remaining 'reflectively aware' citing van Manen (1990) in order to gain understanding of the women's experiences, but she does not address the use of reflexivity to locate her presence in this study. This is evident in the liberal use of both first and third person throughout the text, and the frequent use of the

pronoun 'us' and 'we'. This creates confusion for the reader about the author's presence, voice, and influence over this study and findings. Nelson (2003a) recommends further research with older first-time mothers beyond the first year postpartum, and suggests that more evidence is needed to strengthen the implied need for peer support for older first-time mothers. Finally, the researcher recommended further research is needed with mothers aged 40 and older to explore their experiences of mothering at an older age. Despite the study limitations Nelson's work is one of only a few qualitative studies to have explored the experiences of older first-time mothers during the first year of motherhood. The women in Nelson's (2003a) study responded well to being interviewed more than once and this seemed to be an appropriate method of data collection with this cohort of women.

Carolan (2005) conducted a qualitative study, with a purposive sample of 22 primiparas, aged 35 or older, in Australia; however, only eight of the women were older than age 40. Sixteen were college educated, and there was some diversity amongst her sample. Interviews were completed at three points: 35-38 weeks pregnant, 10-14 days postpartum and only within the first year post partum (eight months). Content analysis was identified as the methodology, and the following themes were identified. *The Project* described a trajectory of planning and preparation which the women initiated prior to becoming pregnant and maintained throughout their pregnancy. *The Nightmare of Early Mothering* (one to four weeks postpartum) represented varying degrees of helplessness and inadequacy felt by the women during this period of early motherhood, followed by *Struggle and Ambivalence* at one to four months postpartum as the mothers realised their lives had changed forever. This theme incorporated many aspects of the women's experiences including feeling the demands of the infant, a desire to hang on to self, maintaining a sense of control,

while still being good and proper mothers. *Giving In* represented acceptance of the centrality of the commitment to the infant's needs at four to six months, as well as recognizing that it was impossible *to do it all.* This recognition lead the mothers to construct their own version of the mothering role. The final theme *Feeling Like a Mother* at six to eight months symbolized a marker at which point women felt like they had assimilated a greater understanding of the maternal role. Whilst they compared themselves to younger mothers, there was a sense of readiness and satisfaction with their role as mothers. The women in this study (Carolan, 2005, p.779) referred to wanting "better health and longevity" and expressed concern with having "enough energy to keep up", a desire to "be there" for the child, as well as "maternal health, and mortality". Several of the mothers expressed the idea that an infant or young child would "keep them young".

Whilst valuable contributions to the state of current knowledge about midlife mothering have been made by these researchers, what was still missing from the qualitative body of work on older first-time mothers was a hermeneutic phenomenological study focused on older women aged 40 and older, which explored the meaning of their mothering experiences beyond the first year postpartum. While that focus alone would have contributed to a gap in knowledge in the literature, the additional focus of older first-time mothers' perceptions of their health as they simultaneously transitioned to menopause was uniquely absent. I believed this gap in knowledge about mothering experiences and women's health was particularly critical and relevant to this growing cohort of women.

Transition to Motherhood

As noted in previous sections, there is little understanding about the meaning of mothering for women, particularly older first-time mothers, or how meaning may

change or be affected by other overlapping life transitions. Meleis *et al.* (2000, p.13) described transitions as "both a result of and result in change in lives, health, relationships, and environments". Mercer *et al.* (1989, p.2) noted that transitions are important to study for several reasons. The first is because they "involve individual change or adaptation over the life span, they contribute to psychosocial development or have developmental potential". Secondly, "transitions are important because they represent a period of disequilibrium or flux for the individual who must adapt to a new situation, new roles, or responsibilities" (Mercer *et al.*, 1989, p.3). Older mothers, while establishing parenting, may also be experiencing symptoms of perimenopause, the gradual transition from menstruation to menopause. Crossing thresholds into motherhood and menopause are not new experiences for women. However, experiencing these lifespan transitions superimposed on each other is a unique phenomenon for women who experience first-time motherhood later in life. Pregnancy, motherhood, and menopause, have been identified as transitions that may create a context for heightened vulnerability (Meleis *et al.,* 2000) and therefore are worth studying. The researchers call particular attention to the "patterns of all significant transitions in an individual or family's life", and in the presence of multiple transitions, examining the nature of the "overlap among transitions, and the nature of the relationship between the different events that are triggering transitions for a client" (Meleis *et al.*, 2000, p.18).

Nelson (2003b) conducted a meta-synthesis of nine qualitative studies comparing the findings relative to the transition to motherhood. The women's ages varied; she included primiparous and multiparous women, and the study periods ranged from late pregnancy to twelve years after giving birth. Primary themes of *Engagement, and Growth and Transformation* emerged, the first of which Nelson (2003b, p.467)

described as a process through which "commitment to mothering, experiencing the presence of the child, and being actively involved in caring for her child does a mother open herself to the opportunity to grow and be transformed". Although active engagement with the child is necessary for growth and transformation, not every woman grows or becomes transformed by motherhood, which includes becoming, growth and development, a widening scope of capabilities, redefining self and relationships, and incorporating motherhood into one's sense of self (Nelson, 2003b). Incorporating the work of researchers like Nelson, Mercer (2004) recognised the long-range implications of adapting to motherhood, which led to a revision of her original theory *'Maternal Role Attainment' (MRA)* into *'Becoming a Mother' (BAM).* BAM recognises the "dynamic transformation and evolvement of the woman's persona...[and]... includes "continued expansion of the self as a mother" (Mercer, 2004, p.231).

For some midlife mothers, the transition into motherhood is closely followed by the transition to menopause. The next section explores the literature on perimenopause, menopause and midlife women's health.

Perimenopause, Menopause & Midlife Women's Health

It is important to note that menopause is considered an 'age normative transition' in many but not all cultures. George (2002) found that each American woman's experience and the meaning assigned to menopause is unique. Women have even been known to "neglect and ignore the menopausal transition because of other imminent demands" in their lives (Meleis *et al.,* 2000, p.14). The transition to menopause is referred to as perimenopause, and can last 6 years or more including the first year after menopause (NAMS, 2006). During this time, women commonly experience irregular menstrual periods, hot flashes, sleep disturbances, and vaginal

dryness, causing varying degrees of distress (Hudson, 2001; Gracia & Freeman, 2004; NAMS, 2006). The transition to menopause has also been described as a time of neuroendocrinologic changes which can lead to depression (Serrano & Warnock, 2007) for some women.

Although all women will eventually transition to menopause, some women find this time very challenging due to the unpredictable and variable nature of symptoms (Lange-Collett, 2002), leading some to label perimenopause a time of "instability and unpredictability" (Hudson, 2001, p.33). Others call out for a broader and positive paradigm for viewing menopause (Cousins & Edwards, 2002) and suggest that the social context in the United States leads women to believe they will have problems during the transition to menopause or as it is known colloquially, 'the change of life', so therefore, they do. Past images and stereotypes of menopause have been predominantly negative. The medical community regards the perimenopausal woman as someone who is in transition from "fertility and ovarian hormonal production to the postmenopausal years- a time of lost ovarian function" (Speroff, 1993, p.124). As early as the 19th century, menopause was viewed by medicine as a physiological crisis that caused a variety of physical diseases like breast cancer and tuberculosis. Women were treated for psychological conditions such as hysteria, depression, and insanity thought to be brought on by menopause (MacPherson, 1995). The stereotypical image of menopause continued to be one of oestrogen deficiency for many years, viewed as a medical problem requiring medical solutions, specialists, procedures and pharmaceuticals (Berg & Hammer, 1994; Collins, & Landgren, 1994; Modelska & Cummings, 2003; Gracia & Freeman, 2004; Nelson, 2008). Oestrogen therapy was touted in the 1960's as the key to the fountain of youth for menopausal women, and led Robert Wilson to coin the phrase 'feminine forever'. The adverse effects of

unopposed oestrogen on the development of uterine cancer was uncovered in the 1970's, but by the end of the 1980's, new knowledge about oestrogen returned it to star status in the prevention of osteoporosis and cardiovascular disease (Bush, 1992; National Women's Health Resource Center, 1995).

In contrast to the medical model, the psychosocial model also reduces menopause, but from the opposite view. Menopause is portrayed as "a natural event which becomes medicalized in a society dominated by masculine power" (Ulacia *et al.*, 1999, p.266). Varying degrees of loss of health are attributable to personal situations of stress, and/or to negative cultural problems such as ageism and sexism that make it difficult for women to thrive and succeed in their later years (Rostosky & Travis,1996; Ulacia *et al.*, 1999). Views of menopause from a feminist paradigm regard it "as yet another biological experience which has been used to suppress women's positions and led to the social control of women via medicalization" (Lyons & Griffin, 2003, p.1630). A more holistic and postmodern model of menopause offers menopause as an opportunity for personal growth, and describes it as a complex, multifaceted process responding to the interaction of different bio-psychosocial factors that can lead to change and adaptation. Some believe that moments of crisis or times of rapid change like menopause can contribute to personal growth (Ulacia, *et al.*, 1999). Though this paradigm may be viewed as an improvement over previous models, the postmodern model persisted to represent menopause as an 'illness' with moments of 'crisis', but at least recognised that each woman's experience is unique and may not be negative for her.

The portrait of women during the menopause years as one of depression, stress, crisis and decline does not concur with the literature available on women's opinions about their own processes during mid-life (Bernhard & Sheppard, 1992; Avis &

McKinlay,1995; Woods, 1996; Ulacia *et al.*, 1999). By the mid-nineties, American women used their collective professional, political, and personal influence to develop a "huge wave of interest in menopause" (Sheehy,1998, p.xv). Most midlife women aged 40-65 described themselves as healthy (Woods, 1996), and women aged 43 to 58 years old reported that they were healthy despite experiencing a wide range of non-worrisome menopausal symptoms. Avis and McKinlay (1995, p.48) noted that 69% of women were not bothered by hot flashes or night sweats, and they suggested that expectations and negative attitudes toward menopause could "become a self-fulfilling prophecy". Northrup (2001, p.124) corroborates this predisposition for expecting problems in her book The Wisdom of Menopause, and adds that a woman's mother's menopause experience may create "a powerful unconscious blueprint" for a woman. A new paradigm for women transitioning to menopause emerged for the new millennium (Northrup, 1994, 2001; Rostosky & Travis,1996; George, 2002; Lange-Collett, 2002; NAMS, 2006), in which menopause is considered a normal natural process, not an event or illness, and one that all women will ultimately experience. The transition to menopause may involve positive as well as negative aspects, but both can be purposeful for women (Rostosky & Travis, 1996). Northrup (2001) recognises that some women do have difficulties during menopause, and the new model does not rule out treatment options. She advises women to assess their total health at this point in their life, and make every effort to "restore or build... health" (Northrup, 2001, p.108). Yet, women's health has only recently become a focus for research, and there is little known about "the effect of the midlife years in general on the emotional and physical health of women" (AWHONN, 2001, p.5).

It is also important to point out that the years women spend transitioning to menopause have only been recognised as separate from menopause for less than

twenty years. A consequence of this has been the absence of research with perimenopausal women (Li, *et al.*, 2000), particularly from the perspective of women's understanding and comprehension, which lends additional importance to the current study. Bender (1998, p.12) writes in the lay literature, The Power of Perimenopause, that it is not surprising to find women are confused about perimenopause for "we certainly didn't grow up hearing the word *perimenopause*, much less knowing what it means".

Walter (2000) was interested in hearing women's stories about the psychosocial aspects of menopause. She interviewed 21 women, including women who were single, married, divorced, separated, widowed, and one lesbian and all were menopausal. Content analysis was used to analyse the data, and seven themes were identified. *A Marker Event in Women's Lives* described menopause as an important positive passage, whilst feelings of uncertainty about their bodies, feeling out of control, and regret for childlessness was captured in the theme *How It Impacts Sense of Self.* In other themes, women described the disinterest in menopause exhibited by their partners, along with criticism for their irritability and mood changes. They shared reduced sexual desire, or symptoms which affected sexual activity, a desire to discuss menopause with their mothers, and a variety of experiences communicating aspects of their menopause experience with friends. The women also revealed a level of dissatisfaction with the amount of information or time their physicians spent discussing concerns with them.

Matarese (2005) explored women's perceptions of the menopause process with a convenience sample of Caucasian women aged 49-63, utilizing focus groups and an emancipatory context. The author described emancipatory context as one which might result in the women making a change in their lives. Menopause was described by the

women as a time of change in many dimensions of their lives, and they utilized coping to deal with the changes. The women reported a need for information, time to process it, and to dialogue with other women. Matarese (2005) recommended that nurses could be facilitators of the knowledge needed by women during this time.

Another qualitative study from the perspective of women's experiences was conducted by George (2002), but once again it was with menopausal women. This phenomenological study aimed to understand the experience of menopause for American women from diverse backgrounds. The sample included 15 women who were from middle class and lower socioeconomic backgrounds; thirteen were white, and two were African American. The women were recruited from a group of volunteer participants in the Boston area. The first of three major themes was *Expectations and Realization* which represented the women's confusion about the transition to menopause. They were either not sure what to expect, or their actual experience did not parallel what they expected to happen. *Sorting Things Out* expressed the need of the women to understand the context of menopause, and minimize confusion, including the decision to take hormone replacement therapy. The participants marked this time in their life as a transition between two distinct stages of their life, including the conclusion of their childbearing years. They looked forward to more freedom, confidence and exploration, and these were represented by the final theme *A New Life Phase*.

The impact of menopause on women was explored by Kafanelis *et al.* (2009) in a qualitative study conducted in Australia which is reviewed here in depth because it was one of the few studies that included the experiences of women transitioning to menopause. The title: *Being in the Script of Menopause: Mapping the Complexities of Coping Strategies* is very insightful, as it alludes to the experience of menopause as a

'scripted' or self-fulfiling prophecy, one for which the text is already written. It also recognizes that women's coping strategies for menopause are not simple or homogenous, and this is the focus of the paper. Kafanelis *et al* (2009) provide an overview of the literature on menopause and note that there are primarily two approaches usually taken: those that focus on physical symptoms, and those that focus on psychological responses to menopause. This is followed by an organized review of the physiological changes associated with menopause, and then the psychological responses utilizing literature from the mid-90s through to 2005. The authors move to a review of the literature on coping, and it was here that they identified a gap in the literature about the unique differences among women as they experience menopause and the coping mechanisms utilized as they journey through menopause. This study sought "to identify the modalities of coping that women employ in responding to their experiences of menopause, through an analysis of the impact menopause has on their lives and health" (Kafanelis *et al*, 2009, p.32). This study aim is both important and relevant to the care of midlife women. It was hoped that new insights could further understanding by other women and lead to "educational programs that facilitate mastery over changing circumstances" (Kafanelis *et al*, 2009, p.32).

The methodology was identified as qualitative, and though the authors did not state that they were doing a phenomenological study, they did apply Giorgi's (1985) four stages of phenomenological analysis to analyse the data. It has been noted in the nursing literature that researchers may read and reference the first generation phenomenologists like Husserl and Heidegger (these did not), but then some move to a phenomenologist like Giorgi who can offer a 'method' to guide their study (Munhall, 2007c). Giorgi's phenomenological method was inspired by the work of Husserl, and presents a particular view of phenomenological psychological research

which aims to be more 'scientific' in the approach to capture the 'psychological essence' of a phenomenon as experienced (Giorgi & Giorgi, 2003). Kafanelis *et al* (2009) are professors, lecturers, and researchers in the fields of medicine and psychology, so it seems logical that they would be drawn to the work of Giorgi. The flaw in methodology which affects the entirety of this study is the failure of the authors to identify a specific methodological approach other than stating that they applied Giorgi's four steps for phenomenological analysis. This raises concerns about the impact on the entire inquiry, implies a lack of rigour, and fails to represent 'best research practice' (Maggs-Rapport, 2001).

The sample included thirty women between the ages of 43 and 61; 14 were perimenopausal and 16 postmenopausal. This was one of the few qualitative research papers I was able to locate that included the experiences of women transitioning to menopause, and equally important, all of the women were over age 40. The women were recruited from an existing University database and through snowballing technique. The researchers do not state how many of the women were snowballed from other participants; this is important because the effects of snowballing can limit the diversity of the sample. The majority of the women were in heterosexual relationships, married, did not work as paid employees, and were middle class. Data were obtained from two semi-structured, audio-taped, in-depth interviews with each woman, and Kafanelis *et al* (2009) defended their use of this method. Interviews last 1 to 1.5 hours, were conducted by one of the authors, and took place in the women's homes or other locations selected by the women. Informed consent was obtained. The second interview was conducted three months after the initial one. This length of time can increase the possibility of idiosyncratic interviews and possibly weaken the connection between the two (Seidman (1998). As previously mentioned, Giorgi's

(1985) four stages of analysis were followed; these four stages are identified, but the researchers did not describe how the main themes emerged from the data. Further evidence of a methodological limitation in this work is the failure of Kafanelis *et al* (2009) to recognise further connections in their work to Husserlian phenomenology when they applied the 'four stages of analysis' which include the Husserlian concept of *bracketing* previous preconceptions in the reading and writing of the text.

Three main themes emerged: *Inventive Copers, Troubled Copers, and Reactive Copers*. Inventive Copers were women who responded "to life circumstances in a harmonious and effective manner" (Kafanelis *et al.,* 2009, p.33). They were highly reflexive in their appraisal of the menopausal experience, and identified past and present events as enabling them to cope so well. It was interesting to me that the excerpts from the data to support this theme were representative of ten postmenopausal women and only one perimenopausal woman. There was no explanation for this imbalanced ratio, so the reader is left to wonder if this is representative of the data, in that the women who were postmenopausal were indeed coping better. *Troubled Copers* were women who experienced higher levels of internal conflict and anxiety when faced with new challenges, and this was identified as a life pattern of coping for them. There was an inverse pattern of data excerpts to support this theme in that only three were from the experiences of postmenopausal women and nine represented perimenopausal women. *Reactive Copers* fluctuated between the first two styles of coping, but expended a great deal of physical and emotional effort to cope. They "found the journey difficult but remained optimistic" (Kafanelis *et al.,* 2009, p.36), and extracts were more equally balanced from both groups of women to support this theme. The authors discovered that for the women, dialogue about menopause while engaged in the study actually enabled them to reflect

on the complexities of their situation. It was recommended that educational and preventive programmes be employed to enhance women's coping techniques which could then be applied to the context of menopause. Kafanelis *et al.* (2009) also argued that a woman's method of coping with menopause is situated and dependent on the context of her life, but I am left to question if the findings support that a woman's method of coping is also situated and dependent on the context of her menopausal experience (Morgan, 2001).

Summary

This chapter discussed the ambiguity in the literature about when to conduct a literature review in a phenomenological/qualitative study, as well as my rationale for completing an initial literature review. The topics and databases searched during the reviews of the literature were described. I have presented a review of the literature on mothering, and included older classic works to provide some historical background to compare with newer works. I furnished a comprehensive review based on the concepts which informed this study including: delayed motherhood, the experiences of older mothers, transition to motherhood, perimenopause, menopause, and midlife women's health, with particular emphasis on women's experiences discovered through qualitative methods. I described the approaches which have already been used to research midlife mothering, along with summaries of findings. I have analysed in depth, three of the particularly influential papers from the literature on these topics (Nelson, 2003a; Benzies, 2006; Kafanelis *et al*, 2009) relative to my inquiry, and which informed the methodology and methods used in my study.

There is a scarcity of literature which has explored the experiences of older first time mothers, particularly women aged forty and older beyond the first year post partum, and there is even less from the perspective of women themselves. Similarly, women's experiences of menopause have been addressed in the literature in recent years, yet little is known about the

meaning of women's experiences as they *transition* to menopause. The studies which have been analysed in depth which most closely addressed issues relevant to my phenomena of interest contained some weaknesses related to sampling, methodology, method, and design which raises issues regarding the integrity and rigour of these studies and their findings. The unique experiences of older first time mothers simultaneously transitioning to menopause was not visible in the literature after a thorough search, and it is this gap in knowledge about women's health which invited study. I commenced with an inquiry that focused on an exploration of older first-time mothers' experiences both as mothers and as women transitioning to menopause. Therefore, a qualitative hermeneutic phenomenological perspective was selected as the framework to guide this study on women's perceptions of midlife mothering during perimenopause. Only the women could give voice to and create meaning around the impact this lived experience had on their health and well-being during these life transitions. The methodological scholarship which was utilized to conduct this research is discussed next in chapter three.

CHAPTER 3
METHODOLOGY AND METHODS

Introduction

In this chapter, I justify my use of a qualitative, hermeneutic phenomenological approach to enable the participants and myself to describe and interpret how the women created meaning about their perceptions of health entwined with midlife mothering and perimenopause at a particular point in time. I discuss how my ontological and epistemological views influenced my choice of a constructivist paradigm to frame and support this study. I explain the growth of phenomenology as a philosophy, and 'method', as it pertains to this study. The appropriateness of hermeneutic phenomenology as guided by the philosophical underpinnings of Gadamer, for the framework, rather than Husserl or Heidegger will be defended for this study. The specifics about how I gained access to the participants, data construction methods, data management and ethical considerations will be presented in the 'methods' section of this chapter. Gadamer's principles for hermeneutic understanding and van Manen's (1990) methodological themes were used as a guide for data analysis and interpretation. I articulate the compatibility of van Manen's concepts with Gadamer's philosophical underpinnings. Decisions about how to present findings in subsequent chapters will be discussed. Finally, I make an argument for rigour, by outlining the criteria used to establish the trustworthiness and authenticity of the findings and the study as a whole. Ultimately, readers will have to judge for themselves if this study represents a "possible human experience" (van Manen, 1990, p.58).

Research Aim and Questions

The research aim of this study was to understand midlife women's perceptions

of their health as they mothered young children, while simultaneously going through the menopause transition. Two research questions guided the design of this study in an attempt to create a capacity for meaning and understanding of women's health and their experiences as midlife mothers. How did women aged 40 years and older who were experiencing perimenopausal symptoms and mothering young children perceive and report their own health, and how did these women's perceptions of their health affect their experiences of mothering young children?

Research Approach

This study was conducted using the qualitative theoretical perspective of hermeneutic phenomenology. Qualitative research is described in many different ways, but the one to which I was drawn is a "situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible" (Denzin & Lincoln, 2005, p.3). Phenomenology is the study of people's experiences of phenomena, and the meaning that people attribute to their experiences. Heidegger (1962, p.51) describes a phenomenon as that "which shows itself", and phenomena as the "totality of what lies in the light of day or can be brought to the light...". In this study, I was committed to bringing to light the social phenomena of first-time mothering experiences for older women, from each woman's perspective and exploring how her world was experienced. What was important to me was each woman's perceptions about mothering, health, and her transition to menopause. A phenomenological study answers questions of meaning, and a "... goodly portion of social phenomena consists of the meaning-making activities of groups and individuals around those phenomena" (Lincoln & Guba, 2000, p.167). In this study, it was the lived experiences of women's everyday lives, their perceptions of health, intertwined with their mothering that provided meaning to this unique phenomenon of mothering

young children during perimenopause. I wanted to draw from the women a "vivid picture of the 'lived experience,' complete with the richness of detail and context that shaped the experience" (Dinkins, 2005, p.113).Only these women could reveal the meanings they have created around these experiences, and the unique contexts in which these experiences have evolved.

Creswell (1998, p.15) defines qualitative research as "...an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem". Creswell uses the metaphor of fabric to describe qualitative research: composed of many threads, in multiple colours and textures, with the loom representing the various frameworks which hold it together. These frameworks or *paradigms* are labeled constructivism, feminism, positivism, and interpretation to name a few, and these will be described in more detail later in this chapter. Paradigms are overlaid with the various traditions such as phenomenology, ethnography or grounded theory that a researcher can choose from to inform, and interpret her study. The researcher herself may be thought of as a *bricoleur*, meaning quiltmaker (Denzin & Lincoln (2005), or as I see it, someone who brings the colourful pieces together in a meaningful way. I am mindful of Creswell's (1998) rationales for choosing qualitative inquiry for a study, and have incorporated these rationales into the following stance in support of my choice. I would argue that midlife mothers' experiences needed to be explored, as explained in chapters one and two. There has been insufficient inquiry into the mothering role, especially from a mother's perspective, and particularly the experiences of older first-time mothers during a time of the overlapping developmental transition to menopause. Secondly, the research questions lent themselves to an in-depth focused exploration of these women's experiences which only the women could give voice to and create meaning around. I

had sufficient time and resources to spend time interviewing participants, and constructing data with them, as well as countless hours immersed in the data to co-create an interpretation of our lives as shaped by the social, political, cultural, economic, ethnic, and gender values of the time. I believed, and still do, that in addition to those compelled to read my work academically, there are also professional and public audiences who will be receptive to the dissemination of this research. I would argue that I was an active learner during this entire process, and am in a unique position to share the interpretations of these women's lived experiences. Therefore, I take a stance that a qualitative phenomenological perspective was the appropriate framework to guide this study toward the goal of understanding women's perceptions of first-time midlife mothering during perimenopause, and the impact this has on their health and well-being.

It is significant that this chapter is called the methodology and methods chapter. As a researcher, I concur with Gadamer (1976/2004a), van Manen (1990), and Koch (1996) who suggest that there is no method, but rather only tradition. However, for the purpose of clarity, any use of the term 'methodology' refers to the philosophical framework and assumptions which provided the foundation for this research, and the "pursuit of knowledge" (van Manen,1990, p.28) to which I aspired. The use of the term 'methods' in this chapter (unless in a direct quote or paraphrased) refers to the 'way' certain techniques or practical procedures were utilized in this study to locate the sample, collect data, conduct data analysis and present findings. The tradition I selected to frame this study was phenomenology. Koch (1995) notes that the philosophical assumptions that underlie a 'method' should be consistent with the researcher's own views and that these should be the necessary starting point of inquiry. Koch (1999) also suggests that the researcher first acknowledge her own

position on the nature of reality (ontology), and the nature of knowledge (epistemology). So, that is how I will begin, by reflecting on my own views of what I know, and what I believe to be real.

For over twenty-five years, most of my professional work was in a clinical nursing setting, caring for women during pregnancy and childbirth. I have had many opportunities to listen to women tell the stories of their birth experiences. It was very illuminating to hear women reconstruct their version of the 'birth', which was often different from my own version as seen from a professional perspective. Was my version more real than theirs? Was there some objective 'truth' that existed? I have heard people say that so often but I do not think so. Upon examination and reflection about what I believe to be real, I have come to believe that people are interpretive, and that all qualitative research (perhaps even quantitative) is interpretive. Women's truths and the meanings of their birth experiences were whatever they believed them to be, just as mine were. It is our unique traditions, that "living force that enters into all understanding" (Gallagher, 1992, p. 86) which leads us to interpret different versions of phenomena or events. Women often have an expressed need to engage in dialogue with the nurse who was present with them during the birth. I now recognise that our unique understandings of these experiences were impacted by the limitations of our own *horizons* or paradigms, but that mutual understanding can occur through a process of merging those horizons, which Gadamer (1975/2004b, p.305) calls a "fusion of horizons". Understanding can take place through interpretation, with language as the 'medium', and "understanding and interpretation are always intertwined with each other" (Gadamer, 2001, p.51). It was through this very human give and take of dialogue, that we co-constructed meaning around their experience of birth.

Based on these epistemological and ontological viewpoints, I do not believe that the researcher can remain detached from the phenomenon she is studying, nor can she prevent any personal values from influencing it. Denzin and Lincoln (2005) describe the effect a researcher's values can have on a study from the very beginning. What problem will be studied, which framework will support it, how the researcher gathers and analyses data, who will be sampled and how the findings will be shared are all decisions made by the researcher which ultimately affect the study. This point became clear to me in the course of my doctoral studies, while participating in a discussion during a qualitative analysis class. Schram (2003) asked the class to think about how he might, as an ethnographer, approach my particular study on midlife mothering, considering his own personal uniqueness, professional background, and gender. My epiphany at that moment was to realise that he and I might start with the same research question, but would travel very different paths to try to gain some understanding of midlife women's mothering and perimenopausal experiences.

METHODOLOGY

Phenomenology

There is not one single philosophy that unifies phenomenologists, and Spiegelberg (1960) calls it an illusion to believe it to be so. Reading the work of Husserl, Heidegger, Gadamer and Koch, led me to recognise that my epistemological and ontological beliefs would influence which tradition of phenomenology I chose to guide me on this inquiry. I felt it was important to immerse myself in the various phenomenological traditions, and to study various philosophical teachings to determine who would be compatible with my own beliefs. Husserl (1857-1938) was a mathematician and prominent philosopher during the German phase of the phenomenological movement. He was considered the founder, and still is the central

figure of the *Phenomenological Movement*. The term phenomenology was in existence long before Husserl's time, and yet, it was still considered "history in the making" in 1960 (Spiegelberg, 1960, p.xxix). Spiegelberg (1960) described phenomenology as a dynamic philosophy, much like a stream which is composed of several parallel currents. These currents are related but not homogeneous, have one point of departure, without a definite or predictable merger or destination.

Husserl's philosophical work began with an interest in analyzing the nature of mathematics and logic (Koestenbaum, 1967). He introduced the concept of the *life-world or lived experience*. The life world is the world that each person takes for granted. Husserl claimed that because the life-world is that which is taken for granted, it must be re-examined to illuminate the ultimate structures of the consciousness which he called *essences*. The interpreter could then critically evaluate the essences of an experience to determine the sense of it all (Koch, 1995). Essences are "those concepts that give common understanding to the phenomenon under investigation... [and] they represent the basic units of common understanding of any phenomenon" (Carpenter, 2003a, p.54).

Husserl aspired to establish phenomenology as a philosophy "free from presuppositions" (*voraussetzungslos*) (Spiegelberg, 1960, p.83). One of Husserl's notions, was that of phenomenological *reduction*, in which he instructs the observer to 'turn off' or suspend beliefs and concentrate on the phenomenon in all its aspects, analyse and describe it. Husserl also used the metaphor of *bracketing* one's beliefs, not to forget about them, but not to be prejudiced by them. Yet, Husserl himself referred to reduction as "the most difficult thing ever attempted in philosophy..."(Spiegelberg, 1960, p.135). Another concept described by Husserl was *intentionality*. Husserl (1967, p.23) believed that an object existed for the ego, (me),

and was real only when one's consciousness became aware of it, and could confirm that an object was "truly there". Things like rocks or trees referred to as *noumena*, are objects that we construct, or project in our conscious awareness of them. There is no meaning to an object until a subject perceives of it, and a subject is what it is when something is presented to it. Intentionality refers to the interrelationship and interdependency of subjects and objects. Through reduction and bracketing, the essence of consciousness can emerge for a pure look (Koestenbaum, 1967). Husserl (1967, p.38) stated that "...a systematically and fully developed transcendental phenomenology is *ipso facto the true and genuine universal ontology*". He firmly believed that man had a responsibility for himself and for his culture, that knowledge was the key, and developing science was the best chance for obtaining necessary knowledge. Husserl described evidence as confirmed or disconfirmed based on prior predictions. He wrote "...existence and essence have for us no other meaning in reality and truth than that of possible confirmation" (Husserl, 1967, p.23).

Interpretive Hermeneutics/Constructivism

In the past, research methodologies were almost exclusively based on the scientific method. Scientific inquiry was accepted as the way to determine the truth: propositions could be tested empirically, and if they could not be tested, then they could never be confirmed as true. Facts were considered separate from values because values were thought to distort scientific data. Science was about cause and effect, prediction and control, and phenomena were both generalizable and widely applicable (Guba & Lincoln, 1989). In the late 1980s, Guba and Lincoln proposed that an over-commitment to the scientific method as a method of inquiry or evaluation led to five essential flaws: the lack of context that occurred in controlled conditions, an overdependence on formal quantitative measurement, the development of an

authoritative, nonnegotiable truth, the lack of recognition of alternative ways of thinking, and finally the lack of moral responsibility for findings. They proposed an alternative approach to evaluation or inquiry called responsive *constructivist evaluation*, also referred to *as interpretive* and *hermeneutic.* This new approach was called *fourth generation evaluation*, and a discussion of the flaws of first, second and third generation evaluation can be found in the work of Guba and Lincoln (1989). This new approach went beyond the scientific method and previous generations of evaluation which focused on measurement, description and judgment, to move toward ontological and epistemological positions, which focused on *negotiation.* Ascribing to fourth generation, or constructivist evaluation for the current study, the women participating in this study, together with me as the researcher, made sense of their stories and responses to questions, and co-created constructions which represented the realities of their experiences at that time. These constructions recognised the value of each woman, and were situated in the contexts within which they occurred. I shared my plans for disseminating information with the women to which they agreed. As Guba and Lincoln (1989) suggested, I moved beyond just making a list of recommendations at the conclusion of this work, and developed an action plan which I am committed to carry out. Finally, all humans involved in the inquiry were treated with dignity and respect, while maintaining their integrity and privacy.

With my paradigm thus established as that of a constructivist, (as described above) I realised that Husserl's phenomenology was not going to guide me on this inquiry. Working from a constructivist perspective, I believe that the findings from this study exist because of the dialogical interactions between the women participants and me. The 'truths' which emerged were a matter of consensus among the participants and myself. Together, we constructed an interpretation "that is as informed and

sophisticated as it can be made at a particular point in time" (Guba & Lincoln, 1989, p. 44). Additionally, I am in complete agreement with Koch (1996) who suggested that the phenomenological (Husserlian) concept of *bracketing,* mentioned previously, to suspend judgment, personal biases, beliefs and assumptions is mutually exclusive from hermeneutic phenomenological dialogue with participants. My stand in favor of researcher participation and against the concept of bracketing also steered me away from Husserl's phenomenology for this study.

Heideggerian Phenomenology

Heidegger was a student of Husserl, but he was influenced by many other philosophers as well, including Kant, Nietzsche and Kierkegaard. Heidegger took phenomenology well beyond his former teacher's interpretation of it. Heidegger's phenomenology was "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (1962, p.58). However, he also believed that which is the essence of the phenomenon of interest "for the most part does not show itself at all: it is something that lies *hidden*" (Heidegger, 1962, p.59), yet it is part of that which does make itself known, and so it is important to the meaning of the total. Phenomena, which are *hidden* may be unknown and undiscovered, or they may have been discovered and then were "*buried over* [*verschuttet*]" (Heidegger, 1962, p.60). It is discourse, which "*lets something be seen*...that is, lets us see something from the very thing which the discourse is about" (Heidegger, 1962, p.56). Heidegger relates that genuine discourse reveals the phenomenon of interest by what is said in conversation and thus, makes it accessible to the other party. The phenomenon which needs to be uncovered is a sense of '*Being*' of the entity, and "the meaning of phenomenological description as a method lies in *interpretation*" (Heidegger, 1962, p.61). Heidegger (1962, p.188) calls the development of understanding *interpretation,*

and stresses that "interpretation is grounded existentially in understanding...". Heidegger's phenomenology became known as 'hermeneutic', though he credits Dilthey with first introducing the word hermeneutic.

Heidegger believed that we bring *fore-havings* or knowledge from our past, and *fore-sights* which are advance expectations and possibilities to any interpretation of phenomena. Interpretation may be conceived from the entity (in this case the participant herself), or the interpretation could force the entity (participant) in the direction of pre-conceived concepts. Either way, the interpretation will always be "grounded in *something we grasp in advance*- in a *fore-conception*" (Heidegger, 1962, p.191). It is within this structure which houses *a fore-having, a fore-sight,* and *a fore-conception* that meaning, or a projection of possibilities is conceived.

Heidegger challenged two basic notions accepted by the followers of Husserl. He criticised the Cartesian position of being an outside observer; in contrast, Heidegger believed that understanding is found by stepping into *the hermeneutic circle.* Heidegger also challenged the idea of 'bracketing or reduction', finding this suggestion fundamentally not helpful to an exploration of the nature of *Being.* The interpreter's background, pre-understanding and co-constitution must work together to make the data inside of the hermeneutic circle. Koch (1995) clarified several ideas or assumptions as critical to understanding Heidegger's essential concepts, and these are *historicality of understanding, co-constitution,* and the *hermeneutic circle*. The first of these is the notion that a person's history or *background* is something that we come to the *circle* with that determines our way of understanding. *Pre-understanding* is the meaning of a culture which already exists; it is "a structure of our 'being in the world'. It is not something we can eliminate, or bracket..." (Koch, 1995, p. 831). *Co-constitution* refers to "the indissoluble unity between the person and the world...A

person participates in this a priori world in cultural, historical and social contexts. Human existence, and the world co-constitute each other" (Koch, 1995, p.831). These concepts provided a framework for reflecting on my own immersion in an American culture of professional nursing and health care, my education and background as a woman growing up as a *baby-boomer* in the United States, and my presence in this study as a midlife woman and mother. I came to this study possessing pre-understandings about the phenomena of mothering, midlife women's health, perimenopause, and menopause. These pre-understandings influenced which questions I would ask during the interviews, and the hermeneutical interpretations of the participants' experiences would be constructed within my own structure of fore-havings, fore-sights, and fore-conceptions.

At this point in my readings, I thought Heidegger's phenomenology could possibly provide an appropriate guide for my study. Many nurse researchers have aligned themselves with Heidegger, and my own views were compatible with his ontology and epistemology. I respect and recognise Heidegger's contributions to the phenomenological movement. However, I found Heidegger's work extremely difficult to read and understand; even the translator for 'Being and Time' (1962) described Heidegger's language and vocabulary as difficult to translate from German. Heidegger's innovative use of words without explanation, and the coining of new expressions for which there was no corresponding word in English, raised questions for me about meaning, understanding, and interpretation. In contrast to Heidegger, the works of Gadamer (1975/2004b, 1976/2004a, 2001, 2006) were easier to read and understand, and his phenomenological underpinnings also supported my own ontological and epistemological positions.

Gadamerian Phenomenology

Hans-Georg Gadamer was born in Germany in 1900, and his lifetime spanned an entire century, during which time he became one of the great 20th century philosophers. At the age of 60, Gadamer broke away from one of the great traditions of hermeneutics, and his mentor, Heidegger, when he "...defended prejudices as necessary for understanding anything" (Gadamer, 2001, p. 4) in his magnum opus Truth and Method (1975/2004b). Gadamer wanted to restore *prejudice* or *pre-understanding* as a positive concept, that which is gained through our socialization and a product of our gender, culture, race and class. Gadamer (1976/2004a, p.13) conceived this idea based on the writings of Plato about a conversation between Socrates and Meno. It centered on the problem of forming an enquiry or asking a question, and Socrates pointed out that in this pursuit, we are never "completely free of custom and society and from all possible factors" in our environment. Socrates disputes Meno's argument that a person should not inquire about that which he knows, nor should he inquire about that which he does not know. Rather, Socrates asserts that inquiry is superior to not seeking knowledge because it makes us inquisitive, and this is the real power of 'hermeneutical consciousness' (Levin, 1961).

Gadamer's hermeneutic philosophy teaches that the traditions and associated prejudgments which shape our efforts to understand are something we can not control and can not set aside at will. Gadamer (2001, p.45) proposed that

> We stand in traditions, whether we know these traditions or not; that is, whether we are conscious of these or are so arrogant as to think we can begin without presuppositions-none of this changes the way traditions are working on us and in our understanding.

Tradition has been described as a "living force that enters into all understanding... [traditions] shape what we are and how we understand the world. The attempt to step outside of the process of tradition would be like trying to step outside of our own

skins" (Gallagher,1992, p.86). Indeed, Gadamer (2001) called it naïve to put so much faith in a method as to think one can leave oneself out of any attempt at understanding. Rather it is through these prejudices or biases that we develop a *horizon*, or a range of vision, and are able to encounter something that can broaden our horizon. One of the basic principles of contemporary hermeneutic philosophy (Denzin & Lincoln, 2005) is that bias or prejudice is not something the interpreter must 'get rid of' in order to have a clear understanding. Gadamer (1976/2004a, p.38) encouraged hermeneutical reflection on given prejudices lest they happen "behind my back". Prejudgments that lead to pre-understanding are also "constantly at stake, right up to the moment of their surrender-which surrender could also be called a transformation". It is through these transformations that we form new pre-understandings.

Contemporary nurse researchers like Koch (1996), assert that we take our prejudices with us into the research process, and that these can foster or hinder understanding. Munhall (2007a, p.6) refers to the subjective perspective of others as "the situated context", that which has "evolved from all our previous experiences". One's age, gender, childhood experiences, relationships throughout life, the cultural, political, and geographical influences are just part of the situated context of the researcher and participants in a study and must be considered in the final interpretation. As a researcher, I had to accept the good intentions of the participants, acknowledge their situated context and my own, remain open to their traditions and prejudices, as well as respect my own presuppositions as I stepped into the hermeneutic circle.

Though the philosophers are presented separately in this chapter in order to build an argument for my primary alignment with the philosophy of Gadamer, it should be

noted here that there are numerous similarities in the philosophy and writings of Heidegger, Gadamer and earlier philosophers like Schleiermacher. The idea of understanding as movement within a circle or circular fashion dates back to Schleiermacher, a German philosopher of theology and theory of knowledge in the late 18th century (Gadamer 1975/2004b; Brandt, 1941/1968). Though Schleiermacher initially referenced his ideas about *understanding* to the reading of text, he later expanded his thinking to include dialogue with others, and asserted that the task or art of hermeneutics was to avoid misunderstanding. The understanding situation is one in which there is a speaker and a hearer, and the locus of hermeneutics is in the divination of meaning (Palmer, 1969). Schleiermacher (1833/1977) points out that it is more rigourous to practice the "art of interpretation that is based on the assumption that misunderstanding occurs as a matter of course, and so understanding must be willed and sought at every point". Meaning of the parts (of a text or dialogue) can only be understood in the context of the whole then back to the parts and so on. That which we understand forms parts or circles, and the circle as a whole helps us to understand the individual parts. It is through dialogue and interaction between the whole and the parts that meaning is created. The circle continues to expand as the context of the whole becomes larger.

Gadamer (1975/2004b, p.294) expanded both Schleiermacher's and Heidegger's concepts of the hermeneutic circle as a metaphor for an "element of the ontological structure of understanding". Gadamer's(1975/2004b, p.269) interpretation of the hermeneutic circle is not so much that there is actually a *circle*, but rather that it is "a description of the way interpretive understanding is achieved". There are commonalities here from both Heidegger and Schleiermacher's work when Gadamer (1975/2004b, p.291) warns that "we must understand the whole in terms of the detail

and the detail in terms of the whole. Thus the movement of understanding is constantly from the whole to the part and back to the whole". Gadamer (1975/2004b, p.176) provides an example of this when he writes about the efforts to understand Scripture as prehistory of modern day hermeneutics:

> For the whole of Scripture guides the understanding of individual passages: and again this whole can be reached only through the cumulative understanding of individual passages.

Contemporary researchers like Rapport and Wainwright (2006, p.235) use the metaphor of 'movement' to describe "the perpetual motion of the hermeneutic circle" within which "understanding, explanation and interpretation of phenomena" leads one to a deeper understanding. Chadderton (2004, p.69) captures the meaning of the hermeneutic circle as "the circularity of play, the temporality of truth, the historicity of language in prejudice and the coming together of interpreter and text in the fusion of horizons".

The concept of the hermeneutic circle provided a methodological foundation for the current study. I attempted to keep the interviews conversational and open ended to enable participants to tell their stories, particularly during the initial meeting. I wanted them to decide what was important to talk about rather then choosing topics that I thought were important. It was during their second interviews that I felt I stepped fully into the hermeneutic circle, in which there was more give and take conversation between the women and myself; this is evident in the transcripts, and captured by sample extracts from all of the women in chapters five through eight. I attempted to remain focused on the women's experiences as older first time mothers and women transitioning to menopause. Schleiermacher reminds that understanding is equally concerned about the common as well as the unique (Gadamer, 1975/2004b) and this has been applied in the current study to capture the shared meaning of the women's

experiences as well as the voice of the women whose experiences were different from the others.

As each woman's telling and discourse was interpreted individually in its totality, so were parts of each participant's interpretation brought together with those of the other women to convey conceptual representations of the experiences of older first-time mothers. There is movement from the whole of each woman's experience in the context of her life, to the parts of each woman's experience as a composition of a larger context or expanding whole of experience for midlife women and mothers in contemporary society. This was accomplished through both agreement and rejection of ideas with the participants, the text, my own reflexive process, and feedback from members of my supervisory committee. During the process of interpretation or understanding, it is absolutely necessary to remain focused on the 'things themselves' in order to project meaning for the text. A process of projection followed by revision continues until the meaning becomes clear to the interpreter. "This constant process of new projection constitutes the movement of understanding and interpretation" that Gadamer (1975/2004b, p.269) writes about. The researcher can be distracted by fore-meanings or prejudices that do not originate from the person or text itself, so Gadamer stresses that projections of meaning should be confirmed by the "things themselves". The interpreter must acknowledge her own bias in order to allow the text to assert itself despite one's own prejudices. Throughout the interviews, and in the writing of the text which the reader will note throughout, I acknowledge my biases and prejudices, recognize and share transformations that took place in my thinking, and sought confirmation of meaning as it emerged from both dialogue with the women and the text. An initial 'projection' of meaning was drawn from the interviews and the text, and this was followed by many revisions of the text over several years. Evidence

of this process is provided later in this chapter in the section on Data Analysis and Interpretation, and in Appendices N through to U.

Gadamer (1976/2004a) explains that understanding is a basic structure of our experience of life. "Understanding and interpretation are always intertwined with each other" (Gadamer, 2001, p.51), and language is the medium through which understanding and agreement take place. It is when we speak to each other that we become caught up in the game of "giving and taking- [and] the real dialogue- begins" (Gadamer, 1976/2004a, p.57).The give and take of conversation with the women is supported by Gadamer's phenomenon of *play*, which takes place when players, or in this case when the participants and I were engrossed in the spirit of dialogue between us, and there was a dynamic "back-and-forth movement" of ideas and possibilities. Gadamer (2001) describes play as the second element of the hermeneutic circle. The first element involves the projection of something, and returning to it again and again as already mentioned. The second element requires that "one participates in play as a partner" (Gadamer, 2001, p.113). Gadamer uses the concept of play as a clue to gaining ontological explanation. Play "contains its own, even sacred, seriousness.....only if the player loses himself in play" (Gadamer, 1975/2004b, p.102). Applying this concept of play to the present study, it was not necessarily critical what I asked the women or what they said. Rather it was the discourse itself that drew us both in during each meeting, through the play of language. Gadamer (1975/2004b, p.484) ascribes to the concept of play in promoting phenomenological understanding of the text in the following passage from Truth and Method:

> When we understand a text, what is meaningful in it captivates us just as the beautiful captivates us. It has asserted itself and captivated us before we can come to ourselves and be in a position to test the claim to meaning that it makes....In understanding we are drawn into an event of truth and arrive, as it were, too late, if we want to know what we are supposed to believe.

Playfulness leads to the phenomenon of *buoyancy*, when conversational partners get "caught" in a discussion, and move "beyond their original horizons" to higher levels of understanding (Gadamer, (1976/2004a, p.xxiii). This occurs when the conversation goes beyond the original inquiry and takes on a life of its own. It becomes "filled with developments that are unanticipated and unintended" (Gadamer, 1976/2004a, p.xxii). In each and every conversation, something different is discovered. The concepts of play and buoyancy are interpreted in the current study in several ways, and provide methodological foundation for the conversations I had with the women and with the text. The unstructured nature of the interviews enabled the women to decide what was important for them to talk about, thereby creating meaning around their experiences. At times, particularly during the second interviews, we would become swept up in a conversation about some aspect of their experience and arrive at a new level of understanding. I would ask the women to comment or provide feedback about some element of midlife mothering or health during perimenopause that the other women had talked about. This sometimes resulted in shared meaning, or at times provided clarity that someone had a different perspective of that experience. Examples of these conversations are evident in chapters five through eight.

An important principle of understanding is the effect that history has on any hermeneutic inquiry. Gadamer (1975, 2004b, p.299) refers to this as "history of effect". The researcher's choice of what to study and how a phenomenon is understood is always affected by the history at work whether conscious or not. Gadamer (1975/2004b) describes the difficulty in consciously describing a 'situation', or standpoint, whilst we are standing in it; this is also true of a hermeneutic inquiry into phenomena which we are trying to understand. As historical beings, we can never fully comprehend the full impact or power that history holds over our understanding.

Even through reflection, we cannot externalize our relationship to the situation. Thus, interpretations are limited by the horizons of the researcher's own outlook, and Gadamer (1975/2004b) defines horizon as the range of vision that includes everything that can be seen from a particular vantage point, and it is always in motion. Gadamer teaches that we can be open to the horizons of others; they can overlap, and through this process we can attain mutual understanding. This is accomplished when we try to put ourselves in the other person's situation, and discover their standpoint or horizon.

Gadamer's (2001,1975/2004b) *fusion of horizons, a* metaphor for understanding, occurs when the researcher is able to show the way in which she participated in making the data while representing the participants' voices within the context of the study. Interpretation (understanding) always occurs through the fusion of horizons of the interpreter and the interpreted, and both are taken up into a higher form of understanding. Gadamer insists that it is through language that one comes to understand, and that this is achieved through genuine conversation. The researcher plays an active role, and the interpretation includes the interpreter's own language, not just that of the text. Thus, "the interpretation of the tradition, of what has been handed down to us is never a mere repetition of its words but rather a new creation of the understanding that achieves determinate expression in the words that interpret it" (Gadamer, 2001, p.51). Meaning is mutually negotiated with the participants and the interpreter, which is different from the concept that the text or social action *has* meaning which will be decided or determined by the interpreter (Schwandt, 2000). Meaning is not something that happens at the end of humanistic research, but is ongoing, and takes place in the *medium* of language. Following these principles, negotiating meaning around women's experiences with midlife mothering and their transition to menopause started at the very beginning of this project, and evolved

during the entire interview and interpretive process. The meaning of their experiences as midlife mothers, and their perceptions of their health were negotiated during each of the interviews, but particularly during the second meetings when they verified or rejected what appeared to be emerging as shared or unique meaning.

Gadamer (1975/2004b) declared that the task of hermeneutics is to clarify understanding through shared meaning. In Truth & Method, Gadamer (1975/2004b) asserts that *method* is not always the appropriate path to knowledge in the humanities and social sciences. He did not totally reject methods; rather, he clarified that methods do exist in the humanities and social sciences, but that one must learn to apply them as *tools* only when relevant. Gadamer felt that a researcher who applies method to their work never creates an interpretation with any originality or revelation. It is "...hermeneutical imagination that distinguishes truly productive researchers" (Gadamer, 2001, p.42). Similarly, Munhall (2007c, p.151) advises researchers to 'liberate' themselves from prescribed steps and formulas in an effort to stay true to the philosophy of phenomenology. "Methods can place you in a formula where you cannot wander outside, and that critical limitation...will handcuff you and keep you from the spontaneous recognition of the appearance and the crucial exploration of the unforeseen". Whilst Munhall's (2007c) view is that researchers cannot proceed totally without method, she warns nurse researchers and others that there are issues inherent in most of the 'methods' designed by second generation phenomenologists with the exception of van Manen. Maggs-Rapport (2001, p.374) agrees that van Manen's method or approach is "flexible enough to endure adaptation without undermining or invalidating its values", and lends itself to a range of research topics including women's health explorations.

I found van Manen's (1990) philosophy to be in harmony with that of Gadamer, as he also refers to the 'methodology' of phenomenology as avoidance of preset or predetermined rules or procedures that would govern any research project. Rather, van Manen (1990, p.30) states it is the "tradition, a body of knowledge and insights, a history of lives of thinkers and authors which, taken as an example, constitutes both a source and a methodological ground for present human science research practices". This *phenomenological scholarship* should be used to guide the researcher toward creating a rich interpretation of some aspect of the *life-world,* while recognizing that in its interpretation it is never quite done, or complete, and always more complex in its reality than any construction of it can be. Van Manen's (1990, p.13) pursuit of a broadened "notion of rationality", that is to accept that common understandings can be reached through dialogue and conversation are also in harmony with Gadamer's philosophical underpinnings. Van Manen's de-emphasis on methods, rules or procedures for analysis created compatibility with Gadamer's philosophy, and his methodological themes were an appropriate choice to guide analysis/interpretation throughout this project. Further discussion on the interpretation and utilization of van Manen's (1990) approach to data analysis for the current study is found in the methods section on Data Analysis and Interpretation.

Gadamer (1976/2004a) speaks of *coming to a stand*, an interpretation of the German word, *zum-stehen-kommen*, to represent that moment when we are certain that we have found the right word or expression to use in translation when learning a foreign language. Schleiermacher (Palmer, 1969, p.87) describes the hermeneutic circle as a place within which the "meaning comes to stand". I use *coming to a stand* here to represent my interpretation of this inquiry as a possible human experience. In this effort, I hope to have first and foremost lifted up the experiences of older first-

time mothers and women transitioning to menopause, avoided misunderstanding and thus fulfilled the tasks of hermeneutics.

METHODS

Setting Access and Sample

Women were recruited through women's and children's health care offices in Maine and New Hampshire, and via personal and professional contacts throughout four states in New England. Eighteen letters (Appendix A) were sent to Obstetric, Gynaecology, Family Practice, and Paediatric Private Offices asking permission to display a notice, advertising for research participants. Ten practices replied affirmatively by sending back a stamped self-addressed post card. I proceeded to display a notice (Appendix B) in the offices of those ten participating practices along with my business cards including my contact information. Women were invited to participate in this study by someone who knew them, i.e. their physician, a relative or a friend, and/or by responding to the notices displayed in the medical offices. Women who were interested in participating contacted me by phone, mail or email, and an informational letter was sent to them (Appendix C). A mutually agreed upon time and location for the first interview was arranged on a day at least two weeks after their initial contact with me to give women a cooling off period to change their minds about participating. Women were given a choice of locations for their interviews, and a variety of locations were used, including their homes, church space, university conference rooms, and participant's offices. The most common location was the participant's home followed by their work setting. At the conclusion of the first interview, women were asked to participate in a second interview, and all of them agreed.

My initial sampling strategy was purposive (Patton, 1990) because I wanted to interview women who experienced the phenomenon and were also good informants. Morse describes *experiential fit and qualities of a good informant* as two criteria for choosing a purposive sample. A good informant is someone who is willing to take the time to participate, and talk about their experience (Morse, 2007). Therefore, I sought women who were experiencing the phenomenon of interest and could participate in meaningful discourse. The importance of finding good informants was illustrated by the response of one woman who was referred to the study. She met the inclusion criteria but declined to participate. Although I initially felt frustrated when she responded that she did not have time to meet with me, I was eventually grateful that she recognised she could not fully participate in the study given her busy schedule. Several women inquired about participating in the study but did not meet the inclusion criteria. A letter was sent to them explaining the reasons they did not meet the criteria (Appendix D).

The development of a trust relationship with each woman began with our initial interaction, through email or phone conversations. As that relationship deepened, and I met and interviewed each woman, the sampling technique of snowballing evolved. I would ask about, or the women would offer the names of others they knew who met the inclusion criteria and could participate in meaningful dialogue about their experiences as midlife mothers and women transitioning to menopause. One possible disadvantage of the snowball technique is that it can limit diversity of the sample (Taylor & Bogdan, 1998). With this in mind, I consciously worked to keep a balance as the sample was evolving, and only three of the thirteen women were snowballed from any one of the other participants. Another sampling issue which emerged was the number of participants who were nurses or women who worked in health care,

partly due to the fact that these professionals comprise many of my personal and professional contacts. There were four nurses in the final sample, one physician and one woman who worked in a related health care field. None of these six were the result of snowballing, bur rather were individuals who responded to the invitation to participate.

The inclusion criteria were initially set to locate women who were 40 years or older at the time of their first delivery, who were mothering children aged 12 or younger, as well as experiencing symptoms of perimenopause. Early in the interview phase, two women responded who wanted to be included in the study and met the criteria in every way except age. They were 39 years old when they became mothers for the first time, and turned 40 within one year of their child's birth. At the time of the interviews, they were mothering at least one child aged 12 or younger and were experiencing perimenopausal symptoms. After consultation with my supervisors, I decided to change the age criteria to 39 to be able to include these women. Another woman wanted to participate in the study who met most of the criteria, but she had not biologically given birth to her child. She had adopted a baby, yet she met all the other criteria. I discussed this sampling issue with my committee, and we agreed that the focus of this study was about midlife mothering and women's health during perimenopause, not specifically pregnancy or childbirth. Therefore, she was invited to participate in the study after I obtained ethical approval from Swansea University and The University of New England for this sampling variance. A fourth woman contacted me because she also wanted to participate, and identified herself as a lesbian woman. She asked if I wanted to include lesbian women in the study. I immediately realised that she could contribute another unique aspect of the phenomenon of interest that I had not originally thought of, and in the end, the final

sample included two lesbian women. Morse (2007, p. 534) refers to this as "sampling to determine variation", to explain those participants who were unanticipated at the beginning of the study, and who self-identified during the process. Women today become mothers in a variety of ways: pregnancy and birth, alternative insemination, adoption, Assisted Reproductive Technologies, (ART), and through lesbian partnerships. I realised that it was important to include women who had achieved motherhood in as many different ways as possible in an effort to understand many possible experiences of motherhood, and felt that having a diverse range of experiences within my sample of women was a strength.

It is well known to obstetrical care givers that age 35 is the cutoff for referring to pregnant women as *older*, particularly women who are pregnant for the first time (Cunningham & Leveno, 1995). Since most women will experience perimenopausal symptoms between the ages of 39 and 51, the inclusion criteria were set to locate women who were older first-time mothers and who were also experiencing the transition to menopause. In keeping with the philosophy of phenomenology, women self-identified themselves as perimenopausal. The initial informational letter that was sent to women interested in the study included a list of perimenopausal symptoms identified in the literature. Women who were uncertain if they were transitioning to menopause utilized the information sent to them in determining whether they met the criteria or not. They then decided if they met the criteria for the study, and made a decision to participate. A sample of a letter sent to women who were scheduled to participate can be found in Appendix E. The sample was limited to those women mothering children 12 years old or younger, because this study aimed to gain an understanding of women's experiences around mothering young children, not adolescents. The number of participants was ultimately determined by satisfying the

qualitative research criteria of sufficiency and saturation. Recognizing that each woman's story was unique, and the context different, I continued to interview women until no new information was being uncovered, and no new categories were emerging (Morse, 2007).

Data Collection Methods

In this study, I wanted to create opportunities for discourse and understanding through the qualitative technique of in-depth interviewing. "Interviewing provides access to the context of people's behavior, and thereby provides a way for researchers to understand the meaning of that behavior" (Siedman, 1998, p.4). The only other way I could 'dialogue' with women on this topic was on the phone, internet, or in writing, but none of those mediums seemed adequate or appropriate for this study. Interviewing was time-consuming, but rewarding, and involved repeated face-to-face encounters between me and the mothers engaged in the study. This involved travel for me and for some of the participants. The dialogue between us was directed toward initially capturing their unique perspective on their lives as they have experienced the phenomenon under study as expressed in their own words. I also invited them through question and answer to respond to ideas or categories that emerged in discourse with other women. This was accomplished by asking them to share perceptions of their health within the context of their lived experiences of delayed motherhood, mothering young children in the 21st century, and transitioning to menopause.

Remaining true to phenomenological philosophy, I recognised that each individual was unique and would interpret her own reality in whatever time it took. I did not have any strict rules for how many times or how long I interviewed women, though Seidman (1998) recommends three interviews, ninety minutes each, three days to one week apart. He asserts that a three interview schedule during this time frame

helps to build the relationship between the participants and the interviewer, maintains a connection between the interviews, allows time for the participants to reflect about the previous interview, and lessens the chances for idiosyncratic interviews due to changes impacting the participants' lives. Although Seidman (1998) feels the three-interview structure is important, he recognises that researchers will sometimes have reasons for altering the structure. One reason he gives for maintaining an interview design is the contribution it may have toward validity and reliability which I discuss further in the section entitled 'Rigour, Trustworthiness and Authenticity' later in this chapter. Although I did maintain an interview design, I felt it was too imposing to ask these busy mothers for three interviews, so I decided to combine Seidman's (1998) recommendations for approaching interviews two and three. The exact number and length of each interview was ultimately determined by each woman and her experience as it unfolded. In the end, I conducted two in-depth interviews with thirteen women, for a total of twenty-six interviews. The time span until the second interview with participants ranged from two to thirteen weeks after the initial interview, and interviews ranged from sixty to ninety minutes each. A second meeting with the women gave them an opportunity to offer further discussion on any of the topics, review and respond to the emerging themes and categories, and retract any information that they felt was inaccurately interpreted by me.

I maintained a flexible interview focus, accepted some ambiguity when necessary, and remained open to the possibility of a change in awareness or meaning of their experience for the women during the interview process (Kvale, 1996). Data were co-constructed during an unstructured first interview as participants responded to open ended questions in a private, mutually agreed upon time and setting. This format was adapted from guidelines described by Seidman (1998), Streubert (1999)

and Duffy (2007). I merged a life-history format combined with focused, in-depth interviewing which is compatible with phenomenology. The goal was to have women construct or reconstruct their perceptions of health within the context of their lives. During interview one, I asked them to respond to questions about what it was like to have a baby or become a mother at an older age, what their mothering experience had been like, and what it was like to *go through* or transition to menopause. I asked them to talk about their health, and if their health had any effect on their mothering abilities. Finally, I asked them what advice they would give to other 40 year old women who were contemplating becoming a mother. A complete schedule of questions can be located in Appendix F. In many instances, I did not actually have to ask all of the questions I had planned. In the course of telling their story after the first question was asked, women wandered spontaneously into the other topics of interest, namely mothering, perimenopause and health. This validated for me the appropriateness of the questions, as it aligned with what the women thought was important to talk about from their lived experience. The women's stories were important to hear in as non-directive a context as possible (Seidman, 1998; Gadamer, 2001), and I anticipated a second interview with each of them during which time I would have an opportunity to question or clarify ideas.

During the first interview, I encouraged each woman to begin wherever she wanted to start, and I gave them an opportunity to tell their story with minimal interruption. I initially had some problems with *scoping* the boundaries of the phenomenon I was studying (Morse, 2007), as I was unsure what should be included, and at what point in their life women should begin their story. This led to some lengthy interviews, and for a few women, some over-sharing of intimate details from their past. During the initial interview, I jotted down points I wanted to revisit, and

later listened to the tapes before meeting with the women for the second interview. During that time between interviews, I took notes, composed questions, and became aware of categories and themes that were emerging. I always started the second interviews by giving the women an opportunity to talk about anything they had thought about since the preceding meeting. I wanted to give them an opportunity to address any aspect of the topics they felt was important, revisit something we had already talked about, and retract or clarify something previously discussed. Most of our dialogue or two-way conversations occurred during the second interviews. During the second interview, we reviewed emerging categories, themes or ideas, I asked for clarification, probed points, they answered questions, and we explored ideas not previously mentioned by them, but were brought up by other women. Seidman's (1998, p.13) opinion is that participants are making meaning through all of the interviews in that they are selecting what to talk about, and "...they frame some aspect of it with a beginning, a middle, and an end and thereby make it meaningful...". By asking the women questions during the second interview in the context of the previous interview, I was calling attention to the meaning of their experiences.

At the end of the second interview, I asked women to describe major turning points or transitions in their lives, and adaptations that they made. *Personal Adaptations* are "changes that have major effect on a person's life and on his [or her] basic relations with others" (Mandelbaum, 1973, p.181). My purpose in doing this was to have them reflect in another dimension, on the meaning of their experiences as midlife mothers, and on their perceptions of their health. Utilizing a *Life History* format for constructing data, I adapted 'The Study of Life History: Gandhi' by Mandelbaum (1973) as a framework. Within this framework, Mandelbaum (1973,

p.181) states that "a turning may occur through a single event or experience, a *turning point* or it may be a gradual shift...and each provides an index to the person's conduct after the turning". As a researcher, I was interested in whether motherhood or perimenopause were turning points for the women in this study. I was interested in any alterations in established patterns of behavior the women may have made in response to becoming mothers, toward a purpose of maintaining health, coping with perimenopausal symptoms, or maintaining continuity in their lives. When participants asked me how far back in their life they should go to respond to this question, I initially told them they could go as far back as they wanted. This resulted in the sharing of personal and intimate details of their lives which were beyond the scope or focus of this study, and which were at times difficult for them to talk about. After a few interviews, and in consultation with my committee, I instructed them to respond to the question about turnings and adaptations only as it related to the topic under study, so they started with how they came to meet their partners or with the time since they became mothers This change in strategy impacted on data analysis in a positive way, because it helped me to stay focused on the phenomenon of interest, and remain close to the research questions. Therefore, I made a decision not to include any data that was beyond the scope of the study, i.e. anything that did not relate to transitioning to menopause and midlife mothering.

Interviews were audio-taped with consent, and transcribed verbatim by me or by one of the hired assistants. Each transcriptionist was given instructions to type all conversations on the tapes, and they followed a modified version of Silverman's (1993) transcription symbols which I gave them. These included using empty parentheses for something they could not hear or only partially heard on the tapes, underlining changes in pitch or amplitude, uppercase for something said loudly or

with emphasis, three dots for a short pause, and eight dots for a long pause. In the final write-up, changes in pitch or amplitude and words said loudly or with emphasis were all displayed with upper case letters. All transcripts were checked personally by me for accuracy against the recorded interviews, and corrections were made. Handwritten notes were taken in the field and following each interview to help achieve a comprehensive and accurate description of the data. In addition to recording, transcribing and analyzing the participants' stories, I also recorded my own thoughts, feelings, biases, interests, and responses, which emerged during data collection and analysis. Drew (1989) and Patton (1990) suggest that a researcher's own feelings, perceptions, and experiences can be considered as part of the data. Since the researcher's interests are represented within the data, meaning and significance may be read into them (Koch, 1996). Samples from my reflexive journal may be found in Appendix T. These represent journal entries made immediately after being contacted by the women or following their interviews. A sample of notes I later made after listening to tapes from a first interview in preparation for conducting a second interview is found in Appendix U. These data were then incorporated into the final text in many different places including the sections on sampling, methodology, methods, analysis, and in places where I engage in reflexivity to share my presence and location in this study. However, I was cognisant of what Sandelowski and Borroso (2002) refers to as *hyper-reflexivity,* indulged in by some qualitative researchers, and recognised that I must create a balance between descriptive data and interpretation. Sandelowski and Borroso (2002) as well as Graneheim and Lundman (2004) clarify that the role of the researcher in the study must be acknowledged; however, this must be balanced with "letting the text talk" (Graneheim & Lundman, 2004, p.111), and "committing oneself to an interpretation" (Sandelowski & Borroso,

2002, p.216). I would argue that I have achieved this balance in the findings and discussion chapters five through eight. This section presented an in-depth discussion of the data collection methods used in the study. Ethical issues and challenges are presented now.

Ethical Considerations

Qualitative research involving human beings poses a number of ethical issues and challenges (Eide & Kahn, 2008). Most importantly, participants must not be harmed, and measures must be taken to ensure the welfare of those who volunteer for a study (Carpenter, 2003b).The nature of potential problems may revolve around one or more of the following: access to participants, the researcher-participant relationship, accuracy, interpretation of data, the research design itself, confidentiality, anonymity, and consent (Patton, 1990; Carpenter, 1999; Carpenter, 2003b; Christians, 2005; Munhall, 2007b). Patton (1990) additionally calls attention to the issue of *promises and reciprocity* as warranting consideration. If the researcher promises to make a copy of the report available to participants, she needs to keep that promise. Christians (2005, p.145) acknowledges that "watertight confidentiality has proved to be impossible", despite the use of pseudonyms and disguised locality. Munhall (2007b) urges researchers to employ methods of renegotiated or *process consent* particularly in the presence of unexpected events or changes in focus during the research process. Process consent is an approach that offers "researchers and participants opportunities to actualize a negotiated view and to change arrangements if necessary" (Munhall, 2007b, p.523). Participants should have input into the details of the consent, and it should be reviewed periodically. Plans for dissemination of findings must be shared with participants as part of consent and researchers should refrain from any deceptive behavior which is so at odds with the ethical beliefs of the nursing profession

(Munhall, 2007b). Eide and Kahn (2008, p.201) caution against the "inherent power differential that is weighted in favor of the researcher, and which contributes to the participant's vulnerability...". Nurses as researchers may find themselves in conflict with their role as clinicians; when faced with participants in distress " the moral obligation... is to refer participants to counseling or ensure that they have regained control of the situation by talking" (Orb *et al.*, 2001, p.94). I contend that all of these ethical considerations have been addressed in this study as discussed below.

Consent & Confidentiality

The participants voluntarily initiated contact with me via phone, email or letter to express interest in this study. I introduced myself, and explained the nature of the study. An information letter (Appendix C) was provided for each potential participant. A time and place mutually convenient for the first interview was arranged, and a two-week cooling off period between the initial contact and the first interview was provided. Participants were asked to give written informed consent (Appendix G), at the time of the first interview, and they were informed that they could withdraw from the study at any point. Women were informed that the research project was approved by the School of Health Science Ethics Committee at Swansea University in Wales (Appendix H), and the Institutional Review Board (IRB) at The University of New England (Appendix I). Yearly renewals were required by the University of New England IRB until data collection was completed, and a sample of this is located in Appendix J. Approval from both committees was sought and granted for the change in sampling which occurred to include women who had adopted children (Appendix K & L). The participants were informed that the personal nature of the topic and the process of sharing their stories with me might trigger some personal discomfort for them. They were told that there was no direct benefit to them from participating, and

there was no compensation being offered. I openly discussed my plans to use information gathered during the interviews in my thesis, at professional conference presentations, and in publications. The women actually responded very positively to this, for they felt there was inadequate information available to them as older mothers. One participant encouraged me to write a book when the research was completed. All of the above information was reiterated in the written consent, which they signed. At the completion of the first interview, participants were asked to complete a questionnaire aimed at soliciting demographics for the sample (Appendix M).

Each woman was assured that their identity would be protected through the use of a pseudonym, and confidentiality of data and records would be maintained. When I realised that I needed to hire transcriptionists in order to manage the volume of data being generated, I informed the women that someone would be assisting me with this process, and would have access to real names if mentioned on the tapes. At the conclusion of the first interview, participants were asked if they were willing to meet again, all of the women agreed to a second meeting, and in many cases a date was set up at that time. Although the date was occasionally rescheduled by them due to illness, work or family reasons, no one failed to meet me for the second interview. Although I did not employ a formal application of process consent, many of the 'processes' (Munhall, 2007b) which contribute to a process consent were respected, and the women acknowledged their wish to continue in the study by consenting to meet with me a second time.

As a researcher, I sought to fulfil my obligation to the women by representing their experiences as authentically as possible without compromising their identities. Munhall (2007b, p. 504) views this faithfulness as the "most critical ethical obligation that qualitative nurse researchers have...". The second interview validated emerging

categories and themes from the first interview, as well as provided some additional new information. The interviews were consistent with descriptions of interviewing women written by Mercer *et al.* (1989). Participants were enthusiastic about sharing their mothering experiences, and the data were meaningful. As expected, recall of earlier unpleasant experiences brought back emotional impact for some of the women, and some of them cried or became tearful during the interviews. However, telling their stories was a positive experience, and all were in good spirits at the conclusion of the interview. Duffy (2007) cautions researchers not to believe that participating in a research interview is therapeutic for the interviewee. I did not assume the role of a therapist, but I did inadvertently find myself on the receiving end of some intimate details which were not necessarily connected to the phenomenon under study. Whilst I did not prevent women from discussing any aspect of their lives that they felt was meaningful to the conversation, I did not invite sharing of any personal information which was not directly related to the topic of study.

Security and Confidentiality of the Data

Data and audiotapes were stored in a locked file drawer in my home office. The data were coded to a master list of identifiers, and the master code was kept separate from the data to protect the participants' identities. No one except the researcher and occasionally a transcriptionist had access to the identities of the women in the study. Pseudonyms were substituted for the participants' real names and used to completely anonymise the data. Transcriptionists occasionally had access to real identities when I inadvertently called them by name at the start of each interview, or when participants referred to themselves and others by their real names on the tapes. Transcriptionists were asked to maintain confidentiality and not speak about anything they heard on the tapes. I also selected transcriptionists who had prior professional experience, and who

lived in a geographical area away from the home of the participant. My supervisors, Professor Joy Merrell, Dr. Dorothy Rentschler, and Professor Hugh Chadderton had access to the anonymised data only. I feel that reasonable precautions were taken to minimize risk of exposure for the women. The tapes will be destroyed five years after completion of the study. Interview transcripts and reports will be retained by the researcher, for possible use in another study. All references to participants in reports and future publications will be anonymous to protect their identities, and the names of specific geographical locations, facilities, and places of employment have been changed or omitted to avoid exposure for the women. The researcher plans to use information gathered from this study in future publications.

Data Analysis/Interpretation

Gadamer's (1976/2004a, 1975/2004b) principles for hermeneutic understanding were used to guide the entirety of this study, and as a result, meaning was mutually negotiated through a participative dialogue with the women, and simultaneously with the text. Gadamer's hermeneutic constructs of prejudice or pre-understanding, traditions, dialogue, the hermeneutic circle, horizon, fusion of horizons, projection, play, and buoyancy provided the basis for interpretation. These constructs have been presented and discussed in a previous section, and though they did not provide a prescriptive method for analysis, they did provide the framework and assumptions necessary to guide a scholarly inquiry. In harmony with the philosophy of Gadamer, van Manen (1990) also refers to the 'methodology' of phenomenology as avoidance of preset or predetermined rules or procedures that would govern any research project. Rather, van Manen (1990, p.30) states it is the "tradition, a body of knowledge and insights, a history of lives of thinkers and authors which, taken as an example, constitutes both a source and a methodological ground for present human science

research practices". This *phenomenological scholarship* should be used to guide the researcher toward creating a rich interpretation of some aspect of the *life-world,* while recognizing that in its interpretation it is never quite done, or complete, and always more complex in its reality than any construction of it can be.

Van Manen's (1990, p.13) pursuit of a broadened "notion of rationality", that is to accept that common understandings can be reached through dialogue and conversation are in harmony with Gadamer's philosophical underpinnings. Van Manen's de-emphasis on methods, rules or procedures for analysis created compatibility with Gadamer's philosophy, and his methodological themes were an appropriate choice to guide analysis/interpretation throughout this project. I applied van Manen's approaches when they were in harmony with Gadamer's philosophy with the aim of achieving methodological consistency. At times inconsistencies between Gadamer's philosophy and van Manen's approaches arose and this required that I adapt the approach to maintain methodological consistency. Van Manen's intent was to provide a research approach to the human sciences which employed phenomenology and hermeneutics and could be useful to researchers in nursing, psychology, and other disciplines. Though his focus has been on education, the approach seemed flexible enough to apply to the current study. Van Manen (1990, p.30) describes six methodological themes or activities to guide researchers through a hermeneutic phenomenological human science study:

1. Turn to a phenomenon of interest which commits us to the world
2. Investigate experience as it is lived
3. Reflect on essential themes which characterize the phenomenon
4. Describe the phenomenon through writing and rewriting
5. Maintain a strong, oriented pedagogical relation to the phenomenon

6. Balance the research context by considering parts and whole

It is the dynamic interplay among these six activities that "animate inventiveness and stimulate insight" (van Manen, 1990, p.30). I believe I demonstrated earlier in this chapter and in chapter one my deep commitment to the phenomenon under study, and my presence in this project. My orientation to the phenomenon of interest was as a mid-life woman, mother, nurse, educator and researcher.

Van Manen (1990, p.54) advises the researcher to "search everywhere in the lifeworld for lived-experience material". I would argue that my decision to include those midlife women who became mothers through adoption or lesbian partnerships in addition to biology represents my intent to explore all possibilities of this lived experience. My approach to 'construct data' through dialogue with the participants and through interpretation of the text addresses van Manen's (1990) concern about the ambiguous nature of the word 'data' and its quantitative implications. Van Manen (1990) argues that data gathering and analysis should be part of the same process as the interview can serve to 'gather lived-experience material' or provide an opportunity to reflect with the participant on the phenomenon or emerging ideas. This recommendation was applied in the current study in that analysis and interpretation began during the first interview and continued throughout the remaining twenty-five dialogues with the women, through reading and rereading of the text, personal reflection and in dialogue with my committee who read each transcript. Each second interview with the women served as an opportunity to reflect on topics that they had raised during the first interview, to introduce experiences that the other women spoke about, and to suggest categories or possible themes that were emerging. All of this is in harmony with the philosophy of Gadamer (2001) who stressed that it is through listening and conversation that understanding can occur, but he also promoted reading

as understanding. Van Manen (1990) recommends trying to capture the participant's experience as they lived through it, and this was accomplished by asking the women to describe 'what it was like' to become a mother at an older age, and 'what is was like' to be a mother in midlife as well as 'what it was like to go through menopause'. They responded to these questions with stories and examples of their experience as lived, and admitted that they had not had many other opportunities to talk about these experiences with anyone.

Van Manen's (1990, p.30) third activity to guide phenomenological research is to "reflect on essential themes which characterize the phenomenon". Van Manen's (1990, p.79) view on themes in human science research is that it is "a process of insightful invention, discovery or disclosure..." to get at the notion of the phenomenon of interest and not something that is bound by rules or frequencies. Themes are not objects or things but rather the "knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes" (van Manen, 1990, p.90).

The idea of themes is one point that I disagree with van Manen about because he describes themes as the 'structures of experience' and states that themes are not conceptual. My own thinking lies more in line with the approach of Graneheim and Lundman (2004, p.107) who regard a theme as a "thread of an underlying meaning through, condensed meaning units, codes or categories, on an interpretive level". The themes in the current study represent the *latent content* of the text, which required "an interpretation of the underlying meaning" (Graneheim & Lundman, 2004, p.106). Each theme emerged out of and is supported by the *categories* which represent *manifest content* or obvious components of the text that "share commonality" (Graneheim & Lundman, 2004, p.107). Therefore, I chose to use the term *category* to

represent what other qualitative researchers may identify as a sub-theme, because I favor the idea that a theme should be "an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations" (DeSantis & Ugarriza, 2000, p.362). Categories placed in quotations and italics represent *in vivo codes* (exact words used by participants) which were mined from the text to represent a concept which most clearly represented the shared voices of the women. However, as each theme and category unfolds, the voices of women whose experiences were unique to those of the others will also be heard.

Initially, the transcripts were read through and *meaning units* (Graneheim & Lundman, 2004) consisting of words, phrases, sentences and paragraphs were identified as key. These were noted in the margins of the transcripts and samples of this process are located in Appendix N. Comparisons were made with members of my committee, and revisions and suggestions were incorporated into a revised analysis (Appendix O). Some extracts of data were identified as containing more than one main idea or unit. Files were created for each individual transcript, with identified categories in the margins. A duplicate set of analysed data were created and extracts were cut and pasted into the categories which I believed they represented (Appendix P). Graneheim and Lundman (2004, p.106) refer to this process as "abstraction, since it emphasizes descriptions and interpretations on a higher logical level". This same process of abstraction was then done across the sample; so for example under the category 'perceptions of motherhood', all of the data from each woman's transcript were then copied and pasted into a larger file that contained all thirteen sets of data which I thought reflected the dialogue and discourse about their perceptions of motherhood. I gave these new larger files a title which represented a more abstract, conceptual idea and might be a possible theme for the phenomena captured. For

example all of the data which represented the women's 'perceptions of motherhood' were placed in the larger file which I initially called 'Intense Mothering' and this was considered a possible theme. An early sample of one of the worksheets I created to organise these large files is provided in Appendix Q. This larger file contained other categories along with data which supported the concept of intense mothering.

I utilized a process of 'collaborative analysis' which van Manen (1990) recommends as a means to gather other insights which can lead to deeper understanding of the meaning of an experience. As noted above, my doctoral supervisor and one other member of my committee who both have expertise in women's health and qualitative research read each transcript, participated in analysis, and hermeneutical discussions about the interpretations. As meaning units and categories emerged, they were validated, rejected, discussed, defended, revised, and revealed until construction or projection of the final interpretation emerged. It represents both the shared meaning of the women's experiences as well as the unique experiences of disconfirming cases (Patton, 1990), and a collaborative hermeneutic conversation about the meaning units, categories and final themes of the work. The final themes emerged out of the data and categories, and though the concepts were of course part of the discourse with the women, the final themes were not formally discussed with the participants. Gadamer (2001, p.75) equates reading with understanding, and that through reading of a text the reader is "...directed toward what the text says" and "any pulling out of the threads of meaning that happens in an interpretation demands that they also be re-interwoven once more". The final construction emerged as a result of overlapping horizons, as well as a deep immersion in reading and rereading of the texts, notes, feedback from others, and all of the activities described thus far.

Van Manen's (1990) fourth recommendation for phenomenological research addresses the writing; he suggests that research and writing are intertwined, and that basically hermeneutic phenomenology is about the writing. As I look around my office at the notebooks filled, the stacks of transcripts, class memos, meeting notes, literature reviews and papers, I can not disagree. The bringing forth of a phenomenological study is much like a pregnancy, growing warmly and safely inside its mother's womb until it must burst forth into the world for all to see. Much like the mother, I feel bonded by a sense of love and connectedness to this work, and though demanding, I am intent on bringing forth the most meaningful interpretation to share with others. I have tried to find the language that will best convey the shared meaning of the women's perceptions of their health and experiences as midlife mothers while representing the contributions of each participant. I actively sought to understand the shared experiences of these women as well as their unique differences. Dinkins' (2005, p.119) metaphor of a midwife which she distilled from the writings of Socrates, is applicable here. Like a midwife who is skilled in "facilitating the birthing process", Socrates saw himself as someone who could help those who were "pregnant with ideas". Like a midwife, I strove to match up the ideas of the women, which were sometimes conflicting, in an attempt to reveal some genuine insights into their life-world as midlife women and mothers. "Meno's Paradox" (Dinkins, 2005, p.120) raises the question 'how did I know what I was looking for, and would I recognize it when I encountered it'? Dinkins (2005) again uses Socratic philosophy to explain that it is the search for understanding that is important, and Heideggarian philosophy to remind that understanding is found through shared inquiry and by stepping into the hermeneutic circle.

Van Manen's (1990, p.31) fifth activity to guide a phenomenological study may not initially seem to have relevance for study of a phenomenon outside of education, yet "maintaining a strong and oriented pedagogical relation to the phenomenon" does have resonance here. The insistence from van Manen (1990) on transparency in an educator's 'stand in life' is comparable with my use of reflexivity to show how my own ontology and epistemology influenced the choice of methodology and methods for this study. My listening and observation skills along with my ability to form relationships with the women who participated in this study affected the course of the interviews and the women's willingness to be interviewed twice as well as the quality of data construction. Speaking and writing styles that are 'pedagogically contagious' are certainly transferable concepts and important to any researcher hoping to disseminate the findings of her study in an effort to be influential in the realms of practice, policy, and education. Van Manen (1990, p.154) states that "all serious and original thinking is ultimately revolutionary" and not just in a political sense. Rather, it makes us more aware of some aspect of human life, in this case, first-time midlife mothering and the transition to menopause, which prior to now we did not know much about.

The sixth and final activity which van Manen (1990, p.33) suggests to guide a phenomenological study is "balancing the research context by considering parts and whole". Van Manen warns a researcher not to lose sight of the 'it' factor that she is trying to convey in the presenting of the final text. Maintaining a balance between parts of the study/text and the total is critical to the final effect or power of the study. I chose to present the findings thematically, with one chapter dedicated to each of four themes which emerged from data construction and analysis. This approach to presentation of findings was necessary due to the large volume of data that were

generated, as well as the significance of the themes which emerged. The organisation of the findings chapters also makes it less cumbersome for the reader to absorb, and allowed me the opportunity to tie in findings with a discussion of the literature rather than presenting the discussion section at the end of all the findings. Van Manen (1990) admonishes studies which present only transcripts in an effort to 'let the data speak' and argues that those researchers do not go far enough to narrate or interpret the data. With this in mind, I would argue that I maintained a balance between original excerpts from the interview transcripts along with my own interpretation, followed by discussion and links to the appropriate literature. In chapters five through to eight, I have crafted a fusion of both conversations with the participants, and dialogue with the text to create a written interpretation of the participants' lived experiences as midlife mothers, and as women transitioning to menopause. This process led to a new understanding of each woman's life-world as she achieved motherhood for the first time at an older age, and then experienced midlife mothering simultaneously with the transition to menopause. I provided an "example composed of examples" (van Manen, 1990, p.122) to help the reader grasp the significance and deep meaning of the women's experiences. Ultimately, I hope that my "interpretive sensitivity, inventive thoughtfulness, scholarly tact, and writing talent" (van Manen, 1990, p.34) were enough to foster understanding about the phenomenon of first-time midlife mothers who were experiencing the transition to menopause while mothering young children.

Rigour, Trustworthiness and Authenticity

There is debate in the literature regarding the criteria by which to judge the rigour of qualitative research, and whether one particular set of criteria can even apply to all research projects (Mackey, 2007). Maxwell (1996) stands by the familiar concept of validity usually reserved for evaluating quantitative research. He feels it is a "commonsense way to refer to the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account" (Maxwell, 1996, p.87). Maxwell assures that use of the term validity does not imply that he believes there is an objective truth to be found, but rather that it helps to establish results that are believable. Morse (1991) developed four guidelines to evaluate qualitative work for journal publication, and these certainly could be applied to any qualitative work. The study should be important in establishing some new knowledge or theory, the results should achieve some level of abstraction, the study was methodologically sound, and the researcher upheld ethical standards. More recently Morse *et al.* (2002, p.18) argued that *reliability and validity* could be actively accomplished through the use of verification strategies... [such as] "methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically and theory development". Morse *et al.* (2002) argues that the attainment of these strategies contribute to ensuring reliability and validity and, thus, the rigour of a study.

Koch (1996) accepts the lack of consensus about rigour and suggests that the researcher choose the most appropriate criteria to demonstrate trustworthiness in a study. She stated that "rigour and legitimacy are tied to the way in which a research paradigm's ontology and epistemology inform the interpretive framework brought to

the question" (Koch, 1996, p.178). I have discussed at length the ontological and epistemological beliefs which have informed this study as well as the philosophical frameworks and paradigms which support it. I have written about my own prejudices, values and personal insights which factored into the topic, interviews, and interpretations. Methodological decisions and guidelines for interpretation have been articulated. The participants experienced the phenomenon under study, and their stories provided a genuine and meaningful description of it. Women's comments were placed in both personal and historical context, and data collection methods as previously discussed support authenticity, accuracy and completeness of the original data.

Guba and Lincoln (1989, p.233) described the *Trustworthiness or Parallel Criteria*, which they "intended to parallel the rigor criteria" used in quantitative research, with which people were familiar. Utilizing these criteria, I would argue for credibility of this study in its entirety. I have engaged at length in the reading of transcribed interviews, field notes, drafts of interpretations, feedback from colleagues and committee members. Doctoral supervisors who are experienced in qualitative research have read the transcripts, notes, interpretations, and provided comment and feedback. An audit trail of field notes, documents, transcripts, analysis and interpretations, personal notes, coding schemes, themes, feedback from committee members, and the text of the final thesis have been made available. I believe that the questions I asked enabled the participants to share their own personal experiences in the context of their life-world, in addition to any theoretical knowledge or pre-understandings they might have had on the topic. Member checks were accomplished during the second interviews when participants were given a chance to correct misinterpretations or factual errors from their previous interview, offer additional

information, validate or negate ideas and categories, and offer comment on the interview process (Guba & Lincoln, 1989). During the second interview, women were asked to confirm or reject ideas or data that emerged during the first interview, to expand on any topic, and were given an opportunity to discuss anything they may not have talked about during the first interview (Duffy, 2007). Any misinterpretations on my part were discarded, and additional data generated from the second interviews were incorporated into a revised text, and disconfirming cases (Patton, 1990) are represented. These efforts to gain *affirmation* by the participants, which Munhall (1994, p.189) calls the "phenomenological nod", contributed to the rigour and the merit of this research. The *nod* "indicates recognition of the findings and agreement that the researcher has captured, at least partially, the meaning of the experience to the participants" (Mackey, 2007, p.562). I received many nods from the participants, particularly during their second interview, as we discussed various topics and experiences. In many instances the women were able to validate or confirm a similar interpretation of their own experience. However, in some cases, participants expressed different experiences and were unable to give their nod to each idea or interpretation. Munhall says this is fine. "If there is one lived experience with many different interpretive meanings, that itself becomes a part of the description" (1994, p.189). The interpretation is rigourous and trustworthy enough to represent the important human phenomenon of first-time midlife motherhood, and the experience of transitioning to menopause. Further, I believe I achieved theoretical triangulation by making conceptual connections between existing theories and those which emerged and were constructed from the data.

The *Authenticity Criteria* set out by Lincoln and Guba (2000, p.180) aim to establish the necessary components which represent "authentic, trustworthy, rigorous,

or 'valid' constructivist or phenomenological inquiry...". *Fairness* represents the presence of all voices being heard in the text. *Fairness* in this study is reflected in the varying perspectives and voices of all the women participating in the study as well as my own, which will be discussed further. *Ontological and educative authenticity are* "designated as criteria for determining a raised level of awareness...by research participants,...[and] by individuals about those who surround them or with whom they come into contact for some social or organizational purpose" (Lincoln & Guba, 2000, p.180). *Ontological and educative authenticity* were achieved through a raised awareness of both the shared and unique experiences of the participants, and through planned dissemination of findings for professionals caring for women during midlife, and the public. *Catalytic and tactical authenticities* prompt political and social action by the participants and the researcher. While I did not actively engage the participants in any form of social or political action, that is not to say that participation in the study did not create capacity for any woman to feel empowered to make a change in her life. Of all of these authenticity criteria, I would like to focus on *fairness* in particular, as it is represented by *voice*, which is crucial to any discussion of trustworthiness or authenticity. Lincoln and Guba (2000) consider *voice* to be a complex issue in the argument for authenticity. The voice of the researcher should be clearly heard in the text as well as the voices of the research participants in their own words. My own active voice and the consistent use of first person is clear throughout the text. I also utilized a reflexive approach (without succumbing to excessive hyper-reflexivity) to demonstrate how my biases and values influenced the choice of topic, questions, interviews, construction and interpretation of the text. Reflexivity is an acknowledgement by the researcher of her role and influence on the research project (Carolan, 1999). There is the self I brought to this study and the self that I created or

was transformed during the process (Reinharz, 1997). How my many selves interacted with the participants and the text was ultimately important to the authenticity of the final interpretation. Reflexivity recognises the relationships I had with the women, the reciprocal nature I had with the text, the interpretive process, and the transformations which took place in thinking about categories and themes. I have made a genuine attempt to represent the participants' voices in a way that did not exploit or distort them. I recognise that although the women and I both shared some control in the direction of conversation, as the person who wrote up the final interpretation, I was in the more powerful position of what appeared in the text. I was conscious of the potential problem in qualitative studies of individual voices reflecting an idea that represents the group, and have in all instances included the voice(s) of a woman (women) who shared a different view, or whose experience was different from the others. I have also attempted to present the women's voices in the context of their lives, and in the greater context of mothering and being a menopausal woman in American society in the twenty-first century (Olesen, 2000).

Schwandt (1996, p.59) offered a provocative new approach to evaluate social inquiry, by offering a radical "farewell to criteriology" about what is true or false, and proposes three criteria for evaluating social inquiry. Social inquiry should "generate (s) knowledge that complements or supplements ...probing of social problems", that is "successful at enhancing or cultivating *critical* intelligence... or [create] the capacity to engage in moral critique", and lastly be evaluated on whether it enables "the training or calibration of human judgment" (Schwandt, 1996, p.69). I would argue that the findings from this study supplement and establish new knowledge about the experiences of mothers, particularly the experiences of 'older first-time mothers', during their simultaneous transition to menopause. The findings from this study

enhance knowledge of a midlife woman's journey to first-time motherhood, her experience of midlife mothering, and perceptions of health during midlife, particularly during the transition to menopause. I believe that zestful discussion could ensue based on the situatedness of motherhood and perimenopause in the twenty-first century. Having discussed in detail the criteria used to demonstrate the validity of this study, the criterion of transferability is now discussed

Transferability

The wonder of this study as a hermeneutic phenomenological inquiry was to bring the unique horizons of the women and myself together, and together construct a story which may create some meaning for other women experiencing similar phenomena. "Fittingness" or "transferability refers to the probability that the study findings have meaning to others in similar situations" (Speziale, 2003, p.39). Van Manen (1990, p.6) suggests that "phenomenology always addresses any phenomenon as a possible human experience. It is in this sense, that phenomenological descriptions have a universal" capacity for shared understanding. I would argue that in the final text, I have provided sufficient information related to the participants involved, in context but without compromising their identity, to enable the reader to judge whether the findings are transferable to them in a similar situation or at least be recognizable to someone who is a midlife mother who has stepped over the threshold into the transition to menopause.

Summary

In this chapter I have justified why I used a qualitative, hermeneutic phenomenological approach to enable the participants and me to describe and interpret how these women created meaning about their perceptions of health entwined with midlife mothering and perimenopause at a particular point in time. I

shared the effect my ontological and epistemological views had on this study from its conception, and how these influenced my choice of a constructivist paradigm to frame and support it. I explained the decision trail leading to the selection of Gadamer's philosophical underpinnings as a framework, as well as partnering these with van Manen's (1990) methodological themes for analysis/interpretation. Details of sample recruitment along with data construction, management, analysis, and interpretation have been made explicit. Ethical considerations were addressed. Finally, I would argue that I created enough of an audit trail to invite trustworthiness in the findings of this study by demonstrating an authenticity among all the parts and the whole of this project. I believe that this study created a capacity for the participants and me to co-create meaning about the phenomena of interest as shaped by our social, political, cultural, economic, ethnic, and gender values as they have been crystallized over time. I recognise that this study is one interpretation, and that remaining true to the philosophical underpinnings of Gadamer's hermeneutics, no single interpretation can ever be complete or final, and that there is always the possibility of a "potentially richer or deeper description" (van Manen, 1990, p.31) at another point in time. The next chapter provides data on the final sample, and introduces the reader to the background and context of the women who participated in this study.

CHAPTER 4

INTRODUCTION TO THE WOMEN

Introduction

This chapter introduces the reader to the thirteen women who participated in this study. I present the demographics of the final sample, and a background summary on each of the thirteen women who were living their lives as older first-time mothers as well as women transitioning to menopause. Remaining true to hermeneutic inquiry requires the reader to have an understanding of the history and context of each woman's life, from which her discourses about mothering, perimenopause, and health emerged. While I chose to write the summaries from my own perspective in this chapter, each woman's story will be forthcoming in subsequent chapters, in her own words and in detail on the phenomena of interest, as told to another mid-life woman. I adapted this approach from one used by Patricia Munhall in A Phenomenological Study of Menopause (1994) in which Munhall introduced the women who participated in her study. In that text, following a brief summary of each woman, the voices of the women prevailed, and Munhall (1994, P.121) wove "a tapestry of the experiences of menopause from the 'stories' of ten midlife women living the menopause transition".

I chose to present thirteen summaries which provide the reader with some perspective and context on the *situatedness* of the women who joined me on this exploration of their lived experience as first-time midlife mothers and women transitioning to menopause. I have attempted to provide enough detail to be useful, while still protecting the identities of the women. Pseudonyms have been substituted for their real names here and in the remainder of the text. Any identifying geographical locations or places of work or health care have been changed or omitted.

All references to their children or other family, friends, and health care providers have also been changed. They are presented in chronological order based on their first interview with me. Additionally, I have provided a table at the end of the chapter (Table 4-0) which provides specifics of the final sample in a condensed format. The final sample is discussed now.

Final Sample

The final sample consisted of 13 women aged 39-47 when they became mothers, and aged 45-56 at the time of the interviews. They were biological mothers, mothers who had adopted, mothers who gave birth and later adopted, one lesbian biological mother and a non-biological lesbian mother. All the women were Caucasian, and had education beyond high school. Three women had completed some college course work, five had bachelor's degrees, and five had advanced degrees. Two women were single, and ten were married, though one of these had recently separated from her husband at the time of the interviews. One of the lesbian women had participated in a commitment ceremony. The median family income was greater than $80,000. Seven of the women (more than half) were mothering an only child, five (more than one third) were mothering two children, and one woman was mothering three children, including one set of twins. Nine women gave birth to only one child, two women gave birth to two children, and two women never became biological mothers. One of these adopted a baby, and the other woman experienced motherhood with her lesbian partner who became the biological mother to three (living) children. Two of the women who gave birth to one child later adopted one each, and one of the lesbian couples each gave birth to one child. The children's ages ranged from 2-10 years old at the time of the interviews. A summary of the background and context from which each of the thirteen women participated in the study is presented next.

Summaries of the Women

Participant #1 Roxanne

Roxanne was the first study participant, and she invited me to meet with her in her home for both interviews. She was 42 when her son was born, and 49 when I interviewed her. She adopted her daughter when she was 47 years old, and her children were 7 & 5 years old at the time of the interviews. Roxanne was a Caucasian, married woman, with a family income over $80,000. She completed a Bachelor's Degree, and worked outside the home part-time. She initially identified seven perimenopausal symptoms, and was using Estrace cream as needed to treat them.

Participant #2 Shanny

Shanny was the second woman I interviewed, and she drove one hour each way to meet with me. She rescheduled her first interview because her father-in-law died right before we were going to get together. We met in a church meeting room. Shanny married at age 38; her husband had two children from a previous marriage who lived with them after they were married. She was 39.5 at the time of her first child's birth, and age 48 at the time of her first interview with me. She had one son age 9 and one daughter age 8. She wanted more children, but her husband really did not even want to have a second child. She was a Caucasian, married woman living with the father of her children. She had a family income of more than $80,000, and a Bachelors Degree. She quit a full time professional position to be a stay-at-home-mom. She identified eleven perimenopausal symptoms at the time of her interviews, and turned out to be one of the most symptomatic women I interviewed.

Participant #3 Rosie

This participant snowballed from the first participant. Rosie was a 46 year old Caucasian, married woman. We met both times in her home, with her daughter present. She seemed much more relaxed and comfortable during the second interview, volunteering information, rather that waiting to be asked questions. Rosie had a history of infertility for nine years, declined infertility treatment, and had two prior miscarriages. She was 39.5 years old at the birth of her only child by caesarean section. Her mother became ill and died during Rosie's pregnancy. She turned 40 when her baby was six months old. She was married for ten years before their daughter was born, and worked full time before becoming a mother. Her daughter was 6 years old at the time of the interviews. Rosie was working part-time cleaning houses at the time of her interviews. She had some college education, and listed their income in the $40,000-59,000 range. She identified nine menopausal symptoms, and what was unique about Rosie was that she had recently had a hysterectomy, and was experiencing surgical menopause. She used an oestrogen patch and testosterone oil. Technically she had not been without her period for one year, so I decided to include her in the study.

Participant #4 Leslie

Leslie met with me in a conference room on a university campus which was convenient for her. She was 43 at the time of her daughter's birth, and 49 years old when I interviewed her. Leslie always wanted to be married and have a family. She experienced some infertility, and utilized Assistive Reproductive Technologies (ART) to achieve pregnancy. Leslie miscarried prior to her daughter's pregnancy. She also had an abortion earlier in her life. Leslie had one daughter 6.5 years old. She was a white single woman living with the father of her child, and he did not want to get

married. Their family income was more than $80,000; she was working part-time and was concerned that she did not have much money of her own. She identified four perimenopausal symptoms at the time of her interviews. Her own mother was aging and unwell, and unable to be supportive with the grandchild.

Participant #5 Susan

Susan was 51 at the time of her interviews, and we met at a local church. She was married at age 37; it was her second marriage, and her husband's second marriage. He had three children who were in their twenties at the time of the interviews. Susan expressed uncertainty about the decision to have a child with this husband, but as she approached age 40 felt it was the "last call". Susan was 40 when her daughter was born and her husband was 46. Her daughter was 10 years old at the time of the interviews, and had a diagnosis of Asperger's Syndrome, which is on the autism spectrum. She was a Caucasian, married woman living with her husband; their family income was more than $80,000, and she completed a Bachelors Degree. Susan identified five perimenopausal symptoms at the time of the interviews; she used a progesterone cream daily.

Participant #6 Jackie

Jackie invited me into her home for both interviews, and at the second interview she prepared tea and sandwiches for us. She was 40 years old when her daughter was born, and 50 at the time of the interviews. She married at age 38, at which point she decided she wanted to have a child. Jackie was a Caucasian woman who lived with her husband who was older. He had children from a prior marriage. Her daughter was age 10 at the time of the interviews. Family income was $40,000-59,000 and she had some college education. She was a stay at home mom but said she was ready to go back to work, and was looking for a part-time job.

Participant #7 Miriam

Both interviews with Miriam took place at her work location during the lunch hour. Miriam was 41 years old at the time of her son's birth, and 49 at the time of the interviews. She became pregnant again at age 44 but that pregnancy resulted in miscarriage. Her son was 7 years old at the time of her interviews. Miriam was a Caucasian, married woman who had recently separated from her husband. She worked part-time as a consultant, earned more than $80,000 per year, and had a Bachelor's Degree. Miriam's parents were experiencing health issues, and she was providing some assistance to them. She identified five menopausal symptoms at the time of the interviews.

Participant #8 Florence

Florence married at age 42, was 44 years old when her daughter was born, and 48 at the time of the interviews. She was a Caucasian woman with an advanced degree, and family income greater than $80,000. She worked full time in an academic setting, and her interviews took place in her work setting. Her daughter was age 4 at the time of the interviews. Florence identified three perimenopausal symptoms.

Participant #9 Monique

Monique was traveling several hours each way to care for her aging, sick parents when she volunteered to participate in this study. We met at her parent's home, and her father and 3 year old daughter were present in the home during the interviews. Monique was a Caucasian woman and married. She was 44 years old at the time she adopted her daughter, and 47 at the time of the interviews. Family income was greater than $80,000; she had an advanced degree, and owned her own business as a consultant. She chose not to pursue vigorous Assistive Reproductive Technologies (ART) for infertility, and she and her husband adopted their daughter abroad. She did

not feel she had the emotional capacity to mother a second child, though her husband wanted to adopt a second. She identified four perimenopausal symptoms that she was experiencing at the time of the interviews.

Participant #10 Mary

I interviewed Mary in an academic setting which was not her place of employment but was a convenient location for her. Mary was a Caucasian woman who self-identified herself as a lesbian woman in a stable relationship. She was 40 years old at the time of her son's birth, and 45 at the time of the interviews. Her younger partner delivered their second son one year after Mary gave birth. Both Mary and her partner achieved pregnancy by alternative insemination with donor sperm. Mary's sons were 5 & 4 years old at the time of the interviews. She is a health care provider who specialised in women's health. Her income was greater than $80,000, and she was working part-time. She identified six perimenopausal symptoms she was experiencing, and was taking oral contraceptives for hormonal support. In her role as a health care provider, Mary cared for pregnant women and for women during the transition to menopause. She participated in this study from the perspective of a woman experiencing the phenomena of interest, as well as from the position of a health care provider.

Participant #11 Peggy

I interviewed Peggy, aged 47 in her office during her lunch break. There was a problem with the tape recorder during her first interview which resulted in the first interview not being recorded. During the second interview I tried to incorporate some of the questions from the first interview in an attempt to re-capture some of that data. Peggy was 42 years old at the time of the birth of her son who was 5 at the time of the interviews. She later adopted a girl who was 2 years old at the time of the interviews.

Their family income was more than $80,000; she holds an advanced degree and works as a University Professor. She experienced the death of her mother at an early age as well as loss of a sister. Peggy initially reported only one perimenopausal symptom, but during the interviews she identified more than one.

Participant #12 Abbey

Abbey invited me into her home for both interviews. Her children were at school and her husband was working. She was Caucasian, and married to an older man with children from his previous marriage. Abbey was 40 years old at the time of her first son's birth and her husband was 49. She was 49 years old had two sons aged 10 and 8.5 at the time of the interviews. Both of her sons were diagnosed with Asperger's Syndrome. Abbey had a Bachelor's Degree, their family income was identified as $40,000-59,000 per year, and she worked part-time in retail. She was experiencing nine menopausal symptoms at the time of the interviews.

Participant #13 Sarah

This participant has been a long time colleague of mine. I personally called her to ask her to participate in this study. Her first interview took place in her home with her twin daughters present. The second interview was postponed and delayed because of my mother's death, her mother's illness, and her daughter's surgery. The second interview was also done at her home, this time without the children. Sarah is a Caucasian woman in a lesbian relationship. She was 47 years old at the time she became a mother for the first time. She was 56 at the time of the interviews. Her partner's pregnancies were achieved by alternative insemination, with Sarah's brother as the sperm donor. Sarah referred to her brother as the father of the children. She has a son who was age 8 and twin daughters age 5 at the time of interview. Sarah received a Diploma in Nursing and a Certificate in Midwifery. She was working full-time as a

nurse midwife. She identified six perimenopausal symptoms at the time of the first interview.

*After note: this couple separated after her participation in this study. Sarah's mother died, and the relationship broke up shortly after that. The couple was sharing custody of the children when I last spoke with her, and Sarah felt that she would be able to retain her status as mother.

Summary

This chapter introduced the reader to the thirteen women who participated in this study. I presented the demographics of the final sample, and a brief background summary on each of the thirteen women who were living their lives as older first-time mothers as well as women transitioning to menopause. The reader should now have some history and context in which to situate the discourse and dialogue on the phenomena of interest which is presented in chapters five through eight.

Table 4-0 DEMOGRAPHICS OF FINAL SAMPLE
W= White M=Married S=Single D=Divorced L=Lesbian
*All names are Pseudonyms

Participant* & age at first interview	**Age at first motherhood**	**Children & ages at time of interview**	**Self-identified perimenopausal symptoms**	**Income & Education**	**FT or PT Work Status**
#1 Roxanne 49, WM	42 at birth	male 7 female 5 (adopted)	Yes-7	>$80,000 Bachelor's Degree	Works part-time
#2 Shanni 48, WM	39.5 at birth	male 9 female 8	Yes-11	>$80,000 Bachelor's Degree	Stay at home mom
#3 Rosie 46,WM	39 at birth	female 6	Yes-9	$40,000-59,000 Some college	Works part-time
#4 Leslie 49, WS	43 at birth	female 6.5	Yes-6	>$80,000 Advanced degree	Works part-time
#5 Susan 51, WM	40 at birth	female 10	Yes-5	>$80,000 Bachelor's Degree	Stay at home mom
#6 Jackie 50, WMF	40 at birth	female 10	Yes-8	$40,000-59,000 Some college	Stay at home mom
# 7 Miriam 49, WM separated	41 at birth	male 7	Yes-5	>$80,000 Bachelor's Degree	Works part-time
#8 Florence 48, WM	44 at birth	female age 4	Yes-3	>80,000 Advanced Degree	Works full-time
#9 Monique 47, WM	44 at adoption	female age 3 (adopted)	Yes-4	>80,000 Advanced Degree	Works part-time
#10 Mary WSL	40 at birth	male 5 partner has male 4	Yes-6	>80,000 Advanced Degree	Works part-time
#11 Peggy 47,WM	42 at birth	son 5 daughter 2 (adopted)	Yes-1	>80,000 Advanced Degree	Works full-time
#12 Abbey 49, WM	40 at birth	son 10 son 8.5	Yes-9	40,000-59,000 Bachelor's Degree	Works part-time
#13 Sarah 56, WL Commitment Ceremony	47+ at birth of children No biological children.	son 8 twin daughters 5 (partner delivered)	Yes- 6	>80,000 Diploma & Certificate	Works full-time

CHAPTER 5

ACHIEVING FIRST-TIME MOTHERHOOD AT MIDLIFE

Introduction

The aim of this chapter and the three to follow is to present my hermeneutic interpretation of the lived experiences of older first-time mothers who participated in this study. This will be accomplished over four chapters. The focus of chapter five, *Achieving First-Time Motherhood at Midlife* is to co-construct meaning around the women's experiences as they sought to achieve motherhood for the first time at age 39 and beyond. These findings are critical in establishing the situated context for the text which follows in chapters six through eight. Gadamer's (1975/2004b) philosophical underpinnings as discussed in chapter three were used to guide the entirety of this study, and as a result, meaning was mutually negotiated through a participative dialogue with the women, and simultaneously with the text. Gadamer's hermeneutic constructs of prejudice or pre-understanding, the hermeneutic circle, dialogue, horizon, fusion of horizons, play, buoyancy and projection provided the basis for interpretation, and will be explicitly and implicitly visible in these chapters. Interpretation (understanding) always occurs through the fusion of horizons of the interpreter and the interpreted, and both are taken up into a higher form of understanding. Van Manen's assertions that common understandings can be reached through dialogue and conversation are in harmony with Gadamer's philosophical underpinnings. Therefore, van Manen's (1990) six activities to guide researchers through a hermeneutic phenomenological human science study (also discussed in chapter three) were employed, particularly to guide analysis of data. Gadamer (2001)

stressed that it is through listening and conversation that understanding can occur, but he also promotes reading as understanding.

In chapters five through eight, I have crafted a fusion of both conversations with the participants, and dialogue with the text to create a written interpretation of the participants' lived experiences as midlife mothers, and as women transitioning to menopause. This process led to a new understanding of each woman's life-world as she achieved motherhood for the first time at an older age, and then experienced the transition to menopause as a midlife woman and mother. Chapter five explores the women's journey to motherhood, while chapter six focuses primarily on the meaning of midlife mothering for the participants, including their perceptions of how perimenopause affected their mothering abilities. Chapter seven reveals the lack of social support which was evident in the women's lives through discourse with them and in the reading of the text. Chapter eight continues the conversation that starts in chapters six and seven, and delves further into the women's perceptions of their health as they transitioned to menopause. My intent is to share with the reader the interconnectedness of these four chapters as a vehicle for understanding the complexity of the women's experiences as midlife mothers during a time of overlapping developmental stages.

The findings in chapter five will be presented as categories which support the main theme *Achieving First-Time Motherhood at Midlife,* in the order in which they emerged during the interviews and in the text. Categories in quotations represent in vivo codes which were mined from the data to represent a concept which most clearly represented the shared voices of the women. As each category unfolds, the voices of women whose experiences were unique to those of the others will also be heard. Chapter five, *Achieving First-Time Motherhood at Midlife* begins with a presentation

and discussion of six categories: 1) *"Not by Choice"*: Delayed Motherhood, 2) *"It Didn't Take That Long"* : Conception, 3) *"A Lot of Ways to Become a Parent"* : Paths to Motherhood, 4) *"Unknown Territory"* : Pregnancy After Age 39, 5)*"Everything Was Going to be Fine" and "Just to Make Sure":* Baby's Health and *6) "More of a Fantasy"*: A Second Child.

The first category, *"Not by Choice"*: Delayed Motherhood illustrates the desire of all thirteen women to become mothers, and the circumstances that led them to become mothers for the first time at age 39 or older. The category *"It Didn't Take That Long"*: Conception is an interpretation of the various experiences of these older women as they attempted to conceive a pregnancy. Ultimately for these women, motherhood was achieved through several different modalities, including normal biology, adoption, alternative insemination, in vitro fertilization, and lesbian partnerships. This winding path to motherhood is expressed by the category *"A Lot of Ways to Become a Parent"*: Paths to Motherhood. As older first-time mothers, most of the women perceived that they were considered 'high risk' during their pregnancies, and hence treated differently than younger women by their health-care providers. This is embodied in the category *"Unknown Territory"*: Pregnancy After Age 39. Their awareness of potential adverse outcomes related to their age is represented by the category *"Everything Was Going to be Fine" and "Just to Make Sure":* Baby's Health, which portrays conflicting levels of concern the women expressed about the potential health of their babies. Eight of the thirteen women expressed a desire to have more than one child, but only two of them actually delivered a second child. This desire for more children is embodied in the theme *"More of a Fantasy":* A Second Child. This chapter includes a discussion of these six categories in the context of known traditions, the women's pre-understandings and mine, as well as a comparison

of findings with the relevant literature. It is my aim that readers of this text will be brought to a higher level of understanding (fusion of horizons) about the women's experiences as they realised motherhood for the first time during midlife.

The next section presents the first category "*Not by Choice*": Delayed Motherhood in which the women expressed concern with the passage of time, and the fact that they were getting older and not yet mothers. They faced the probability of never becoming biological mothers, and shared their understanding (horizon) of why they became mothers late in life.

"*Not by Choice*": Delayed Motherhood

All the women were asked at the first interview to initially respond to the question: "Tell me what it was like to have your first baby at 40 years old?" (or whatever age they were at first time motherhood. Two of the women were 39 at the time of the birth, but turned 40 within the first year). Each woman shared her unique perspective on why she did not become a mother until later in life. The pre-understandings of the women led them to believe that they would be mothers at a younger age, but this belief changed to doubt as they aged, and began to question whether they might be too old to become a mother. The women were not confident about being able to conceive as they considered a reality in which they might never achieve biological motherhood.

With varying degrees of intensity, these thirteen women wanted to be mothers, yet they recalled the uncertainty they felt as they approached age forty, and wondered whether they would ever become mothers. I came to this study believing that most women who delayed motherhood into their forties probably had infertility issues, so I had to make an adjustment in my horizon early on in the study. Initially I was thinking only about biological mothers and had not even considered adoptive or

lesbian mothers for the study, so that required another shift in thinking. Since the aim of this study was to explore perceptions of health of older first time mothers who were simultaneously experiencing perimenopausal symptoms, as well as their midlife mothering experience, the way in which women became mothers was not critical to the study. The combination of experiencing these two transitions simultaneously was the phenomenon of interest and therefore women did not have to be biological mothers. This enabled a much broader range of experiences to be captured. The following is an excerpt from the first interview with Abbey which exemplifies the initial limits of my own horizons on this subject:

> Pat: *It's interesting ...when I first was putting this study together and starting out I thought... one of my assumptions, which I've been wrong, was that I would meet more women who had infertility issues versus... .....it SEEMS so far and you're like number twelve ...but most of them it's been about relationships and just late- not meeting the person they wanted to be with until later.*
>
> Abbey: *that's right*
>
> Pat: *Is that would you say that [Abbey: yeah] describes your situation?*
>
> Abbey: *definitely... ... ...20 years of dating* [before she met her husband] (Abbey, I_1, p.28).

During her second interview, Abbey responded to a question about her transition from being a working woman to a stay-at-home mother when her children were younger. It was then that she revealed that she had expected to be a mother by the time she was 25 years old:

> Abbey: *I did* [like staying home with them]. *I mean I worked a long time and I took care of myself for all those years I did, I always was a homebody. I always liked... I wanted to have a house ...um I mean I thought I would be married by the time I was 25 so you know, I was ready, I was ready to be home* (Abbey, I_2, p.47).

Eleven of the thirteen participants in the study did not make an intentional choice to delay motherhood, and only two women temporarily delayed motherhood to pursue

advanced education and careers. None of the women intended to wait until they were 39 years old or older to become a mother for the first time, and in retrospect all wished they had started when they were younger. Roxanne, age 49 and mother of a 7 year old son and a 5 year old adopted daughter had this to say about what she was thinking as she turned 40:

> *I kind of always thought that I would have children, but I wasn't dealing with the reality of the fact that gee I'm 40 and I'm not married, and I have no prospects. When am I going to fit this in?* (Roxanne, I_1, p.7)

Roxanne and her boyfriend were planning to be married, and though pregnancy came as a surprise to them, they worried that they might not have another chance, so they proceeded with the pregnancy. Shanny, age 48 and mother of a 9 year old son and 8 year old daughter now advocates for motherhood at age 40, but by age 35 she had given up. She said "I'm too old. It's not going to happen, and then I met my husband" (Shanny, I_1, p.35). Shanny remembered that she and her husband did not talk much about having children, since he already had custody of two children from a prior marriage. She worried that he might not want more children, so it "just sort of happened". Leslie was 49 and mother of a 6 year old daughter at the time of the interviews. She recalled that she had always wanted to be a mother, but the years were slipping away. She described a conversation she had with her boyfriend as follows:

> *I said to Matthew, you know I really wanted to have kids and he didn't want to get married. He was really ambivalent about having kids. Now I'm 38 or 39 years old. So, we ended up, I was turning 40 and we had stopped using birth control, and I wasn't getting pregnant. I thought you know, I bet I have something* [some problem preventing her from conceiving] going on (Leslie, I_1, p.9).

Florence, age 48, and mother of a 4 year old daughter, did not feel confident that she could have a baby. She reflected on her feelings at the time:

> *I wasn't really confident that I could get pregnant. I was kind of surprised it was as easy as it was. All that birth control all those years, it really did work.*

> *I wasn't really that confident. I knew that we were going to adopt if we couldn't have our own. I was determined to be a parent, and my husband was okay with that. We tried for six months to have Paige. We went to a meeting on adoption, and I got pregnant* (Florence, I_1, p.21).

Only two of the women, Susan and Jackie, described some initial uncertainty about whether they should have a child at all. At the time of the interviews, Susan was 51 and mothering a ten year old daughter, as well as older step-children. She described feeling the pressure of a ticking biological clock; her husband was four years older than she, and he had three teenagers from a previous marriage:

> *He is four years older than me so we had talked about whether or not we should have a child together, and when it got to the point when I was close to 40 I kind of felt THIS IS LAST CALL, so we talked about it for probably about a year prior to attempting...* (Susan, I_1, p.1).

Jackie was 50 years old and mothering a 10 year old daughter. She too was married to an older man who had children from a prior marriage. She shared that until about one year after her marriage it did not really matter whether she had a child or not. At that point in time she became fearful that she might be alone in the future:

> *Because up to that point* [when she married], *it really didn't matter one way or the other. I could've gone without. But I just had this NEED, and um, I don't know I guess when you get older like that you start to think what's going to happen to you in the future. I didn't want to be all alone* (Jackie, I_1, p.2).

Jackie's reason to have a child may not be considered altruistic, and could be placed in an equally opprobrious category with having a baby to try and save one's marriage, or to get another opportunity to fulfil one's dreams (Lotz, 2009). Perhaps less scornful, but still not morally admirable reasons for having children are named by women such as "to give my life purpose and meaning, to gain social acceptance, or to keep me young" (Lotz, 2009, p.292). We seem to be more accepting of people's desire to "to experience the joys and challenges of parenthood," or even the more redeeming desire to offer something to a child, whilst having their best interests at

heart (Lotz, p.292). Some women, like the two just mentioned in this study, gave consideration to not having any children, despite the still strong social mandate to reproduce both in the United States and Canada (Miall, 1986). In fact, surveys done in European countries reveal that more women actually remain childless, than the percentage who claim that they do not want children (Rowland, 2007). The author attributes this paradox to women appearing to "conform to 'traditional' family norms; however postponements strengthen preferences for a lifestyle without children" (Rowland, 2007, p.133).

Contemporary childlessness in developed countries is primarily a voluntary choice, though delayed motherhood can affect fecundity and result in undesired outcomes for those expecting to have children, which then results in a form of involuntary childlessness (Rowland, 2007; Koropeckyj-Cox, 2007). This may have been the case for participant Monique in the current study; she delayed motherhood into her 40s, and then never achieved a pregnancy. Another participant, Jackie, was ambivalent as a younger woman, and her ultimate motivation to have a child at age 40 to avoid being alone, is addressed by Rowland (2007) who points out that having fewer children has led to many elders in developed countries ending up with less support due to fewer close relatives. Rowland confirms that there has been an increase in childlessness among women born in developed countries from mid-twentieth century (after 1945) on, compared to earlier cohorts of women born in the first half of the century. An increase in the number of women who choose to remain childless in the United States since the mid-1960's has been linked to voluntary factors like "fertility control, contraceptive technology, Sexual and family norms, and female work patters and preferences" (Poston & Kramer, 1977, p. 304), and this trend has continued. In June 2006, twenty percent of women 40 to 44 years old were childless

in the United States, which is twice as many as in 1976 (Dye, 2008).This trend could reflect the changing demographics for women who are delaying childbirth, or it might also be attributed to the socialization of women who grew up as baby boomers, and were exposed to the feminist movement, which initially took a negative view of motherhood. This indoctrination may have influenced this cohort of women to question the necessity of motherhood to fulfil them, or at least consider a rejection of the *motherhood mandate* (Russo, 1976, p.8) which put pressure on women to have "at least two children...and raise them 'well'". Koropeckyj-Cox (2007) found that women actually have positive or neutral attitudes about childlessness, and adults with a college (or more advanced) education, have more positive attitudes as well. The more educated group in the Koropeckj-Cox (2007, p.1077) study was "significantly more likely to agree that childless persons can lead fulfiling lives (compared to those with a high school education)". Those working full-time were less likely to have a negative attitude, and income was not a significant factor.

In the current study, all of the women were Caucasian, and had education beyond high school. The majority of them were married, the median family income was greater than $80,000, and seven (more than half) of the women were mothering an only child (for more details, see Table 4.0). These demographics are consistent with the literature on older mothers, who tend to be married, well educated and financially stable (Mercer, 1986; Winslow, 1987; Reece & Harkless, 1996; Martin *et al.*, 2002; Nelson, 2004; Joseph *et al.*, 2005; Carolan & Nelson, 2007). The women in the current study experienced a multitude of significant circumstances in their lives which caused or resulted in delayed motherhood. However, despite a lack of desirable partners, boyfriends or husbands, time out for education, establishing careers, mothering step-children, and facing the real possibility of decreased fertility, all but

two of these women were determined to be biological mothers. This is consistent with the work of Nelson (2004, p.287) who found that despite opportunities available to women today, "many women continue to experience an underlying, inexplicable maternal drive", and Winslow (1987) who has noted that the intensity of that drive may vary. These findings contrast with others who found that childless women aged 39-46 years old had fewer childbearing goals than women aged 29-35 (Heckhausen, *et al.* (2001).

The women described several different reasons why they did not become mothers at a younger age. Ten of them cited lack of the right relationship as the primary reason for delayed motherhood, and two of them delayed temporarily to complete advanced educations, and establish careers. Florence aged 48, and the mother of a 4 year old daughter explained why she did not become a mother until she was over 40 years old:

> *The reason I didn't have a baby until I was 44 was because it took me a long time to find the right guy. That's why I didn't have a baby til... I would have PREFERRED to have a baby in my 30's, somewhere, but I just didn't meet the right guy until I was... I didn't meet my current husband until I was almost 40. We got married when I was 42...I knew that I wanted to be with a guy who was open to being a dad. Mark was definitely very open to being a dad. We talked about that pretty early on in the relationship... We tried having a baby right away* (Florence, I_1, p.1).

Shanny was one of four women in the study who had older step-children. Like the others, she wanted children of her own and was mothering a nine year old son and an 8 year old daughter at the time of her interviews:

> *I've waited quite a while obviously to have children – really not by choice – I did not marry until I was 38 and I took on two step-children when I married my husband, but I got pregnant right away after we got married so it was exciting. I thought it would take a while, and it didn't. I got pregnant on my very first try* (Shanny, I_1, page 1).

The ease with which many women conceived is a recurrent theme which is addressed in the next section. Others like Monique were not prepared for delays; she thought she would have children in her early 30's, and was shocked when she did not become a mother until she was 44 years old:

> *I got married at 40 and we waited a couple of years before I even wanted to have a child because I wanted to get used to being married because I'm a combination of married older as well, which is a very big adjustment when you did your own thing for all that time. I think from there we tried* (Monique, I_1, p.1).

Only one woman in an established relationship at a younger age, experienced infertility, and she cited this as the primary reason for late motherhood. Rosie, a 46 year old mother of a 6 year old daughter, married at age 30, and tried to conceive for nine years. After two miscarriages, she finally became pregnant for a third time:

> *Sure we tried- I got married, we did that at 30, tried to have a child for nine years, didn't work, had two miscarriages. The doctor basically said that without any fertility, [treatment] we weren't going to get pregnant. My husband and I just didn't* [want to do fertility]... *I mean I didn't want to wait until I was 39! I was feeling pretty steady at 30 when we got married and I would have been happy anytime ON...* (Rosie, I_1, p.1).

In her second interview Rosie qualified her previous statement when she said:

> *So, it doesn't necessarily have to be 39 or 40 that's just how it worked for us. I'd lived a full life by then* (Rosie, I_2 p. 20).

Though finding the right relationship was an important theme in the discourse on delayed motherhood, Miriam was one of only two women who seemed willing to list motherhood as a higher priority than a stable relationship. Although a relationship was important to her, she felt life was not complete without a child, and she wanted to have her own by the time she turned 40. This is what she had to say:

> *And I remember thinking, you know, if I don't get pregnant by the time I'm 40 I'm going to have a baby anyway. It's funny, because then, like in my late 30's I ended up meeting David and everything seemed so good and so wonderful, and then next thing I know I'm pregnant and I'm having the kid that I always wanted, you know. And it kind of like fell right into that scheme of... so it wasn't 40, it was 41* (Miriam, I_1, p.32).

Sarah initially attempted pregnancy as a single, lesbian woman, despite the fact that she was not in a relationship with anyone. She utilized alternative insemination, but was unsuccessful, and considered adoption, but could not afford it. Although she did experience some infertility, she attributed delayed motherhood for her, to the lack of a stable relationship. She eventually achieved motherhood at age 47 and again at 51 with her younger lesbian partner as the biological mother of a son, and then twin daughters. She described the events that led to her not becoming a mother until later in her life:

> *Oh, definitely, yeah, I wasn't in any relationship that was good enough... and for a long time in NO relationship. And it was during that time that I was in NO relationship that I actually did try and I was – I don't know, in my mid-30s to late 30s when I was trying. So I had been there and then started looking into single-parent adoption, which I sort of realised was financially an impossibility for me, at least for the agencies that would accept me as a single ... you know, single person. There was also big bucks involved* (Sarah, I_1, page 3).

Several of the women who established relationships later in life also experienced varying degrees of infertility as well, which will be discussed in the next section entitled *"It Didn't Take That Long"* : Conception. Of the two women who made a choice to delay motherhood temporarily in order to establish their professional careers, one also cited lack of the right partner as a contributing factor and one did not. Mary delayed motherhood to pursue advanced education and establish a professional career. She is the biological mother of a 5 year old son using donor sperm, and her younger lesbian partner is the biological mother of their 4 year old son:

> *I think that the biggest reason* [I had a baby at 40] *is probably because of my career actually, but I always felt like the first step to becoming a parent was a good stable relationship and that took me until my late 30's...* (Mary, I_1, p.1).

Peggy delayed motherhood to pursue a doctoral degree, and establish her career as an academic. She was unaware of possible issues associated with age and fertility so she thought she had time to wait. She and her husband decided not to pursue fertility assistance, and were willing to adopt if unable to conceive naturally. She was 42 when her son was born, and they adopted their daughter three years later.

None of the women in this study chose to delay motherhood until age forty. This is in contrast to earlier findings (Winslow, 1987, p.94) in which women aged 35-44, chose the "right time" to become pregnant when "everything just sort of tied in at the same time". Instead, the women in the current study cited lack of the right relationship as the most common factor for delayed motherhood, because they felt it was critical to be in the right relationship before having a child. This supports the literature for women over age 30, in that a stable relationship has been cited as critical because women do not want to raise a child on their own (Benzies *et al.*, 2006). Older women aged 35-44 identified a "committed and loving relationship with the father of the baby as being of paramount importance" (Winslow, 1987, p.94). It is interesting that these baby boomer women wanted a stable relationship before contemplating motherhood and for most this meant marriage. This generation of women came of age during a time when feminism and opportunities for women were at its highest, yet they seemingly held traditional values and beliefs on the importance of stability, marriage, family and of fathers in rearing children. As traditional as this first appears, they really were unlike their mother's generation who married young, and gave up jobs and college opportunities to stay home and parent. In truth by delaying childbirth and mothering, they broke away from the traditional values and expectations their parents held for them to go to college and get married right away. The majority of these women were willing to wait for the right partner whilst they completed their

education and established their careers. These findings support the literature which cites "an inverse relationship between educational attainment and the proportion of births out-of-wedlock" (Bachu & O'Connell, 2001, p.5). This pattern among older women contrasts markedly with the increasing number of unmarried mothers who accounted for 38.5% of all U.S. births in 2006, a 16% increase since 2002 (Martin *et al.*, 2009). Although the birth rate for unmarried women aged 35-39 has increased from 10 to 27 (per 1000 unmarried women), the numbers are much higher for younger women, particularly those aged 18-29 (Martin *et al.*, 2009), and in 2000, 83% of births to teenage mothers occurred outside of marriage (Bachu & O'Connell, 2001).

Despite their strong belief in waiting for the right partner, a few women in the study considered single adoption, and single parenting, and one woman utilized assisted reproductive technologies (beyond insemination) despite the lack of a stable relationship. Citing a ticking biological clock and fear of being alone in the future, two women who were initially uncertain about becoming mothers, moved forward with attempting a pregnancy. This is consistent with Benzies *et al.* (2006) who suggest that advanced maternal age, and the pressure of a ticking biological clock may propel women into single motherhood. Only two of the women in the current study postponed motherhood temporarily to complete advanced education and establish careers, which is in contrast to available literature (Dion, 1995; Benzies *et al.*, 2006) in which establishing independence through education, career, and financial stability were named as primary reasons why women delay motherhood. Eventually, all of the women in this study attempted to become biological mothers. Motherhood was ultimately achieved by all of them, but for some, not through traditional means. As already indicated in the data presented so far, most of the women conceived easily

and for many this outcome was unexpected. Shared meaning emerged from the women's accounts of conception, and is presented next under the category *"It didn't take that long":* Conception, which is an interpretation of the relative ease with which most of the women conceived a pregnancy.

***"It Didn't Take That Long":* Conception**

Uncertainty about ever becoming a mother led most of the women to prepare themselves for the possibility that it might not happen, at least not biologically. Ten of the women spoke of some expectation of reduced fertility related to their age, yet eight of the women described getting pregnant without any problems. Roxanne, age 49 and mother of two, revealed that she was living vicariously through her nieces and nephews, mentally doing things to prepare herself that she might never have children:

> *...I'm so blessed to be one of the people who was able to conceive a child at such a late age, having not had any other children. I think if I had missed that experience I would have been very very sad* (Roxanne, I_2, p.26).

Miriam, age 49, and mother of a 7 year old boy, revealed that life did not feel complete without a child, and she wanted her own child, even though she had considered adoption. Shanny was almost 40 when she gave birth to her first child. She had two step-children, but it was very important to her to have "*her own children*". She described a real absence of communication with her husband about whether they would have children together, but soon after he agreed to think about it, she became pregnant:

> *He was a divorced father, but he had custody of the children. So he's raising these two children...So I'm thinking he is never going to want to have kids. Quite frankly, we never really talked too heavily prior to having my son. He just sort of happened. I sort of said, I want to think about having kids, and he said okay* (Shanny, I_1, p.35).

Susan described some initial uncertainty deciding whether to have a child with her husband, but once the decision was made, conception did not actually take very long,

probably less than six months. Jackie's pre-understandings developed in conversation with her physician. This is how she described that turn of events:

So, I mean I always wanted to be a mother, but I was a little concerned because of my age. Um, but anyway, but he [her husband] *said if it happens it happens and it was boom, right off the bat. I went to my gynecologist and spoke to him about it and he said well, you know, it may take a long time, it may never happen, we never tried before, we don't know, you know, how fertile you are, whatever and...But it was just right off the bat. I, I went off the pill and, um, it just seemed like a month later, two months later, it happened* (Jackie, I_2, p. 24).

Miriam age 49, remembers thinking that if she did not get pregnant by the time she was 40, she was going to have a baby anyway. She said she met her husband and:

> *The next thing I know I'm pregnant and I'm having the kid* [son age 7] *that I always wanted, you know...so it wasn't 40, it was 41* (Miriam, I_2, .32).

Florence age 48, mother of 4 year old daughter, got married at age 42 and they tried to have a baby right away:

> *I got pregnant within six months and lost that baby at about three months. That was pretty hard, but at least I knew I could get pregnant, which was exciting, and it didn't take me that long to get pregnant. Then I waited a few months and tried again, and in six months Paige was in my belly* (Florence, I_1, p.1).

Two of the women in the study had additional opportunities to become mothers which the other women did not have. Much like the other women, Mary and Sarah each had a desire to be a biological mother. However, if this was not possible because of their age or infertility issues, they both had lesbian partners who were younger, who could also potentially conceive. Mary had delayed motherhood for her career, but also because prior to her current partner, she had not been in a stable relationship, which, for her, was an important prerequisite to becoming a parent. Mary and her partner initially wanted some time together as a couple before having children, but Mary knew that another delay could jeopardize her chances of becoming a biologic parent. Additionally, Mary would require donor sperm and procedures to fulfil her dream of becoming a mother:

> *...we used anonymous donor sperm and um I on the very first cycle I think I had a very very early miscarriage cause I had a briefly positive pregnancy test and negative the next day...I kinda went through some grieving and I said ok I am going to take Clomid* [a drug which induces ovulation] *the next cycle...I will do one more cycle with Clomid, and if I don't get pregnant then I'll think about going for um- to a specialist for a super-ovulation and I got pregnant that month* (Mary, I_1, p.2).

Mary was 40 years old when she became the biological mother of their first son; fifteen months later her partner delivered their second son. Sarah, the other lesbian woman in the study, did not intentionally choose to delay motherhood; she had tried for a long time on her own to conceive with donor sperm, but was unsuccessful, and as mentioned earlier, adoption as a single woman seemed unattainable to her at the time. Sarah never did achieve biological motherhood, and this is how she described what that realization was like for her:

> *I went to a couple of workshops about lesbians adopting, workshops about international adoption, and slowly, you know, I sort of...I experienced a sadness about not being able to get pregnant myself pretty quickly, and then dismissed it because that didn't mean I wouldn't be a mom* (Sarah, I_2, p.42).

Once she was in a stable relationship with a partner who agreed to start a family as well as be the biological mother, they lost a twin pregnancy, which was followed by surgery and later infertility drugs for her partner. Finally, her partner gave birth to a son when Sarah was 47 years old, and then twin girls when Sarah was 51.

The women's pre-understandings of their ability to conceive at age 39 or older were mostly negative, yet most were still prepared to wait until they were in the right relationship to conceive. Ten of the women expected reduced fertility because of their age, two did not, and one did not mention it. This contrasts with literature which cites that 89% of the 28-40-year old women who participated in the *High-Achieving*

Women, 2001 survey believed that Assisted Reproductive Technologies (ART) would "allow them to get pregnant deep into their forties" (Hewlett, 2002, p.114). Others, (Benzies, *et al.*, 2006; Tough, *et al.*, 2006) note that women may be aware that fertility decreases with age, but not how significantly it drops after age 35. All but two of the women in the current study considered that biological motherhood might not happen for them, and six women considered adoption as a possibility for becoming a mother. Several of the women were actually surprised by the ease with which they conceived, and it is noteworthy that eight of the women achieved pregnancy easily. As mentioned earlier, I had assumed that most of the women who would volunteer for this study would have had a problem with fertility, so my horizon shifted after hearing their stories, and the ease with which most of them conceived. This finding contrasts with literature that warns women over age 30 that "an insidious decline in fertility ensues and becomes evident in women older than 35 years" (Eisenberg, 1994, p.820). Each month, a healthy 40 year old woman has only a 5% chance of getting pregnant, which is 15% lower than when she was 30 years old (American Society for Reproductive Medicine [ASRM], 2003).

Not all of the women who participated in the current study conceived quite so easily or quickly. Five women experienced varying degrees of infertility, though only one woman cited infertility as the primary reason for delayed motherhood, and she ultimately did become a mother after nine years of attempting pregnancy. Peggy was one of two women who delayed motherhood by choice to advance her education and establish a career. She and her husband decided that they didn't want to pursue infertility "*stuff*" if unable to conceive, and were fine with adoption if unable to do it naturally. Peggy stated:

I was sort of flabbergasted when I heard the statistics of how difficult it can be to get pregnant once you're past 35 or something... (Peggy, I_2, p.1-2).

She remembered that conception "*took awhile*", but she felt lucky when she was able to deliver a son at age 42. She then adopted a daughter when she was 45. Monique delayed pregnancy for several years after marrying at age 40. She wanted some time to adjust to being married at an older age, and was 43 years old when she and her husband sought help with becoming pregnant. She was 44 when they adopted a baby girl:

> *We didn't do a lot of vigorous trying. We just know that nothing really happened...then we did the whole infertility and worked that up. Went through a couple rounds of the artificial insemination, but I knew... I could not go through the whole in-vitro business. The facts were pretty bleak about it being successful. I didn't feel very comfortable going through that kind of situation to get pregnant* (Monique, I_1, p.1).

Despite an awareness of potentially reduced fertility with advancing years, most of these women waited until they were in stable relationships before attempting to conceive. There was a real sense of rejection of artificial means (beyond insemination) to achieve pregnancy, and more willingness to consider adoption if necessary. This may have been a result of the women's awareness of the limited options for infertility treatment for older women, and the reduced rates of conception, even with assisted reproduction technologies (ART), but this was not a dialogue I pursued with the women as this was not the focus of the study. Among the five women who experienced infertility, four did not use ART, and two of those women never achieved a pregnancy. ART includes advanced techniques to produce conception, like in vitro fertilization (IVF), or gamete intra-Fallopian transfer (GIFT), and usually involves using powerful hormonal medication to stimulate the ovaries resulting in multiple follicle development (Wang, *et al.*, 2004). The one woman who did utilize ART at an older age conceived and became a biological mother. Leslie was

a nurse with an advance practice degree. She was the only woman in the study who ventured into fertility assistance beyond insemination and fertility drugs after age 40. She was 49 years old and the mother of a 6 year old daughter at the time of her interviews. She spoke of her fantasy as a young woman of getting married and having kids, one that she thought might never happen. She employed both fertility drugs and procedures, finally conceiving with in vitro fertilization (IVF).

Forbus (2005) notes that there is not much that ART can do for infertility related to older women over 40. Pregnancy rates are low despite advanced infertility therapies like ovarian hyper-stimulation and in vitro fertilization (IVF), (ASRM, 2005). Reasons for infertility among older women are different than for younger women. Miller *et al.* (1999) noted a trend toward more unexplained infertility for women aged 40-45; explained causes were uterine factors (fibroids), male factor infertility (older partners), and luteal phase deficiencies. Maheshwari (2008) found that women older than 35 are more likely to experience unexplained infertility. In a study of couples who were not using contraception, the average age of the last pregnancy ranged from age 39-42 (ASRM, 2005) which suggests that natural conception beyond age 42 is less likely to occur.

Following conception, six of the eleven women who achieved pregnancy experienced at least one spontaneous abortion, also known as miscarriage to the lay public. Rosie experienced nine years of infertility, and two miscarriages before delivering a daughter at age 39. She pretended she was not pregnant for the first three months when carrying her daughter because she was afraid she might lose yet another desired child:

> *So I thought oh I just can't have another miscarriage, so I'm just going to pretend I'm not* [pregnant] *for three months until we hit that mark* [the gestational week that she lost the other pregnancies]. *And he* [her husband]

> *said alright whatever you want, and til my birthday, that's when I was 39, we never talked about it. I threw up every morning but we didn't talk about it* (Rosie, I_1, p.1).

Florence also kept her second pregnancy a secret, because after one miscarriage, she was afraid that she was going to lose another baby. Abbey had three miscarriages, before achieving motherhood, and three of the other women in the study each had one. The fear of loss was prominent even for those women who did not miscarry. Shanny was six weeks pregnant with her first when she started to bleed and worried that she might lose her baby. She successfully carried that pregnancy to term, delivering a son when she was close to forty. The literature on miscarriage notes that ten to fifteen percent of pregnancies are lost prior to twenty-four weeks, and that a miscarriage during a first pregnancy can carry some increased risk for those women in a subsequent pregnancy. Obstetrical complications including threatened miscarriage, induced labour, post postpartum hemorrhage, and preterm delivery are higher for women who had an initial miscarriage (Bhattacharya *et al.*, 2008). The miscarriage rate for a 20 year old is about ten percent, and increases for women age 45 or older to more than ninety percent. This contributes to the fertility issues that older women encounter (Heffner, 2004), and provides a possible explanation for the increased incidence of miscarriage among the women in the current study. It is probably more noteworthy that the other five women who became pregnant did not miscarry, which represents a lower incidence than stated in the literature. However, this should be viewed with caution as I only sought to include women who had achieved first time motherhood at age 40 or older, so I engaged a somewhat biased sample. Spontaneous abortion among assisted reproductive technology pregnancies are reported to be higher than naturally conceived pregnancies, usually in the range of 18-30%, but this figure may be misleading. Women who are receiving ART are under intense scrutiny,

so documentation of losses may be more accurate. Additionally, women utilizing ART may have factors which predispose them to higher rates of spontaneous loss (Wang, *et al.*, 2004).

All but two of the women achieved biological motherhood, and all of the women eventually became mothers. The variety of ways and means with which they accomplished this is discussed next.

"A Lot of Ways to Become a Parent": Paths to Motherhood

When faced with the possibility that they might not become biological mothers, the women explored alternative means to achieve motherhood. Their pre-understandings were that they did have options open to them as an alternative to 'natural conception', and for several, the option to remain childless was initially considered. A range of options were pursued which included adoption, alternative insemination, IVF, and for two women, lesbian partnerships. The original proposal for this study did not consider adoptive mothers or lesbian mothers. I do not believe I had any prejudice against either of these groups of mothers, although I would admit to having limited experience as a nurse caring for them. My horizon was initially limited, and I was surprised and grateful that women self-selected into the study who could contribute the experiences of mothers who adopt and mothers who are in lesbian relationships.

Six of the thirteen women considered adoption as a possible path to motherhood, and three of these women ultimately did adopt a child. Peggy discovered that after delaying motherhood to pursue her education and career, she was not getting pregnant. She and her husband did not want to pursue infertility assistance, and were fine with the adoption option if necessary. She gave birth to a son when she was 42 years old, and they adopted a daughter when their son was three years old. Roxanne

gave birth to a son at age 42, followed by adoption of a three year old daughter when she was 47. She said:

> *We wanted to have another child- I didn't want to be pregnant again at 45 um so we thought we'd adopt*..... (Roxanne, I_1, page 13).

She elaborated more about her desire to adopt during her second interview. This is what she said:

> *I'd always wanted to adopt, because I wasn't exactly sure that I would ever get married so adoption was always my first thought as I got into my 30's and realised there weren't a lot of good men left, I might end up alone cause I wasn't going to get into a bad marriage just to have children. So having been able to do that as well is just a gift for me to have had children in both ways to experience what that is like for people that have children late in life and then choose the adoption route is the way to go* (Roxanne, I_2 p. 26).

Monique was one of two women who never achieved a pregnancy. Her husband really wanted to have a baby, and she became more interested because of his enthusiasm. She experienced some infertility, participated in unsuccessful intrauterine inseminations, but did not want to go as far as in-vitro fertilization. She and her husband adopted a baby girl when she was 44, and this is what she had to say about her initial experience:

> *I always knew I wanted a little girl* from [abroad], *way back when*... ..... *Anyway, my husband took the paperwork on. He became, he is like a second mother. Took that on, and then we waited a year, then went to* [name of country]. *It was GREAT! I mean I think in the adoption world, you get a couple of weeks reprieve because you get the baby, you're in a nice HOTEL, you eat out, you know. You can send your laundry out. For two weeks you don't have anything except the support of other new parents who have also adopted. Actually it was a good experience* (Monique, I_1, p.2).

Adoption was not an option for all of the women. Leslie was 43 when she gave birth to her daughter. She experienced infertility, and adoption was not something her boyfriend would consider, so she pursued Assisted Reproductive Technologies. Her first pregnancy happened quickly, but resulted in a loss which was devastating for her. Despite her partner's ambivalence about having children, she continued on until she

conceived her only child. This was how she described her life while trying to conceive, while at the same time she lost her position as a manager:

> *I feel I really can't go anywhere* [to start a new job] *because I do have some flexibility here to do the infertility treatments and where I'm going through all this stuff at least I don't have to do it in a new environment and say well I'm going to be trying to get pregnant and I have infertility problems so I'm going to be having to come in late or leaving early or I'm taking a day off here. You know, you can't go into a new job like that* (Leslie, I_1, p.12).

Mary was in a stable lesbian relationship, and her partner was younger, so they had options that other heterosexual couples did not. Mary admits to going through some soul searching, and realised that she might never become a biologic parent because of her age, but that "*life would go on*". She really wanted to experience pregnancy because of her own professional work as a provider for women's health, but she recognised that there are lots of ways to become a parent. She became a biological mother through alternative insemination using donor sperm, and then her partner also had a baby; they have two sons by the same donor. Similarly, Sarah experienced sadness about not being able to get pregnant herself, but recognised that there were other ways to achieve motherhood, including the possibility of adoption. When she achieved a stable relationship with her lesbian partner, there was some indication that the partner might be interested in having a child. Sarah remained doubtful until her partner actually started inseminations. They have an 8 year old son and twin daughters age 5, with Sarah's brother serving as the sperm donor for all of the children:

> *Well, we... I think we had been together five years, but probably within the first two years of being together we started – I had wanted to have children and TRIED for a long time on my own BEFORE we were together. Then once we got together, [she] said that she had also wanted to have a family and so we spent a couple of years just getting our feet on the ground together and just talking about it, a little here, a little there, but I really kind of... I really felt real strongly I wanted it to be her choice and not anything that she was doing influenced by my desires. And she REASSURED me time and time again that*

> *that certainly was her idea, and so then we came up with the idea of asking my brother to be the donor* (Sarah, I_1, p.1).

Several of the women voiced how important it was for them to have their own biological child. Five of the women were mothering stepchildren, and only one of those five gave any consideration to adoption. Shanny became step-mother to two children when she married her husband. She wanted children of her own, and did not want to adopt. After minimum discussion with her husband about having children together, she conceived and delivered her first baby when she was almost 40, and the second when she was 41. She articulated how the experience of mothering her own children was different than mothering someone else's children:

> *I can honestly say, I was very fortunate I raised my stepdaughters. I have a fairly good relationship with both of them. They lived in the same house as me. They went to visit their mother on weekends. We raised them, but very different experience. No one can ever say it's the same, because when they are your biological children...most people say that is not true and I say no it is true, for me. Maybe not for you. Raising someone else's children, and I love them and I've cared for them. I've taken care of them when they are sick and when they're throwing up. But it's not the same as having your own two kids. It's just not the same. I honestly say that. People sometimes don't like to hear that, but it's true* (Shanny, I_1, p.35).

Shanny's perception that mothering step-children is different from mothering one's own biological children is in line with the literature on step-parenting, which in particular defines the stepmother/stepdaughter relationship as "the most complex of all family roles" (Hart, 2009, p.128). Hart's review of the literature found these particular relationships characterized by "less affection, less respect, less acceptance and higher levels of conflict and stress than other stepparent-child relationships" (Hart, 2009, p.129). As Shanny revealed in the excerpt above, she was raising someone else's children, and their biological mother was still actively involved, which placed her maternal status at *second tier* (Hart, 2009) despite her best efforts to mother her husband's children. It is understandable that women who want a full mothering experience, would want to have their own children despite having step-children. Miriam was

one of the six women who considered adoption, but she too went on to have her own biological child. She delivered her only child when she was 41 years old, and has since separated from the father of her son. She felt her life was not complete without her own child:

> *But I remember having a lot of baby envy and feeling that, you know, my life wasn't complete, you know, without a kid. And I wanted my OWN, you know? I mean, I could have adopted. And you know, if my situation hadn't been so volatile, you know, maybe I would have,* [adopted another after having her son], *but you know, now it's just not a good idea* (Miriam, I_2, p.32).

As evidenced by these women, motherhood, and parenting can be achieved through several paths, including normal biology, adoption, IVF, alternative [uterine] insemination, and through lesbian partnerships. Bartholet (1993) equates adoption with choice, and taking back control of the goal to become a parent. The author believes adoption in the 1980s and 90s in the USA was constructed as a "last resort parenting choice, vastly inferior to biologic parenting" (Bartholet, 1993, p. xxii). This was not the case for three of the women in the current study. Two of them chose adoption over a second pregnancy which could have produced another biological child, and one woman opted for adoption because she did not want to pursue in-vitro fertilization. Three other women considered adoption and this is consistent with the literature which cites that more women will consider adoption than those who actually do it (Fontenot, 2007). Like two of the women in the current study, the author Bartholet experienced both biological and adoptive motherhood. She described a system in the 90s in which older parents were discriminated against, by precluding them from adopting children 35 or 40 years younger than themselves. She pointed out that despite society making adoption difficult and politically complex, for women, "adoption can be seen as an important part of reproductive autonomy" (Bartholet, 1993, p. xxi).

As recently as the 1980s in the USA, the idea of a lesbian becoming a mother was quite rare, but by the mid 90s, this was much more of a possibility (Martin, 1993). In the mid 90s, most lesbian mothers were raising children conceived in the context of a heterosexual relationship, and *came out* as lesbians after the child's birth. A more recent trend in the past fifteen years has been toward lesbian women who are already *out,* declaring their desire to become mothers through insemination, adoption or foster care (Erwin, 2007). The availability of donor insemination in the last twenty-five years, has led some to suggest there has been a *baby boom* among lesbians (Gartrell *et al.*, 1996). Some lesbian women will choose single parenting, but as Sarah discovered, the economics of only one income was a barrier for adoption, and insemination did not work for her. At one time in the United States, adoption and foster care was not even open to lesbian women, and particularly single women. Co-mother adoptions are viewed more favorably now so that in the event of relationship failure, there are two mothers to share responsibility for the child/children (Gartrell *et al.*, 2000). Despite more opportunities for lesbian couples, adoption is still not an option in many states in the USA. The state of Florida only recently lifted a state law that prevented lesbians and gay men from adopting (Cates, 2008).

Some lesbians choose to have heterosexual intercourse with men to achieve pregnancy, but neither of the women in this current study mentioned this as a possible option for them. Both Sarah and Mary discussed a unique option for motherhood that heterosexual women do not have. If they themselves could not be the biological mother because of their older age, they had younger partners who possibly could. This is consistent with others (Martin, 1993; Renaud, 2007) who note unique dimensions for planning conception among lesbian mothers, including which partner is going to be the biological mother. Most lesbian women who desire motherhood choose to

conceive via "alternative insemination" (Martin, 1993, p, 10) a term used in an attempt to avoid use of the more offensive term 'artificial insemination'. The lesbian women in the current study chose the same sperm donor (in each case) to inseminate both pregnancies. One was the brother of the partner who was not the biological mother, with the intent that there would be a family connection to the child, and some genetic traits passed along. This choice is consistent with Martin's (1993) work as a psychotherapist and author who notes that when a family member, usually a brother, is the donor, the child may then resemble both women. It results in the non-biological mother becoming the children's aunt whilst the father is also the children's uncle. The other lesbian woman in the current study chose the same anonymous donor for both children through a sperm bank, so their children are actually half-brothers. The donor was reputed to be a successful donor in that he has 'fathered' twelve other children through the sperm bank who are technically step-siblings to each other. These findings agree with what is known about lesbian mothers tendencies to choose known donors so that children can contact the donor at a later time, and even sperm bank policies that allow 18 years olds to seek out their donors (Renaud, 2007). Martin (1993) raised the question about the importance of biology to the establishment of parental bonds, and the issue of whether the man is merely a donor, or will play a father role in the child's life at some point. Noble (1987) argued passionately that biology creates a genetic connection between the father and child, something she calls *cellular consciousness* which binds them together. Martin (1993, p.82) warns lesbian mothers to expect their child to "want a relationship, at some point, with his or her biological father". In an effort to prevent the sperm donor from becoming too important a connection, some lesbian mothers intentionally choose different donors

when having more than one child. Others believe a strong biological connection between siblings offers advantages, both emotionally and legally.

Regardless of which path to motherhood each woman followed, all but two of the women experienced at least one pregnancy which resulted in the birth of a baby. Those who successfully conceived shared their experiences of being first-time older pregnant women in the American health care system. Their perceptions of being treated differently as 'high risk' or 'elderly primiparous' women conflicted with the image they had of themselves as healthy women, and this paradox is discussed in the next section. This tendency by providers to label older women during pregnancy added stress and anxiety to an experience the women considered to be a *gift* or a *gift from God.*

"*Unknown Territory*": Pregnancy After Age 39

Eleven of the thirteen women experienced at least one pregnancy which resulted in the birth of a baby. One of the women described herself as the *"blissful pregnant woman"*, and felt she was on a "*path of discovery*" when she was pregnant. Others described themselves as "*deliriously happy, blessed to have conceived, overwhelmed with joy, very excited, and lucky"*. Some thought the pregnancy and child was *a gift,* and for some it was *a gift from God.* Among the women who experienced a pregnancy, only one described any major or chronic health issues before she got pregnant, and only one woman cited a pregnancy complication (gestational diabetes). Despite a feeling of well-being by most of the women during their pregnancies, four of the eleven women perceived that they were treated differently by their providers because they were older. These women were aware of their *high risk* status due to their age, and some of them perceived anxiety on the part of their providers, which in turn made them nervous. Susan said she was considered high risk because she was 40,

and also because she had gestational diabetes which put her into another high risk category. Miriam was 41 when she delivered her son. Her perception was that she was treated by her providers like she had a chronic illness for nine months. She found the ultrasounds, visits and blood work, very nerve-wracking and scary. She suggested that pregnant women age 40 and older must be so unusual that it is like they have wandered into "*unknown territory*" for which there are no maps or guideposts:

> *And it's just... it's scary, it's just SCARY, you know, going through it and being old, and they make you feel like, you know ... it's like over 35 I think to 40 is one age group and then like the 40 and up, it's like, you know, unknown territory* (Miriam, I_1, p.5).

Florence was 44 when she delivered her daughter. She chose to work with a midwife during her pregnancy, who she felt would be less of an interventionist. She felt her choice to have a home birth alienated her from the medical community, and she advocated for change within the obstetrical community so that women can have the benefit of a low intervention birth experience with back-up from the medical experts. This is her perception of how she was treated during her pregnancy:

> *So I ended up working with a midwife, and I don't think she treated me differently because I was older. I think if I stuck with* [physicians], *they would have done a few things. They would have recommended perhaps that I be on some hormones. They would have looked at some more things, I think if I had gone with them. I ended up working with Cheryl, a midwife. I was pretty pleased to be working with her, yet it felt a little hard NOT to have a more traditional medical community. We are kind of in a strange position if you want to do a home birth, you often feel alienated from the medical community. That is something that has to be worked out. I think that I still see that as kind of a problem in our society* (Florence, I_1, p.2-3).

Mary was in a unique position during her pregnancy at age 40. As a provider herself, she became personally aware during her pregnancy of how the physician or midwife's level of anxiety can be transmitted to the patient's experience. In her own practice, she believes it is more about the health of a woman, and not necessarily her age that influences the course and outcome of a pregnancy. She voiced a personal preference

for working with older healthy pregnant women over younger women who are not healthy:

> *I found out after the baby was born that* [one of the midwives]... *was terrified for me the entire pregnancy. She was sure I was going to get really sick and have high blood pressure and just have a terrible time and she didn't tell me that until the end but it's really funny you know ...if the physicians are nervous like that and they trans- they transmit that; however they do it to the patients that's just going to create anxiety, so it's like a self fulfiling prophecy...* (Mary, I_1, p.17).

She went on to share her own philosophy of care for older pregnant women in her practice:

> *I took care of a lot of older women in pregnancy, I think because they appreciated that I said alright lets look at your general health and we'll deal with the chromosome issue and then after that I'm going treat you like everybody else ...and I think now in the current day and age you have to look at people's you know there's biologic age and then there's true age and once you define the known risk factors which were truly chromosomal everything else you know probably a little higher incidence of blood pressure, but you're checking everybody for blood pressure. You know so I think that there's provider bias in that* (Mary, I_1, p.17).

In contrast, not all of the women perceived additional concern from their providers, or felt they were treated differently than a younger pregnant woman. Jackie was 40 when her daughter was born. She considered herself in excellent physical condition, and was only a "*little concerned*" about complications related to her age. She felt her provider did not seem concerned because she was older, and though he did discuss her options for genetic testing, he did not try to convince her to have an amniocentesis. Rosie denied any pregnancy complications, and described her pregnancy as if "*it was a dream*". She did not find her age a limitation for having a healthy and uncomplicated pregnancy, and worked at a physically demanding job until the day she delivered. There was a real sense of pride when she described her pregnancy at age 39:

> *Obviously I could have carried many kids; I carried her, I worked at* [name of company] *the day she was born. I had no... I guess 39- that's pretty good*

having no complications. Nothing was wrong with me, I did it great... (Rosie, I_1, p.26).

These women were healthy, yet almost all of them were aware of concerns related to their age, and some were treated as high risk or like they were ill during their pregnancies. They did not like the labels such as *elderly primip, advanced maternal age, or at risk pregnancy* assigned to them during their pregnancy, and felt anxious when their providers were anxious. Several chose midwifery care because it was their pre-understanding that the midwives would be less intervening, and would treat them like a normal pregnant woman. This finding is consistent with the advice of Goetzl and Harford (2005) who alert women over the age of 35 that midwives will not automatically assign them to high risk status just because of their age. The perceptions of the women were consistent with commonly held beliefs and practices of obstetric nurses, physicians and some midwives that women over 35 are considered to be at advanced maternal age, and therefore at risk for adverse pregnancy and neonatal outcomes because of their age. As a member of this professional group, I confess that though I never approved of the labels assigned to older pregnant women, I have been bombarded during my nursing career with literature that has pointed to the increased risks for mother and foetus related to maternal age. Carolan (2003, p.19) notes that "management of pregnancy in women older than age 35 centers on increased surveillance and a high-risk status". First time pregnant women over 35 have been referred to as *elderly primiparas*, a "term which carries a negative undertone suggesting not only risk but of failing to be 'on-time'" (Berryman *et al.*, 1999, p.108). The authors note that in the 1980s, a woman having her first baby at age 30 used to be considered *elderly*. Thirty-five became the new "watershed of later pregnancy," when the statistical odds (about ½ percent) of "having a baby with Down's Syndrome is equal to having a miscarriage as a result of amniocentesis" (Nagle, 2002, p.179).

A review of the lay literature reveals the liberal use of language which connotes risk and invites fear as recently as 1994. In First Time Mothers Last Chance Babies: Parenting at 35+ (Cain, 1994, p.41), the author states that "while all pregnant women face increased risks to their health, the older pregnant woman faces even more risks". Similarly, in Midlife Motherhood: A Woman-to-Woman Guide to Pregnancy and Parenting (Blackstone-Ford, 2002), in the section entitled '*I'm High Risk?: Medical Facts'*, the author uses the word *high risk* six times, and *risks* five times on slightly more than one page of text. Four pages later, the author reassures the reader that *More Risk No Longer Means High Risk*, but does so in fewer than nine complete lines.

The professional literature has been replete with warnings about delaying pregnancy to after age 35, and has primarily focused on risk factors for the mother and foetus, pregnancy and fertility issues, complications of labour and delivery, and long term health consequences (Cunningham & Leveno, 1995; Abu-Heija *et al.*, 1999; Stein, 2000; Astolfi & Zonta, 2002; Alonzo, 2002; Tough *et al.*, 2002). However, a recent shift in the professional literature has begun question the long held beliefs and practices about midlife pregnancy. Windridge and Berryman's (1999) study of labour and delivery records found few adverse affects attributable to maternal age. Carolan and Nelson (2007, p.536) point out that the "actual statistics relating to infant morbidity do not significantly differ between the groups", yet there is a contradiction in the literature which juxtaposes poor neonatal outcomes with unaffected outcomes due to maternal age. Joseph *et al.* (2005, p.1417) counter that despite higher rates of perinatal mortality for the infants of older mothers, "perinatal death rates are at their lowest point historically and women with healthy lifestyles and without chronic disease have very low absolute rates of perinatal mortality.....[therefore] most older mothers will have the desired pregnancy outcome".

The findings from the present study support a recent paradigm shift to reassess the long-held assumptions and assignation of risk for older mothers (Windridge & Berryman, 1999; Carolan, 2003; Carolan & Nelson, 2007; Suplee *et al.*, 2007). Lavin and Wood (1998, p.36) differentiate between using the terms 'more at risk' and 'high risk', when describing potential complications for midlife pregnant women, and add that "...healthy midlife women shouldn't expect any complications...". Berryman *et al.* (1999) admonish the use of previously assigned labels for older pregnant women, and suggest we turn our attention to a woman's health and medical history as predictors of risk. This new shift in thinking about midlife pregnancy can also be observed in some of the more recent lay literature. There is a distinct change in tone and language used in Moore and De Costa's book Pregnancy and Parenting after Thirty-Five (2002) written by physicians who are also women who have experienced midlife mothering. They speak realistically of the challenges of midlife pregnancy and mothering, without the fear inducing labels and references to high risk pregnancy so common in older literature. Carolan (2003) suggests that changing demographics and socioeconomic status of older mothers place these women at significantly lower risk than their counterparts of 20 years ago. Women have achieved higher levels of education, reducing the gap that has existed between men and women. Twenty-eight percent of women aged 25 and over have a bachelor's degree or higher, and seventy-three percent of these women are labour force participants (Women's Bureau, 2007). Older mothers tend to be married, well educated and financially stable (Mercer,1986; Winslow,1987; Reece & Harkless,1996; Bachu & O'Connell 2001; Martin *et al.*, 2002; Nelson, 2004; Joseph *et al.*, 2005; Carolan & Nelson, 2007). First-time birth rates for women in their late thirties and forties, who have college degrees have increased and these women have the lowest incidence of smoking during pregnancy.

In 2008, 60% of American women aged 16 and older were in the work force and women made up forty-six percent of the total work force in the United States (Women's Bureau, 2008). This represents almost a twenty percent increase in the civilian workforce than what existed in 1970 (U.S. Dept of Labor, 2008). Midlife women identify work and personal achievement as central to their life, along with family events, and this is in striking contrast to women from an earlier cohort (Woods, 1997). There seems to be a lag between the social context of more women conceiving and delivering healthy babies in their forties and the norms or parameters which the medical and nursing professions are still applying to these women. This stems back to an earlier time period when mothers having babies in midlife many have experienced a very different set of circumstances and health status than the women in this study. This demonstrates the importance of studies like this one, to capture women's experiences and enable health care providers to refocus or recalibrate the frameworks and norms they apply to first- time midlife mothers.

Each woman in the current study was aware of concerns held or raised by her health care provider related to her age, for herself, and/or for the health of her baby. There were various opportunities to become conditioned to her 'at-risk status', through dialogue with providers, hearing the labels applied to older pregnant women, reading the lay literature, enduring diagnostic tests, or stepping into the shadow of provider anxiety. Each woman addressed her concerns or those of her partner in her own unique way, yet there were some experiences they shared by virtue of being an older age at pregnancy, or by unknown factors introduced through adoption or insemination. Despite a veil of risk which continues to shroud pregnancies for women older than 35 and particularly after 40, some of the women felt strongly that their babies were healthy and declined the amniocentesis usually offered to older

pregnant women. Others in this study did not feel as confident about the health of their baby, and made different decisions about diagnostic testing. These conflicting levels of concern are represented in the next section.

***"Everything Was Going to be Fine" and "Just to Make Sure"*: Baby's Health**

The women's pre-understandings centered around whether they considered themselves healthy, whether they 'felt' the baby was healthy, what they thought their decision would be when offered genetic testing, and making "*the decision*" (to terminate or not) if they received results which indicated the baby may have an abnormality. As reported in the previous section they all considered themselves to be healthy, but expressed conflicting levels of confidence that their baby was going to be healthy. Six of the eleven women who experienced pregnancy verbalized feelings that their baby was going to be healthy; they reflected back on feeling an inner sense that the baby was okay. Although they were aware of concerns (their own or those of others) related to their older age, only two of those particular six women (and only three of the eleven) followed through with amniocentesis, a diagnostic test recommended by their health care providers. Amniocentesis is a procedure done between fifteen and twenty weeks gestation for the purpose of genetic diagnosis. Women who will be 35 or older at delivery are routinely offered this test in the United States as part of antenatal assessment for chromosomal and biochemical abnormalities (Olds *et al.*,2004) and pregnancy is now conceptualized as the time prior to prenatal testing and the time after results are received (Sandelowski & Bárroso, 2005). Test results are referred to as negative when they predict a good outcome and positive when they indicate a negative outcome or the presence of an abnormality, which can be very confusing to women and their partners. Two women proceeded with amniocentesis in spite of feeling that their baby was healthy. One of these said she

did it because her partner wanted to have it done, and the other just wanted to make sure the baby was okay. Rosie became pregnant after nine years of infertility, and she was 39 years old at the time of her caesarean section. Like the others, Rosie considered herself healthy, physically fit, and though she sensed that the baby was fine, she was one of the women who decided to proceed with amniocentesis "*just to make sure*":

> *There's no way, I don't know if it was God or fate or anything, I just felt that life was not ...that everything was going to be fine with her. Mom was sick and dying, but, this was not her replacement, but this is how life goes on, and I just felt in that respect... we had the amnio just to make sure. But even as the months went by I just knew she was fine. I knew she'd be perfect and yeah it was peaceful, I knew that everything was ok* (Rosie, I_2, p.26).

Mary spoke about the decisions women face once they receive results from the amniocentesis. As a provider of care to pregnant women in the past, she stressed that women do not always do what they think they will do prior to having prenatal diagnostic testing. She herself thought that she would terminate if the baby had Down's syndrome, but once she found herself pregnant, she reconsidered. Preferring to decline the amniocentesis, she made a decision to respect the feelings of her lesbian partner who wanted her to proceed with testing:

> *... I'd always decided that I would have an amnio because of my age and we decided that as a couple, and then once I got pregnant I was like, I don't want to have an amnio. I mean I also always thought if I had a baby with Down's syndrome I would terminate the pregnancy and once I was pregnant I don't know if I COULD HAVE... But I had the amnio, mostly I would have skipped the amino actually but my partner wasn't comfortable with that...*(Mary, I_1, p.16).

Those who declined the test felt they would not have terminated the pregnancy even if something was wrong with the baby. Two of these women referred to their children as

being a *gift* or *a gift from God.* Shanny was almost 40 years old when her first child was born, yet she declined amniocentesis during both of her pregnancies because she felt strongly that her babies would be okay. This is what she said about amniocentesis:

> *The interesting thing was I had no fear about birth defects and anything going wrong. I thought about amniocentesis, and I didn't do it. I felt that safe. I thought if this is happening to me now, there is a reason for it. I wouldn't have done anything anyway should I have found out something was wrong. It just wouldn't be something I would do. It was always in the back of my head, you know, you're 42 having these babies. You could, but would not, just didn't give into those thoughts. I just kept telling myself, this is going to be perfectly fine, wonderful* (Shanny, I_1, p.34).

Jackie was 46 and Florence was 44 years old when their daughters were born. They considered themselves healthy and in excellent physical condition at the time of their pregnancies and both had considered amniocentesis, but decided against it. Like Shanny, neither Jackie nor Florence would have terminated the pregnancy even if there was something wrong with the baby. In the next excerpt, Jackie responded to a question about how she had felt about the health of her baby, in the context of being a pregnant woman over age 35, and hearing the labels 'older primip' or 'high risk' used by her providers:

> *I felt I was very positive. I was in excellent physical condition because I had worked out for ten years at a gym and I was running every day, like six miles a day, so I was in physical, excellent physical condition and they didn't really have any concerns. I never thought that way, like negative about it...I didn't do it, no. I just, um, my doctor, like I said he's very good, very conservative, that's what I liked about him, and he said well, these are your options, God forbid if we do the amnio and it shows something, he says really what it is it's an out for you to terminate that pregnancy, would you, if you found out the child was retarded or if anything was wrong, could you do that? And I said no, I wanted this baby. So to me, what was THE POINT, you know* (Jackie, I_2, p.25).

Florence responded to the question "Was anything done differently for you [during your pregnancy] because of your age?" She applauded the question, and confided that she did not want to have an amniocentesis, because she could not abort the child even

if he/she had a disability. Florence considered amniocentesis to be an invasion of a "*sacred space*", though she understands why some women choose to go through with it. Her own capacity for motherhood was so great, that she was even open to an experience in which her child might die after birth:

> *I ended up not wanting to have the... amnio done. I think partly because I knew that if the child had a disability I wasn't going to abort anyway. That comes from another thing, my Catholic background's part of it. I was raised catholic. I'm not a practicing catholic, but I still couldn't abort the baby.* [laughs] *Also as an occupational therapist, having worked a lot with people with disabilities I knew that if I had a child with a disability I would still want to be in there loving it, cherishing it. And then if it was going to DIE, if it was a child with a disability whereby it wasn't going to live long, that was okay for me too. I was really open to that whole disability experience. I also heard that... I knew someone personally who had an amnio and had a miscarriage after it. She was in her 40s too. That was enough to make me not want to go. My sister told me when she had the amnio that her daughter stuck her hand out to block the needle. I just think IT IS an invasion of that sacred space to some extent. I understand why people do it, and I do think it is a good thing, but for me personally I decided I didn't want to go that route. But we did the ultrasound, and the ultrasound looked really great. We did it LATER when I was in my last trimester so we could really see. She looked great. She didn't LOOK like she had any disabilities* (Florence, I_1, p.3-4).

Three women proceeded with amniocentesis, despite the fact that two of them also referred to their children as a *gift* or *gift from God.* One of these women shared a perspective that was very different from the others. She did not feel confident about the health of the baby. She confessed that she was very concerned, and along with her husband did not know if they could handle a child with special needs. She felt strongly that she could not celebrate her pregnancy until results from the amniocentesis were normal, and she kept her pregnancy a secret until the results of the amniocentesis were back:

> *...I did have an amnio done um and that was just really...we definitely were CONCERNED with all of that especially my husband and even when we adopted Eva, very concerned about health issues because you know I hate to say it but I feel we are SELFISH PEOPLE and we have very busy lives and we were concerned about how dealing with a child with special needs would, would impact us if we'd be able to HANDLE it you know so, so we in both*

cases we were really concerned about that and so when the results came back from the amnio I knew that was the biggest celebration for us that we actually didn't tell anybody that I was pregnant for a really long time because I was really scared about that and I, I was worried that if something were wrong what would we do? ...up until that time [amnio results], *I don't think I had that feeling that everything's going to be okay because I was I was concerned after hearing the statistics; but once we had that news then I you know he was always moving around and doing all the things that he should do. After that point I really didn't worry anymore* (Peggy, I_2, p.3).

Marteau *et al* (1989) suggest that women perceive that their physicians play an important role in the ultimate health of their foetus, until they receive one abnormal test result. The women in the current study were aware of heightened concern on the part of their providers regarding the health of their baby due to maternal age. This is consistent with the medical literature, and some of the literature for older pregnant women (Windridge & Berryman,1999; Berryman, *et al*, 1999). Others (Windridge & Berryman,1999; Carolan , 2005) note that it is women over 35 who have a heightened sense of vulnerability that their infants are at risk because of their age. Sun *et al.* (2008) discovered a prevailing sense of uncertainty among women aged 35 and older throughout their entire pregnancy because of the amniocentesis procedure. Several of the women in the current study kept their pregnancies secret until they received results from chromosomal diagnostic tests. This may be explained by levels of worry (Davies & Doran, 1982, anxiety (Marteau *et al.*, 1992), distress (Tercyak (2001), and guilt women feel before and after making prenatal choices (Gregg, 1993). Marteau *et al.* (1992) reported that only10 out of 18 women aged 38 or older at time of delivery proceeded with amniocentesis during their study. The women's choice to test or not test was reflective of their attitudes about the risk of miscarriage, and their attitudes toward terminating the pregnancy if the foetus had a defect. Similarly, women who choose amniocentesis have greater perceptions of risk to the health of the foetus, but more importantly they have more favourable attitudes toward having an abortion if

the foetus has a defect (Tercyak *et al.*, 2001). The current findings also support those of Davies and Doan (1982) who identified two factors women of 'advanced maternal age' worry about regarding amniocentesis: the risks of miscarriage, and concerns about harming the foetus.

This inherent fear of pregnancy loss may explain a recent and significant drop in the number of women over age 35 having amniocentesis in the state of Colorado. Henry *et al.*, (2008) found that in Colorado, there has been a concurrent rise in the number of babies born with Down's syndrome, and a significant divergence from the statistics for women younger than 35. The authors suggest that an increased reliance on less invasive antepartum screening methods has replaced diagnostic testing with its inherent risk of pregnancy loss. This over-reliance on screening creates some residual risk for missed cases of Down's syndrome among older women. The findings from the current study suggest that some older first time mothers are choosing not to risk their pregnancy by having diagnostic testing, because they would not terminate even if the foetus had a chromosomal abnormality such as Down's syndrome. This is in line with the dilemma that Sandelowski and Barroso (2005, p.307) call "the travesty of choosing after positive prenatal diagnosis". In an integrative review of qualitative studies related to receiving a positive prenatal diagnosis, Sandelowski and Barroso (2005) discovered that the most prevalent theme across studies was about the dilemma and consequences of making a choice, and this dilemma has been created by the availability of prenatal testing. Lupton (1999, p.143) pointed out that women embrace expert advice and fall into a "web of surveillance" during pregnancy which includes prenatal testing in an attempt to do everything possible to have a healthy baby. Seavilleklein (2009) recently argued that prenatal testing does not 'protect or promote women's autonomy' in most cases, and that the strongest determining factor which

influences women's decisions to proceed with screening are the recommendations of their health care providers. The author calls for an expanded view of choice which would allow women not only to accept or decline the offered option of testing, but participate in reflection on the *practice* that has given rise to the standard. These considerations in the context of a woman's life may have an important impact on her decision making processes (Seavilleklein, 2009). One of the paradoxes of prenatal testing and diagnosis is that women and their partners may be faced with making a decision about a pregnancy that was very much desired (Sandelowski & Borroso, 2005). As Peggy pointed out in the current study, she and her husband wanted to be parents, but were not sure about parenting a child with special needs. It was surprising to me that in the current study, eight of the eleven women who gave birth, chose not to have amniocentesis, because the information it would yield was not going to affect their decision to continue the pregnancy. They wanted these babies regardless of any problems which would be discovered through prenatal testing. My own pre-understandings were drawn from clinical practice in which women over age 35 usually made the decision to proceed with amniocentesis followed by termination for genetic abnormalities, but this was during the years prior to newer diagnostic screening tests now being offered to all women. Once again, the fusion of my own horizon with those of the women resulted in a clearer understanding of the women's experiences as older pregnant women.

Having explored the reports from the women regarding their experiences of mothering their first child, a number of women spoke about the dilemmas they faced with regard to having a second child. Although the majority of them wanted more than one child, this did not become a reality for many. This unfulfiled yearning is presented and discussed in the next category: *"More of a Fantasy"*: A Second Child.

"More of a Fantasy": A Second Child

Women in the study experienced uncertainty about whether to have a second child (in addition to their step-children). Pre-understandings revolved around whether they were too old, fears of having a child with a disability, worry that they might not be able to conceive or adopt a baby again, feeling like one child was enough, not feeling like they had a choice in the decision, and questioning whether they had enough emotional reserve to mother two children. Eight of the thirteen women wanted more than one child, yet only two women gave birth to a second child, and two adopted. Another two women were able to parent a second child through lesbian partnerships. Having more children was not always a unanimous desire, and four women expressed conflict with their spouses about the decision to have a second child. Two women did not want to mother a second child despite strong pressure from their spouses to have or adopt a second child. Conversely, one woman adamantly wanted a second child despite her husband's desire not to have any more children, and one woman said she had no choice in the decision.

Shanny was one of the two women who gave birth to two children. When her son was only six months old, she broached the idea of a second pregnancy with her husband. He was *not* all for it, and even her physicians recommended that she wait another six months, but she was anxious that she might not get pregnant again. This is what she said about how determined she was to have another biological child:

> *...I was adamant that I was going to have another baby. So we had a couple of months of discussion which was not a pleasant time, because he did not really want another child, I really did...But I thought I really don't have six months to wait and then I thought I'm not going to get pregnant again. It's not going to happen. What are the chances of this happening again, so I went out and got an ovulation kit, and I brought it home once my husband made the concession to move forward with me. I think my husband thought the same thing; she'll never get pregnant again. You know, we're done here. It's not*

> *going to happen, and I bring home my ovulation kit because I think I better work on this and he said you can put that away..... Anyway the very first attempt we made, I was pregnant again* (Shanny, I_1, p.5).

Of the eight women who wanted another child, two chose to adopt. Roxanne wanted a second child but not another pregnancy at age 45. She adopted a three year old girl when she was 47:

> *So having been able to do that* [adopt] *as well is just a gift for me to have had children in both ways to experience what that is like for people that have children late in life and then choose the adoption route is the way to go* (Roxanne, I_2, p.26).

Peggy shared the concern she had about the health of her baby during her first pregnancy, and that worry was present even when they decided to adopt their second child, a daughter. Rosie also wished for more children, and like Peggy, she was uncertain about the possibility of having a child who might have problems:

> *I worry about having a child with Down's syndrome, or you have the amnio and something's wrong, making that decision. I don't want to make that decision, and I don't think I'd want to be 45 and having, no I don't want to have another child at this late stage. We have Kayla, she's healthy. If I'd had another child right after her, that's what I wanted...so if you were doing it to have a family, you know I wanted them closer, and plus I'm feeling too old* (Rosie, I_2, p.25).

Two women did give birth to children with disabilities. Abbey gave birth to her first son when she was 40 years old. She did not suspect anything was wrong until he was almost three years old and not talking, at which point they had him evaluated. He was diagnosed with Asperger's syndrome, a non-verbal learning disability, which is on the Autism Spectrum. Despite the challenges of mothering her first son, and unaware of his pending diagnosis, Abbey delivered a second son twenty months later who was also affected by Asperger's Syndrome. Susan was 40 when her daughter was born. She reported that her daughter always seemed really bright, yet always seemed

difficult at the same time. She too was diagnosed with Asperger's syndrome when she was eight years old:

> *She doesn't have a disability as some kids could, so I've spent a lot of time researching online what it is, and how to work with her...at the same time trying to educate the teachers and the professionals that work with her that have no clue as to what non-verbal disability is-which is another disadvantage you know if she had something that was better known then it would be much easier to say oh, she has this, and they know how to deal with that* (Susan, I_1, p.4).

Unlike Abbey, Susan did not have any more children, nor did she discuss whether she had contemplated having another after her daughter was born. I was surprised to discover that two of the thirteen women were mothering children with an Autism Spectrum Disorder (ASD). I was not aware of the link between maternal age and autism as opposed to other conditions such as Down's syndrome, but advanced maternal age has been attributed to increased risk for autism. Women aged 40 and older have "a 30 percent increase in risk for having a child with autism (1 in 123) when compared to mothers between the ages of 25 and 29 (1 in 156)". A paternal age of 40 or older has had "up to a 50 percent increased risk of having a child with autism (1 in 116), when compared to their 25-29-year-old peers (1 in 176)" (Kaiser Permanente, 2007, p.1).

As discussed in a previous section, the two lesbian mothers had options open to them that were not available to the other women in the study. A relationship in which either or both lesbian partners can be a biological mother is a distinct advantage unique to lesbian families, though one partner may have to forfeit becoming the biological parent. Sarah was 56 when her twin daughters were born. Her younger lesbian partner delivered the girls three years after giving birth to their first child. Mary's partner reminded her that they wanted to have two children close together in

age. Her partner got pregnant during the second month of trying, and through use of the same sperm donor; she gave birth fifteen months after Mary's son was born:

> *We had the advantage of having them close together without having to worry about the biology of one person giving birth too close together. A lot of our friends say they wish their husbands could have had the second baby* (Mary, I_1, p.3).

Leslie wanted another, but felt she did not have any choice in the decision to have a second child. Her boyfriend was not interested in adopting, and she unsuccessfully tried IVF again when she was 45 years old. At the time of the interview, she had recently had a light period, and experienced some nausea and wondered if she might be pregnant again:

> *...it was probably a fantasy thing, I mean after going through all the fertility, and fertility stuff thinking you know wouldn't that be the thing. I'll be this person who goes through all this, has a kid at 43 and then has one of those change of life babies wouldn't that be you know but, it's probably more of a fantasy* (Leslie, I_2, p.42).

It turned out that she was not pregnant. The women had a strong desire to achieve motherhood, yet just slightly more than half of them wanted a second child. As noted earlier in this chapter all of the women in the study were well educated beyond high school, with some earning advanced degrees. Although this usually correlates with a desire for fewer children, it also usually results in giving birth to fewer children (Martin *et al.*, 2007), as was noted here. At the conclusion of the interviews, seven of the thirteen women were mothering only one child.

Two women did not want to have a second child. Jackie was 50, and her husband wanted to have another child, and though she admitted to sometimes wondering about it, she firmly stated:

> *No, there's absolutely no way. No way, one is enough with her...he's even wanted to adopt* (Jackie, I_1, p.17).

Monique struggled with the decision to adopt a second child at age 47. Her husband wanted another, but she was not sure she had the emotional reserves to mother a second child. She felt conflicted because she wondered if a sibling would be beneficial to her daughter. Her additional concerns were that the longer they waited and the older she got, their chances of adopting an infant would go down, and she had concerns about adopting an older child (toddler) away from foster parents:

> *So, I think a lot about that. I don't know if I want to sacrifice my ability to do one* [child] *well to do two marginal* (Monique, I_1, p.15).

We explored this topic in more depth during her second interview. She admitted that she did not set out to have an only child, but the combination of being an older mother, in addition to the demands of her career, and caring for aging sick parents raised doubts about her emotional capacity to mother another child:

> *...I think it's about capacity, whether you have emotional capacity to do it. I never wanted really to have an only child, but, I think with my parents being ill, the practice growing, the challenges on my marriage and all that its placed, I don't know if another child would really break the camel's back, you know...I think if I were ten years younger, my parents were healthy, you know, my husband had a job he liked, and we had a nanny,* [laughs] *a bigger house, you know, then it might be possible...* (Monique, I_2, p.37-38).

Monique's concerns about what the future held for her parents and the impact this would have on her own life were important issues she considered along with her responsibilities as a primary caregiver for her daughter. She scripted a fantasy in which she could mother another child and it included being a younger mother, employing a nanny, having a larger house, healthy parents and being married to a man who enjoyed his own job.

Summary

This chapter's theme *Achieving First-Time Motherhood at Midlife* illuminated the meaning of the women's experiences as they sought to become mothers for the

first time at age 39 or older. Meaning was mutually negotiated through a participative dialogue with the women, and simultaneously with the text. The findings were presented as categories which supported the theme, in the order in which they emerged, and represent the shared voices of the women as well as the unique perspectives of those women whose experiences were different from the others.

The first category, "*Not by Choice*": Delayed Motherhood, illustrated the desire of all thirteen women to become mothers. These women did not choose to wait until age 39 or 40 to become mothers for the first time, and the primary reason they cited for delayed motherhood was lack of the right relationship earlier in their lives. The category *"It Didn't Take That Long"*: Conception, was an interpretation of the various experiences of these older women as they attempted to conceive a pregnancy. Though most of the women expected some reduction in fertility due to their age, eight of the women were surprised when they conceived with relative ease. Ultimately, motherhood was achieved through several different modalities, including normal biology, adoption, alternative insemination, in vitro fertilization, and lesbian partnerships. These were expressed by the category *"A Lot of Ways to Become a Parent*": Paths to Motherhood. Despite feelings of well-being by most of the women during their pregnancies, they perceived that they were considered high risk and treated differently than younger pregnant women by their health-care providers. Anxiety on the part of their providers made them nervous, and they did not like the labels typically ascribed to them just because they were older. This disparity was embodied in "*Unknown Territory"*: Pregnancy after age 39. Their awareness of potential adverse outcomes related to their age was represented by the category *"Everything was Going to be Fine" and "Just to Make Sure"*: Baby's Health, which portrayed conflicting levels of concern the women expressed about the potential

health of their babies, and the decisions they had to make around fetal surveillance. Eight of the women expressed a desire to have more than one child, but only two of them went on to deliver a second child. Their desire for more children was embodied in the category *"More of a Fantasy"*: A Second Child. This chapter included a discussion of these six categories in the context of known traditions, my pre-understandings and those of the women, as well as a comparison of findings with the relevant literature. This process led to a new understanding of the women's journey as they achieved motherhood at an older age, and contributes to the situated context for the text in chapters six through eight. Chapter six presents a hermeneutic interpretation of the life-world of first-time midlife mothers.

CHAPTER 6

INTENSIVE MOTHERING

Introduction

Chapter six presents a written interpretation of the participants' lived experiences as midlife mothers. The theme *Intensive Mothering* is used conceptually to convey the overarching experience of the women as being concentrated and dynamic, filled with joy, yet challenging, advantageous, but not without disadvantages. One of the major challenges for the women in this study was coping with the demands of mothering young children while simultaneously experiencing perimenopausal symptoms. The theme *Intensive Mothering* is authenticated by six categories which provide substance and support to the concept of midlife mothering as an intense experience. As each category unfolds, the voices of women whose experiences created shared meaning as well as women whose experience was unique to those of the group are expressed. This chapter presents and discusses six categories: *1) "Exciting and Almost Immediately Challenging"*: Becoming a Mother; 2) *"Your Life is Changed Forever"*: Unprepared for Reality; 3) *"A Good Mother"*: Doing Mothering Right ; 4) *"It's a Triple Whammy"*: Older is Harder; *5) "It's Almost a Catch 22"*: Older is Better, and *6) "Bubble Children"*: Hyper-vigilance.

The first category, *"Exciting and Almost Immediately Challenging"*: Becoming a Mother, conveys the participants' initiation into motherhood, whether through pregnancy and birth, adoption, alternative insemination, in vitro fertilization, or lesbian partnerships. Despite how passionately these women wanted to be mothers, or how 'ready' they thought they were, most of the women felt unprepared for the life changes that accompanied first time motherhood. This enigma is represented by the

category "*Your Life is Changed Forever*": Unprepared for Reality. These women had very clear ideas about pre-requisites for motherhood, and the kind of mother they wanted to be, and these are represented by the category *"A Good Mother*": Doing Mothering Right. Though they spoke of a lack of explicit guidelines for being a 'good mother', their shared voice imbibed the implicit expectations which contemporary society upholds to symbolize the characteristics of a good enough mother. For most of the women, doing mothering right also meant mothering differently than they had been mothered, which contributed to an intentionality to 'do things right' for their children. As their stories unfolded, a cluster of complex issues emerged as common meaning and are discussed in the category *"It's a Triple Whammy"*: Older is Harder. There are challenges and issues which accompany mothering young children at an older age, and the women shared their perceptions that they were different from younger mothers. One of these unique and inescapable differences was that as older mothers, they were simultaneously transitioning to menopause at the same time they were mothering young children. Decreased patience, mood swings, and fear of losing control placed additional stress on their interactions with their families. They also made adjustments to their careers in order to establish balance in their life which facilitated time spent with the child/children. Finally, as older mothers, they had aging parents, many of whom had health problems. Despite disadvantages to mothering at an older age, the women were clear that there were also many advantages to starting motherhood in midlife, like financial stability and life experience, and these are captured by the category *"It's Almost a Catch 22"*: Older is Better. The final category *"Bubble children"*: Hyper-vigilance uncovers the heightened level of vigilance with which these older mothers watched over their children. The women viewed this behavior on their part as both an

advantage and a disadvantage, so it stands alone as shared meaning for this group of women. This chapter includes a discussion of these six categories in the context of known traditions, the pre-understandings of the women and me, as well as a comparison of findings with the relevant literature and theories.

The next section presents the first category "*Exciting and Almost Immediately Challenging*": Becoming a Mother, which captures the women's immediate transition to motherhood as a positive experience, despite challenges.

"*Exciting and Almost Immediately Challenging*": Becoming a Mother

Although the focus of this study was not intended to create meaning about older women's pregnancy or birth experiences, I did encourage participants to tell their story of becoming mothers, because I believe that this is one of the most important and significant events in a woman's life. The women confirmed this when I asked them to name major transitions or turning points in their lives. They all included the birth or adoption of their children as a major transition. I believed that gaining some understanding about how they perceived early motherhood would provide additional insight into their particular situated context, and shed light on the transition to motherhood for older first-time mothers. The pre-understandings of the women about pregnancy were presented in the previous chapter, and despite being labeled by health care providers as elderly primipiras, or high risk pregnancies, nine of the eleven women who experienced a pregnancy described theirs as *easy, good or healthy.* This was the case, even for two women who developed the pregnancy complications of gestational diabetes and placenta praevia. One woman was diagnosed with a chronic health problem during her pregnancy, yet she referred to herself as "*blissful*"; she had so longed to be pregnant that she enjoyed even the uncomfortable parts. Jackie was 50

and the mother of a 10 year old daughter. Her recollection of pregnancy was highly representative, though not identical to the shared experience of the other women who were also very positive about their experiences:

> *I was very happy about it, and it was a wonderful experience, I had a great pregnancy. I never was sick or, I just had a great pregnancy. I was very happy...In fact I was euphoric. People used to... I would just be happy, I was very, very happy. And um, felt good, um. Like you said, just wanted her so badly, you know it was a wonderful experience* (Jackie, I_1,p.1).

All but one woman recalled her labour and birth experiences as positive despite a number of interventions and complications. Two of the women had caesarean births, two were delivered with forceps, two recalled epidurals, and four were induced. Roxanne's baby was in a breech presentation, which was not diagnosed until the second stage of labour. Here she described the sequence of events after her primary care physician requested a consultation with the obstetrician:

> *I mean it was probably all of seven minutes from the time she* [the consulting obstetrician] *got there til the time he was delivered. I mean literally she saying they're having me push, I had another contraction, wanted to push, didn't push, flew into the room, and I'm telling you, it was about 50 seconds before they had him out* [baby was in breech presentation]. *Ron almost missed it. It was remarkable, and his head got stuck in the incision, which made me think I was VERY GLAD I didn't deliver him the conventional way. So um and that was my labour and delivery experience. I got there at 4:30, by 10:30 I was done, and labour was about the easiest part of the nine months* (Roxanne, I_1, p.5).

Roxanne had not thought about her birth experience in a long time and spoke positively about being able to share her story with me. One of the benefits of sharing birth stories with other women is the opportunity it provides for women to "share a significant life experience with another interested woman..." (Callister, 2004, p.509). Despite my sensing an air of calamity within the details of her story, Roxanne considered the birth "*remarkable*" and "*easy*". Shanny, aged 48, was one of only two women who delivered more than one child, and the experiences of those two women were very similar. She recollected the difficult time she had labouring and delivering

her first baby at age 39, followed by a much easier experience at age 40 with her daughter:

> *It* [the first] *was a very healthy pregnancy. I had no problems except the basic fatigue towards the end, I was regularly going to the doctors.....I did have a long and a pretty difficult labour with my son. It was 23 hours ... I pushed for almost 5 hours ... had to have Pitocin and they used forceps. I was adamant that I did not want to have a Caesarean Section. That was my own thing. I wanted a natural birth* (Shanny, I_1, p.1).

This was what Shanny had to say about her second delivery:

> *I'm in hard labour now and it's only been a couple of hours. It was very hot ...I thought this is crazy, I cannot be having this baby. But then I'm thinking, I'm going to have this baby in the car, if he doesn't get me there..... My doctor came down ... it was his partner, not my doctor ... I said I need something for the pain. I cannot do this like I did the last time. He said all I'm going to do is break your water and you're going to have this baby. I said no, no. I really..... He said there is no time for this. Just relax. He was really good. My husband said, he must know what he is talking about. He actually broke my water, and two pushes and I had that baby which was amazing to me! And she was 10 lbs. So that was a BIG baby very quickly, but I would say it was a much easier birth than my son's* (Shanny, I_1, p.8).

Jackie delivered her only child when she was 46 years old. Her labour progressed very smoothly until second stage when her provider considered emergency surgery. In the end though, she felt "*lucky*" that there was no real pain, and glad that her baby was healthy. This is what she had to say about her labour and delivery experience:

> *So I did the best I could and they were like you're not pushing hard enough. But I couldn't feel it...cos' I was so numb* [from the epidural]. *So in about 15 minutes later, um, I guess they started to yell the baby's going into bradycardia and, so they said we may have to do emergency c-section. Meanwhile now I'm not feeling any of this ok...I'm like do whatever you have to do for the baby. So the doctor came in with forceps and she you know, I remember when, I remember when she came out... but there was no real PAIN. It was just this unbelievable you know thing up and out and then she was out and she was fine. You know, I remember and I heard her cry, and um, but as far as PAIN. I was very lucky. I guess, you know and um I heard her cry and they took her over to the incubator to clean her up. I was just glad she was ok* (Jackie, I_1, p.5).

Jackie's relief when she delivered a healthy baby is representative of a pregnant woman's investment and "possessive love" towards her baby which "stimulates a maternal protectiveness to ensure safe passage" for the child through the pregnancy and birth (Rubin, 1984, p.65). Making a good baby is also consistent with the work of Rubin (1984, p.116) who found that following the birth of an intact healthy infant, new mothers feel a sense of "marvelous completeness...[which] makes the demands and sacrifices of the pregnancy, labor, and delivery 'worth every minute of it' ".

Despite being labeled by providers as high risk, the positive outcomes that the women experienced in the current study are consistent with some of the literature on older pregnant women, which claim that women aged 35 years and over can expect good birth outcomes (Cunningham & Leveno, 1995; Windridge &Berryman ,1999). Several made distinctions between the effect of age, the presence of chronic medical conditions, and pregnancy complications, (Eisenberg, 1994; Tough *et al.*, 2002) the latter being of greater influence leading to more preterm deliveries and low birth weight infants among women aged 35 and older. In contrast, Joseph *et al.* (2005, p. 1417) note that despite higher rates of perinatal mortality for the infants of older mothers, "perinatal death rates are at their lowest point historically and women with healthy lifestyles and without chronic disease have very low absolute rates of perinatal mortality.....[therefore] most older mothers will have the desired pregnancy outcome".

The next excerpt is an example of a birth not going to plan, yet the mother delivered a healthy infant and subsequently was not unhappy about her birth experience. Florence was 44 years old when she gave birth to her daughter. She had made a choice to use midwives to provide her prenatal care because she thought they

would be less interventionist, and she wanted a home birth. Due to complications, she ended up delivering in a hospital:

> *Since I was having a home birth I didn't have to go to the hospital and have to be sent back home, but um..... my midwife didn't come... let's see my contractions started Friday. She didn't come until Friday night because they weren't that intense and then they went away most of Saturday. Then they got real intense all day Sunday. My water didn't break until Sunday night AND I didn't get to sleep at all Friday night, Saturday night, so Sunday night I'm in the midst of really HEAVY labour and also started throwing up* [laugh] *and I threw up for 12 hours.* [Pat: Oh no] *It was really .... So the water broke and sort of by mid-morning Sunday morning, I was dilated to 9 cm., and then I was 10 cm and actually started to push a little bit, but there was no progression at that point and um Paula* [the midwife] *thought my cervix had really had gotten swollen, and at THAT point I had been throwing up so much, I was pretty dehydrated and my contractions were slowing down. I thought, it was time to go to the hospital. So I went to* [name of hospital]. *It was great! Midwife was there. She is just incredible. I ended up, you know I wanted to have as natural a childbirth process as possible, but at that point I elected to have a spinal so that I could sleep, and I needed Pitocin again because my contractions had really slowed down. I don't know how much of that is age. There is a lot I think about in retrospect. If I had to do it over again, I WOULD DEFINITELY DO A HOSPITAL BIRTH ALL THE WAY FOR ME because of the throwing... the dehydration and the throwing up. And also...I don't WANT to have another child. I'm DONE, but not because of labour and delivery* (Florence, I_1, p.5).

As mentioned earlier, the women enjoyed talking about their birth experiences, or how they came to be mothers. Here, Florence recollects those first moments after the birth of her daughter:

> *Mothers love to talk don't they? It's fun to go back through it. I remember just the bliss that evening of being with my husband and the new baby and all our friends who were there were singing as she came out. They were singing, oh it was so beautiful, sort of welcoming her. I remember the next morning feeling just energized, excited* (Florence, I_1, p.7).

As noted previously, all but one of the women in the present study related positive birth experiences, and this supports the literature for older mothers (Windridge & Berryman, 1999) which notes that older women have positive recollections of their birth experiences, and even when problems arose, they were happy with the way things were managed.

It is important to point out that there did not appear to be any "missing elements" (Rubin, 1984, p.96) left over from the birth experiences of all but one woman in the current study. Rubin notes that missing elements need to be "backfilled for wholeness, and then summed up for perspective: it was worth it; it was a good or a terrible pregnancy". Leslie's interview really stood out from the others as someone who did not have positive recollections of her birth experience. She was 49 years old, and mother of a 6 year old daughter. Her recollection of feeling isolated and alone on the post partum unit, and the passion with which she told her story led me to suspect that she did have *missing elements* left over from her birth experience. More than six years later, she mused that there was still something missing from her life story. When I asked her if someone could have prepared her for mothering in midlife, she reached back to her experience in the hospital which she referred to as a "*nightmare*". This is how she described it:

> *Well one of the things, and this goes back to my delivery that I just am astounded that in this day and age, um, that there are not more you know that the OBGYN community and I, you know I don't know because I just felt like I had such a bad experience that was so, didn't have to happen and I just ...and the way it impacted me and there's got to be other people out there that go through this and that maybe there is a worse outcome. Um, because it does effect the way you bond with your child and it does effect ah, I mean those are probably some of the people that, I mean some people go through really bad post partum depression and stuff, and um and I just I don't know why there isn't more SUPPORT and more CARING around the, you know the labouring mother or the that they don't.....you know that they could see that Mathew* [boyfriend] *and my mother and Sherry were just kind of not really doing anything and I was so sick and kind of needy during the labouring, that they weren't more supportive and caring and that there wasn't some, and that's why people hire doulas* [lay birth attendants who provide non-medical support] *now you know but who, you know not everybody goes through that. I mean there are some people who have the most wonderful experience and an easy baby and probably go out and say oh it's the most wonderful thing you have to do it... you, you know you just can't imagine. I mean I, that wasn't how it was for me* (Leslie, I_2, p.60).

Leslie continued to have problems with breastfeeding, and she was not happy with how her care was managed during her hospitalization. During her second interview, six and a half years after the birth, I asked Leslie what advice she would give to a friend about having a first baby at age 40. She was hesitant to recommend it to other women based on how her delivery and hospital experience had gone:

> *I mean like to tell someone else that's going through infertility that I had the worst delivery and a horrible new born screaming and my nipples are killing me. They don't want to hear that. They're like shut up you got a kid, that's you know. So it's very- and that might be influencing too, you know why I had the feelings. Because of the infertility stuff and then, oh my god all these other women that can't get pregnant and then I finally got pregnant at 42 and had this baby. So, yeah so, and then the post partum support too, I mean they should have home visits should be mandatory for everybody for the like the first couple of weeks after delivery. They should have some, a nurse or somebody, whoever, somebody go to the home* (Leslie, I_2, p. 61).

Women who perceive an adverse childbirth experience and are disappointed in the amount of emotional support they received from their partners are more prone to negative psychological effects (Lemola *et al.*, 2007). Traumatic birth experiences "lie in the eye of the beholder" though they may be viewed as routine by the health care providers (Beck, 2004a, p.28). When psychological dimensions surrounding birth are "marginalized", women express a "range of feelings including disappointment, anger, inferiority, inadequacy, and bullying" (Baker & Henshaw, 2005, p.332). It is common knowledge that negative birth experiences have been linked with greater risk for postpartum mood disorders (Bernazzani & Bifulco, 2003; Soet *et al.*, 2003; Beck, 2004b), and that a birth experience can "have long-lasting, and broad implications for her sense of self-efficacy and her connectedness with others, including her child" (Callister, 2004, p.513). Leslie's unfulfiled expectations and her perception of lack of caring by staff may be the *missing elements* which have persisted years beyond the birth experience. Beck's (2004a, 2004b) recent work on post-traumatic stress disorder following birth revealed that perceived lack of caring during labour and delivery

contributes to a woman's perception of traumatic birth, thus demonstrating the powerful effect a negative birth experience can have on a woman. Negative or traumatic experiences can also impact future pregnancies, particularly for primiparous mothers, and contribute to issues with maternal/infant attachment and mothering experiences (Annandale & Hunt, 1998; Bryanton *et al.*, 2008).

As discussed in chapter five, some of the women were aware of health care provider anxiety related to their age, and their assigned status as high risk. Mary was a provider of women's health herself, and she was 40 years old when her son was born. She was keenly aware that older pregnant women have a higher caesarean birth rate. Her personal experience with provider anxiety led her to propose a connection between provider's anxiety and the caesarean birth rate for older women, so she chose to see nurse midwives for her own prenatal care:

> *Labour was harder I'm sure because I was 40. You know if you look at the data on labour the C-section rate is much higher I don't know if that's just cos' doctors are anxious because of the elderly* [primipara], *but I certainly had kind of a dysfunctional labour... but everything was fine. Luckily I was working with midwives so they were patient so I got to have a vaginal delivery...* (Mary I_1, p.11).

Moore and DeCosta (2006) note that older women do have more medical indications for caesarean delivery, and are also more likely than younger women to have an emergency caesarean at some point during their labour. Additionally, physicians may make a quicker decision to do a caesarean based on fear of losing the infant, or of the infant being damaged in the process. Older women's fertility issues as presented in chapter five may spark a provider's decision to act sooner than those caring for younger women in labour. Four of the last seven women I interviewed who experienced a pregnancy felt that the physicians were anxious and passed that along to their patients. (This issue did not emerge until the fifth woman was interviewed, so I did not have an opportunity to present it to the first four women). Moore and De

Costa (2006) counter this finding when they state that older pregnant women are more anxious, and they communicate that to their providers, resulting in a lower threshold for operative births. Berryman *et al.* (1999) suggest that both women and their providers believe that older women carry more risk, and it is this that leads to increased inductions of labour, use of pain medication and more caesarean births. As discussed in the previous chapter, a reassessment of risk for healthy pregnant women older than 35 may challenge some of the long-standing assumptions made in the past about this group of women.

Sarah and Monique were two women launched into motherhood through extraordinary means. When I asked Sarah what it was like to become a mother for the first time at age 47, she conveyed the excitement she felt when her first child was born to her lesbian partner. This is how she described the birth of her first child, and the subsequent days and weeks to follow:

> *What was it like? It was invigorating. It was all those things that you get at your first birth, with adrenaline rush. It was ... you know, it was very exciting and then almost immediately very challenging because Jason* [son] *had trouble with nursing and then became critically jaundiced..... So it became INSTANTLY overwhelming, I think* (Sarah I_1, p.1).

Despite not being the biological mother, Sarah's transition to motherhood was still exciting, and subsequently intense. There was no diminished sense of elation at the birth of her first son, or less concern for his health because she had not given birth to him herself. Monique was the only other woman who never became a biological mother. She was 44 years old when she and her husband adopted a baby from abroad. She found it to be a very positive experience, and in fact, this was one of the few points in our discourse during which Monique said anything positive (during her two interviews) about her mothering experience. It was also the first of several times that

she referred to her husband as the "*second mother*" or the "*real mother*". This is how she described her initial transition to motherhood:

> *Funny, just trying to figure out what to do, you feel like, oh my God this baby, what am I going to do, how to take care of it?* (Monique, I_1, p. 1)

Though Monique's international adoption experience was unique compared to the other women's transition to motherhood, this statement gave voice to a reality that was shared by almost all of the other women. There was a dichotomy between their perceived 'readiness' to be mothers, their expectations of what it would be like to be a mother, and the realities which they were ultimately unprepared for. This is now thoroughly discussed in the next section.

"*Your Life is Changed Forever*": Unprepared for Reality

A consistent contradiction emerged during the interviews and in the text which provided insight into one of the enigmas of early motherhood. Despite how passionately these women wanted to be mothers, or how 'ready' they thought they were, ten of them felt unprepared for the life changes that accompanied first time motherhood. Whilst this may not be unique to older mothers, an older mother may feel the changes more intensely due to the amount of independence and sense of accomplishment she has experienced prior to becoming a mother. Several of the women were married to older men, and five of the women were mothering step-children with their spouses so it might be expected that they would have had some insight into what life with children was like. Susan's husband had older children from a previous marriage, and she remarked that prior to conceiving, he cautioned her about how much their life would change, but she still did not understand the full impact until she had her first child at age 40. This is how she described it:

> *When you spend your entire life being independent and doing what you please and then all of a sudden you realise your life is changed forever, so no matter*

> *how much my husband would tell me, you know this is going to change our lives, you don't know until the baby actually comes* (Susan, I_1,p.2).

As discussed in Chapter five, the women wanted these babies very much, and they prepared for motherhood by reading books, going to classes, talking with other women and couples, observing mothers, yet, there was still a sense of ill preparedness for the real experience of actually mothering a child. Rosie felt particularly lost when she brought her daughter home from the hospital. This is how she described her early mothering experience:

> *I was 39, I turned 40 when she was 6 months old. Scary and exciting and I had no idea what to do. You read books and you think you're prepared, and then you have the child ...I thought that would prepare me a little bit but I was lost* (Rosie, I_1, p.1).

The idea that no one and nothing can prepare someone for motherhood emerged from the interviews and the text as shared meaning. During her second interview, I asked Rosie to expand on something she had said in her first interview, which was "I'm glad I didn't know beforehand all it [motherhood] entails". This is how she finished that thought:

> *Cos' you probably wouldn't do it* [mothering]. *It was, again I read up in my little... you know that book Nine months and counting, you know that book with the pregnant lady on it. I read every chapter, and it was, and when she came home from the hospital my husband and I looked at each other like "Oh my God, what do we do with this itty biddy thing"? ... ...It's a learning curve, I wanted to have another child because I probably made a lot of mistakes with her just being mental and crazy and not knowing what I was doing* (Rosie, I_2, p. 27).

A paradox existed in which the women thought they were prepared, (their pre-understandings) yet the realities of mothering were surprising to them. Florence was one of several women who repeatedly said how prepared she thought she was for having a baby, yet she found the demands of infant care in addition to the normal schedule of her life overwhelming and exhausting:

> *That is one thing, I was exhausted but it wasn't because of lack of sleep because we kept her in bed with us. I was exhausted from the work of feeding a new baby, trying to feed myself, and then manage all the other things associated with life that are just almost impossible to do. You are totally clueless* (laughs) *UNTIL YOU HAVE ONE, YOU HAVE NO IDEA, AND NOBODY CAN TELL YOU* (Florence, I_1, p.8).

I reflected on this paradox and sought understanding on why women are not able to comprehend beforehand what the realities of mothering will be. Some women said no one told them what it would really be like. Others thought that friends and family sugar-coated the realities, or glossed over the difficult parts. Sarah spoke of a romantic aura about families, which was very appealing to her. Perhaps the realities are visible, but women who want children think it will be different for them. Perhaps they are not capable of hearing how hard, difficult or challenging mothering can be. Roxanne had an unplanned but wanted pregnancy at age 42. She kept thinking that at some point as her son got older, she would get her old life back. It took her five years to realise that that was never going to happen. Rosie suggested that if women really knew all that mothering entailed they would not choose to be mothers.

These findings are consistent with the work of Carolan (2005, 2007) who interviewed twenty-two women older than 35, during pregnancy and then again 6-8 months postpartum. The participants in her study experienced immediate euphoria following the birth followed by a myriad of concerns regarding the mothering role, with many of the women "feeling really lost and helpless... ill-prepared and ill equipped for their new role" (Carolan, 2007, p.1168). The current findings are very similar to Carolan's (2007) sub-theme *Impossible to be fully prepared* in which her participants practically use the same words to express common meaning that no one can prepare women for the mothering role. Cusk (2001) believes that non-parents are not prepared for parenthood because they are tone-deaf to what parents have to say.

"In motherhood a woman exchanges her public significance for a range of private meanings, and, like sounds outside a certain range they can be very difficult for other people to identify" (Cusk, 2001, p.3). Although Mercer (1986) reported that the older first-time mothers in her study (aged 30-42) were not surprised by anything during the first year of mothering, Nelson (2004, p.289) suggested that older first-time mothers were "at risk for reality shock because of their high level of anticipation coupled with little prior experience with infants and the great significance they tend to place on the mothering role". Kalmuss *et al.* (1992) agree that the most critical time for a divergence to occur between the expectations and realities of parenting is after the birth of a first child. Though the authors (Kalmuss *et al.*, 1992, p.516) worked with a younger sample (aged 22-36), women's expectations about "how parenting would affect their lives and how they would fare in the maternal role did not match their experiences..." resulting in a pattern of *violated expectations* which make the adjustment to motherhood more difficult. Kalmuss *et al.* (1992) found that women's expectations around the effects of parenting were inflated in a positive way prior to the birth of their first child.

Similarly, Pancer *et al.* (2000) discovered that both men and women demonstrate more complex thinking about the impact of parenting six months after the birth of their first child. Women's thinking about the effect of the transition to motherhood on their lives was more complex than that of men, which may coincide with women anticipating that becoming a parent will have greater impact on their lives than their male counterparts. Pancer *et al.* (2000) did note that women who had more complex expectations prior to delivery, demonstrated better maternal adjustment after their babies were born, so this certainly could be an area of focused education for pregnant women. This could be accomplished through more preparation and participation in

activities of parenting, which can lead to more complex thinking, and thus improved adjustment. Older first-time mothers experience better adjustment to parenting, and this may be due to some extent from more complex thinking on their part (Pancer *et al.*, 2000). The authors also note that social support can counteract or buffer "the impact of stressful events and experiences...and women with higher levels of social support tend to experience greater satisfaction and less distress in adjusting to their role as parents" (Pancer *et al.*, 2000, p.273). These are important concepts and will be further explored in the section entitled *"It's Almost a Catch 22"*: Older is Better, as well as in chapter seven.

Reality did not meet expectations when the women in the current study realised the intense nature of caring for their infant and the centrality of commitment they would feel towards the child. For most of these women, the long awaited child or children became the focus of their lives, and that preoccupation contributed to the intensity of the experience. These older first-time mothers had completed their education, established careers, and enjoyed independence for many years prior to having their first child. Eleven of them negotiated changes in their work schedules to accommodate their desire to be more available for their child or children. Six of the women expressed disappointment with the level of involvement of their partners in sharing parenting responsibilities. Their pre-understandings were that their husbands would share more of the responsibilities for caring for the child/children. They expressed disappointment and some disillusionment when their expectations were unfulfiled. Florence gave an example of how her reality did not live up to her expectations:

> *He* [husband] *was* [working] *part time for a while. We thought maybe he would be home a lot with Paige. I didn't want to go back to work right away. We*

weren't quite sure. I thought that he would have more time and be more involved in parenting (Florence, I_1, p.22).

She recalled feeling stressed by the demands of motherhood and the fact that despite her expectations for shared parenting, she became the primary care provider for their daughter:

> *My husband was working. He was only able to take not quite a week off. I think that was what stressed me the most, and just how much that baby didn't want to get put down. I wasn't prepared for that at all.* [Pat*: they are a lot of work*]*They are with you constantly. How hard it is to take a shower. How stressful it is when they are in the other room, crying, and you are trying to engage in self-care, and they are screaming. You know they want you, that is very challenging* (Florence, I_1, p.8).

Unfulfiled expectations were an important part of my discourse with Peggy about motherhood. Here she responded to a question about what advice she would give to other women over 40 who want to become mothers. There was a quiet resignation as her voice trailed away that despite different expectations on her part, she has been the one who bears primary responsibility for her children:

> *How you look at it, you know, here in our family, we're both working people, and we both have full time jobs, but it falls on the mother ultimately, all this stuff. At least 90% of the cases of my friends, that's the way it is. It's very rare that you find that the mom's not the one that's really dealing with all this, and so that's a part of it too. I mean I think if you had more of a relationship where you had more space or time away from your children or something, and there was more of the partner being really truly an equal partner, maybe some of this stuff wouldn't be as hard. That's just the way it seems to be.*
>
> Pat: *Did you come into, come to motherhood with certain expectations about that?*
>
> Peggy: Yes. *Well and it has not been that.....But then, that whole conversation,* [he] *wanted to HAVE them more, kids more than I did, so the whole thing was 'It was going to be so EQUAL, and we were all going to share all this responsibility," and I had this sort of vision that society was different now, and a couple of my friends had been stay at home dads for a little while, and I just had this sort of pie in the sky idea that it was all going to BE that way, and it HASN'T panned out like that at all. And it's partly the fact that he has his own business and he's so much LESS flexible than I am with my job, and that's part of it. But it's definitely still culturally that the mother does so much more* (Peggy, I_2, p.19).

Despite greater expectations for involvement on the part of fathers, women still tend to be the most important parent for young children, (Lupton, 2000), and as the current findings reveal, this dissonance created stress and hardship for the mothers. Shanny related how a very fussy baby and lack of sleep were more stressful than both of her pregnancies and deliveries:

> *She literally did not sleep – maybe 4 or 5 hours out of the day and then she would just cry. She would cry all the time. Then you would feed her, and it would be worse. By the time she was about 4 weeks old I was ready to put a gun to my head to say the least* [gasps] *because there was just no sleep with her. I had a toddler as well* (Shanny, I_1, p.9).

(Carolan (2005, p.781) concurs that the "anxieties and struggles" of older first time mothers transitioning to motherhood may be "unusually poignant". The combination of autonomy, independence, and higher expectations for coping related to maturity can create stress for older first-time mothers. Jackie quit her job to stay home with her daughter. Now that her daughter was 10 years old, she was ready to find part-time work again. This extract captures the element of stress in her life generated by the dedication she made to being available to her child:

> *It's really hard to find something just to keep myself busy but, your whole life revolves around that child. And boy if you're not willing to give it you know it's, it's hard, it's very hard. Especially being alone all the years I had been, like I said you like things just so um, you like to be able to go, go down the gym or run here and there, and now you can't. You either have to take her or make sure there's somebody to mind her um, it's just a , it's just very stressful. Very, very stressful. As much, there's joy to it too. But there's, it's a lot, it's a lot* (Jackie, I_1, p.17).

These findings are consistent with several of the sub-themes in the work of Reece and Harkless (1996). Their theme of *Centrality* described the mother's ability to put baby's needs above their own, and the difficulty women face when leaving the baby. Mercer (1986) found that lack of preparation for the extensive changes in relationships, schedules, social activities, and time for self leads women to experience distress and stress. Older first-time mothers experience an overall intensity within

their mothering experiences related to their life experiences, anticipation for motherhood, desire to do mothering right, and the effort of mothering (Nelson, 2004). In a meta-synthesis of nine qualitative studies examining the transition to motherhood, Nelson (2003b, p. 469) noted that the concepts *engaged or engrossed* were used in the literature to represent the presence of "maternal commitment and a bond between mother and infant". Centrality or placing the child at the centre of the mother's focus is one of the tenets of intensive mothering, and was a critical part of the discourse with the women in this study. These women waited a long time to become mothers, and were determined to do mothering right. They expressed clear ideas about proper mothering, and these views are explored next.

"*A Good Mother*": Doing Mothering Right

The women articulated very passionate ideas about what constituted appropriate mothering, and they all wanted to be a 'good mother'. Their pre-understandings included the knowledge that they always wanted to have children, (all but two), they thought they would have children at a younger age, and most of them wanted more than one child. They waited a long time to have a child, and they possessed strong ideals about how to do mothering right. There was also shared meaning for most around the desire to mother differently than they had been mothered. The women recited a list of pre-requisites to motherhood including a stable environment, a solid relationship, financial stability, and two parent families. Doing it right meant that as the mother they wanted to "*be there*" physically at home with the child/children, and be emotionally available to them. A few of the women thought prior to having their first child they could "*do it all*" (work and motherhood), whilst others recognised that this was an impossible feat if a mother wanted to really *be there* for her children. My own pre-understandings were that women and couples make a variety of choices

about parenting and child care. I was younger than these women when I had my children (aged 27 & 30). I was married, in a stable relationship, owned a home, and was financially stable. I worked part-time when my children were young, and often when I was at work, my husband was home with the children. I continued to work for personal, professional and economic reasons, but I also recognised that I could not be a full-time stay-at-home mother. I believed that I would be a better mother to my children if I could continue to pursue my career, and have time away from my children. Too much time has passed to vividly recall what feelings this choice may have generated. I believe I was a good mother, but I do remember feeling twinges of guilt for leaving them at times in the care of others. This was an arrangement that worked for my family. I recognise that not every woman has choices about whether or not to return to work, or how many hours she will work. This enabled me to remain open to opinions and choices different than my own.

Here, Rosie spoke of basic requirements she thought women should meet before having a child:

> *You don't need a lot of money but I think you need to be stable. And some people can have a child without a partner, but I can see how having a father and mother definitely affects the child. Because we're so different and we give her different things, so it's kind of being prejudice but I don't know, some people can do it and some people can't. There's so many things, the toys or things they'd like to have, and time with them and medical attention* (Rosie, I_1, p.13).

Miriam talked about the responsibilities of a good mother, and though she lamented like most of the mothers interviewed that there was not an explicit handbook, she had very specific ideas about what constituted a good mother:

> *...I mean I think there are certain things that I feel that I have to provide for him, you know, a nice, you know, comfortable environment, you know, a pretty serene home life, some consistency in his schedule, because I feel like our life is really up and down. You know, his dad has one way of doing things and it kind of goes*

> *against what I do and -- you know, I mean Evan definitely has a routine. I mean I provide a really stable environment for him. I'm sure that I do, and even the paediatrician - you know, I had a conversation with him about it. You know, I mean you HAVE TO TAKE CARE OF YOUR CHILD.* [lowers voice for emphasis] *I mean, he's my kid..... I don't know, it's like there's no handbook written about how to be a good mother* (Miriam, I_2, p.53).

Shanny was working in a high paying position when she had her first child. She thought she could "*do it all*" and went back to work, juggling motherhood, and career for awhile, but not without conflict. She found she could not keep it all in balance, and felt like she was falling down on society's expectations of her:

> *It was very difficult to admit to myself, I think, that I couldn't do it all; but I had really worked hard in my career and I had really moved up the ladder. ..... So now I'm a mother. Is this going to be enough for everybody – myself and everybody else, but I really struggled with that fact. It became overwhelming to me at one point. Leaving the kids started to get more and more difficult. I kept thinking I don't want to miss this. I need to be with them. People are supposed to do it all- same thing like I was, but I knew I couldn't. I just knew it was not me ..... I thought I don't want these kids being taken care of by anybody else. I waited 40 years for these kids. ..... I walked out that door* [quit her job] *and it was like. I can't explain it. I WAS HOME WHERE I SHOULD BE AND IT WAS JOYOUS. It was joyous to be with the kids every day. Every day to get up and be with them, go to nursery school. It just became a joy I have never known. All the guilt went away like almost in a couple of week's time. Everything was fine no matter what was going on. It was fine because I was there. It was a real turning point for me it was a very good choice* (Shanny, I_2, p.41).

Later in the interview, Shanny's transformation was complete, as she related how she shifted from work outside the home to the occupation of mothering. The intensity of her focus was now placed on her children:

> *I just look at this as my job. As I say because I had 23 years as a career I have no career drive. When I go out next time to work, it's going to be a job. I have no desire to set the world on fire or make my mark. I had a fabulous career. That is all fulfiled. My career now is to raise these kids to be really good, wonderful, human beings, but I often think, when I am done with them and I am in some mediocre job, when I say done with them, when they become young adults and go off to college. Where is that going to leave me? Every bit of my life, every breath I take is focused on them* (Shanny, I_2, p.70).

Mary was passionate about doing it right when she became a mother. As a professional woman in medicine, she competed with men for her education and career. She witnessed previous generations of professional women try to do it all, and observed that others spent more time caring for their children than they did. Here, Mary shares her belief that the expectation to 'do it all' is a myth, and has led women to miss out on some of the fulfiling aspects of motherhood:

> *I'm kind of in that in between at the very end of the baby boom but I was lucky enough to figure out that you know but what my friends who are ten years ahead of me went through was you know this myth of believing they should be able to do it all and as a result they, they DID MISS OUT you know I think they and a lot of them ended up missing out on that day to day parenting which you know ... and I don't think all women feel like they missed out but I think some of them do*...(Mary, I_1,p.8).

Mary made a different choice for herself, and created a flexible work schedule that allowed her more time at home with her children:

> *So I work part-time. I didn't want anyone else to be with my kids more than me. You know, I don't... so we had a part-time nanny and grandmother help when they were little but mostly so I stayed home for three months and then um actually between 3-6 months we set up a nursery area at work and he came in 1 or 2 days a week and then we had part-time help at home and then they've been part-time initially but at the daycare centre* [name & location] *here which is a fabulous place* (Mary, I_1, p. 3).

Later in the first interview, Mary shared her perspective on a decades old argument between mothers and experts about whether quantity of time versus quality of time spent with children is critical:

> ... [mothers are] *going to have to decide whether it's the quantity or quality of time that's important and what I would say at this stage of my life is it's the quantity of time AND the quality of time that's important and you do need a certain amount of quantity and I think that if you don't have that you miss out both as a parent and your children miss out on that relationship with you. Does that mean you can't you can't you know you can't make it work in other ways? You CAN of course, and I don't think it's a non-valid choice but it's not a choice that I would make. I WANT TO BE THERE with my children and um and be an active, daily participant*...(Mary, I_1, p.7).

Her position is that women should be able to mother their children and it is society and the culture which needs to reform in order to make it all work:

> *Cos' you know... cos' I'M A FEMINIST. I am a you know I'm a liberal you know totally you know left wing pro-life- women should do whatever they want but I think that you don't have to deny the for people for whom it's the right thing the importance and fulfilment associated with motherhood in order to embrace those things and it's almost like you know that's kinda the next step in understanding the life cycle of women we gotta be able to make it ALL FIT. And um you know I don't know if we have to think of the way we do... and I think we already are in subtle ways careers, you know, you don't have to step off the career track. You don't have to choose between, you have to- they have to make a middle* [track] (Mary, I_1, p.13).

A different view on mothering was provided by several of the women who wondered whether they had made the right decision to become a mother. Monique confided that she never needed to have a child to be fulfiled. Her career accelerated shortly after she adopted her daughter, and she honestly shared that she did not want to stay home because motherhood did not fulfil her as much as work did. She was not willing to 'be there' as all of the other mothers desired, and she was clearly feeling bad about that. Her pre-understanding was that sometimes mothers are the "*sacrificial lambs*" for their children, and she was not willing to be that. This was part of the dialogue that took place between us as I was trying to gain understanding about her views. Although this is an unusually long passage of dialogue, I feel it is critical to establish the contrary voice and provide an alternative to the notion of centrality, and 'being there' for the child. Monique still wanted to do mothering right, yet she made different choices from the other women interviewed. This is also an example of Gadamer's construct of *play,* in which Monique and I got *caught up in dialogue*, and emerged with a higher level of understanding:

> Pat: *So if you had the choice and from what I've heard – to see if I'm right about what I've heard, you really don't want to stay at home.*
>
> Monique: *No, No. I can't.*
>
> Pat: *You really like working and like that stimulation.*

Monique: *Yeah, yeah. I couldn't be home cleaning all day and arranging play dates. I couldn't do that.*

Pat: *You're feeling that you've got to find a balance here somehow, but you really want to pursue your career. OK- that's what I thought I heard. You talked about as an older mother you want to do things right, and I've heard that from the other women.....Is there a standard for motherhood? What does that mean? What do you think about when you think about doing it right? What are some of the values within that?*

Monique: *Well, I guess that you hope that you raise a child that is polite, and CARING, and kind and WELL-BALANCED EMOTIONALLY. All those high ideals you have for a child, you know. I know you spend time over the years looking at other people's children, thinking that "well mine will never be like that or mine won't be going to bed at that time or mine won't be eating junk food." You just try to think that, or you hope that because of your life experience that maybe you'll do things differently or more mindfully. I don't really know. I think parenthood is a challenge at any age. I can't say that I have more tools, or, probably I do, or maybe I don't really know- it's different* (Monique, I_2, p.26).

I shared with Monique that many of the women I had interviewed (eight before her) had commented on how fulfiled they felt now that they finally had a child. This is how she responded, and demonstrates how a back and forth 'movement' (Rapport, 2006) of conversation brought me to a more informed level of understanding (fusion of horizons).

Monique: *When I think about that* [her own lack of fulfilment] *I feel kind of bad, because one woman was single, and she was miserable until she adopted her child, and now the whole world revolves around her, but she's so happy to be a mother, that the rest is not really that important. I think oh my God to find that peace, I don't know, for me I can't be there, you know. I mean I love her dearly, but mother be all, I mean I can't, that can't be all for me.*

Pat: *You want both, yeah, I see it as you want both.*

Monique: *Yeah, it's not going to be, it's not like it's (( )) that I needed fulfilment in, you THINK SO maybe a little bit when you're younger but now... some people really needed that ... I've met women who really needed that,* [motherhood] *to feel that they've had a fulfiled life,* [Pat: *right*]. *I can't say that. Well I don't think so for me, no* (Monique, I_2, p.33).

Monique's choice to engage more fully in a flourishing career (she owned her own business), and less fully in mothering responsibilities, created poignant conflict in her

life, impacted on relationships, and led her to question whether she was a good mother because she did not feel fulfiled by motherhood. Her presence as a dissenting opinion in this study was crucial in order to uncover an alternative model of mothering and point out the contradictions imbedded in the socially constructed ideology of mothering (Gadamer's notion of tradition is well suited here). Hays (1996, p.x) argued that "the contemporary cultural model of socially appropriate mothering takes the form of an ideology of *intensive mothering*...which advises mothers to expend a tremendous amount of time, energy, and money in raising their children". There exists a combination of beliefs which are adopted either implicitly or explicitly by many American mothers and understood as the "proper approach" to mothering:

1. The mother as the central caregiver, and when mother is unavailable, other women serve as substitutes.
2. The focus is child-centered, with copious time and energy and material resources lavished on the child.
    a. The child's needs are placed above those of the mother, and
    b. Mother must acquire detailed 'expert guided' knowledge of proper development and then foster it.
3. The concept of the 'priceless child' who is far more important than any paid work, and deserving of special attention (Hays, 1996).

Miller (2007) suggests that assumptions and beliefs about the "natural and instinctive" (traditional) capacities of mothers are part of the dominant discourse of the 'good mother' which women may find difficult to resist. Hays (1996) suggested that in a society where more than half of all mothers with young children work outside the home, (that figure is now 64% , Bureau of Labor Statistics, 2009) and one in which so much power is derived from capitalism and self interest, creating a 'best

model' of intensive mothering sets up a contradiction for most mothers. Thurer (1994) worried that a 'mythology' of perfection would threaten the progress that women have made in establishing careers, involving fathers in child raising, and finding child-care that works. The findings from the current study suggest that current ideologies may create greater tension for younger women who are pursuing careers and more closely fit Woodward's (1997) description of 'independent mothers'. This template for motherhood seemed to create less conflict for the majority of the older mothers in the current sample who had experienced autonomy, attained educational goals, and careers prior to becoming mothers and were ready to settle into motherhood.

Although only three of the women is this study were not working in some capacity outside of the home at the time of the interviews, most of the women had cut back their hours at work, switched to part-time, or even quit their jobs altogether. Most were involved in some kind of negotiations at home or at work in an effort to balance career and mothering. When work or home demands felt off balance, this generated conflict or guilt:

> *I really struggled the first two or three months – as do all mothers, but you know he was a big baby. I was nursing him, and I did go back to work after three months which was difficult. I found that to be very difficult. I did not want to leave him as everyone, any mother can understand. I really struggled with that. I cried probably every day for the first two months that I went to work* (Shanny, I_1, p.3).

Shanny expressed one of the tenets of intensive mothering when she stated she "*did not want to leave him*" to go to work, and her belief that all mothers should be able to understand how she felt. Florence was a high achieving academic who orchestrated a series of negotiations with her department to find a schedule that would work for her employer as well as allow her to spend time with her daughter. This is how she described the early transition back to work:

> *It was HARD to go back to work. Part time would have been ideal and what I would have really liked, but the department really didn't want me to go part time. It was probably good in the long run that they were not supportive of that... They let me cut the corners when I first went back to work. I think in a lot of jobs you can get back, but some you don't..... then I negotiated that further.....If I were to recommend, I think part time work makes a lot more sense. In an ideal situation, that's what I would have preferred. Like going in every day; four hours/day. You know, that's what I think is really a reasonable situation. Anything else is not... not really reasonable* (Florence, I_1, p.22).

Florence stressed that it was not reasonable to expect a mother to work more than four hours each day, but Monique disagreed. Her situation was unusual compared to the other women. Rather than negotiate fewer hours in her job, her career accelerated after she adopted her daughter and she was working more than ever. Her interviews focused largely on her struggle to balance work, mothering, caring for her aging, ill parents, and still find time for herself and her relationship with her husband. She found that her choice to pursue her career was in conflict with the traditional values and expectations that her husband (and society) held of what mothers do. This excerpt captures the complex nature of her life:

> *My husband comes from a very traditional family where all the women stayed at home, except, one sister-in-law who is a professional and wants to work. The others have been home, so it's been hard for him. He LIKES it because I make money, but it's an adjustment for him. The other hard part is that I've been used to be able to go out, come and go as I please. Go to restaurants, go to this, go to that. We can't do that. Basically, we live in an area where there's no extended family. There are no babysitters walking around looking for money. It is a little bit more homebound, which is a big change, when you are sort of used to doing your own thing. Some of the challenges balancing work and family personal time and then time with a spouse you know, to try to have enough energy. Then you have the whole issue of aging parents* (Monique, I_1, p.4).

At the start of her second interview, I asked Monique to elaborate on why she thought her life was such a struggle. I wanted to understand why she was experiencing so much conflict. Did she want to work or stay at home with her daughter? This is how she responded:

> *It is an external time management struggle. I want to work. I like working. I find a lot of satisfaction with working. I would have to. I couldn't be a full time at home mom. That would be too difficult for me. I guess the struggle is how to balance it all. My husband and I try to do it with very little child care. He really thought I would be home with the child. He thought that he would be working and I would be home doing per diem or twenty hours per week. What happened is that my career took off. He hasn't been happy with his career. He actually has cut back to help me. What we are doing is trying to manage the career, taking care of her, our parents* (Monique, I_2, p.23).

I was intrigued with Monique's story because it was different from the other women. She was making choices that were in conflict with what societal expectations place on working women who become mothers. She and her husband were negotiating and trying to reverse roles on some levels, but there was still an imbalance that created a 'double shift' for her.

A range of issues surrounding balancing work and motherhood have been observed in other studies of older mothers. Mercer (1986) reported that older mothers (aged 30-42) had a major concern balancing motherhood and careers. Reece and Harkless (1996) identified a work/career issues theme that included loss of interest in career, and the difficulties of juggling work and motherhood much like the current findings. The authors noted an overtone of stress surrounding the work/career theme, and suggested this might be an issue unique to older mothers, since it was different from themes analysed from a study of younger mothers (Pridham & Chang, 1989). Gersick and Kram (2002) found that younger women in their thirties encountered more difficult career-family dilemmas, whereas women in their forties were focused on balance in their lives, and postponed major new commitments, though children and work were both important to them. Most of the women in the current study were still working, though they made clear choices and adjustments in their careers in order to facilitate more time with their children, thus constructing their own version of intensive mothering. These older first-time mothers seem to have abandoned the idea

concocted in the 1980's and 1990's that they have to be superwomen, or 'do it all', in favor of motherhood. This shift favors the child over ambition which is in contrast to the career climbing behaviors of early feminists. "For many women, perhaps most, motherhood versus personal ambition represents the heart of the feminine dilemma" (Thurer, 1994, p.287), but that did not seem to be true for the older mothers in the current study. The second wave of feminism pushed for opportunities for women who were career focused as well as those who wanted to combine career and family (Thurer, 1994), yet this resulted in a generation of women who tried to be *superwomen.* In the book titled The Second Stage, Friedan (1986, p.86) suggested that women stop playing the "superwoman game" in order to conserve energy necessary for home and work, and to make equality livable. She offered a new view of feminism which would no longer deny that "part of one's personhood as woman" which desires motherhood. The real essence of the women's movement was about the "personhood of women" (Friedan, 1986, p.86), which could be compatible with a choice in favor of motherhood. With rare exception, the women in the current study believed that being with their child/children was more important than their career, and they believed their presence was something that their children needed and deserved. It is important to note that these were mostly professional, upper-middle class Caucasian women with family incomes still greater than $80,000 (even after work adjustments), so there was presumably less pressure on them to maintain full-time careers, and more opportunity for true choice.

Another tenet of intensive mothering is that the mother is the central caregiver. As noted earlier, six of the ten women in heterosexual relationships expected their husbands/boyfriend to share more of the responsibility for childrearing, yet it was the mothers who took primary responsibility for these duties. This was another area in

which Monique voiced distinctly different feelings from the other mothers. She made it very clear that she could not be the central caregiver for her daughter because she found it stressed her out and left her feeling angry and tired:

> *I think I have to have a balance. I could never, I couldn't parent all the time. Like, I could never be home all the time. It would be too much for me. I think I'd feel that there was too much AT ME. It would literally suck me dry and I don't feel like I have the reserves for that. I thought that I would have had more than that, but I find that I really don't have the reserves to meet all her needs all the time. I find that I reach a certain limit of what I can give. I'm finding its better that, I've said to my husband, it's better if I do some working, you're home and she is some kind of child care because I AM NOT THE ANSWER. And I know that. I'm better off, a smaller amount of hours with greater quality than a lot of hours and feel stressed and angry and too tired* (Monique, I_1, p.10).

Monique and her husband attempted to install him as the primary care provider, but this excerpt demonstrates that there were still traditional values at work, and a true role reversal had not transpired:

> *I think it is still a struggle. As women I think we ultimately still have to keep up the house. Even though my husband is home more, it's not like he's turned into Mr. housekeeper or anything. He did a few things, but you know... the house is a cyclone. Laundry is maybe done but not folded. We may or may not have GROCERIES. They can do one thing. They can't do FIVE like we do when we are home. I find that we are always sort of negotiating who has time for what. If I am not working, I am with Grace, and vice verse. It's a struggle, I don't know. If I didn't like what I do so much, I probably wouldn't do it. I wouldn't recommend it. It is really hard* (Monique, I_2, p.24).

This finding supports Hays (1996) work in which women considered men in the child rearing role as incompetent, possibly because they were not trained for the job through socialization, the way women have been. In addition to lack of training, it is postured that men's incompetence stems from lack of knowledge derived from the experts and from talking to other mothers. A new culture of parenting might encourage fathers to be responsible for gaining the necessary knowledge to competently engage in the child caring role, but again, this may not be in the best interest of a capitalistic society. Hays (1996, p.xiii) argues that the ideology of

intensive mothering is "protected and promoted" because it serves the interests of society, and is a sacred bastion against the "impoverishment of social ties, communal obligations, and unremunerated commitments".

Another prominent attribute of being a good mother emerged in seven of the interviews. The majority of the women voiced a desire, often fervently, to be a different kind of mother to their children than their own mothers were to them. As they reflected on their own childhood experiences, there was shared meaning about not getting enough affection from their mothers, not hearing their mothers say "I love you", and not feeling important in their parents' lives. Rosie attributed her adult lack of confidence and poor sense of self to the way she was parented by her mother. As a result, she was making conscious changes in the way she interacted with her daughter towards a goal of fostering self-confidence and a deep knowledge on her daughter's part that she was loved and wanted. What follows is a dialogue between Rosie and me that focused on her desire to be a different kind of mother:

> Rosie: *I grew up never feeling I was the most important thing to my parents because they always told me God was more important. Which was, it was fine if that's the way they felt, they should've never told a six year old..... I felt I always had a great weight on me that my parents loved God more than me* (Rosie, I_2 p.15).
>
> Pat: *...you said at one point " I don't blame her anymore, she was 21" [yeah] ...but I thought you were talking about your mom at that point, and you said there was no talking, no I love you's, um and so um you know, what do you feel that you didn't get from your mother that you want to be sure that- you're trying to do it differently?*
>
> Rosie: *Just acceptance, and love, unconditionally. I wasn't the frilly little girl she wanted, and therefore she, unknowingly, but she was always mad at me, always mad at me. I didn't like dresses, I played with the boys; she wanted a frilly little girl that sat in a lap and played with dolls and I wasn't that. So I consciously when I was pregnant, decided that no matter how Kayla was, if she played with the boys or liked dolls to let her know that that was perfect. And I don't want to use the word perfect too much, but however she was... was fine. I didn't want her to change, I didn't want her to be someone she wasn't, however she turned out or however she was ... that's fine, and build on her strengths, not dwell on the weaknesses* (Rosie, I_2 p.16).

Later in the interview she added:

> Rosie: *And I think one of the things I just didn't get from my mom was love ...And I'm not saying that she didn't love me ... but she didn't show it... So that's what I consciously* [do] *every day... hug and kiss and tell her I love her* (Rosie, I_2 p.20).

I interviewed Susan after Rosie, and used dialogue to share horizons and promote understanding. I wanted to know if there was shared meaning for most of the women around the idea of being a 'different kind of mother than their own mother'. Susan's perspective was that every woman wants to be different than her mother, but she also recognised that she and the other women are mothering in a different historical context than their own mothers did, prior to the women's movement, and also that in trying to fill in gaps in the parenting they received, they may create new gaps in the process. Here is a portion of the exchange between Susan and myself on the topic of mothering differently:

> Pat: *alright, this has come up quite a bit, and I wanted to toss it out to you. Are you a different mother than your mother was?*
>
> Susan*: I think we ALL are to a great degree just because of time, just because time changes. I think we always, well I shouldn't speak for everybody else... I think everybody WANTS TO BE a different mother than their mother was because they want to cover the bases that our mothers didn't cover. But then in doing so, we sometimes neglect what they covered, so I'm the same kind of mother in that I think my mother's children were very important to her, but I'm different in that my children aren't my everything either.*
>
> *So, to go back to your question, well I think there is more in my life than what my mother had, and I think that is true of any women now days compared to what it was a generation or two ago, but the basics are still there I think.....I had a very narrow perspective. I was one of 4 children. My father was home at 5:30 every night for dinner. We had standard schooling. We had a vacation every year. We did the same things over and over again. Routine was very important. My life is so different as a mother. Every day is so different. Of course you try to get your kids in activities that you think they might like for their life. You try and get them the resources they need to help with whatever the issues are. It's much different from the way my mother raised kids* (Susan, I_2, p.34).

Miriam was another participant who felt her mother was emotionally distant and not affectionate to her while growing up. She grew up in a traditional household with her father as the breadwinner. In contrast, she strived to be demonstrative to her son and keep the lines of communication open with him. Like many of the other women, Abbey related that her mother was not demonstrative at all. Sometimes when she hugged one of her sons, she remembered that she never received hugs like that. Here she recalls her feelings about the way she was mothered:

> ... *they couldn't say they resented it* [having 3 children by the time she was 24] *but she's SHOWN it by her... I think by her unaffectionate way. I think she's shown it and maybe she would have...could've had a college scholarship but her parents- they couldn't even afford to come up with the money to make up the difference so you know she, she used to talk about that "I wish I could've done that"...instead she had three kids so*...(Abbey, I_2, p. 57).

Monique's mother worked in a factory and her perception was that her mother came home stressed. Other women in her family filled in the gaps where she perceived her mother failed her. She tries to avoid being overly critical like her mother. This topic of mothering differently was also extremely important to both Florence and Mary.

Florence felt strongly that children need attention, should feel significant, and have a voice in decisions that affect them. She described growing up in a very traditional, patriarchal home, and she believed her mother was subservient, and a victim of sexism. She doesn't want her daughter to be a victim because of her gender or her (future) role as a mother. She believed her mother did not make choices about family size due to her faith, and as one of five children Florence did not feel she got enough attention from her parents. She works to help her daughter feel cherished, wanted and significant, while at the same time tries to be a role-model for mothering that is not one of *suffering and martyrdom*. A dichotomy existed between Florence and her parents who criticised her parenting techniques which they felt 'spoil' her

child. Florence's parents believe they were the better parents. This is how Florence responded to my probe about mothering differently:

> Pat: *One of the topics that has come up with some of the women, not all of the women is that they were very consciously trying to be different mothers than what their own mothers have been to them.*
>
> Florence: *Oh yeah. Very much, very much. Oh, yeah. IT'S HUGE. I feel like I think my parenting kind of stands out. Again, because I am raising an only child as well. I think sometimes your parenting looks pretty unusual because you give that child a lot of attention. I grew up in a family of five where we didn't get a lot of attention. Children of MY generation were expected to entertain each other and not have a lot of adult attention. We give Paige a lot of attention. It stands out and it looks a little of, particularly to my mom and dad and mother*[in-law]. *They think we are spoiling, really RUINING her. I don't think we are, you know.*
>
> Pat: *Some of the other women talked about because they had similar experiences or as one woman said, I never felt like I was special or that I was number one in their life, and that had an effect on her feelings about herself and self-esteem. So she is trying to do that differently. Did their style of parenting have any effect on you?*
>
> Florence: *Oh, yeah the same thing, feeling like one in a crowd. My husband was one of NINE children, so we definitely felt like we were one of the crowd and that we weren't significant. Paige feels VERY significant. That is a big BIG difference. The other thing we do differently is that we let her have much more of a voice. Have her say how her life goes. We didn't get to do that. It is a generational difference, but I think raising Paige now that we are older, I have done a little bit of counseling and my husband has done a little bit of counseling to kind of re-evaluate how we were parented. So we are making some very conscious decisions to parent differently; .....empowering her a lot more* (Florence, I_2, p.28).

Florence shared that she had done some peer-counseling with a friend to work through some of the issues of her childhood, namely her socialization as a female in American society, and her desire to raise her own daughter differently. I asked her about the context of her childhood and this is what she said:

> *Oh the context was very much traditional with the man working and ruling the roost, and the woman being very subservient. That was my role model; it made me very angry you know. By the time I was a teenager and an adult I was really pissed about sexism and about the way it operated in my family. I wanted to really GET PASSED that before I was parenting; I wanted to do a lot of work on that. Get out of the victim role that society puts women in. I still STRUGGLE there as a parent even NOW. I want to model for Paige not being*

a victim, you know as a female and not being a victim to parent suppression either, or the oppression of mothers. How to really have a good model for her having a really good life while parenting, and not suffering, not being a martyr, not sacrificing, you know there's some of that, you have to do some sacrificing... (Florence, I_2, p.30).

Mary was 50 when her first son was born. She and her partner made a conscious decision early in their relationship not to parent the way they were parented. Mary's perception was that her own mother was an inappropriate mother in that her parent's marriage was a disaster, and she remembers growing up in chaos. She feels the biggest difference in the way she mothers is language, in the way she and her partner talk to their children, and they have tried to be the parent each child needs. Mary spoke of being a "good enough" mother, someone who Bassoff (1991, p.176) says can "let go the expectation of perfection-perfection in our mothers, perfection in ourselves...". Even some of the women who thought their mothers were good mothers expressed ways they wished they were different. Peggy wanted to be more patient than her mother:

But I do remember thinking, I want to be more patient than my mom was, and I want to try to be more reasonable, and not just yell about stuff so much. But other than that, no not really. My mother was a very good mom, so, and I think she did a wonderful job of raising us and trying really hard to communicate with us. It broke down, when she sometimes lost it, so that one piece which I always said I wanted to do differently, I'm trying, but I don't know how successful I'm being (Peggy, I_2, p. 23).

Sarah remembered her mother being "*the epitome of unconditional love*", yet she did not remember receiving much affection from her mother, and she wondered if it was because she had five children and was too busy:

... I don't have a lot of recollection of a lot of hugs and kisses, and snuggles, and things like that. And I don't know if it's because she had five kids and there just wasn't enough time and arms. And I don't say that we NEVER had it, but I can remember being only seven or eight and it becoming my perception that I didn't kiss my mother good night anymore...I'm NOT going to let that happen. I mean, I don't always KISS them good night, but at least there's a hug and, you know, a good night, I love you kind of thing going on (Sarah, I_2, p.47).

Jackie was one woman who hoped to live up to being the kind of mother her mother was. There was nothing she wanted to do differently:

> *But she, I always looked up to her and to be honest with you, because I've thought a lot about it, I don't think that there's anything that I would have wished that she would have been different. She was just a really good mother. She was very honest with us. She had the patience of a saint. That's what, I wish I had more of that* (Jackie, I_1, p. 19-20).

Along with the first wave of feminism came a cultural tendency to blame mothers for everything that went wrong in their children's lives. At the same time feminists were advocating for women, they were 'bashing' mothers (Thurer, 1994). In her book My Mother/My Self, Nancy Friday (1977) examined the relationship she had with her mother, and whilst staunchly upholding her argument that she was different from her mother, she admitted to living with the 'helpless mother' who lived inside of her, and held her back from mothering children of her own. Friday believed that when women became mothers, they experienced an unconscious drive to be like their mothers, even if they dislike them. Contrary to this view, by acknowledging aspects of their own upbringing they did not like, the women in the current study were consciously attempting to break the "pattern of repetition between mother and daughter" (Friday, 1977, p.343). Caron (1998) found that mothers of more contemporary young adult women were not being blamed for their daughters' unhappiness. In fact, the young women she interviewed genuinely liked and respected their mothers and grandmothers. Some of this change may be attributed to different sociological and economical circumstances, or greater knowledge about women's development. It could be that like the women in the current study, change happened following examination of patterns of behavior, and conscious decisions to mother differently.

The common denominator in the interviews with the women in the current study was *inattention*, as well as insufficient physical and verbal demonstrations of love and affection. Hays (1996, p.110) found "love" to be the "basis of the necessary commitment to parenting" among the women she interviewed, and it is a component of the "logic of intensive motherhood". A time-consuming, labour intensive, child centered, constant nurturing gives children back the unconditional love they deserve, and is practiced to the extreme by "middle-and upper-middle class mothers"(Hays, 1996, p.115). If this is the standard for good mothering, and what is best for children, it too should have created conflict for the majority of women in the current study who were also working outside the home. Yet in the current discourse on mothering, even those women who worked outside the home accepted the ideologies of intensive mothering. At the time of the interviews, I did not ask them the source of their beliefs about good mothering, but based on their ages, levels of education, and the lack of similarly aged role models, it can be assumed that much of their knowledge and assumptions about motherhood have been drawn from the professional and lay literature. This would be in line with twentieth century mothers who relied increasingly on advice from experts such as Dr. Spock's Baby and Child Care, first published in 1945, Brazelton's publications, and Burton White's The New First Three Years of Life (1995). Thurer (1994, p.263) criticised the wealth of child-rearing manuals available at that time for imparting a sense of "moral superiority and absolute science, persuasive enough to put fear in the hearts of most inexperienced young mothers". A recent edition of White's guide (1995, p.15) stresses the importance of parenting in a "loving and attentive way in order to establish [in children] a feeling of being loved and cared for...", as well as having fun, showing affection, talking to them, and playing. White (1995) noted that some older first time mothers tended to be

overindulgent with their children, and this could make childrearing more of a challenge. Spock's book on baby and child care was recently updated by Robert Needlman (Spock & Needlman, 2004, p.12) who advises parents to establish a "loving, nurturing, and mutually respectful relationship" with their child. This is accomplished through accepting the child for who they are, playing and sharing happy moments every day, making a commitment to meet their child's needs, and setting limits. The women's efforts to live up to these standards of good mothering were made more difficult because of the unique challenges they faced as older mothers which are discussed now.

"It's a Triple Whammy": Older is Harder

A cluster of challenges impacted on older mothers and these were referred to by one of the women as the "*Triple Whammy*". Triple Whammy is used conceptually in this section to represent the primary complex issues which emerged as common meaning for these older first time mothers. The first of these was the challenge incurred by women who mother young children at an older age, an experience which the women perceived to be different from that of younger mothers. All but a few of the participants in the study complained of fatigue, and low energy, and all were experiencing perimenopausal symptoms to varying degrees. Decreased patience, mood swings, and fear of losing control placed additional stress on their interactions with their families. Additionally, as older mothers, they had aging parents, many of whom had health problems. Several were being actively cared for by these women during the timeframe of the study, and several had already lost their parents. Most of the women related they were *out of sync* with family members and friends, and the advanced age and/or health status of their parents contributed to an insufficient social network and lack of social support which profoundly affected their mothering

experiences. Their contemporaries were mothering older children or experiencing an empty nest, a metaphor for no children left at home because the children are either away at college or have moved out of the family home, and this created a dearth of mentors and support for these women. This section explores the shared and unique lived experiences which the women found challenging in these domains. Though the women spoke of both advantages and disadvantages inherent in being older mothers, the focus of this section will be on the disadvantages. Lack of social support was so prevalent in the discourse on midlife mothering that, although mentioned briefly here, it is presented fully in chapter seven.

All but two of the women identified themselves as different from younger mothers in ways they perceived to be a disadvantage. Common points of separation centered primarily on fatigue, lack of energy, lack of patience, decreased physical capabilities and perimenopausal symptoms. Leslie who was 49 years old, spoke of being different from younger mothers. She noticed a communication gap with younger mothers when she tried to talk to them about menopausal symptoms. Prior to this, she had not been perceived by them as an older woman, so there was some dissonance amongst the younger women when she complained about hot flashes. Leslie was also one of several women who felt out of shape and overweight which she perceived put limits on what she could do physically with her children compared to younger mothers. She gave several examples of times when she felt different from the other mothers:

> *It's funny now that I'm getting into this other age phase with the menopause and almost 50, there does seem to be a little bit more of the separate, the age thing is a little more an issue because they don't know what the hell I'm talking about when I'm having hot flashes. They all think I'm joking because most people say you don't look 50. They think I'm joking when I say I'm having a hot flash or I'm always hot. Aren't you guys hot? You're making me hot looking at you, you've got on a turtleneck and a sweater and I'm dying*

with this light jacket. They have no idea what is wrong with me (Leslie, I_1, p.25).

At the start of each follow-up interview, I asked the women if there was anything they had been thinking about since our first meeting. In response to this invitation, Leslie shared one of her beliefs about what mothers 'should do', which is to participate in activities with their children. Although she cited fatigue, less energy and more physical ailments that prevented her from sledding with her daughter, she did not understand why the younger mothers did not participate when they could be doing something she longed to do with her daughter. This is what she said:

> *I think maybe I feel more tired and so I, so my perception is that I'm not as energetic and doing as much which you know again I think a lot of it is a perception thing and maybe it's just the ability to internalize or, or you know fight through whatever's going on and just keep going. And um, I guess I sometimes I feel guilty about that and then I think, you know, I've seen 20 and 30 and 40 year old mothers who won't go sledding with their kids because they don't want to... And right now I'm not going sledding with her because I hurt my knee and I don't want to mess it up anymore but I've DONE THAT in the past* (Leslie, I_2, p.40).

Florence responded to a question about whether her health had any effect on her ability to mother her daughter. She too cited physical limitations due to her age which affected her ability to play with her daughter:

> *Oh, YEAH, oh yeah. I definitely think if I were a younger mom, I could be even more physical, in you know some of the play. She still loves to be carried a lot, and I still like to carry her, but I can't do it now. I don't know how much she weighs, now, probably 35 or 36 lbs. I do think that is weight bearing, since I don't have time to lift weights. I just carry my daughter instead. I tell her, I am an older mom. I can't do some of the things that I would really love to do especially when I start to get aches and pains in my shoulders* (Florence, I_1, p.15).

When I asked Peggy what it was like to be a mother at this point in her life, this is how she responded:

> *Tiring- I remember talking last time* [she was referring to the first interview] *about tiring. Just the lack of sleep still is one of the biggest challenges for me um and when I get sleep I'm very much happier, so I'd say challenging in*

> *terms of just being tired um and having PATIENCE with them*...(Peggy, I_2, p.3).

Susan found it difficult to keep up with her schedule. She was mothering a daughter with a disability, and spent additional time with teachers, as well as appointments with physicians and therapists:

> *Then of course, we have the multitude of schedules and all the things we have to go to; the school, the school meetings, school committees that I'm involved on now, and the school activities that you go to. Not to mention the extracurricular things, which most of Hayley's extracurricular things are therapy related, not sports related. So, we have all of those things which is a lot to handle when your energy is dying down and you want to go to bed just as soon as she goes to bed. The energy level is really tough... I mean I know that my energy was much greater when I was ten years younger than that, and that now it is just difficult to keep up there and do all the things you want to do* (Susan, I_1, p.9).

Besides fatigue, the domains of play and flexibility were areas in which older mothers thought they were different from younger mothers. Here, Rosie voiced her perception that younger women can 'play' better with their children:

> *I think younger mothers also have in them more flexibility, more energy, more you know they can probably play better with the kids. I think in that respect they are fortunate that they have more youth to, you know, have a different mothering experience with their kids, not in their life experiences, but definitely I think it's probably less rigid, although we're just in this house, we're we clean, we have rules. That's just how we want to raise our one child* (Rosie, I_2 p.19).

The women were quite willing to discuss the disadvantages of mothering at an older age, which is in distinct contrast to Nelson's work (2004) in which she noted that older mothers were reluctant to discuss negative aspects of midlife mothering. Yet, similarly negative concerns amongst older first time mothers relating to fatigue and less energy were noted by others (Mercer, 1986; Enter, 1993; Reece & Harkless, 1996; Carolan , 2005). Current findings are also consistent with the work of Reece and Harkless (1996) who found that older mothers compared themselves to younger mothers and believed they would have had more energy if they were younger. The lay

literature alerts mothers over 35 that stamina will be less than younger mothers, and a lack of energy may result in stricter parenting (less tolerance for chaos), and that cumulatively, the transition to menopause will result in even more fatigue (London, 2001; Moore & De Costa, 2006). In contrast to these findings and advice from 'the experts', findings from the Leicester Motherhood Project (Berryman *et al.*, 1994) noted fatigue to be less prominent among first-time 40-plus mothers than what the mothers originally expected. This suggested to the authors that perhaps older women attribute the normal fatigue of motherhood to their age whereas younger women chalk it up to a normal expectation of motherhood.

Miriam is an example of an older mother who did not experience diminished energy. She was 49 at the time of the interviews and she reported an incredible amount of energy. Jackie also offered a different perspective than the other women. She still felt young and attributed her youthful appearance to her attitude. She reported that she has been able to befriend some of the younger mothers, and has found ways to "*get along*". Here is what she had to say about herself and younger mothers:

> *...you know I, I still, in my mind I still feel like I'm 20 years old. Um, I think it's all attitude. And, to be honest with you some of them that are like 20 years younger than me I don't really see much of a difference sometimes, you know? Most of the girls have let themselves go, um, they're just, they're overweight, no makeup, baseball jackets, you know and it's like ok fine, that's you. But I feel good, I always took pride, I always get up, I always do my hair, put a little make up on. Takes 2 seconds, I always dress decent and um I, I GET ALONG FINE. A lot of them are friends, because of my daughter* (Jackie, I_1, p.16).

Jackie did admit that she is reminded on occasion that she is older than the other mothers when she is mistaken for her daughter's grandmother. She did not like it when that happened, though she thought it was understandable when it happened to her husband who is older than she:

> *But ... once in a while you'll get a smart alec* [someone who displays smug cleverness] *who'll say, oh is this your grand-daughter? I'd like to punch them one you know I'm like, NO, and, but that, sometimes that hurts you know, others say, is this ah is this your niece, or they're afraid. I'll say geez do I look bad or, maybe I do. In my mind I don't think so, but... My husband gets that a lot, oh is this your grand-daughter, course he's almost 60, so um, he still looks good though, but him I could see him mistaken you know. But, no I feel good though* (Jackie, I_1, p.16).

Shanny, aged 48 validated the challenge of diminished energy among older mothers, and addressed the added burden of perimenopausal symptoms which affected her ability to keep up with the children:

> *Yet I wouldn't be dealing with this aspect of whatever* [perimenopause] *if I were younger, and it definitely is tougher energy wise and I have a real high energy level. I am a Type A. There is no question. I often wonder you know, could I keep up with these kids if I weren't a Type A. It would be difficult, physically with all the running around and the emotional stuff. So, you know on that end they are dealing with my menopause, they are dealing with my age and I'm saying I am not average, but I think another person who didn't have a real high energy level would really find it difficult to deal with this and raise kids (Shanny,I_2, p58).*

Someone with a type A personality exhibits time urgency, impatience, aggressiveness, and a strong sense of achievement (Scott, (2009). Shanny's point was that if she were not so driven, she would have had more difficulty keeping up with her children's level of energy. The women shared a pre-understanding that as older mothers they would have more patience with their children. Rather, more than half of them expressed concern because they were less patient with their children than they thought they would be. Jackie offered an explanation for why she felt less patience. She was 50 and mothering a 10 year old daughter; she attributed her lack of patience to the fact that as an older mother she was too much of a perfectionist, and did not deal as well with the messiness that comes with having children in the home.

> *It's, I think it's very hard... I mean it's a hard job, I, I didn't realise how difficult it was, would be..... But sometimes I think it's harder, um, I don't have the PATIENCE that that probably I would if like my mother would say that's why we had them at 21, you don't know any better and nothing bothers you and, I think*

there's a lot to be said for that. The younger you are, maybe things bother me more because I'm older and more of a perfectionist at this point, um I like things just so, and it's hard to... you know like I said you just do something and it's messed up two minutes later or there's stuff to pick up and um, I guess it's, it depends on the person. You know, it's, it's very hard though (Jackie, I_1, p.16).

Most of the women voiced concerns about decreased patience in the context of experiencing perimenopausal symptoms, which had an emotional or psychological affect on how they were feeling. It is in this domain that the overlap of perimenopause with motherhood was most significant. The most commonly named complaints were feeling moody, short-tempered, anger, rage, on the edge of losing control and sometimes losing control. The impact on mothering was noted to be decreased patience, yelling, and screaming at children, snapping, over-reacting to insignificant things, 'turning into a bitch', and decreased ability to cope. None admitted to actual child abuse, though several women feared that they might hurt their child. One said she could identify with the rage she imagined a woman probably felt when she killed her children in a widely publicized case in the United States. There appeared to be a correlation between the severity and frequency of menopausal symptoms, and the degree of impact on mothering abilities. Roxanne's perception at the time of her interviews was that she was feeling better and seemed to be "*coming out of it*" (perimenopause). However, she described a period of two years when her perimenopausal symptoms were "*really bad*" and the impact on her children was at its height. The following exchange is long but critical to understanding how difficult it can be to carry on with the responsibilities of mothering during this time:

Pat: *Can I take you back to those two years that you talked about that you mentioned were really really bad with the hot flashes, and mood swings, while the kids were little. Can you re-construct a day in your mind, you mentioned one in your journal that you remembered, when everything "going on in your life combined with your mood swings"* [I visualized this as a collision of these overlapping threads in her life] *"to make it difficult in the house"?*

> Roxanne: *I don't know if I can think of one day but I can think I remember waking up Oh- and I hadn't even gotten out of bed yet,* [crying a little, sniffling] *and I feel like oh God I've got to do this again, and I knew there was going to be, I would have to spend a whole day with my children who were going to aggravate me and I was going to try so hard to not be angry. And I hadn't even gotten out of bed yet and I already knew I was going to fail. And it made me feel like such a horrible mother, and I would start the day praying and beg God to please give me patience. I would sometimes just look at the clock and it was 11:00 it's still good, you know, it's still OK, and then something would happen. We would be trying to get in the car or someone would call from work or something, I just couldn't, something would happen that I couldn't get it all done, and I would start yelling at the kids 'you've got to get your shoes on' or 'we have to get going' or I would get in the car and start leaving because I would ask them fourteen times to get ready and the screaming would start. I would be screaming in the car at them, and they would just be sitting there looking at me and I would just be I'd know I have to stop, stop screaming at them, just stop. But I couldn't, I would drop them off wherever they had to go, they both went to afternoon kindergarten or pre-school, and then I would sink into this horrible feeling that I've just yelled at my kids again. 'Why, why did I just do that?" And I would feel so bad* [voice is very deep and low].....
>
> *And especially at that time there were so many things in the paper- there was the woman in Texas who drowned her kids, and I couldn't even read that story...It was in People Magazine and I would purposely not look at it- I just couldn't read that story because it was- not that I would ever hurt my kids- but it was too close, like I know her rage and I was so afraid of that and I did everything to keep myself away from my children when I was angry like that.* [sniffling]*I would put myself in a time-out. I would say you know I am so angry with you two right know that I'm going to go in time out- you need to be quiet. And I would go upstairs and calm down* [crying a little] *and read or pray or do something so that I could come downstairs and be calmer with them you know* [pause]. *It wasn't- most of the time I was able to control it and they didn't know, it was just those probably- in that two year period there was probably twenty times that I felt that way- been mean, I just felt that I'd been mean, I had just been so angry* (Roxanne, I_2, p.36).

Roxanne never made a connection between her health during this troubling time, and how it had impacted on her mothering. She thought she could not handle the stress of being a mother, and thought she must hate her kids. Her provider told her she was not menopausal and that she just needed to get some sleep. At the time of the interviews, she was feeling much better, though she wished someone had validated what she was going through, acknowledged her symptoms, and given her a timeline for how long perimenopause might last.

Shanny was the most symptomatic woman I interviewed, and like Roxanne, the impact on her mothering was significant. She was aware of a change in her health for about one year or more, and this was how she described what she was experiencing:

> *...I would say about a year or a year and a half ago I started to exhibit the signs and symptoms of perimenopause. It's as I said to you my biggest issue with the menopause is the lack of patience that I have. I find it really difficult because my kids are the centre of my life. They're used to me being very calm and that has just changed. Like it or not. I work very hard to keep myself intact but my anxiety level is high and stupid things will set me off. I yell a lot more than I should. I lose my temper. I just in general am short, short with them and I don't have any patience. That is the worst part with this menopause* (Shanny, I_1, p.15).

Here she described how she thought the children were dealing with her transition to menopause:

> *EVERYTHING WAS OK WITH EVERYONE ELSE. Now I feel like does anybody get it? I'm not feeling great here. I tell my kids as young as they are. Mommy is in what they call menopause. It's a change in her body. There are a lot of things going on. Her body doesn't always feel good. She sometimes has no patience, she gets hot, she gets headaches. When I get a little aggravated, I try to explain to them in their terms. I say it's hard, because it's not your fault, but you have to be a little bit more patient with me and have to try and cooperate a little more. I try to do all this age appropriate target. It's kind of a joke with them. They look at me like what are you going to do with me next, like all children do* (Shanny, I_1, p.18).

A little farther along in the interview, she admitted that not only were her children aware of her lack of patience, they confronted her with it:

> *They say you yell too much. You don't have any patience anymore. They are aware of it. They verbalize it. My kids are very well adjusted and say, can you cut it out. We don't want to listen to you yelling. My daughter says, why you yelling? I say, you're right and I apologize. I say look I'm just having a bad day and she says "you're always having a bad day"; then I try to explain it to them* (Shanny, I_1, p.36).

Leslie tried not to blame 'menopause' for how she was feeling, but then questioned whether she was losing her mind, and whether she was too old to be a mother:

> *And um and I think that's a BAD thing almost* [not to blame menopause] *because then you're wondering oh am I losing my mind you know, do I not have you know, am I too old to be a MOTHER you know ..., if I feel like I'm being impatient, which some I guess sometimes that's I, I've been told I am*

> *very out of perspective with myself as far as patience because I, I feel like sometimes I am not patient. And then I've had people say, oh you're so patient. You have so much patience I don't know how you do it. And so maybe I'm very good at internalizing it and I just feel inside that I'm, ahhhhhh, I'm gonna lose it* (Leslie, I_2, p.38).

Leslie questioned whether her six year old daughter was even aware that she was 'going through menopause' and wondered how she would explain it to her:

> *Oh my God it's it must be bad enough for older kids but when you're six how to you ex- you don't even really want to explain it to a six year old. And um then if you do, do they get it? I mean they probably get it a little bit but they're still kind of egocentric at that point...* (Leslie, I_2, p. 41).

Though not as symptomatic as Shanny and Roxanne, Leslie also described trying to maintain control to prevent her daughter from detecting that she is irritable. There was some ambiguity in the text that first suggested her daughter was not aware and later she refuted this when she said her daughter was capable of seeing through her pretenses.

> Pat: *And some of them* [the other women] *talked about a real rage almost like this monster inside them that they kind of had to suppress to be able to parent. But it sounds like you haven't had the symptoms affect you as dramatically maybe.*
>
> Leslie: : *But they* [perimenopausal symptoms] *do carry over and sometimes he'll* [boyfriend] *make comments about you know, mommy's tired if he feels like I'm being more irritable or short* (Leslie, I_2, p.44).

Her discourse went on to muse if her daughter will be affected by her menopause experience:

> Leslie: *And I'm thinking oh- is going through menopause and having a child my age gonna have long term implications for her because even though I'm trying to put on this front she can read through it... type thing. Cos' kids can read through stuff* (Leslie, I_2, p.46).

Jackie spoke about decreased patience and 'losing it' when she yelled at her daughter:

> *...and I'll say mummy just needs a nap honey. But she gets really upset. I think it's cos' she doesn't have my undivided attention. I know that's what it is. ... but she tries my patience a lot and I do, I do a lot of yelling. I mean after you try to explain something calmly like THREE times and there's still...then I just lose it* (Jackie, I_1, p.22).

When I asked Florence about anger, mood swings and irritability, she was quick to confirm what the other women had said about feeling irritable. She was concerned about her irritability, and a propensity to 'snap'. This is how she described how quickly her mood could change:

> Pat: *Several of the women talked about anger, severe mood swings, irritability. You didn't...*
>
> Florence: *Oh definitely my irritability. I feel like...as a parent you're so generous. You just give and give and give, but you can switch* [snaps her fingers] *very... Like I'm amazed at how quickly I can TURN INTO AN ABSOLUTE BITCH.*
>
> Pat: *I know and that is what they are talking about*
>
> *Florence: FROM DOORMAT TO BITCH IN 3 SECONDS. I mean it's just yeah, yeah* (Florence, I_2, p.33).

Monique described a short fuse, increased anxiety, and less patience over the past few years. I asked her if she could describe how her anxiety manifested itself:

> *I think my fuse is very short. Fuse is very short, I reach a point where it's like...I can't possibly... Anyway, I think it is just the fuse is short, and I can only handle SO MUCH, and something's going to give, and that whole thing, you know. At one point, I was thinking, I'm going to leave everything and I am going to go to California. Admit defeat. Some kind of crazy thoughts like that I'll have where I sort of have to get away from it all. It is impossible to do all this. It was a crazy idea to begin with. What was I thinking at my age. The only answer is to leave it all behind and write her* [daughter] *a note [laughs loud]. Sorry – I really tried, but I can't do it...* [she is laughing loudly] I've had crazy thoughts like that (Monique, I_1, p.8).

During her second interview, Monique elaborated a little more about mental health issues, which were of concern to her:

> *Well, I am definitely feeling more depressed lately, and I think just a combination of my business, the marriage, child, parents. I'm definitely feeling a lot more moodier and needing a little bit of a tune-up in that area, which I'm going to be getting you know* (Monique, I_2, p.31).

Peggy was concerned about feeling more moody, not handling stress very well, and loss of control. She worried about her irrational behavior at times, and like many of

the women, she talked about 'losing it' over things that would normally not have pushed her over the edge:

> *Oh yeah, in terms of my period, is still pretty regular, but when it comes, it comes gangbusters* [heavy] *for a day or so, and then it sort of dribbles off, and uh mood changes, I think I talked about my inability to be RATIONAL, that I do find myself being more moody, and is also somewhat related to the sleep deprivation that when I'm in one of those sort of states of mind where things do really bother me, that I don't I don't handle stressful situations very well, and I tend to fly off the handle in ways that I would later realise I'm being irrational, so yeah definitely...* (Peggy, I_2, p.13).

The presence and/or significance of psychological symptoms during perimenopause have been vigorously debated in the literature over the years. Recently, Bromberger *et al.* (2001) found irritability to be more prevalent during perimenopause than during pre or post menopause. Freeman *et al.* (2007) examined six common symptoms of midlife women, and found stress and depression increased during the transition to menopause, however, irritability was not one of the symptoms assessed. Li *et al.* (2000, p.12) assessed 214 perimenopausal women aged 40-55 years old and found lack of energy and irritability part of the experience for more than 40% of the woman in their study. Irritability and other psychosomatic symptoms were found to be ""quite a bit" or "extremely distressful" by 29% of the women and "somewhat distressful" for 20% of them. The particular concern of the women in the current study regarding irritability and lack of patience was their fear of losing control, loss of control, and the efforts they had to exert to maintain control or 'keep it in' because they did not want to act out, or let their children see them as anything but loving doting 'good mothers'. The current findings contribute new understanding to the literature on older first-time mothers as most other studies were conducted with younger women who were not simultaneously perimenopausal.

Issues of control and loss of control are not new in the women's health and psychology literature. A discussion around fear of losing control and losing control in

a context which most parallel's that of mothering during perimenopause can be drawn from the literature on premenstrual syndrome (PMS). Chrisler (2008, p.2) examined the literature and self-help books on premenstrual syndrome (PMS), and found that "women frequently confide fears of losing control of themselves", and much like the women in the current study, losing control engenders feelings of shame. Chrisler (2008) identified a gap in the literature that fails to identify what it is that women are afraid of, but that anecdotally, emotions and anger are among the biggest fears. In order to maintain control, and thwart any "impulses that might discomfit others or appear to be a selfish expression of one's own desires", women engage in the practice of *self regulation.*

Self regulation theory is based on systems theory, uses a feedback loop, and requires three elements: "standards, self-monitoring, and ability and strength" (Chrisler, 2008, p.2). I would argue that self regulation theory can be used as a framework for understanding the effects of perimenopause on midlife mothering capabilities. For these mothers, the standard they are desperately trying to uphold is the ideology of intensive mothering with the mother as the primary care provider, and the child/children as the central focus, deserving of special attention and more priceless than any outside work or career (Hays, 1996). In order to self-regulate their behavior, the women monitored their expressions of emotions in an effort to prevent or override the impulse or impetus to lose control. The women described this monitoring as conscious, continuous, and exhausting. They questioned the impact their menopause experience was having on their children, while at the same time denying that their children were aware of anything amiss. Susan's daughter was 10 years old and has Asperger's syndrome. Susan's perception was that her menopause experience must affect how she mothers, but she could not identify what the impact

was. She tried to explain to her daughter that she does not feel well at times without relaying the message that she is 'sick'. This is how she responded to a question about the intersection of menopausal symptoms and mothering a young child:

> Pat: *Does the intersection of menopausal symptoms and how you are feeling affect your ability to mother your daughter?*
>
> *Susan: I think it has to. I think it has to. It's hard for me to see it and it's hard for me to know how it would be different. There are times I tell her, you know, I just don't feel good. You just have to lay off, and don't badger me today because I just don't feel that well. I don't know also how that comes across her. I don't want her to feel like I'm a sickly person, because I'm not. It's just these symptoms that come up..... We talk about our health issues but she doesn't respond to us. .....She takes it all in, but I don't know how she is processing it and how that might affect her too In that respect, I don't think I'm not doing things because of my symptoms, but there has to be some sort of emotional effect on her based on how I feel some days* (Susan, I_1,p.10).

Susan agreed with what the other women said about being short tempered and irritable and that things that would normally not have bothered her prior to perimenopause now pushed her over the edge. She found her own behavior disturbing at times, and was concerned that despite examination and self-recrimination, she seemed to repeatedly be harsh:

> *Yes, insignificant things. I guess I don't know how much that is my daughter being in her pre-teen years or the combination of that and the short tempered symptom of being perimenopausal. I don't know because I really don't have anything to compare it with. My memory says that I was CALMER when my step-kids were teenagers, but then some of that had to do with ...I was able to defer a lot to their father that I didn't have to face too. Whereas, now I'm kind of like, "THE PARENT" half ...being the single parent half the time. That is disturbing because I think, oh how could I have been that harsh? Yet, I'll do the same thing tomorrow. It's like I can't help myself from stopping* (Susan, I_2, p.31).

Less empowering explanations of control issues with PMS suggest that women have dual personalities, and it is the 'other person' who loses control. This explanation might comfort a mother who can interpret this and pretend that she is still upholding the tenets of good mothering, while the 'other mother' behaves badly.

Shanny referred to this 'other person' who lost control as the "*monster*" she had to keep at bay. A more academic definition of self-regulation (Chrisler, 2008) poses the idea that sometimes lower processes override higher level processes which result in self-regulation failure. The latter offers a woman hope that the next time she might be successful at regulating her behaviors, versus the notion that she has lost the ability to resist her impulses (Chrisler, 2008). The third element of self-regulation would require that a woman has the ability, strength willpower and self-efficacy to make changes necessary for self-regulation. Shanny and Roxanne both talked about having to control their behavior or keep themselves in check to prevent losing control and saying or doing something they would regret. This is how Shanny described the conscious efforts she made to maintain control:

> *The other thing with my body, you know, the mood swings and everything. The way I describe it now, I'm so conscious of snapping and being short tempered that it's almost become a full time job to not do it. I'm just adamant that I can't do this with the kids, that I can't be snapping at them, and I can't be angry at my husband for stupid things. So now I have to keep myself in check, and that is like emotionally exhausting almost, you know to keep myself in check* (Shanny, I_2, p.51).

Keeping themselves in check to prevent losing control helps to maintain their standard of the good mother. "The social and cultural silence about the stresses of motherhood supports the expectation that good women, and especially good mothers, are always soft-spoken, patient, receptive, nurturing, and kind" (Chrisler, 2008, p.4). Yet, the women in the current study were able to break through the usual taboos and break their silence to express the sometimes negative realities of their experiences as midlife mothers. They held themselves to a high standard of mothering, one which required constant monitoring, in part due to the infiltration of self-described negative emotions. However, maintaining control over negative emotions can deplete resources that older first-time mothers may have difficulty restoring.

It is well known and accepted that restoration of self involves finding time to relax or indulge in activities that one finds pleasurable. Yet, the women admitted that it was very difficult to find time for themselves, or to do things that they used to do. Susan admitted that taking time for herself made her feel guilty. It took Roxanne ten years to finally take the time to have a bath in her tub. She unexpectedly found herself with a day to herself and savored the time as a "gift":

> *SO I HAD THIS WHOLE DAY AS A GIFT, AND I THOUGHT IF I HAD KNOWN THIS I WOULD HAVE DONE THIS A LONG TIME AGO- WHAT A GREAT GIFT THIS WAS* (Roxanne, I_2, p.40).

Shanny felt bad for trying to claim some time for herself. She waited 40 years for motherhood, and her perception was that motherhood should be enough to sustain her. Recently, while perimenopausal, she has started to ask for more:

> *I feel like I want to do more things for myself. You know what, I don't want to clean my house anymore, and I'm a meticulous person. It's like oh God all this stuff is like, I just want to take care of me. I guess that's something you want to do all along. Then again, I say to myself, well you know what, all you ever wanted were these kids and this life. You waited 40 years for this. Get over it! You had a really good life before this, you know, and I did. I have a good life now. I don't mean it that way, but it's just that there is no me time as most people will tell you. I am trying to cut that out, and I'm not getting a lot of support for that* (Shanny, I_1, p.30).

Monique was juggling a business, mothering her daughter, home responsibilities and caring for her ill parents. This next excerpt was an inquiry into how she carved out any time for herself:

> Pat: *Where is the time for you?*
>
> *Monique: I don't have any. I don't really have time to see my friends. I was just thinking lately I want to go to dinner with people. People will call me and say they haven't seen me in a while. But touching back on that, if I work all day, my husband wants me home in the evening to relieve him from our daughter because he has been with her all day. If I'm home during the day, and I take care of her, then I may need to work in the evening to catch up with what happened during the day. Somehow we are always passing the baton. I don't know what the answer is, I don't know* (Monique, I_2, p.24).

Monique was so desperate for time to herself that she actually fantasized about separating from her husband so she could have a break from responsibilities:

> *... I think it's the juggling of how to do IT ALL that I find challenging and emotionally draining right now. I fantasize about... it goes through my head, I might as well be honest, is that in a perfect world, what now would be best for me is if I were split from my husband and had my daughter three days a week. And then to me, that would be like ideal, because I would have some time to myself, you know I'd have my daughter part time, I'd feel rested for that, and I wouldn't have to negotiate WITH A SPOUSE. And I could deal with my parents, and that's what's sort of been going through my head. I think about that's just kind of DESPERATENESS of how I feel about MY TIME* (Monique, I_2, p.32).

Miriam was separated from her husband and her son spends some time with his dad. She admitted it was difficult to find time for herself, but she worked at it:

> *I work it in. You know, I can work it into the schedule. It's HARD sometimes. You know, the days that I work especially, you know, are very busy, you know, and then it's like the after school, figuring out like where's Evan going to go, you know, who's going to be watching him. But I exercise, like I said, mostly on my days off. But even like on the weekend, like when he's with his dad, it gives me an opportunity to go out and do stuff* (Miriam, I_2, p.56).

Part of the problem finding time to restore themselves was due in part to the lack of social support these women had available to them, and this will be explored in depth in the next chapter. Despite the challenges facing older mothers discussed in this section, most of the women were very positive about the advantages afforded them as older first-time mothers, and these are discussed now.

***"It's Almost a Catch 22"*: Older is Better**

Eleven of the women were able to cite advantages to mothering at an older age. These included more life experience, education, financial stability, career fulfilment, feeling settled in their life, possessing a wisdom that allowed them to keep 'things' in perspective and the ability to see the bigger picture. Peggy described the two sides of

her experience as the "*ying and yang*" of mothering. Here she reflects on a life perspective that may be more common to older mothers:

> *I just appreciate them [her children] sooo much and I think I do have being older I have more of a perspective of sort of life as a whole, and we've been through a lot of tragedy's in the last well... my mom died when um she was only 57 that was now 16 years ago but a in the last 3 years I've also lost my sister* [Pat-*oh no*] *and my stepmother so we've had a lot of tragedy in our lives so I think that has made me really able to appreciate a lot of the good things in life and so having these two little kids has just been, you know, so I just I often will just step back and watch them or some of the things that they'll say and it just you know it just melts my heart it's so wonderful so it's like this...ying and yang or whatever these you know, the times when it's just SO WONDERFUL and then it's the other times when it it's just so hard (*Peggy, I_2, p. 3).

Most of the women reflected on how mothering at a younger age would not have been the same experience for them because they were in a different place in their life now. Shanny was 48 years old and mothering an 8 year old daughter and a 9 year old son at the time of the interviews. Here she reflected on the advantages of having her children in midlife:

> *I honestly think about the age thing too. You know, if I were younger and had these kids, I feel like it's almost a Catch 22. If I had had these kids at 25 – 30 years old, I couldn't give them a lot of what I am giving them now with my life experience, my education. The research I do about everything on these kids- I couldn't have given them* [if I were younger] (Shanny, I_2, p. 58).

Rosie was 46 and mothering a daughter age 6. She confirmed that she felt different because she is an older mother, but she reveled in being different. She too thought that this provided advantages over younger mothers:

> *It's wonderful and it's odd,* [being an older mother] *because I go to the school for functions, and everyone is 20, bouncy, and had two or three* [children], *and you know. Not that I feel like the odd duck out but and I don't really care, but I'm different and I don't care, but it's interesting to me to go and listen to some of the younger mothers as to what their concerns and problems are. They haven't had as much life experience as me and I think " don't worry about that" you know...and I think it's been helpful, I couldn't have had kids at 20 I was too wild. Probably being as old and wise I know all the tricks* (Rosie, I_1, p.3).

During her second interview, Rosie described a situation which several of the women in the study have experienced: being mistaken for the child's grandparent. Despite this, she continued to stress the advantages of being an older mom.

> *I mean I am different but I revel in being different. I love it. I went to the gym the other day to pick her up early and someone said oh are you the grandmother? I said, you know, I said I know I have grey hair and I'm looking a little bad today BUT I'M THE MOM. Thanks anyway. And she was horrified, and I said it doesn't bother me* (Rosie, I_2, p.21).

Peggy also felt that being older helped her keep things in perspective. This is how she responded to a follow-up question from me about whether she thought she was in a different place in her life because of life experience and losses:

> *You know I think that's really true I think...but it also so, so that's an advantage because it allows you to sort of put, put things into perspective and I definitely think the little things a... that use to bother me a lot are not as much now I don't know if, if that's my getting, my being OLDER or if it's just my children are getting older and I'm getting more used to all that...stuff and I don't freak out now when they get SICK and I have to miss WORK and everything gets you know thrown into a tailspin I don't get as upset about those things or the daycare person is sick and all of a sudden I have you know I have kids for the day so that doesn't bother me as much but part of it I think is that I am better able to put things into perspective* (Peggy, I_2, p.11).

Shanny also noticed, like most of the women, that there was something different about how she mothered her children compared to younger mothers:

> *I think every mother loves their child. Parents protect their children. They love them. They want the best for them. There is something about how I feel when I talk to other people, there is something that is different [from younger mothers] in the way that I focus on my kids and I prepare for my kids. They just are all consuming to me at this point. I feel I can do that* (Shanny, I_2, p.71).

In the second interview with Rosie, I followed up on a comment she made about her ability to be a better mother because she was older. This is another example of how the women and I participated in dialogue to reach an understanding (fusion of horizons):

> Pat: *One of the things that you talked about [in the first interview] was you said, "at this age I can be a better mother"* [Rosie: *right*] *and you talked a little bit about ...if you had been a mother in your twenties you don't know how that would have gone because you were wild. Do you want to expand on why you think you're a better mother at this age?*
>
> Rosie: *Sure. I think in your twenties you're so young you just want to experience so much of life, and I don't think you understand. I don't feel now that I'm straddled with a child- now I'm blessed with a child. I think at twenty if you get married and pregnant while you want to experience and do so MUCH, you are in a way held back because you have to take care of a child which is all consuming. And I wouldn't have done a good job at my age because I was too busy doing other things and living.* [Now] *I'm more street wise. Education not in school, but I'd say life. That's who I am, all your life experiences get you to where you are*
> (Rosie, I_2, p.14).

Florence at age 48 captured the unique advantage that older mothers may have in that before they became mothers they had many years to pursue careers, dreams and travel. This is what she had to say:

> *I think mostly there are advantages actually... I think it's mostly I've had enough time to do everything that I've wanted to do. I really don't feel deprived like I think some OTHER PEOPLE DO. A friend of mine had all of her children when she was in her early 20's. She had four children. Even though they are teenagers and young adults, they still need her a lot. She says, when do I ever get to have MY LIFE? I feel like I've really had my life. Until I had her, I had ALL THAT FREEDOM from young adulthood. I did WHATEVER.. I traveled..... The traveling I got to do! I don't have this big feeling of I'll never get to have my life. I got to do what I wanted to do, and now I WANT TO BE PARENTING. So, maybe I'm a little bit more tired and have a few more aches and pains in the way, that seems less, you know, so much less than the gains from having waited* (Florence, I_1, p.16).

These findings lend support to Dobrzkowski and Stern's theory (2003, p. 250) that a woman uses her "past knowledge and experiences to mold her present and future relationship with her child(ren), but that being different takes its toll". Older women are satisfied with their life and ready to embrace parenting (Winslow, 1987; Carolan, 2005). However, the commitment to parenting for the women in the current study placed them in contrast to Woodward's (1997) contemporary 'independent mother' who combines motherhood with a flourishing paid career, a blend of

autonomy and independence, and Nelson's (2004) older mothers, struggling to blend career and motherhood. Perhaps because these women were older than most other samples in the literature, the women in the current study have already experienced independence and autonomy; they have 'been there and done that' and chose to make concessions in the work domain in order to be more present and available to their children.

Nine of the thirteen women expressed an overall sense of satisfaction with the mothering role. They were content to be doing exactly what they were doing, and felt settled. This is in contrast with Mercer's (1986) older mothers, who reported the least gratification in the maternal role. It is important to note that the women in Mercer's 'older group' were only 30-42 years old, significantly younger than the current sample. Furthermore, twenty-five years have passed since Mercer's study was conducted, and the changing demographics of women who delay motherhood today may not parallel those of the women in Mercer's study. During the interview with Shanny, I asked her why she thought she was different from younger mothers. I shared with her that one of the other women in the study described younger mothers as 'itchy' to get out into the world, and less satisfied with being at home with their kids. This is how she responded to this probe:

> *That has been pervasive through nursery school, and again now that my kids are in elementary school. I am still the oldest mother there. I belong to an Education Foundation. They are all in their 30's. They are in a very different place than I am. When we go out socially, they are very nice women, but they are all itching. They want to get out. The other thing I find interesting about the 30ish crowd as I push 50, I'm not saying all of them, some of them are very discontent. Their feeling is there is no time for me* (Shanny, I_2, p.72).

Rosie cautioned that women should not have children at a very young age because the desire to get out into the world and find out what they've been missing can be detrimental to a family:

> *I think it's a shame if you're conflicting that with your children and family and husband. You haven't-I think it's a mistake to get married very young and have kids, because EVENTUALLY at some point in your life you are going to want to know what you've missed. And however it comes out and however you do it, you know sometimes it affects the family gravely* (Rosie, I_2, p.19).

Mary suggested that older mothers have reached a higher level of development prior to having children. They have figured out who they are and have probably worked out relationship issues with family:

> *You know but I feel like I... really it took me took me till my late 30's to kinda know who I was and to settle a lot of you know family origin issues and which I think is a universal frankly, I mean people have different baggage. So to have done that before you become a parent I think is a great gift. And you know everything is A TRADE OFF..... I think that that settled-ness you can have in life that isn't necessarily just a function of age by any means but I think it brings a perspective to parenting that I think is GREAT you know. I feel very fortunate to have had that. I don't think you have to be this old to HAVE IT but um for me it came at the right time in my life* (Mary, I_1, p.11).

Susan was 51 and mothering a 10 year old with Asperger's Syndrome. She felt that as an older mother she was better equipped to recognise that something was wrong with her daughter, and to meet the challenges of mothering a child with a disability.

> *They* [older parents] *spend time researching it* [their children's disability]. *They spend time trying to work with the disability a lot more than a 25 year old would. So, had I had my daughter and she had been the same girl when I was 25, I would not have known to even, I mean I don't have another child to compare her with, so she is it. I would not have had the same ...reading the same things. My focus wouldn't have been the same. I wouldn't have been as attentive, um just thinking back to what I would have been like 15 years earlier as a parent. I would not have had the financial resources to do these same things that I'm doing now for her and the time to do it either and probably the support of my husband as well because he's been through three parenting experiences already. I think it is a real advantage for her that we are older parents in that respect* (Susan, I_2, p.19).

Not all of the women were equally confident that being older gave them an advantage. Monique aged 49, questioned whether she had more 'tools' at her disposal for motherhood, and suggested that perhaps she had delayed too long. She was not as content as the other women with her decision to become a mother in midlife, and advised friends to consider childlessness as a viable option:

> *The whole thing about being married and having children and buying houses; when you're single, you tend to say, I am missing the boat here. Everything looks pretty nice over there. No one is going to tell you otherwise. It's just different. I wouldn't say one is better than the other. I kind of caution my single friends now that don't think that you're totally missing this whole you know package. It's a nice package, but it isn't the only package. You've got to do what is right for you...Some people are honest. I do think, yeah, it is different. You have to give so much of yourself, and I think that. Not everybody's cut out for it. My husband always joked " I don't know are you cut out for this"? I said, I was probably more so like in my early thirties, that's when I felt my biology kick in. I really GRIEVED about not having children. Then it sort of went away. My older friends told me it would pass, and it did pass. In my late thirties, I really didn't think about it much. In my early forties I really had to push myself to even think about it. At that point I had gotten over that whole biological. I really felt more the ticking, more than the* [need] *real pull to... To me, probably the ideal time would have been between 30 & 35 having two to three kids. At this point, they would be bigger. That would have been the ideal* (Monique, I_1, p.17).

Sarah at 56 sometimes wondered whether she should have had children because at times she found the mothering role very difficult. This is what she had to say:

> *Yeah, and then, you know, the other side of that is, Pat, that often when things are really bad for me with the kids, or whatever ... you know, having a really bad, impatient day or something, I often look up and say, you knew what you were doing* [remember she never conceived] *and I should have left well enough alone* (Sarah, I_2, p.56).

The women in the current study exhibited the ability to offer different perspectives on the experience of mothering at an older age, which were both positive and negative. This demonstrates a complex capability that goes beyond just *awareness* which Suedfeld and Bluck (1993) refer to as "*differentiation*" of different perspectives. Through their poignant accounts of both the pros and cons of midlife mothering, the participants established their ability for integration of different perspectives in an attempt to link these different dimensions together. The concept of *integrative complexity* (Suedfeld & Bluck, 1993) provides a framework for understanding the women's seemingly contradictive appraisals of midlife motherhood as both disadvantageous and advantageous. The negative aspects of midlife mothering, i.e. the intensity, disadvantages, challenges, together with the effect of

perimenopausal symptoms on their health and their abilities to mother, may have actually created a capacity which increased the integrative complexity of their thinking. This in turn potentially contributed to their ability to consider the multiple dimensions of their entire experience. Similar levels of complex thinking occur during the transition to parenthood and "marks a time of significant developmental growth in the parents" (Pancer *et al.*, 2000, p.271). A relationship exists between integrative complexity and adjustment to stressful events, such as parenting (Gottlieb & Pancer, 1988), so theoretically, the transition to menopause could be appraised as another time in women's lives which presents a significant opportunity for developmental growth. This is an important possibility, and the women's appraisals of their transition to menopause and the impact of this on their health and their lives will be discussed in depth in chapter eight.

The final section in this chapter highlights one particular domain of mothering which these older mothers viewed as both an advantage and a disadvantage. While they cited life experience, and awareness of the world as traits that made them better mothers, these traits also contributed to a heightened level of vigilance with which they watched over their children, and this is presented now.

***"Bubble children"*: Hyper-vigilance**

Within the discourse, stories, and text of this study emerged common meaning around a heightened level of vigilance with which these older first-time mothers watched over their children. Seven of the women spoke of it as both a responsibility of good mothering, and a handicap that could be potentially smothering to their children. Shanny admitted that her children are referred to as the 'bubble children', a reference to the 'bubble boy' who was kept in a protective enclosure as a measure of reverse isolation years ago. This is how she described herself:

> *They come in with a bloody knee and I'm like oh my God – I have anxiety. That is heightened as well. I have always been over-protective... they call my kids the bubble children. I was always very protective. I think I've done well in letting a lot of that go, but I can feel myself getting that way again. I'm like, oh my God, watch out for this and watch out for that..... I feel like I sort of made progress in that area over the last 3 or 4 years, but now IT'S BACK, IT'S BACK* (Shanny, I_1, p.21).

Six of the women referred to their child/children as a "*gift*". Shanny attributed her over-protectiveness to having her children at an older age and appreciating what a gift they were. She fears "*all the time*" that something may happen to them.

> *I think that's the other thing. I feel having your kids late and thinking that I was never going to have them, I think that made me incredibly overprotective of them. They were like these little gifts, and I thought nobody appreciates this. People who just have kids without thinking about it..... Most of my friends, they just got pregnant and had kids, and I thought Oh my God do they know this miracle?* (Shanny, I_1, p.34)

Hyper-vigilance and an expressed fear of loss emerged in the first few interviews with Shanny and Rosie, and later with most of the other women. The following is an exchange between Rosie and me during her second interview where I am probing on this emerging idea of over-protectiveness. Rosie added that it is the older mother's life experience which has been viewed as an advantage of midlife parenting that keeps her alert to potential dangers out in the world which could threaten her daughter:

> Pat: *One of the other things I wanted to touch on with you because I'm hearing it was... you talked about being very vigilant about your daughter's safety, and I'm hearing that from the other women as well, and I didn't know if you wanted to expand on that a little bit in terms of... maybe I can remind you a little bit about what you said: " Younger mothers are more relaxed. I have more anxiety about it because it took me so long to have her. I've experienced more"...you were talking about life and loss... accidents, deaths of friends. "I'm more street wise," so you know what's out there. Is there anything else you want to say about that?*
>
> *Rosie: That's something I have to really calm myself down on, cos'...the thought of anything happening to her...just about tears me apart, so I can't think like that, and I don't generally. You know what life is like... so you can't. So all I can do, I can only take care of the things that are in my power, to keep her safe...* (Rosie, I_2 p.34).

Susan agreed that safety was a major issue of concern for her, particularly because her daughter had a disability. Like Rosie, Susan does not perceive that younger mothers worry as much as older mothers about safety issues:

> *It's an issue. I worry about the guns. I worry about her being pulled into somebody's house. Then of course you have the normal worries about traffic and being run over. You think of absolutely EVERYTHING that could happen and you are paranoid about how another parent might DRIVE if they go to a museum or something. There is nothing you don't worry about. I don't think my sister even cared about that when she had her kids when she was 20 years old* (Susan, I_1, p.15).

Jackie confirmed this as shared meaning, and articulated the stress and strain this vigilance placed on her as a mother and on their lifestyle:

> *Jackie: Everything is structured today so she has to be taken everywhere, have to take her to school, pick her up, because I'm just nervous of her being outside. Cos' of all the pedophiles around and um she goes to piano, she goes to horseback riding, but everything is structured, there's soccer. So when I was a kid we would go out eight, nine in the morning summer, you know summer time- take our bikes my mother didn't see me till, till supper time. But there wasn't that worry. You know and it, it's just, that frightens me very much, if she's in that yard, probably every 5, 10 minutes I'm where are you Megan, where are you? Just to keep tabs on her. It's awful that we have to live like that.*
>
> Pat: *So, it's been one of the themes actually that's come up talking to the women, um about sort of being, they felt more vigilant about their kids' safety then younger mom's. Have you? Are you aware of that?*
>
> Jackie*: Yes I do notice that. Yup, I notice that like I said most of her kids, her school age children their parents, they're in their 30's and I notice that they're much easier as far as if a kid wants to sleep over see I don't, I don't go in for that at all* (Jackie, I_1, p.18).

I was struck by the intensity of the mothers' watchfulness, their fears and anxieties, but I also felt sad for the lost innocence of child's play, and the freedom for exploration that older generations of children, even just twenty years ago (like my own children) used to have. Here Jackie expressed concern for the effect all of these limits and anxieties will have on her child, but she rationalized that the top priority is to keep her safe:

Right because she'll say Mummy can I go just go to the bottom of the street? Cos' there's like a bunch of kids down there and they're nice kids I mean but you just hear so much. You know and then you feel, jeez I'm gonna make her neurotic or I'm over protective but you something I don't care, I'd rather have her mad at me in my front yard where I know where she is...(Jackie I_1, p.18).

Miriam agreed with what the other mothers were saying, as she too felt she was overprotective. This stemmed from a fear of other people, and fear of losing her son. Her perception was that younger mothers were too lax, and allowed their children too much freedom. She thought that younger mothers with several children were so stressed out that they don't watch over their children as well as older mothers. Unique in this situation was that Miriam's fear also encompassed time her son spent with his own father who has a problem with alcohol impairment. Like the other women, she gave an example of the limited freedom her son was allowed:

...he doesn't ride his bike in the neighborhood. He could, but he doesn't. And he doesn't really like roller skate around. Like, you know, we down to the... there are some tennis courts near our house. Like we'll go down there and sometimes he'll bring his skateboard down. But he doesn't really DO a lot on his own. Like we live within walking distance of the school and I won't let him walk to school by himself. I go with him. You know, we've ... I've done a lot of work with him as far as, you know, not talking to strangers ...(Miriam, I_1, p.22).

During her second interview, I followed up on this idea of vigilance with Miriam. She compared it to her perceptions of how younger women with more than one child approach mothering:

... you know, I'd say like the 35 to 40 range even, they also have multiple children. But I don't know, maybe when you have MORE than one, they're so used to having kids that it doesn't -- like you know, by the second or third one it doesn't matter what they're doing, you know what I mean, because the other ones are around to kind of look after them even thought they're not really emotionally available to them...(Miriam, I_2, p.43).

Florence said she hadn't thought about it, but admitted that yes she was more vigilant, and attributed it to only having one child. Monique offered a different viewpoint from the other mothers. She reported that her husband is more vigilant about their daughter,

because he is afraid of losing her. At several points during her interviews she referred to him as the *real mother*; she has divested half of the parenting responsibilities to him. The following dialogue explores this different position on vigilance:

> Monique: *Well the thing is my husband has that role in the family. He is the one who is more of the nervous Nelly. He takes that away from me totally because he is always worried these things. I am more nonchalant. We sort of have reversed roles. Yeah, he grew up in a fretful household. .....He's always sort of co-parented since the day she was born. I've sort of let parenting... I've sort of divested of half the parenting to him* (Monique, I_1, p.13).
>
> *Monique: I always think that he's really the mother, I'm uh... he's more hyper-vigilant, so I really don't have that role. I think it's because we share it and I have full confidence in what he does.*
>
> Pat: *and you've let go of some of that responsibility*
>
> Monique*: I've let go of some of that responsibility. Like I don't think it is only Me.*
>
> Pat: *Because you are out working.*
>
> Monique*: Right. He's been delegated a lot of stuff.... he's more the hyper-vigilant one. I think his big concern, he's always worried something's going to happen to her. He'll lose her, you know*
>
> Pat: *Yes and that is kind of the underlying fear.*
>
> Monique*: Right. He is fearful. I don't really worry about that. I don't know why, but I haven't any worries about that. His big fear is... he wants to have a second because he is fearful that something is going to happen, and then he'll have no one* (Monique, I_1, p.14*).*

Ruddick(1989, p.128) stated that "a child's life must be protected", and noted that the daily activities which promote protection are reflective of a mother's commitment to her child. She also warned that "the scrutinizing gaze, the watchful eye of preservative love, can become obsessive or intrusive" (Ruddick, 1989, p.72). She speculated that most mothers are tempted by an illusion of 'perfect control' in a world where there are no "perfectly protected children" (Ruddick, 1989, p.73). Therefore, mothers should strive to put limits on the amount of control they exert lest it become domination. The women theorized that it was fear of losing the child which drove

their vigilant behavior. Brown (1989, p.466) explained that emotional intensity develops in families through the "family projection process" in which the child/children are viewed by parents as "extensions of their hopes and dreams in life, [and] "the loss of the child is an existential wound of the worst kind". A long awaited child, and for many of these women, a one and only child could intensify the sense of responsibility these mothers felt to protect their child/children. In the book Protecting The Gift by Gavin De Becker (1999, p.7), parents are reassured that they are the 'defence system' their child needs. It is their "wild brain" as opposed to their "logic brain" which is programmed to protect their child, and that part of their brain is "unfettered by emotion, politics, [or] politeness...". While at times, the wild brain may appear illogical, "in the natural order of things, [it is] completely logical". DeBecker's (1999) beliefs are in harmony with those of the mothers in the present study. He stresses protecting children is a parental duty; parents must accept the presence of violence in the world, and around their child in order to protect them. When the women in the current study cited life experience and knowledge of the world as advantages for mothering at an older age, it was this violence to which they referred. A consequence of 'knowing' about people and the realities of 21st century society contributed to their fear of possibly losing their long awaited child. Yet, their abilities for integrative complex thinking allowed them to recognise that excessive control and limits on the children's activities could have a negative effect. This led once more to conscious attempts to control their behavior in an effort to be 'good mothers'.

Summary

This chapter presented a written interpretation of the participants' lived experiences as first-time midlife mothers. The major theme *Intensive Mothering* was

chosen for its ability to conceptually convey the overarching experience of the older first-time mother as one replete with unique advantages, as well as challenging disadvantages. *Intensive Mothering* was built around six categories, set in the context of each woman's individual life-world, and framed by the larger cultural and societal influences of the 20th & 21st century. The voices of women whose experiences created shared meaning, as well as those whose revelations were unique to the group were heard.

Findings and discussion began with the first category, *"Exciting and Almost Immediately Challenging"*: Becoming a Mother, which conveyed the participants' initiation into motherhood as a major transition, and primarily a positive experience. There was shared meaning around their pregnancy experience as easy, good or healthy; they enjoyed sharing their birth stories, and had positive recollections and outcomes despite provider anxiety. Despite how passionately these women wanted to be mothers, or how 'ready' they thought they were, three quarters of them felt unprepared for the life changes that accompanied first time motherhood. This paradox was represented by the category *"Your Life is Changed Forever":* Unprepared for Reality. There was shared meaning for the idea that no one and nothing can prepare a woman for the realities of mothering. The women experienced unfulfiled expectations after the infant entered their lives; these focused on the centrality of commitment to the baby/child, and an unfulfiled parenting partnership they thought they entered with their spouse or partner. These realities contributed to intense mothering experiences which at first glance appeared to be very traditional in nature, with the mother as the primary caregiver. Upon deeper reflection, I would propose that possibly they represent the opposite: a third wave of feminism in which women were finally in a position to weigh their options, and truly make a choice for motherhood. They

expressed very clear ideas about pre-requisites for motherhood, and the kind of mother they wanted to be, and these were represented by the category *"A Good Mother":* Doing Mothering Right. Though they spoke of the lack of explicit guidelines for being a 'good mother', a common voice confirmed implicit expectations which contemporary society has created to convey the characteristics and behaviors of a good mother. The good mother is invoked by Hays' (1996) description of the mother or her substitute as primary caregiver, with the focus on a 'priceless child' who has copious time, energy and material resources lavished on him/her. For most of the women, doing mothering right also included mothering differently than they were mothered, and it was with much intentionality that they reflected on their own experiences of being mothered, and set out to do a better job.

The category "It's a Triple Whammy": Older is Harder, embodied the complex issues which emerged as common meaning for older first time mothers. These were the unique challenges which accompany mothering young children for the first time at an older age, and the women interpreted how their experiences were different from those of younger mothers. In addition to fatigue, decreased energy, and physical ability, the transition to menopause involved emotional and psychological feelings and fears of losing control which led the women to self-regulate their behavior in an effort to remain in control of their emotions. Another layer of complexity for these midlife mothers included the adjustments they made to their careers in order to establish balance in their life which favored time spent with the child/children rather than work. They had older parents, many with health problems, several already deceased, and several actively cared for by these women during the timeframe of the study.

Despite the disadvantages, the women were clear that there were also many advantages to starting motherhood in midlife, like financial stability and life experience, and these were captured by the category *"It's Almost a Catch 22"*: Older is Better. The women expressed a high level of satisfaction with the mothering role, due in part to the years they spent without a child. They waited a long time to be in a stable relationship, completed their educations, established careers, and were financially stable. They demonstrated a complex ability for differentiation, to think about and offer different perspectives on their experiences as older first time mothers, as part of a process of integration. One very clear example of this integrative complexity was their perception of the elevated level of vigilance with which they watched over their children. The women viewed this behavior on their part as both an advantage and a disadvantage, so it stood alone as shared meaning for this group of women, and was captured in the final category *"Bubble Children"*: Hyper-vigilance. This chapter included a discussion of these six categories in the context of known traditions, and the pre-understandings of the women and me, as well as a comparison of findings with the relevant literature and theories. It was my intent that readers of this text were brought to a higher level of understanding (fusion of horizons) about midlife women's mothering experiences in contemporary society.

The women discovered that the age and/or health status of their parents, as well as being out of sync with other family members and friends contributed to an insufficient social network and lack of social support which contributed to the intensity of their mothering experiences. This was such a significant finding, that it is presented as the theme *Out of Sync* which is discussed now in chapter seven.

CHAPTER 7

OUT OF SYNC

Introduction

Chapter seven presents a written interpretation of the participants' lived experiences as first-time older mothers who were '*Out of Sync*' with friends and family. *Out of Sync* is presented conceptually to represent the women's achievement of motherhood at a time in their lives which did not uniformly synchronize with other women, friends and family's experiences of parenthood. As a result, they lacked a sufficient social network and level of social support to help buffer the intensity of their mothering experiences. Eleven of these midlife mothers gave examples which revealed a perceived lack of social support on many levels. They shared the experience of feeling socially *out of sync* with younger mothers, family and friends, in addition to the added isolation for some of being separated geographically from family and friends. This gap in life stages made it difficult to find common ground with their siblings, parents, friends, and younger women, and they did not feel comfortable reaching out to ask for help. Similar others, or women like themselves were difficult to find. As a direct result of their own delay in achieving motherhood, their mothers and fathers in turn became older grandparents. As noted in chapter six, a few of the participants found themselves sandwiched between their own families and aging parents, and several were actively caring for a parent or parents during the timeframe of the study.

The theme *Out of Sync* is authenticated by five categories which provide substance and support to the concept of midlife mothering as an isolating experience. As each category unfolds, the voices of women whose experiences created shared meaning as well as women whose experience was unique to those of the group are

expressed. This chapter presents and discusses five categories: 1) *"Arrested Development"*: Off Time Motherhood; 2) *"You Don't Have the Same Network"*: An Isolating Experience; 3) *"Minimal Support"*: From Friends and Family; 4) *"I Connect More with Mothers Who Are Older"*: Similar Others; and 5) *"It's Like a Vacation"*: When You Have Support.

The first category, *"Arrested Development"*: Off Time Motherhood acknowledges the non-synchronized reality in which these older first time mothers lived compared to the majority of women their age. While friends and family were parenting older children, or adjusting to empty nests, these women were mothering young children, and attending school functions. Their satisfaction with motherhood did not completely obviate the difference in the context of their lives compared to those of their friends and family, or that their children's friends had much younger parents. This disharmony in life stages resulted in a very thin social network, which is represented by the category *"You Don't Have the Same Network"*: An Isolating Experience. The context of being *out of sync* with members of their social network contributed to the absence of adequate available social support, which the women described as isolating, and is revealed in the category *"Minimal Support"*: From Friends and Family.

The circumstances which led to their achievement of motherhood at an older age, also created a phenomenon in which their parents became grandparents at an advanced age. Most of the women spoke of an aging parent or parents, six of them noted that their mothers were ill, and several of them have already lost their mothers. The lack of meaningful connections with younger mothers, and even women their own age, led the women to seek out older mothers like themselves for social support. This desire to find women who were older mothers like themselves is revealed in the

category *"I Connect More with Mothers Who Are Older"*: Looking for Similar Others. The final category *"It's Like a Vacation"*: When You Have Support shares the limited experiences of a few women who felt they had adequate social support.

This chapter includes a discussion of these five categories in the context of known traditions, the pre-understandings of the women and me, as well as a comparison of findings with the relevant literature and theories on social networks and social support. The first category is presented now.

"*Arrested Development*" : Off Time Motherhood

One of the primary reasons the women felt out of sync with family and friends was that they were in a different phase of life than other women their age. While friends and family were parenting older children, or adjusting to empty nests, these women were mothering young children, and attending school functions. Their satisfaction with motherhood did not completely obviate the differences in the context of their lives compared to those of their friends and family, or that their children's friends had much younger parents. Roxanne referred to this phenomenon as "arrested development" and this is what she said:

> *I feel like I've had a little bit of an arrested development here. I should be at weddings, not at kindergarten graduations. It feels right to have children, it just feels a little odd that they're just so young.....but it does feel very weird. Most of my children's friends' parents are all ten years younger than us* (Roxanne, I_1, p.9).

Peggy tried not to call attention to her age, but realised her son was very much aware that she was an older mother:

> ...*Actually just the other day Jason came home from school and he said to me "how old are you mom"? and I said I had to think because I always have to calculate so I really don't think about my age that much but I said I'm 47 and he said oh I thought so. I said well why do you ask and he said... his kindergarten teacher said you COULDN'T be 47* (Peggy, I_2, p.6).

Leslie also experienced a disparity in her life stage, which set her apart from friends and family, and this led to a lack of social support and reciprocity from others. Her desire to find support drove her to seek out the company of others:

> *Everybody is busy. Their kids are all at these levels where they have school and sports, and their parents work. They don't have TIME to be running up and visit me with a newborn..... .....So if I want to see anybody, I have to go. So that was kind of hard..... .....My best friend who is six months older than me, her kids are 30 and 32 and she is having empty nest syndrome. Here I am changing diapers. It's kind of crazy. The people that you are closest to aren't in the place that you're at. They are so far removed from that* (Leslie, I_1, p. 24).

Several of the women related stories in which they were mistaken for their child's grandmother instead of mother. Jackie points out that in her circle of friends, most of the women are grandmothers, while she is the mother of a ten year old:

> *Because I know most girls my age that I've gone to high school with, they're grandmothers! You know they're my age and they they're grandmothers. And um, a couple times it's happened in a store and I'll be with my daughter and, oh is this, oh is your grandmother going to buy you that?* (Jackie, I_2, p.52).

Several of the women shared stories about feeling different when they were at their child's school because the other mothers were younger. I explored this experience with Florence, and asked her about her relationship with younger mothers:

> Pat: *When you are with younger mothers at school, some of the moms have talked about this: do you feel out of sync? Do you feel that you have things in common with them?*
>
> Florence: *That is a bit of a stretch.* [having things in common with younger mothers] *That is a bit of a stretch. I feel a little out of it in the neighborhood* [too] *because all the moms are in their mid 30's is the average. It's a little bit harder to really, really relate, but I REFUSE to have that be too much of a barrier because I need them and they need me* (Florence, I_1, p.17).

Abbey spoke of lack of role models for women like herself. She even felt disconnected from other women her age even though they had menopause in common, because she was also mothering a young child. Her own mother was not an

older first-time mother; she had six children by age 36. Here she explains how it felt to be an older first-time mother who was transitioning to menopause:

> *Yeah, oh yeah it's a totally like I mean sometimes I'm talking to my friends and we're talking about menopause stuff or and then it's like well I gotta go cause I've got a meeting at the elementary school you know. It's like being two people. ...now* [that] *they are 10 and 8 years old, I've kind of gotten use to it. Initially I thought it was kind of hard, very hard* (Abbey, I_1, p.9).

While the timing of life-course transitions like motherhood may be less standardized than in the past, these excerpts highlight the unique phenomenon the women experienced when one lifespan transition became superimposed on another. This phenomenon of *off-time* versus *on- time* motherhood created an awkward niche in society for this group of older first-time mothers who found themselves out of sync with friends and family, as well as other women their age. Nelson (2003a) noted similar findings in her work with older mothers, in that they were 'out of step' with friends and co-workers, and felt isolated by their engagement in a different life stage than others. The mothers in Nelson's (2003a) study noted a 'wide chasm' between themselves and younger mothers, also similar to the women in the current study. In 1989, Mercer *et al.* (p.79) reported developmental patterns of mothers aged 41-50, citing transitions like "being widowed, being divorced, parental deaths, child-related transitions (illnesses, marriages, deaths), self illnesses" to name a few. This is in stark contrast to the major transitions named by the women in this study, with marriage, birth or adoption of their child, being a primary transition for ten of the women.

Perhaps achieving motherhood for the first time at an older age could be viewed from the perspective of an 'idiosyncratic life cycle transition' (Imber-Black, 1989), one which lacks familiar rituals linking women to individuals, family and community. There is no 'available map' to guide women, little contextual support, and few similar

others, which results in a "skewed sense of either denying the differences or maximizing them to the exclusion of a sense of connectedness with others" (Imber-Black, 1989, p.150). Pregnancy, motherhood, and menopause were identified by Meleis *et al.* (2000) as transitions that may create a context for heightened vulnerability. Perhaps one of the vulnerabilities lies in the absence of the usual network of support available to these mothers because they have not followed a typical pattern of development for their age. Women in Mercer's (1986) study viewed motherhood as granting them new social status, yet Bornstein *et al.* (2006) found that support from extended family members decreased with maternal age. The women in the current study described a thin network of support for themselves as mothers, and this lead to an isolating experience which is presented now.

"You Don't Have the Same Network": **An Isolating Experience**

Delaying motherhood until midlife and being out of sync with friends and family members can create social isolation for older first-time mothers. They may not have the same social network and level of support available to them that younger mothers do. Florence revealed her lived experience here:

> *I think I was definitely overwhelmed as a mom of a newborn. A mom with a newborn AT MY AGE, in a way not having a social connection some of the young moms have. I felt sort of isolated. Most of my friends had children when they were younger. I think it would be really fun to be parenting while your friends are parenting. That is not my experience at all. My friends are now parenting teenagers now. So there was that ISOLATION that I definitely felt* (Florence, I_2, p.27).

Susan was 51 and the mother of a 10 year old daughter. She reinforced the women's shared experiences of being socially *out of sync* with friends and family members, and the lack of a social network which for many of the women lead to inadequate social support. Susan compared her mothering experience to that of her stepdaughter who

was mothering at a younger age, and who had a much larger support system built in to help her:

> *My stepdaughter is like that* [doesn't want to leave her child with anyone but family]. *She didn't even want to hire babysitters because she has a whole NETWORK of people, aunts and uncles, and her mother and the other grandparents; so she doesn't have that problem* [childcare]. *It's DIFFICULT when you are older. You don't have the same network because even if you do have siblings nearby they are in a different stage of life* (Susan, I_1, p.13).

Susan went on to point out that she felt very alone because of her age and geographical separation from her family, so there was no one she could count on for help. She did not feel comfortable asking her family for help with childcare or to give her a break from parenting:

> *I think you have a very thin support network at that point. I didn't think I could call my sister who had her kids when she was 18. They were in their early 20's by then. I couldn't, my parents were older and they were always geographically away from my family anyway so it's not like I could say, could I please drop her off so I could get some SLEEP or something like that. So geographically I couldn't do that, but also the age difference* (Susan, I_1, p.26).

Monique was 47 years old and mothering a 3 year old daughter whom she adopted as a baby. She described how out of sync she was with friends who had their children at a younger age. Despite her efforts to stay in touch with them, they were oblivious to her needs when she visited with them. She identified a lack of "*community*" for older mothers as one of the issues that made her own situation harder, and why it was difficult for her to find commonalities with younger mothers. As an adoptive mother, she also felt estranged from women who experienced pregnancy and birth. She described community as social support, and having people to help you. This is what she said about not having it:

> *Yeah and I think the other thing that is hard, the other thing that I notice is that there is not a lot of community for older mothers. It seems that way. At least in* [names state] *what I've noticed a lot are younger parents – a lot of them are home. I'm kind of shocked, they're home,* [and] *they all kind of bond together. First of all they had their own natural children. They talk about*

> *BREASTFEEDING and all that kind of stuff, so there is no commonality there. The older parents that I do meet, they are busy trying to juggle too, I think. Everybody is tired! I think it's trying to find some kind of community* (Monique I_1, p. 3).

Several of the women experienced geographical separation from friends and family. Leslie moved 3,000 miles to move in with the father of her baby. She gave up her social network, but felt that even if she had not moved east, there was a disconnect (disconnection) created by having a child later in life that set her apart from friends and family. That disconnect created an isolation in which she found herself functioning as a woman and a mother:

> *I mean I came in here I didn't know a soul, and so it isn't my home town. And even if I lived in my home town, where there are some people still around there, some of my closer friends have moved away and just their lives, I mean this is the whole thing about the disconnect, and you know they're here and I'm here, and even though you know we still keep and touch and we've known each other for a long time. You know this one's got kids getting ready to go off to college and mine's just starting first grade* (Leslie, I_2, p.50).

It became clear during their discourse on mothering and in the reading of the text that the women in the current study lacked sufficient social networks, and social support to meet their needs. Gottlieb (1981) stressed that although people have to have social connections to receive social support, having social connections does not necessarily equate to or guarantee a person social support. Although women may report more supportive and intense relationships than men throughout the life span, they may also be more critical, make more demands, or deplete their resources (Oakley, 1992; Koch & Mansfield, 2004). Social support is viewed in the literature as a resource, which must be accessed, used, and developed (Lazarus & Folkman, 1984; Heaney & Israel, 1998) yet most of the women felt they could not reach out to friends and family for support because of the difference in their life stages.

Lazarus and Folkman (1984, p.249) clarified the difference between one's social network and social support. A person's social network refers to the number of types of relationships someone has, versus social support which is a perception by a person of ..."the nature of the interactions occurring in social relationships". The existence of social ties is referred to by Heaney and Israel (2002) as soc*ial integration,* and the web of social relationships that someone has, becomes her social network. Characteristics of a person's social network include whether there is emotional closeness or "intensity" within the relationships, whether there is "homogeneity" or similarity in age, race, and socioeconomic status, geographical proximity, or "dispersion". "Density" is the extent to which those in the network know and interact with one another; "complexity" describes how many functions of social support members provide, and "reciprocity" is the extent to which support is given and received (Heaney & Israel (2002, p.186). Assessing and analyzing the current data according to these characteristics, as well as from the women's perceptions of their social networks, led me to understand that the women in the current study had an extremely thin social network, which lacked most of these characteristics. Lack of support and isolation for older first-time mothers has been identified as a theme by other researchers (Mercer, 1986; Reece & Harkless, 1996; Nelson, 2003a). Mercer's (1986) older mothers (aged 30-42) reported that isolation was the most difficult part of their mothering experience. A thin social network contributed to minimal levels of social support for the mothers in the current study, and this is described in the next section.

***"Minimal Support"* : From Friends and Family**

Being out of sync with friends and family contributed to the intensity of the women's experiences as mothers. They did not have a strong social network from

which to draw upon for social support to buffer the stressors of parenting. The circumstances which led to their achievement of motherhood at an older age, also created a context in which their parents became grandparents at an advanced age. Most of the women spoke of an aging parent or parents; six of them noted that their mothers were ill, and several of them had already lost their mothers. Having aging parents creates a paradox for older mothers. Instead of receiving support from the grandparents of their child/children, they instead became the ones having to care for or provide support to aging or ill parents. Midlife women commonly refer to themselves as part of the 'sandwich generation', a familiar American metaphor which represents the conflict which exists in women's lives as they struggle to meet the needs of their families as well as care for aging parents, and this was particularly poignant for these mothers. Miriam was one of three women who was caring for parents who were ill, as well as mothering a young child and balancing the demands of a career. This was uppermost in her mind at the start of her second interview when I asked her if there was anything she had been thinking about since our last meeting. She described the turn of events which placed her as her parent's caregiver:

> *I think that the one thing about the mothering, and that I didn't really mention or put into these kind of terms, is being, you know, part of the sandwich generation of taking care of both my son and my parents, and that's been a STRUGGLE because I have a sibling who's estranged from me so I basically have the BURDEN of taking care of them* ...(Miriam, I_2, p.35).

She went on to say that if her child was older, she would not have to be responsible for taking care of everyone's needs. I asked her how this affected her life and she responded:

> *Well IT'S VERY STRESSFUL. I mean, I work three days. I do some geriatric case management on the side, but that's sporadic at best, you know, as far as the income with that goes. And, you know, it just feels like all my time is totally taken up either picking up my son, making arrangements for him, figuring out what I'm going to do with him, you know, after school on the days that I have to work, and then dealing with my parents and all THEIR ISSUES, and not having a lot of really good supports of my own. It's tough* (Miriam, I_2, p.36).

Monique and Sarah were also caring for an ill parent(s) at the time of the study, and though providing direct care for a parent was not a major issue for the other ten women at the time of the study, it was clear that caring for aging or ill parents could readily add more complexity to the lives of older mothers. There was a poignant element of caring and stress in Monique and Sarah's situations, made all the more meaningful for me, as my own mother was ill and dying during the final year of the interviews. As Monique described her role as caregiver to her parents, I was reminded of my own journeys 'home' on weekends to visit my mother and provide some respite for my siblings. The major difference was that Monique did not have respite, and she had a very young daughter who was dependent on her:

> *I have sort of a triple whammy. I also have aging parents out of STATE. My mother has been ill for a while... I guess about a year after we came home* [from abroad with their adopted daughter] *is when things started getting worse for my mother. So for the last year, she had to go into a nursing home for rehab; she was not doing well here [in her home]. My father was taking care of her; my father ended up getting ill. They were both in rehab at the same time. He came home. She had to stay because he could no longer take care of her any amount of time. In the middle of all this I had my daughter. When I come up here* [2.5 hour ride] *I take her* [my daughter] *with me because my husband works, and I just pretty much have someone cover my business* (Monique, I_1, p.5).

Sarah's story was equally emotional and again personal since I had met her mother years ago. It was painful for me to listen to Sarah talk about her mother's steady decline at the same time I was experiencing it with my own mother. Sarah confirmed that stress had been the biggest challenge for her as an older mother. She was mothering three young children, working in a demanding career, caring for her mother, and experiencing menopausal symptoms all at the same time. This is how she described her life after the birth of her son:

> *... Since Jason was born it has been the beginning of the decline of my mother. Two years into his life my mother moved in here, and six months later the girls were born.*

> *And my mother did a SLOW but steady decline the whole time she was here and she was here for almost four and a half years. Four and a half years that she was here, so three, almost four years of the girls'* [lives]*... she moved into the nursing home in February and the girls turned four in May, so that was more than I ever dreamed could ... you know, my whole life I said I would take care of my mother. And for a lot of my life I was single and so I always said, you know, just when it's time you can live with me. And I still wanted to maintain that promise and that return gift* (Sarah, I_1, p.6).

Despite caring for her mother in her home for over four years, Sarah was still feeling guilty because she could not visit the nursing home as often as she wanted due to her other responsibilities. She was unable to fully reciprocate to her mother the care she had received as a child, and that evoked strong feelings. Bassoff (1991, p.176) reminds women that "there can never be a quid pro quo" or total repayment for the mother love received by a child from her mother. She suggested that women shift the nurturance they received from their own mothers to become 'good enough' parents to their own children. The concept of reciprocity revealed in Sarah's texts, also emerged in my interviews with Leslie and Florence. Here Leslie talked about how no one came to visit her, and she had to seek out her own support:

> *So here I am once again schlepping* (tediously dragging herself) *to visit everybody because when I was single, I was always very considerate of my friends and thought well I'm not going to expect them to drag their two kids to my house that's not baby-proofed. It would be much easier for me to go there. So that's what I did. I went to everybody. So now here I am with the baby and I'm still going to everybody because now everybody is in a different place and they still can't visit* (Leslie, I_1, p. 24).

Florence continued to anguish over friends who did not visit her or provide meals after the birth of her daughter. She expressed anger over the lack of reciprocity of services which she had provided to others in their time of need. This excerpt expresses how upset she still was four years after her daughter's birth:

> *Oh, the isolation also stressed me. I couldn't believe that more people didn't visit and MORE PEOPLE DIDN'T BRING FOOD! I was just ASTOUNDED by the isolation. I never thought I would be that isolated as a new mother, and I didn't have family around. I had some close friends. Family was in* [named another state]. *My parents were in* [named distant state], *but I just assumed*

> *that people would want to swing by and see this baby and bring food. You know – it just didn't happen* (Florence, I_1, p.9).

This reference is to a particular type of support called instrumental support. It is the provision of "tangible aid and services" that directly assist a person in need (Heaney & Israel, 2002, p.187). Though women in the study were well-educated and financially secure, they still expressed a desire for help with child care, time for self, meals, and visits. Lazarus and Folkman (1984) suggest that tangible support from others can connote a sense of caring, which in turn makes the receiver feel valued. Gouldner (1960, p.171) described a norm of reciprocity which is universal and plays a role in stabilizing social systems. It requires minimal demands: "(1) people should help those who have helped them, and (2) people should not injure those who have helped them". However, for several of the women, these expectations for help went unfulfiled.

Several other women expressed concern that their parents were either unavailable to them for support due to geographic separation, or they were physically or mentally not capable of being helpful to them. Rosie's father was geographically and emotionally distant:

> *My father remarried a year later so he has his new family and he doesn't come and visit as much, and it's almost, you know I haven't lost him, but he's got a whole new life, and I'm like almost... you know... second* (Rosie, I_1, p. 9).

Leslie pointed out that her daughter will never enjoy a relationship or have experiences with her older grandmother, and she expressed concern about leaving her daughter with her mother because of potential safety issues:

> *...my mother does nothing for me. I mean she, they, my child can't enjoy having you know, like if I was the grandparent. I wouldn't even leave her for two hours with mother and her house in* [names state] *with the pool. Cos' I'd be afraid she'd forget about her and Kylie would go out there being, doing something you know, putting a toy in or taking a toy out fall in and drown. And my mother would FORGET, you know even though Kylie is pretty*

> *responsible, still you hear stories like that all the time so. I wouldn't, I wouldn't leave her* (Leslie, I_2, p.59).

Susan's mother was also geographically too far away to be helpful, and Susan felt her age also made it difficult for her to help with childcare:

> *My mother was 70 when she was born. At that point she had been a grandmother for a long time, and I'm not sure she could have really helped me too much, especially not being around* (Susan, I_2, p.26).

Peggy expressed similar issues related to family not living close by, and the problems which ensue when there is such a gap with members of one's social network:

> *My family and my husband's family live kind of far away, so that's an issue just the distance. But the age thing I think is a factor and to some extent with my mother-in-law I think that she's old enough that she just doesn't remember what it's like to have little kids and so the expectations that she has sometimes for us are really unrealistic and she doesn't understand how difficult it can be to do some of the things that she wishes we would do in terms of coming to visit them and doing such and such and they really we don't have any support from that side of the family. My DAD who lives in Chicago actually will come and stay with us for a week has done this before during school vacation week and hang out with Eli which is helpful but again he lives in Chicago so...* (Peggy, I_2, p.8).

Some of the women in the current study described extremely isolated situations in which they had little to no support, and others described loving families and friends who were simply not providing the support they needed. These findings are similar to the work of Bornstein *et al.* (2006), who noted that support from grandmothers and other relatives, decreases for older mothers. My own horizon expanded when the women identified others who were providing support to them, but it was not always the type of support they wanted or needed. Miriam was 49 and mothering a 7 year old as a single parent. She was separated from her husband, and identified her parents as providing really good support. However, she later qualified that support and said she felt "*annoyed*" that they do not or can not do more with her son:

> *Yeah. Yeah, I have really good support from my parents. I mean, they'll help pick up Evan... like you know, the days that I have to work till 4:30, they'll pick him up, like today...But you know, they don't DO a lot with him, which kind of annoys me. But*

> *you know what, they're not like really physically able. I mean they could, but, you know, it's too hot or, you know, dad is tired... you know. So some things goes on, you know, I'd like them to like take him out and do more things like outdoors. He ends up usually in front of the TV set* ...(Miriam, I_1, p.13).

Heaney and Israel (2002, p.186) describe three more functional categories of social support. Informational support is described as the provision of advice, suggestions, and information that can be used for problem solving; emotional support is the expression of "empathy, love, trust, and caring" and appraisal support provides information that a person can use as "constructive feedback, affirmation, and social comparison. Yet, for the women in the current study, being out of sync with friends and families and a thin social network led to minimal or no support in any of these categories. Susan stated that she had no real support, either from family or friends. In the absence of these usual sources of social support, she turned to hospital run group support. The problem with these substitutes was that they became short term solutions:

> *So there was no real support. My best friend that I've been best friends with for ten years or so had never been married or had kids so I couldn't really talk to HER about it..... I really was trying to seek help through... the postpartum groups. I really liked having that one group that I went to, but it lasted six weeks and then it ended at the hospital. I thought I've got to call up somebody, but there was nobody, nobody that I got to know through the birthing groups or anything like that that I could really call because their situations were all different...* (Susan, I_2 p.27).

Lacking informal sources of support, older mothers like Susan may rely on more formal sources of support, i.e. schools, classes, and health professionals. However, this reliance on experts and the parenting literature may intensify the buy-in to the socially constructed ideals of intensive mothering as discussed in chapter six. To buffer this, hospitals and other more formal avenues of support can provide opportunities for women to make connections with each other, thus providing informational and emotional sources of support. Florence gave an example of one

such connection which enabled her to break the isolation of her early parenting experience:

> Florence: *There was a mom in my neighborhood who had a baby the day before me; she was at* [the same hospital] *as well. We were in the same childbirth class.*
>
> Pat: *Oh- that's nice.*
>
> Florence: *We would go for walks and we both had slings, so we would be walking with these babies in the slings. That was great during those first three months. She was on a leave and I was on my leave. So that was really a lifesaver. Then I took a class at the birth centre... and met two other moms that I am still pretty tight with...and again, that just BROKE through the isolation; that was only once a week for a half hour, but it was SO IMPORTANT to have that time. Maybe it was an hour* (Florence, I_1, p.9).

Sarah was one of two lesbian women who participated in the study. In addition to decreased levels of social support already discussed, there were unique issues for Sarah and her partner that have not yet been mentioned in this chapter. Lack of support from both sets of grandparents was evident during our dialogue and in the text, and contributed to the intensity of Sarah's parenting experience. This is how she described it:

> *...there was minimal family support on* [my partner's] *side and more support on my family's side, but they're all brothers and my mother was not capable of other than being there very much for us emotionally, which was always nice. So it became INSTANTLY overwhelming, I think* (Sarah, I_1, p.1).

Sarah compared the amount of support her partner's parents gave to one of their other adult children who was in a heterosexual relationship, and mused that their avoidance of Sarah and her partner's children represented disapproval of their lifestyle and decision to have children together. Sarah made little effort to hide her resentment over the lack of support they received from this set of grandparents:

> *And the reason they don't come here, I think a long time ago there was that... when Carol was first pregnant, we just told them that she was pregnant, and that was, "why are you doing that?, how dare you do that ... and this would not be my grandchild". And then we found it was twins and, "oh, we're so excited", and then we lost them and then they've always been a little*

> *standoffish since then. When Jason was born, they came to the hospital the day he was born but they never so much as, you know, came and ... they've never changed a diaper, never done anything for us. So there's been, you know, a little bit of resentment there, I think, because of that* (Sarah, I_1, p.16).

Sarah's situation with her partner's family is not unusual. The literature notes that lesbians rely more on friends and their 'family of choice' to provide a social network and support than they do on the families that raised them (Erwin, 2007). This may be due to various obstacles and the social discrimination lesbian parents face when interacting with others, including family members, the effects of which are "mediated by, the resources, supports and strategies that people have and use" (Short, 2007, p.60). In contrast, a study with 84 families, 70 of whom had a birth mother and a co-mother who ranged from age 23 to 49 (mostly in their thirties) Gartrell *et al.* (1996) noted that the women demonstrated strong social support systems, including regular contact with families of origin.

It became evident to me that for almost all of the women who participated in the study, they were mothering with very little support from friends and family. As discussed in the previous chapter, as well as here, they felt they were different, and had little in common with younger mothers. However, they spoke very positively about other women like themselves with whom they could discuss midlife mothering and menopausal topics, but these women were difficult to locate. This need to find similar others is discussed now.

"I Connect More with Mothers who are Older": **Similar Others**

Florence, Peggy, and Abbey voiced the added value of having older women as friends and confidants. Most of the women in the study concurred that it was much easier to talk to other older mothers/women who were having similar experiences. Florence was 48 and mothering a daughter age four at the time of the interviews. She supported what the other

women were saying about feeling out of sync with younger mothers, though she has tried to find common ground with them. This is how she described her experiences:

> *When I meet a mom MORE my age, I like it a lot. It's easier. There is a lot more that we have to talk about. My friend who is 43 and has a daughter has brought that to my attention. She's funny and it means so much to her. I hadn't really thought about it all that much, but she has me to thinking that yeah that really does mean a lot* (Florence, I_1, p.17).

Peggy agreed that she too is drawn to older mothers, even those who are ten years younger than she is, because she does not know how to make connections with women in their twenties when she sees them at school:

> *I definitely look around and notice that you know I'm one of the oldest in the crowd and I find that I tend to a... just talk to or connect more with those mothers that are older. We do. I tend to find that although I will say that I don't you know those mothers that are even ten years younger than I am still are kind of those are the ones that I'll connect with more so I don't, I don't feel like I'm totally off the chart say I um I still am a pretty active person and, and so and I'm in good health and all that stuff so I, I a I don't really feel that too much. But I, I will say that when I go to school events and there's mothers there in their twenties I don't even really know too much what to talk to them about* (Peggy, I_2, p.5).

Later in this second interview she told a story as an example of how important it was to have even just one person like her that she could rely on for support:

> *You know when things are ROUGH that, that can be hard cos' I don't really feel like I have someone that I can... except for one person actually that I can think of who has a son who is Jason's age and I've called her when Jason was younger... he was sick and I didn't know whether I should bother the doctor or not. I called her and told her what the symptoms were and do you think this is worth calling the doctor so that was nice to have um but of course my sister's gone so I don't have HER for that either so I really yeah there's I don't have that group of like ok there's five of us that our kids are all hanging out and we're doing stuff together that doesn't really exist* (Peggy, I_2, p. 9).

Monique reported that even when she found women who were also midlife mothers, they made choices about their careers which were different from hers, and so they became unavailable to her. Monique thought other professional women would be a good community for her, although she did not know when she would have time to

meet with them. Here she relates how difficult it has been for her to make a connection with other women:

> *I find that most of the mothers my age, the mothers I've met who are my age are either stay at homes or they are professionals who have seriously cut back, and that is the second thing they do maybe part time. One woman is a lawyer, and she does it one day a week. She had two girls back to back, and that's her life, so the others stay at home. I don't think I really connect with anybody. I really haven't had the time* (Monique, I_2, p. 26).

Abbey and Susan were the two participants who had children with Asperger's syndrome. They created similar meaning around the benefits of having the support of other women mothering children with disabilities. This relationship with similar others was a common bond that forged a connection, and provided support for these two mothers:

> *Not every situation is going to be the same, but I know when the first time I met... other mothers that had girls that had non-verbal learning disabilities, it was like oh my God, there is so much comfort in this because their daughters were a few years older than mine. They had already been through certain things. They gave me resources that I used. Just to even meet with them two or three times a year was so valuable, and to have that support and that connection and the common ... bond. It is just invaluable* (Susan, I_2, p.27).

I asked Abbey about her support system, friends, and family, and whether she felt out of sync with them. Abbey gave me a 'phenomenological nod' when I used the phrase 'out of sync' to describe the older mother's experience, but she also described the benefits of having women friends her age who were similarly mothering young children. Like her, one of her friends has a child with a disability, so that was a powerful connection for her: Following a long pause, she responded:

> *Well, I'm, I'm lucky I have a couple of friends who are my age who also had their kids late so we LOVE it when we get together because we're BOTH from that same you know yeah hey we're putting on weight, we've got night sweats, we have blah, blah, blah and then we turn around and yell at the kids and tell them to stop fighting, so it's kind of that's really that's when I really notice like oooh we are a little bit different you know... it is um that's really fun but so I feel lucky I have my I have two especially one good friend who has two*

> *children. One of her kids has Down's* [syndrome] *so we know what it's like to have that stress in the house...* (Abbey, I_1, p.9).

A lack of informative conversations with younger mothers, and feeling out of sync with friends and relatives lead the older mothers in the current study to seek out others who were more like themselves, and this is consistent with the literature on first-time mothers (older than 30) who have a need for support from women like themselves, even if they are multiparous women (Dobrzykowski & Stern, 2003). However, older mothers like themselves were difficult to find, and even when they did find them, busy schedules sometimes prevented them from getting together. Similarly, Nelson (2003a, p. 129) found that the older mothers in her study desired contact with other older mothers like themselves, but they were hard to locate. This was expressed in the theme "Feeling Out of Step", in which participants were looking for role models and the companionship of other older mothers, and found themselves out of step with friends, and co-workers. While the mothers in Nelson's study (2003a) found some comfort in the knowledge that older celebrities were becoming mothers, I would offer a caution to women who are looking for role models who have worked out what Nelson (2003a, p.130) calls "the challenges of older motherhood"; celebrity mothers' lifestyles may not offer much in the way of practical advice. This lack of similar others may contribute to the tendency of "older, middle-class, educated mothers to prepare for mothering through extensive reading and information searching..." (Carolan, 2007, p.1170).

For the women in the current study, a perceived lack of emotional support stemmed again from the unavailability of older mothers like themselves to confide in, as well as being out of sync with siblings, family, and friends. Many of the women expressed to me that they were interested in getting together with the other

participants, because they sensed that they would have a lot in common with them, and perhaps because they thought that I could act as a catalyst to make this connection happen for them. They verbalized how much they enjoyed participating in the study because it gave them an opportunity to talk about topics that were important to them.

Six of the thirteen women opened their homes to me to conduct their interviews, and all were gracious in offering beverages and snacks. One woman even spread a linen tablecloth, made tea and sandwiches as well as sweet desserts. They showed me pictures of their children, and on three occasions, their child/children were present at the time of the interview. There were only a few reports of support from those who received help from their mothers or parents despite their older age, and this is discussed next.

" It's Like a Vacation": When You Have Support

Jackie (aged 50) relayed stories of continued support from her mother, and was appreciative of the break she occasionally had from the responsibilities of parenting. Here, she validates the idea that support of that kind lessens some of the intensity of mothering by allowing some time for her own restoration:

> *...My mother's wonderful. She'll take her and she'll keep her there for, even OVERNIGHT. IT'S LIKE A VACATION, you know. Like last night, it was so nice, it was so quiet, she wasn't here and, there were no interruptions* (Jackie, I_2, p.44).

Mary thought that the older mother's experience of isolation was not much different from that of younger mothers, and attributed reduced social networks to a casualty of our contemporary society. This is what she said:

> *I think that I see young women isolated too I mean I think it's a nature of society now that people move around and, and you know people work so maybe you know um and so I think there's, I think there's a variety when I think about the older women that I know that are parents I actually have you know sometimes the parents are retired and so they have the opportunity to spend MORE time with their kids* (Mary, I_2, p.26).

Mary's impression of her own situation was one of support, but there were persistent threads of geographical separation and reduced levels of caretaking expectations because of aging parents:

> *I mean Kristin's mother has been VERY involved at one point was doing two days a week of childcare for our younger son you know um in the house during the day and is still a big part of their lives and at 82. And, my mom when they were little and Kristin* [my partner] *traveled, cause Kristin was traveling a lot she would come up from* [named city] *and help me out when Kristin was traveling so my, my father was pretty much worthless, and his wife I mean they were interested in the kids but they weren't interested in changing diapers or anything like that...* (Mary, I_2, p.27).

The benefits of support are consistent with the findings of Reece and Harkless 1996) who noted that women aged 35-42 with a perceived sense of social support experienced a sense of well-being and satisfaction compared to those who lacked support or felt isolated. The relationship of social networks and social support to health has been advanced by several researchers (Hirsch, 1981; Armstrong *et al.*, 2005; Jackson, 2006). Armstrong *et al.* (2005) explain that the primary effect of social support is the benefit on well-being. This effect is seen with or without the presence of stress in someone's life. A second, more buffering effect of social support also exists (Armstrong *et al.*, 2005), and if this was applied in the context of the present study, I would project that it could have helped to protect the women from the potentially threatening effects of the stressors of intensive midlife parenting and isolation.

Perceptions of close social support for women also reflect on their health through health-seeking behaviors like: improved nutrition, regular examinations with their health care providers, possibly more exercise, and less incidence of substance abuse (Jackson, 2006). Hirsch (1981, p.163) noted that coping and psychosocial well-being rely on a "good fit" between women and their social networks. This fit is necessary in order for women to integrate with and "participate actively in a viable segment of the

larger culture and society". Conversely, women with lower levels of social support experience more psychological distress, psychosomatic complaints, physiological symptoms of stress (Solomon & Rothblum, 1986), poorer dietary practices, less compliance with recommended health care, are less likely to exercise and more likely to engage in substance abuse (Jackson, 2006).

Lazarus and Folkman (1984, p.259) viewed social support as a resource, and placed it under "the rubric of coping". Armstrong *et al.* (2005) named social support and physical health as two of the vital components which contribute to coping capabilities. They conducted a review of theoretical models of stress and coping which led to a consensus on coping as "a complex interaction between the individual and the environment, with the goal of management of stress rather than mastery" (Armstrong *et al.*, 2005, p.270). Heaney and Israel (2008) hypothesize further that social networks and social support provide access to people and information which can enable a person's problem solving capabilities. The researchers suggest that it is through social interactions that meaning is assigned to events. This being consistent with my own ontological and epistemological stance, I would argue that interventions aimed at improving social networks and social support for older first-time mothers would enable them to interpret the experience of midlife mothering in a more positive light. Access to people and information could improve coping, management of stress, and foster more capable problem solving.

Constructing greater levels of social support could potentially be accomplished by creating opportunities for women to develop new social network linkages and building capacity within community and professional resources which the women utilized, i.e. classes, support groups, hospital sponsored events. Heaney and Israel (2008, p.201) suggest that new social network linkages can be introduced to those

with small networks (like midlife mothers) through the use of "mentors" – "people who have already coped with the situation being experienced by the focal individual" or 'buddies', those who "are experiencing the stressor or life transition at the same time as the focal person". Internet-based support groups or virtual communities may be a viable option for older first-time mothers who are well-educated and financially likely to own a computer in their home, maintain internet access, and possess the skills necessary to maneuver through virtual space.

Though there is little evidence to date of the effectiveness of such groups (Heaney & Israel, 2008), the lack of available 'similar others' might motivate midlife mothers to engage in this option. Drentea and Moren-Cross (2005) also acknowledge the lack of evidence using internet mediums. They examined whether virtual communities in 'cyberspace' could offer mothers a source for building social capital and social support. The researchers found three types of social support were enhanced through the women's participation in a mothers' website discussion board: emotional, instrumental, and community building/protection, particularly for new mothers who were isolated. It has been documented in the literature that women enjoy making connections and forming relationships with others and that these can have an effect on "cognition, affect, and behavior" (Hurdle, 2001, p.74). Hurdle notes that women prefer to hear about health information from friends and family, in one-to-one situations. Being out of sync with family and friends, and the lack of similar others creates a void in communication with other mothers, and with other women transitioning to menopause. This is an important connection which is discussed further in chapter eight.

The current study advances understanding of the older first-time mother's experience as one lacking adequate social networks and social support. However,

current findings do not support the work of others who suggest older first-time mothers are also out of sync with society at large (Dobrzykowski & Stern's, 2003). I would suggest that this may be due in part to a growing acceptance by society in general for women who delay mothering. The changing demographics for older first-time mothers would support this view, as well as the heightened visibility of older celebrities who have given birth or adopted children in recent years. Dobrzykowski and Stern (2003) did note that the maturity of older women diminishes the influence that the values and structure of society has on their decisions, and this is exemplified by one of the participants in the current study who bragged, she was "different", but she didn't care. Perhaps this explains why this topic was not a salient point during my discourse with the women.

Summary

Chapter seven presented a written interpretation of the participants' lived experiences as first-time older mothers who were *Out of Sync* with friends, family, and other women their own age. *Out of Sync* was used conceptually to represent the women's achievement of motherhood at a time in their lives which did not uniformly synchronize with other women their age, or friends and family's timing of parenthood. As a result, they experienced an inadequate social network and an insufficient level of social support necessary to buffer the intensity of their mothering experiences. A lack of similar others, or women like themselves also contributed to the experience of midlife mothering as isolating. As a direct result of their own delay in achieving motherhood, their mothers and fathers became older grandparents, and several of the participants found themselves sandwiched between caring for their own families and aging parents, which added stress to their lives.

The theme *Out of Sync* was authenticated by five categories which provided substance and support to the concept of midlife mothering as an isolating experience. The first category, *"Arrested Development"*: Off Time Motherhood acknowledged the non-synchronous reality in which these older first time mothers lived compared to the majority of women who become mothers at a younger age. Understanding of their experiences was enhanced when viewed from the perspective of an 'idiosyncratic life cycle transition' (Imber-Black, 1989). Older first time mothers have no 'available map' to guide them through the experience, little contextual support, and few similar others, which tended to maximize the differences they had with younger mothers, almost to the exclusion of a sense of connectedness with others. This disharmony in life stages resulted in a very thin social network, which was represented by the category *"You Don't Have the Same Network"*: An Isolating Experience. The women experienced diminished density, complexity, reciprocity, homogeneity, dispersion and intensity of their social network. They described their experiences as isolating, and these were revealed in the category *"Minimal Support"*: From Friends and Family.

Having aging parents created a paradox in which they became the ones having to provide support to aging or ill parents. They sought out older mothers like themselves for social support, and this preference was presented in the category *"I Connect More with Mothers Who Are Older"*: Similar Others. The final category *"It's Like a Vacation"*: When You Have Support presented the experiences of a few women who felt they had adequate social support, along with a discussion of the literature on the benefits of social support on health and well-being. Improving social networks and social support for older first-time mothers could have beneficial effects on midlife mothering experiences. This could potentially be accomplished by creating opportunities for women to develop new social network linkages and building

capacity within community and professional resources which the women tended to utilize.

The next chapter, *Perimenopause as a State of Uncertainty,* delves more deeply into the women's perceptions of their health as they transitioned to menopause. These aspects of health and midlife will be discussed next.

CHAPTER 8

PERIMENOPAUSE AS A STATE OF UNCERTAINTY

Introduction

Chapter six presented a written interpretation of the participants' lived experiences as first-time midlife mothers. The major theme *Intensive Mothering* conveys the overarching experience of older first-time motherhood as one replete with advantages, as well as unique challenges. The women experienced greater fatigue, decreased energy and physical abilities, as well as physical, emotional and psychological symptoms which accompanied their transition to menopause. Chapter seven was an interpretation of the participants' lived experiences as first-time older mothers who were '*out of sync*' with friends and family. The theme *Out of Sync* represents the women's achievement of motherhood at a time in their lives which did not uniformly synchronize with other women, friends and family's experiences of parenthood. As a result, they lacked a sufficient social network and level of social support to help buffer the intensity of their mothering experiences.

The content in chapter eight delves more deeply into the women's lived experiences as older mothers and midlife women transitioning to menopause. The major theme *Perimenopause as a State of Uncertainty* is used conceptually to convey the experience of transitioning to menopause as one that lacks familiarity and is shrouded in ambiguity. The absence of a distinct timeline for perimenopause and the lack of support from credible sources to guide them through their experience contributed to the women's perceptions of menopause as predominantly negative. As older mothers, these women also experienced uncertainty about the future, and worried about "*being there*" for their children. The theme *Perimenopause as a State*

of Uncertainty is authenticated by six categories which provide substance and support to the concept of *Uncertainty* as a framework for further understanding the meaning of health for midlife mothers during perimenopause. As each category unfolds, the voices of women whose experiences created shared meaning as well as those whose experience was unique to those of the group are expressed. This chapter includes a discussion of these six categories in the context of known traditions, the pre-understandings of the women and mine, as well as a comparison of findings with the relevant literature and theories.

The first category *"It Must Be Something Else"*: Transition to Menopause relates the women's perimenopausal experience as one shrouded in ambiguity, so much so that many of them were not sure what was happening to them physically, emotionally, and psychologically. The range of symptoms they experienced or thought they should be experiencing was confusing to them, and this is discussed in the category *"What is Going On?"*: Unfamiliar with Symptoms. The women were preoccupied with wanting to know how long the transition to menopause was going to last and whether the symptoms were going to get worse, and this aspect of their experience is discussed in the category "How L*ong Will This Last?"* : Uncertain Timeline. The category *"It Just Didn't Happen"*: Lack of Support from Credible Sources captures the women's lived experience of being unprepared for perimenopause. They identified lack of support, anticipatory guidance or education from physicians, midwives, and their own mothers about the transition to menopause. *"So Many Negative Things"*: Perceptions of Menopause reflects the predominantly negative views of perimenopause/menopause which the women held. They had concerns about the future, and were more in touch with their mortality since becoming mothers. For these reasons, they believed their health was precious, and they had a powerful desire to remain healthy, active and

available to their child/children despite their older age. This is revealed in the category *"Being There"*: Uncertainty about the Future. The first category is presented here.

***"It Must Be Something Else"*: Transition to Menopause**

Through questions and answers, narrative stories, and dialogue, the participants shared their experiences of transitioning to menopause. It became evident to me that as each woman crossed this threshold, her transition was a highly individual experience, situated in the unique context of her life. Their pre-understandings about transitioning to menopause conditioned them to expect night sweats, hot flashes, and menstrual irregularities. They did not consider this transition to be a major event or turning point in their life, as opposed to marriage, or the birth of their child which was a major event. There was common meaning around the belief that other events in their life took priority, like work, parenting young children, caring for aging parents, or dealing with relationship issues, and some admitted they were simply unfamiliar with what to expect at all as they navigated through this developmental life transition.

My own transition into menopause was similarly superseded by other things going on in my life, including family, work, graduate and doctoral studies, my mother's illness and her untimely death. My own lack of monthly menses, (as a result of surgery) allowed me to blithely ignore any signs or symptoms that I might be approaching menopause. I experienced an epiphany when one of my sons asked me why I was so irritable all the time. This was occurring at a time in my life when I was making major changes in my career and pursuing advanced education. I was in a graduate programme, and had accepted a new position in a women's health outpatient centre, where I began caring for women who were transitioning to menopause or were menopausal (how ironic). This was the point in my life when I developed a keen

interest in an aspect of women's health that extended beyond the reproductive years in which I had been professionally immersed for more than twenty years.

Imbedded within the discourse and very personal stories of the women in this study were shared experiences which uncovered perimenopause as a state of uncertainty. Furthermore, concerns about their own mortality, and uncertainty about their continued presence in their child/children's lives emerged as a consequence of their older age. There was shared meaning in their discourse about feeling unprepared for the perimenopause: ten of the women related that they were unfamiliar with symptoms; eight felt they lacked anticipatory guidance and support from their providers, and most found even their own mothers unwilling to discuss menopause with them. Eight women were so unsure of what was happening to them that they thought they were experiencing "*something else*". Roxanne, age 49 thought there was something else wrong with her because she was not experiencing what she thought were the typical symptoms of menopause. This is how she responded to a question from me about whether someone could have done or said anything to make her transition easier:

> *I kept looking for the night sweats or the hot flashes which I didn't have. So I thought I had something else... this* [perimenopause] *can't be what I'm going through- this must be something different and not knowing that not everybody suffers with all of the same symptoms. So I think that would have been helpful for me to know that while I had the forgetfulness and I had the rage and the not sleeping, just because I didn't have the night sweats and the hot flashes doesn't mean I'm not going through this. I kept thinking there's just something wrong with me; it would have been helpful for me to know this was physical and not emotional, and not that I wasn't just angry at the world or my kids or my situation* (Roxanne, I_2, p.41).

Several of the women identified prominent issues in their lives which distracted them from focusing on perimenopause, and these women had not given much consideration even to the idea that they might be transitioning to menopause. Leslie, age 49, talked about serious relationship issues and the possibility that she might leave

the father of her child to whom she was not married. She had not thought much about attributing any of her physical changes or emotional symptoms to perimenopause, and as a result, there was a clear lack of awareness in her description of how her body had changed:

> *So, I think, I think one of the things, you know again I don't know if a part of this is the menopause but I think part of this might be the menopause is, you know, it's been two years and, and I gained all this weight. And I'm noticing changes in my body...* (Leslie, I_2, p.50).

Susan was 51 and parenting a child with a disability. She experienced symptoms for five years before she realised "*what they were*". Florence, age 48 worked full-time as a college professor, and attributed her symptoms to the challenges of parenting. She confessed that she "*was not even that familiar with what else might be perimenopausal symptoms*". Sarah, age 55, and mother of three young children, was simultaneously caring for her mother who was dying. She had cared for her in her home for many years before moving her to a long term care facility. During her second interview, she participated in discourse on symptoms being attributed to age versus perimenopause:

You know, I don't know, part of the thing is, is when you're in perimenopause, you also do have those other factors sometimes playing in: poor health of your parents or, you know, in my case a very much OLDER, you know. And I think we all feel that pressure of being set for retirement because we don't feel like, you know, is anything going to be out there for us and all those UNCERTAINTIES are greater (Sarah, I_2, P.33).

Jackie was one of only two women who recognised at the onset that she was perimenopausal. She described a somewhat textbook transition to menopause as indicated below:

> *I knew because like I said, I've always been like clockwork right. I could tell you the day I was going to get it. My whole life, I never had missed periods or anything. So that was the first sign, and then, then I'd get back on schedule. This happened I think over a period probably of, I tracked it like five years, that I'd miss one, that it was fine the rest of the...the next year I noticed uh, I missed two, and then each year I missed more and more, um, and then the actual hot flashes probably a couple years now, that those started....and then got to a point where it was horrible and then the night sweats started. Then they'd go away for three months. Then they'd come back for two months but I noticed like off and on* (Jackie, I_2, p.45).

The other study participant who was certain about perimenopause was a physician, and she shared her experiences caring for women who find the transition to menopause confusing. She agreed that if she was not a gynecologist, she might not have recognised her own symptoms of perimenopause at age 40:

> *I think the very... what I see as the first evidence of getting, of sneaking towards menopause is actually the worsening of the PMS type symptoms. So I have people coming in at 34, 35, 36 saying maybe I'm having, maybe I'm menopausal* [symptoms], *but really what they are describing to me is PMS and then that kind of segways into perimenopausal symptoms and then they get more severe so um so I see a lot of that so I'm trying to figure out what the connection was* (Mary, I_1, p.6).

It is important to point out that the years women spend transitioning to menopause have only been recognised as separate from menopause for less than twenty years. A consequence of this has been the absence of research with perimenopausal women (Li *et al.*, 2000) particularly from the perspective of women's understanding and comprehension, which lends additional significance to the current study. Findings are similar to those of George (2002) who conducted a qualitative study with fifteen menopausal American women. She revealed that women were confused about the transition to menopause; they were either not sure what to expect, or their actual experience did not parallel what they expected to happen. Bender (1998, p.12) writes in the lay literature The Power of Perimenopause that it is not surprising to find women confused about perimenopause: "we certainly didn't grow up hearing the word *perimenopause*, much less knowing what it means".

Transition theory can be helpful in understanding the experiences of women as they cross the threshold toward menopause. The transition to menopause along with childbirth and parenthood have long been considered normal developmental, lifespan transitions (Meleis, *et al.*, 2000). Mercer *et al.* (1989, p.3) note that menopause is an age-normative transition in many cultures, and suggested that characteristics of the

transition to perimenopause involve "individual change or adaptation... [which] contribute to psychosocial development or have developmental potential. [This can also be a] "... period of disequilibrium or flux [for women] who must adapt to a new situation, new roles, or responsibilities". Increased feelings of vulnerability may also be experienced during times of transition (Meleis *et al.*, 2000) and this aspect of the transition will be discuss further in the last section of this chapter. Selder (1989, p.437) described the theory of life transition as a "...process that bridges from a reality which has been disrupted to a newly constructed or surfacing reality". The new reality incorporates the triggering event in order to maintain the integrity or sense of self for that person. This process involves resolution of uncertainty which Selder (1989) states is a major characteristic of all transitions.

When asked to describe the major transitions or turning points in their lives, the women in the current study named marriage, careers, births, deaths, and motherhood. Perimenopause or menopause was not cited by any of the women as a major transition or even a turning point in their lives. This is consistent with the work of Mercer *et al.* (1989) who found that fewer than half of the mothers in their study experienced transitions between the ages of 41 and 45, as opposed to half of the mothers aged 51-55. Menopause was not considered a transition or turning point among the mothers in Mercer's work, but the births of children were cited as transitional events. This failure by women to perceive perimenopause or menopause as a major event in their lives may be explained by the idea that anticipated events do not have as much effect on women's lives as unanticipated events (Mercer *et al.,* 1989). For some women, like Leslie, in the current study, there may be more prevalent transitions which take priority, and push the menopausal transition to the background. Leslie was struggling with a major decision to stay or leave her relationship with the father of her child, and

for her that was the prime focus she was dealing with. This explanation is supported by the work of Walter (2000, p.119) in which one unmarried woman declared that menopause was more of a "bigger marker event" for single women without children who do not have other important events to "mark important life transitions".

While the women in the current study did not think perimenopause was a major event in their life, they did acknowledge physical, emotional and psychological changes related to 'going through menopause' which were stressful to them. I interpreted these as components of uncertainty or disruptions in the 'structure of their reality' (Selder, 1989); utilizing transition theory, I expected the women to do some *restructuring*, or create meaning about perimenopause in an effort to resolve or manage the uncertainty. Utilizing Selder's concepts about transition theory as a framework for understanding in the context of the women's lived experiences, I would expect that creating meaning about perimenopause would be influenced by the assumptions and expectations the women held about what that reality should or could be. This is very much in harmony with Gadamer's concept of pre-understandings, and was useful for creating a mutual interpretation of the women's experiences. As the discourse continued about the ambiguity of the menopausal transition, one particular aspect which the women found confusing was the wide variety of symptoms they experienced or thought they should be experiencing, and this will be discussed now.

***"What is Going On?":* Unfamiliar with Symptoms**

Ten of the women expressed a lack of familiarity with symptoms usually attributed to perimenopause. It was very interesting to hear the words they used to describe the changes they were experiencing. Symptoms were described as "*erratic, crazy, different, unusual, difficult to handle, difficult to explain*", and some even struggled to find the right words to describe what they were feeling. Perimenopause

was described as "*waiting for something to happen, not feeling good, a struggle, a big difference, being in a body that is acting differently, feeling like a constant battle and at war with her body*". Shanny was one of the most symptomatic women in the study. She described the transition in the following two excerpts:

> *Again, my body . . I don't feel as good, I don't know how to explain it if I had to put it into words. When I sleep, I don't feel rested. Even when I exercise...I walk almost every day, I'd say, I used to feel better...* (Shanny, I_1, p.17).

> *I had these erratic periods sometimes I would bleed for 10-12 days, over the last three or four months and then for this couple of months, I didn't have a period for two months. So, it's something obviously your body... it's crazy, and my body is really feeling all the time, like I don't know, like it's waiting for something to happen, but it's just not happening...* (Shanny, I_1, p.18).

Later in the interview, Shanny expressed her desire to "*do this* [menopause] *naturally*", without drugs or hormone replacement, but other women kept warning her that it was going to get worse. Here she reflected on that omen:

> *I keep thinking, well it doesn't have to get worse. I don't know if it has to. Maybe this is as bad as it gets. Not that it's bad, but it's definitely difficult, in the last 1 ½ years my entire psyche and my body have changed. It's in a constant battle. I feel like I'm at war with my own body every day. That's all I can say. It's like a constant war* (Shanny, I_1, p.30).

Roxanne also described a difficult transition to menopause, though at the time of her interviews she felt like she was "*coming out of it*":

> *And I didn't feel that I was depressed, I felt I was angry. I didn't have any other symptoms of depression; I wasn't losing weight, I wasn't going... I didn't feel blue, I just felt I didn't cope as well anymore. I used to be able to handle things all the time, and then all of a sudden I just couldn't handle things anymore* (Roxanne, I_2, p.45).

Some of the women voiced confusion about whether they were in the perimenopause because they were not experiencing the classic symptoms they expected which were menstrual changes, hot flashes, and night sweats. Miriam, age 49, was a nurse, and stated she was familiar with the signs and symptoms of perimenopause, and that she was prepared, yet she still voiced confusion about

symptoms. She was one of the women who had serious personal issues taking priority over the transition to menopause, so she was not sure what to attribute to it:

> *I get my periods every three weeks as opposed to... they used to be every four like clockwork, and I thought that was kind of unusual because I thought when people went through menopause that the cycles got LONGER NOT SHORTER. But I haven't really noticed any other symptoms. I don't have any night-sweats or hot flashes. It's a little hard to say because I have so many other things going on in my life that ... if my mood swings have to do with, you know, my cycles or just my personal problems. So that's... I can't really differentiate* (Miriam, I_1, p.6).

Monique age 47 was busy mothering her 3 year old adopted daughter, building a business, and caring for aging sick parents. She was not sure what she was experiencing:

> *I have no idea what comes from menopausal symptoms versus outside stressors, I really can't tell. I mean yeah certain things, vaginal dryness, lack of desire, that could be a symptom who knows?... I don't really have hot flashes, I don't have night sleep disturbance, a little change* (Monique, I_2, p.28).

The women completed a Personal Data Survey (Appendix M) at the time of the interviews and identified themselves as perimenopausal. They identified anywhere from one to eleven symptoms from a checklist of thirteen cited from the literature. The onset of their symptoms ranged from age 40 up to 50 years old, and lasted up to six years. During the interviews, women described twenty-five symptoms or behaviors they associated with the transition to menopause. The most common symptom identified by eleven of the women was menstrual changes. Participants additionally named irritability (7), mood swings (7), night sweats (7), hot flashes (6), losing control (6), various levels of depression (6), and feeling more emotional (5) as major symptoms they had experienced. Decreased patience, memory issues, sleep disruption, heavy bleeding, and increased stress were also identified, but only by four women, and finally, migraines, fatigue, anger/rage, panic attacks, palpitations, feeling overwhelmed, decreased ability to cope, anxiety, vaginal dryness, nocturia, decreased libido, and weight gain, were mentioned by fewer than four women.

Roxanne's symptoms began when she was 45 and lasted four years. She felt that the symptoms were at their worst when she was 47 years old, but that "*things were really really bad for two years*". This is how she described that period of her life:

> *I just didn't understand what was going on. Why am I always angry? I think it was so many changes happening so quickly, and then throwing this on top of it. I had my period ALL the time, I bled, you know, when I had my periods it was debilitating, and they've never been debilitated before. It was- you know every day was just impossible... I never yelled at anybody. I'm not a yeller, and now I think..... ....ugh and I think. I wish people would prepare you for that more. To tell you that this is normal.....crying ugh I'm embarrassed and ashamed that I was like that...* (Roxanne, I_1, p.17).

Shanny had experienced symptoms for less than two years, and cited lack of patience and palpitations as the worst part of her transition to menopause:

> *It's as I said to you my biggest issue with the menopause is the lack of patience that I have. I find it really difficult because my kids are the centre of my life. They're used to me being very calm and that has just changed. Like it or not. I work very hard to keep myself intact but my anxiety level is high and stupid things will set me off. I yell a lot more than I should. I lose my temper. I just in general am short; short with them and I don't have any patience. ... I started with night sweats. I have hot flashes. I have my palpitations back. They come and go. I have very erratic periods. I also feel... I used to be very in tune with my body. I could tell you a day or two before my period because I had that PMS thing. I'm not a big believer in PMS, but I could tell.... And now I have that feeling three or four weeks a month. It's like PMS all the time* (Shanny, I_1, p.15).

Rosie was one of two women who did not experience a gradual transition to menopause because she had a hysterectomy with ovaries removed. She identified herself as pre-menopausal prior to her hysterectomy. She experienced heavy menstrual bleeding for years leading up to her surgery. She was six months post-hysterectomy at the time of her interviews, but still symptomatic. The following dialogue is lengthy, but since it represents a different transition to menopause than almost all of the other women experienced, I felt it was important to include it:

> Pat- *Perimenopause is the term we kind of use to describe going through menopause* [Rosie: *right*]. *Menopause is actually a year without your periods, then we consider you post-menopause. What has that experience been like for you?*

> Rosie: *Surgical menopause- hot flashes, I had migraines, ever since I had her and they stayed the same, my doctor said it wasn't going to correct that, or it could or it could get worse and I've just stayed the same, maybe a little bit better. No sleep until I started taking the hormones estrogen, it was like being pregnant with brain fog, but twice as bad. I'd look at you and say start a sentence and couldn't finish it, I couldn't remember anything. I JUST COULDN'T REMEMBER THINGS. And then I read up, there's a good website called 'Mistersisters'- it's very good information, it was all normal and natural. So once I started taking the estrogen some of the symptoms lessened. I still have trouble sleeping, I'm hot* (Rosie, I_1, p.5).

I asked her if she experienced sudden menopause and this is what she said:

> Rosie: *Yeah- at about my six week checkup my doctor didn't start me right on estrogen. Some doctors will stick a patch on you in the hospital; she wanted me to wait cause of my migraines. She wanted me to wait to see what and how bad the symptoms were, cause now with the new studies out it's not as prevalent that they slap or give you a pill right away because they're concerned about heart and other. Doctors are waiting to see how bad your symptoms are and what's going on. In six weeks I was mental* (Rosie, I_1, p.7).

During her second interview, she elaborated more on what it was like to experience surgical menopause:

> *You can read it, but until you experience it it's just a big difference. So I had read everything I needed to, and knew kind of what was going to happen, but until I felt all these things at once...I had...didn't...couldn't...can't until you experience it. I mean I was pretty ready and just needed to get the right direction on how to handle some of the symptoms so that I ...it's crazy* (Rosie, I_2, p.23).

During Rosie's second interview, I explored the issue of depression, because several of the women had mentioned it, and Rosie had shared that she was seeing a therapist. She described her 'depression' similarly to the other women as different from a 'real' or clinical depression:

> *I don't know* [that it's like] *the real depression like a clinical depression, but I definitely was depressed. After my mom died, dad remarried, and you know blah blah, and after having a hysterectomy I was definitely depressed. Not, I don't think clinical, that's why they put me on Lexapro. I didn't take it for a couple of days and I started feeling...I didn't feel good like mentally, A weight, a pit in my stomach, and I realised I wasn't taking that, I forgot, or whatever so it has definitely helped me. I think it's hormones that you're missing...* (Rosie, I_2, p.32).

Leslie had been noticing changes for three years, starting at age 46. Irregularities with her periods, and hot flashes had stopped at the time of her interviews. She was unsure about what to attribute to the transition to menopause, and what to weight gain or other issues going on in her life.

> *I skipped them, I skipped them and I would go, I mean I think have gone like three or four months without one. And I went for a really long period of time like that. And then I thought, well maybe I'm finally done. Because you know I've been doing this for well I had my first symptoms three years ago ...so it's already been three years since I ...and the first thing that I had was intense, like thirty a day hot flashes for days in a row and now I haven't had ...and I think this summer I had a lot of hot flashes but you know, sometimes you blame it on well I'm overweight and it's hot so I'm sweating more. You know it's hard to know, but I haven't had any hot flashes now for a while* (Leslie, I_2, p.42).

Susan's primary symptom was panic attacks. She first starting experiencing them about five years ago at age 46, and she would have a feeling of losing control all of a sudden. She also experienced chills and hot flashes. She thought she was having hot flashes, but was not sure because they are not what she expected:

> *I feel loss of control. My heart races, but not to a dangerous level, I get shaky. It's just...not anything ... there is nothing I can do about it. There is nothing I can eat to make me feel better. I can exercise, and it doesn't help it. I can rest, and it doesn't help it, so it's not like there is anything I can do to help that feeling. I think I do get some, I don't know if they are hot flashes or not, because they are not as severe as what I've read described, but I do get hot sometimes in the middle of the night and I have to pull the covers off and then wait until I cool down, then I bring the covers back again, but that kind of wakes me up sometimes* (Susan, I_1, p.6).

The findings from the present study are consistent with the work of George (2002) who found women to be confused about the transition to menopause because of lack of factual information, preparation and the various presentations of symptoms. The obvious confusion for women around perimenopause and menopause is highlighted by the fact that three of the thirteen women who volunteered for this study and identified themselves as perimenopausal, were no longer having periods. The North American Menopause Society (NAMS, 2006, p.5) defines women as

menopausal after "the final menstrual period, confirmed after 12 consecutive months without a period or when both the ovaries are removed or permanently damaged". Jackie was one of those women who was actually one year beyond menopause, but was still having "*horrible symptoms*", so I decided to include her experience with the others. She found the worst symptoms were hot flashes and especially the night sweats, which she described here:

> *...the hot flashes are horrible, they're horrible. And the night sweats are worse I mean you just lay there and actually I will soak my sheets, my nightgown, my head is soaked. Sometimes it runs down my face. And even, even in the cool weather, it's like oh my God everything comes off, I have to open the windows ...yeah sometimes I get very warm,* [during a hot flash] *um, but I don't get that like raining sensation that I do with the, with the night sweats. That you actually, I mean it just, I can actually wipe with my... you know, off my brow. And do this and I'm just soaked and my head's soaked, just like I went in the shower. It's scary* (Jackie, I_1, p.10).

Another source of confusion for the women was being told they were or were not menopausal and then having symptoms or signs contradict what their provider told them. Abbey related that her perimenopausal symptoms started about one year prior to the interviews, and at the time of her interviews she was having "*bad night sweats*". Here a description of a visit with her physician exposes the dissonance between what she was told and what she was experiencing:

> *My period- I was always very regular- just started to get very irregular so a I went to the doctor and had a check up and cos' this summer I didn't have my period for two or three months and a she said they did the FSH test* [follicle-stimulating hormone] *and they came out wherever I was on the range it was the area they considered you in menopause but I have actually since then had a couple of periods so or whatever they are but...yeah it's hard that's hard cos' I'm not sleeping* (Abbey, I_1, p.10).

Miriam recently started noticing changes at age 49 as she transitioned to menopause. Initially, the only symptom she identified was that her menstrual periods were closer together. Like some of the other women, she did not think she was "*into menopause*", but as she described

how she was feeling, it was clear that she had some of the common symptoms of perimenopause:

> *Right before I get my period I'm very, very moody, cry easily. I'm not... I'm definitely not into... not what I think of menopause* (Miriam, I_1, p.7).

Later in the interview, Miriam talked about a few other changes she was experiencing:

> *But I find something else that's happened to me over the last few months; I get up every single night and go to the bathroom – and I do occasionally take like a Xanax or a Benadryl at night to help me sleep. Because I really need to ...like tonight because I haven't slept well in the last like two or three nights and I need to sleep like eight hours...The only time, though, I do sometimes get a little bit like it feels like what night sweats are is right before I get my period. I wake up sometimes and I'll be drenched. But other than that, I don't get them, or I don't get hot flashes* (Miriam, I_1, p.30).

Florence declared that she was definitely perimenopausal, and had been having symptoms for 6 years:

> *I am 48 now and will be 49 in February. I still get a regular period, but it's a much smaller period. It's different. It's different period than what I used to get. I don't get cramps at all after having had a baby. At least nothing feels like cramps anymore after going through labour. I don't know. ..The BIG difference is my period goes on for about seven days. It used to be three days. I would have a heavy flow for three days and then peter off. Now it is a very light flow that goes on and on* (Florence, I_1, p.12).

Sarah was the final woman interviewed for this study. She represents another example of a woman who by definition was postmenopausal, but was still symptomatic, and therefore, seemed appropriate to include in the study. She had one remaining ovary, and recalled that her worse symptoms were one to three years prior. It is important to note that during the years spanning this study, the terminology for describing perimenopause was revised by NAMS (2003, 2006). Perimenopause is now referred to by professionals as 'transitioning to menopause'; however women and the public were familiar with the term 'going through' menopause. Rather than take a pejorative stand, I decided to incorporate both descriptions while interviewing the remaining women for the study. Here I asked Sarah to describe what it was like to 'go through' perimenopause:

> *Well I would say my worst symptoms were probably the emotional things, the labile moods, which I think contributed to my impatience, et cetera... I'd already had my hysterectomy but I still had an ovary. And I had horrific hot flashes when I came to from my hysterectomy just because of losing an ovary, and I think all the manipulation she did trying to get the other one out but she couldn't. So I woke up having terrible hot flashes, but within a few days that was all gone. And then I really had infrequent hot flashes in my perimenopausal time* (Sarah, I_1, p.7).

"More than 80% of women experience psychological or physical symptoms in the late reproductive years, with varying degrees of severity and disruption in their lives" (Gracia & Freeman, 2004, p.675). As the extracts demonstrate, the symptoms most frequently noted by the women in the current study were menstrual changes, hot flashes, mood swings, night sweats, irritability, loss of control, depression, and emotional changes. While hot flashes have been documented in the literature as the most common menopausal symptom, irritability, depression, and mood swings are the most commonly reported emotional symptoms (National Women's Health Resource Center, 1995). In fact, Berg, *et al.* (2008) recently reported sleep difficulties followed by forgetfulness and irritability as the most frequently perceived symptoms among perimenopausal women aged 43-55. Irritability, mood swings, decreased patience, lack of control, loss of control or fear of losing control, were common areas of concern for women in the current study, particularly in the context of mothering young children, and were discussed thoroughly in chapter six. Additionally, the women gave examples of how their bodies used to look and function, prior to perimenopause, which Wiener and Dodd (1993, p.23) call a "shaken faith in the taken-for granted body". The women described a prevailing sense of their bodies failing them during the transition to menopause, coupled with a propensity to emotionally lose control over things that normally would not push them 'over the edge'. Similar findings emerged in a study of women 'navigating' the journey to menopause (Matarese, 2005, p.39) in which women described a "constant struggle for

control of a changing body". This too is in line with the descriptions women in the current study used to create meaning.

Uncertainty about what was going on, and lack of familiarity with the symptoms they were experiencing was compounded by the lack of a timeline for how long perimenopause would last. Selder's (1989) theory of life transitions explains that disruptions in a person's reality structure will result in a collapse of time, in which a person will be preoccupied with a decision or event triggering the transition. This provides a framework for understanding the women's desire to know how long the transition to menopause was going to last and whether the symptoms were going to get worse, and this interpretation is presented and discussed in the next section.

"How Long Will This Last?" **: Uncertain Timeline**

Another aspect of the transition to menopause which caused consternation among the women was the unpredictable timeline for perimenopause. Eight women expressed a desire to know how long they could expect perimenopause to last. They were also uncertain about whether their symptoms were going to get worse, or if they were already at the peak of it. As Roxanne reported:

> *Like I said...just knowing that it was going to be over would have been enough, to know that I'm going to feel the way that I used to feel, cos' I remember thinking when did I stop feeling good about myself?* (Roxanne, I_2, p.45).

Shanny found the uncertain timeline scary, and this is what she said:

> *The thing that scares me the most, I think is that when does this end? Does this get a lot worse before it gets better?* (Shanny, I_1, p.24).

Later in the interview, she summed up her struggle with the uncertain timeline, and symptom severity:

> *Basically those are the things that I struggle with right now. I think my big question is, how long is this going to go on? Is it going to get worse? Much worse? Is it going to get any better? Am I going to get to the point where*

> *people say I should take hormones, because I don't want to do that. I don't take an aspirin, you know what I'm saying. But people say wait until it gets worse, you'll be taking those by the handful if they give them to you* (Shanny, I_1, p.38).

It was evident that the women did not have any pre-understanding about how long the transition to menopause might last, or where they could place themselves on the timeline continuum. Jackie (age 50), lost forty pounds and noted that her hot flashes stopped at that point. She was mildly symptomatic at the time of her interviews, and here she reflected on where she was on the continuum:

> *Since I've dropped the weight I haven't had any hot flashes. Then they started up again, but NOT as severe. So that means I'm either at the end, which I hope, would be nice, you know, but you hear about women that go through menopause like through their fifties*...(Jackie, I_2, p.46).

Abbey was also unsure of what lay ahead of her:

> *So menopause I my... I just hope it doesn't drag on. I just want to get it over with. I hope it comes and goes quickly for me, you know, not like a five or ten year I don't know, I DON'T EVEN KNOW* (Abbey, I_2, p.64).

The women were looking for a timeline for when they would be "*at the end*" of perimenopause; not knowing how long it was going to go on was stressful to them. This preference for predictability is consistent with the findings of Mishel (1988). Predictable or signaled events are preferable to people, possibly because having knowledge or a warning permits them to prepare is some way, thus reducing stress. Thus warned, people may be able to predict the stimulus, and also control it (Lazarus & Folkman, 1984). The women described the ambiguous nature of both symptoms and the timeline during perimenopause, and the extracts highlight this period in their life as a complex transition, in which feelings of uncertainty were embedded. Together with other unfamiliar, unpredictable, inconsistent and vague factors which accompany perimenopause, a shared meaning emerged from the dialogue and the text.

Meaning culminated in the construct of uncertainty as theoretical embodiment of the women's transition to menopause.

The concept of uncertainty has predominantly been utilized in the context of 'illness' through the work of Mishel (1984, 1988, 1990, 1991) and others (Hilton, 1988, 1992; Wiener & Dodd, 1993). Mishel's (1988) theory of uncertainty in illness model has been applied as a framework for understanding acute illness and cancer. Mishel (1988, p.22) defined uncertainty as: "the inability to determine the meaning of illness-related events. It is the cognitive state created when the person cannot adequately structure or categorize an event because of the lack of sufficient cues". Hilton (1994, p.18) defined uncertainty as a "cognitive perceptual state that ranges from a feeling of just less than surety to vagueness; it changes over time and is accompanied by threatening and/or positive emotions". In a concept analysis of uncertainty in illness, McCormick (2002, p.128) cited six situations in which uncertainty is present. They are: "ambiguous, vague, unpredictable, unfamiliar, inconsistent and unknown factors related to living with an illness", but McCormick notes that, not all six characteristics need to be present simultaneously, since they describe the situation, and not uncertainty itself. Uncertainty is a "person's perception of those situational attributes" (McCormick, 2002, p.129). The concept of control was paramount in the literature on uncertainty. While Mishel (1997) noted that 'lack of control' has not been a consistent antecedent to uncertainty, McCormick's (2002) concept analysis of uncertainty stressed that loss of control is not the same as uncertainty, but may be linked to uncertainty in an inverse relationship.

Mishel's original theory was based in part on the work of Lazarus and Folkman (1984, p.103) who defined uncertainty as "confusion about the meaning of the environmental configuration". Adopting this broader definition of uncertainty, I

would argue that a leap can be taken to apply the concept of uncertainty anywhere along the health continuum where the characteristics of an uncertain situation exist, and the components or attributes of uncertainty are present. McCormick (2002) described three attributes of uncertainty: probability, temporality, and perception. Probability refers to the likelihood of something happening, temporality represents the aspect of time, duration or frequency of the situation, and perception is an interpretation of something. Due to the presence of these three attributes during the transition to menopause, I would propose that uncertainty is an appropriate conceptual framework for understanding women's experiences during the transition to menopause.

The proposal to extend uncertainty theory as a framework for understanding women's experiences during perimenopause is consistent with the work of Lemaire and Lenz (1995) who cited the unpredictable nature of the menopause, and first proposed uncertainty theory as a possible framework for understanding women's experiences during perimenopause and post-menopause. Lemaire and Lenz (1995) utilized Mishel's (1990) *Uncertainty in Illness Scale-Community Form* for measuring the perceived uncertainty levels about menopause in women attending an educational programme about menopause. Prior to Lemaire and Lenz's work, uncertainty as a framework for understanding the menopause had not been systematically studied. Several other researchers have cited aspects of uncertainty in recent qualitative studies with samples of perimenopausal and menopausal women. Bannister (2000) conducted an ethnographic study with eleven women aged 40-53 who identified themselves as experiencing menopausal changes. They voiced uncertainty and confusion over physiological changes and voiced some dissonance between their personal experiences and the information they received from medical sources. Walter (2000,

p.121) interviewed 21 perimenopausal women, most of whom experienced "feelings of uncertainty regarding their body, which heavily influenced their emotional and cognitive reactions". George (2002, p.80) interviewed 15 menopausal women who "had expectations that were not congruent with their actual experience", had varying degrees of symptoms, and identified a need for clarification about the menopause experience.

Mishel (1988) originally attributed uncertainty to situations in which patients were unable to construct meaning, or form a cognitive schema for an illness event.

> A cognitive schema is the patient's subjective interpretation of illness, treatment and hospitalization ... [the] stimuli frame, cognitive capacity and structure providers precede uncertainty and offer the information that is processed by the patient. The primary antecedent variable, stimuli frame, refers to the form, composition and structure of the stimuli that the person perceives... (Mishel, 1988, p. 22).

Symptom pattern, event familiarity and event congruence provide the stimuli which the person can potentially structure into a cognitive schema, which would lessen uncertainty. The lack of familiarity with the transition to menopause, the incongruence between what women in this study expected and what they actually experienced, and the variability and ambiguity of symptoms made it difficult for the women to form a cognitive schema for perimenopause. Additionally, the women identified a strong sense of temporality, or wanting to know the timeline for completing the transition, and this is consistent with periods of uncertainty (McCormick, 2002).

In addition to the lack of familiarity with the transition to menopause, the incongruence between what they expected and what they actually experienced, and the ambiguity and variability of symptoms, the women also perceived that they were not prepared for perimenopause. They identified a lack of support, anticipatory

guidance or education from their physicians, midwives, and even their own mothers about the transition to menopause and this will be presented now.

"It Just Didn't Happen": Lack of Support from Credible Sources

More than half (seven) of the women held a perception that their physicians and midwives did not provide anticipatory guidance or education about the transition to menopause, and four of those seven women additionally felt their providers were actually unsupportive when they tried to talk to them about symptoms or asked for help. I felt this was a significant finding early in the interview process, and asked the women to share their experiences with me. Roxanne was the first woman I interviewed, and here she shared her feelings about a visit she made to her physician asking for hormone replacement for perimenopausal symptoms:

> *Yes, I'm disappointed that my doctor dismissed me when I went to him and said I need hormone replacement and said I'm angry all the time and he said I just needed more sleep. I wish that he had been more supportive and said "let's look into that"; if he didn't want to give me hormone replacement that's fine, I would have been ok with that had he told me and I had a chance to look at the studies and understood why. When he told me I wasn't in menopause- then I walked away thinking ok then I'm just a witch. I had just turned into some awful human being and now I have no excuse – no reason for it..... So I would like more health care providers to be more supportive about that* (Roxanne, I_2, p. 41).

Roxanne told me that if she had known what she was going through, she might have coped better with the transition. I initiated a dialogue with Shanny during her second interview on the concept of health care providers preparing women for the menopause transition. What follows is a sample of that discourse:

> Pat: *Did they* [your physicians] *provide any anticipatory* [guidance]? *Did they talk to you before your symptoms started? Was there any education or anticipatory guidance* [that] *in the next few years you may begin to experience* [symptoms of menopause]?
>
> Shanny: *No absolutely not.*
>
> Pat: *Would you have found that helpful*?

> Shanny: *Yeah. I think it's something they should do* [provide anticipatory guidance] *when you get to be perimenopausal, or even when you are in your forties, somebody should say, well along with age this is going to come. I think especially in this age group if you're an older mother, it would probably be very helpful to say on top of the fact you have a 4 or 5 year old, and you know you are 45, 46 years old, other stuff is going to start to happen. Yeah, I think it would be very good, but it didn't happen* (Shanny, I_2, p.67).

Susan thought some of the lack of preparation for menopause could be because menopause is not as exciting as pregnancy, and women do not want to really know about it until they are experiencing symptoms:

> *I think anything that can be done to prepare you for menopause would be good because I don't think there is anything that prepares you right now. Not that I've seen. Maybe there are some doctors' offices that do, but I don't even think, I mean there are so very few books out there on what to expect. Of course, when you're pregnant, you are wanting to read as much as you can because you are so excited about having a baby. You don't feel that excitement about menopause so you're not running out there trying to find every book you can about menopause because you're so excited about it. You only turn to books on menopause when you are having symptoms, and you start thinking okay something is happening to me. Could it be menopause? You don't have the same enthusiasm for it, so I think the more that the doctors' offices talk to you about it, the more... and support groups would be great too* (Susan, I_2, p.37).

Despite a scheduled hysterectomy, and an abrupt onset of menopausal symptoms, Rosie found her provider was not willing to discuss options with her, so she left that practice and found a physician who was open to dialogue:

> *She* [the original physician] *just doesn't have any...not any...she's very abrupt. She writes the prescription for Premarin,* [estrogen replacement hormone] *"here you go" you're in menopause. I said I was having problems, did she have anything else I could try, I just wasn't feeling well. Her response was "you're in menopause...get over it"* (Rosie, I_2, p.22).

A few minutes later, Rosie described what was different about her new physician:

> *I just liked her* [new doctor] *open-mindedness that there are other avenues to try and if you're not feeling well, let's try something else. Whereas the other doctor was "just deal with it" ...which I think is kind of old fashioned...to say you know "you're in menopause, just deal with it and get over it". I don't mind dealing with it, but it seems there are so many things out there drug wise* (Rosie, I_2, p.23).

Rosie raises a number of issues here which point to the flaws in the traditional medical model of viewing menopause. Nurses have criticised the medical model for reducing menopause down to a hormone deficit, and the belief that women's 'problems' during menopause can be relieved with hormone therapy. Rosie's physician's response to 'just deal with it' represents what is wrong with the psychosocial model of viewing menopause which is also reductionism but from the opposite perspective. Supporters of the psychosocial view suggest that women's symptoms are more related to the pressures of life, negative cultural influences, ageism, or sexism. Rosie was searching for a provider with a positive, healthy paradigm for viewing menopause, someone with whom she could have a dialogue about her options. This new paradigm has emerged (Northrup, 2001) and is available to women in the lay literature. It encompasses ideas from various models, acknowledging that while menopause is a normal natural event for most women, it is also a complex process which recognises that some women have difficulties during menopause, and does not rule out the option of hormone therapy for some women.

Both Shanny and Jackie found their providers more helpful once they became more symptomatic, and were experiencing symptoms that were making life more difficult. At that point Shanny said her provider offered some suggestions:

> *I said "this is ugly". That's when he said he would do all this testing..... He did inquire, are you depressed? But I'm not going to say to you "maybe you need to take something". He was kidding when he said "the magic pill". He said because that's not who you are and I understand that. I said I don't take anything and I don't want to take anything. He was very good..... He spent about a good twenty-five minutes with me which is a long time. He chatted with me and said we will watch "this period thing" over the next six months. He said, it could get worse and it could get better, but menopause is on its way and you could be going through this for a while. You have to keep me informed. So he was, I would say, "good"* (Shanny, I_2, p.64).

When I asked Jackie how she could have been better prepared for menopause, this was how she responded:

> *I mean I know there's literature out there and, um, nothing, I mean he never talked about it or, gee now, you know within the next couple years you may be experiencing this and that. It was never discussed. Until it started to happen, then I brought it up ...and then we talked about it and he gave me options. I guess I didn't really think much about it until it started. And uh, but he's very kind, and he spends time with you, and, um, nothing overboard. You know, um, ok well," you can do this, you know, there's these hormones, or you could try this", um, "if it gets really bad give me a call", that kind of a thing. If it's something you can't handle or experience something, you know he's good, he's good that way* (Jackie, I_2, p.43).

Miriam was a nurse and one of the few women who said she had done her own research about menopause. She felt she knew how to get the information she needed to feel informed, but was consistent with the other women in reporting that her doctor had not given her a lot of information:

> *I kind of know what to expect, but I don't think my health care provider has really given me a lot of information. But also, you have to understand my doctor's up in* [city]. *I see her once a year...she doesn't really give me a lot of information. You know, I guess if I needed it I could ask for it, but I feel like I'm able to obtain it myself just because I know where to go and get it* (Miriam, I_1, p.23).

The women sought information and options from perceived experts, and this has been documented in the literature on menopause (Matarese, 2005). Yet, there was a lack of consistency in the willingness to discuss the topic, and in the amount of information these women received about perimenopause from their providers. In most cases, the providers did not give the women any anticipatory guidance or education about the transition to menopause until the women broached the topic at an appointment. This is in line with the work of other researchers (Walter, 2000; Bannister, 2000; Stephens *et al.*, 2002) who found that women are not satisfied with the amount of time to discuss issues, not satisfied with what their physicians tell them, and some do not trust the advice they receive.

In utilizing uncertainty theory to understand women's experiences during the perimenopause, I would propose that health care providers are one component of Mishel's concept of "structure providers" (1988, p.22). As credible authorities, they

are one resource available to assist women in the transition to menopause. Structure providers and women's cognitive capacity will influence the ability of women to perceive the three components of the stimuli frame: symptom pattern, event familiarity and the incongruence of perimenopause. Other components of the structure providers are education, and social support (Mishel, 1988). The women expected their providers, particularly their physicians, to provide information, be supportive, and discuss options with them, and this is consistent with the literature (Hunter *et al.*, 1997; Griffiths,1999; Walter, 2000; Stephens *et al.*, 2002; Matarese, 2005). Indirectly, education provides more information to help women place perimenopause into the context of their lives, and potentially help them to derive meaning from the experience, which should reduce levels of uncertainty. Lemaire and Lenz (1995) predicted a more direct association between higher levels of education, social support, the receipt of information about menopause from credible sources and lower levels of uncertainty. In the current sample, the women were well educated, but admittedly they were not prepared for perimenopause. Inadequate preparation by their providers, including lack of information about menopause and lack of social support (as identified in chapter seven) could all be linked to greater uncertainty during their transition to menopause.

Lack of anticipatory guidance and information from credible sources was not limited to health care providers. Women in the study looked to their mothers, to provide information and guidance about the transition to menopause as well. What most of them discovered was that their mothers did not offer them any information, and when pursued, they did not want to talk about it. Without specific information, the women were left to draw their own conclusions about what their mother's experience with menopause was like. One participant viewed her mother's experience

as "*ugly*", and thought she was crazy; others noted that it was not a topic their mothers even discussed with them. Only five women thought their mother's menopausal experience was easy. Susan was not familiar with her mother's experience with menopause, so she sought out her mother's perspective on it:

> *I think menopause comes late in my family. When I ask try to ask my mother she says I really don't know. So she tries to explain well, "when this was happening", and as best as he can tell she went through probably late fifties so I still have some time yet as far as that goes* (Susan, I_2, p.6).

During her second interview, Susan reflected on menopause, and was not sure whether she would "*go natural*", or use hormone replacement, but it was important for her to "*feel good*". She was not sure if she would have an experience similar to her mother's:

> *I'm not sure that everybody has symptoms that eventually cease. It seems like some women always have problems. Yet, when I talk to my mother, my mother doesn't ever remember having a hot flash. She doesn't remember having any menopausal symptoms. Although I could tell you that she was moody, but I don't know if my mother had the same kinds of things I have...So I think it is not just one thing. I think it is a combination of things, and so I'm not sure I could look to my family for what the trend is there* (Susan, I_2, p.33).

Peggy and Florence were two of five women who shared that their mothers did not discuss menopause with them. I asked Peggy if she remembered her mother's menopause and this was how she responded:

> *And when I was in I guess junior high and high school it would have been, um she was DEPRESSED, and I didn't know it at the time but later she talked to me a little bit about that, so my guess is that that's when she was probably going through some of this* [menopause], *but we never we never really talked about that. She never shared that with me, my mother and I were very close but it wasn't ... we were mother and daughter, and she didn't share some things with me that... probably because she didn't want to worry me. She had her best friend for that. We didn't talk about stuff like that* (Peggy, I_2, p.21).

Florence attributed lack of information from her mother to generational differences, and her Catholic upbringing:

> *My mom is not that clear on it. She's also Catholic...There is a lot of 'not in touch with your body' in the Catholic culture. There is sort of denial about the*

> *body in the Catholic culture, and particularly our parent's generation. My mom is not very aware when she went through menopause because she is a Catholic woman who had five CHILDREN and then finally weeping in a confessional, a priest gave her permission to use the pill. Those are hard stories. She was on the pill for a lot of her thirties and forties. She continued to take it. No doctor really fought with her about it. Should she still be taking the pill? Finally she stopped taking the pill, she never got her period. She never really went through menopause* (Florence, I_1, p.18).

Abbey voiced a very strong opinion about her mother not sharing information on the subject of menopause, and she just did not understand the lack of communication:

> *You know when I ask her she'll say you know oh I don't really I don't know I don't remember. I don't know why that generation is kind of um they didn't talk about it ...so um she doesn't mind talking about OURS THOUGH, she'll say well you know I've noticed this or something or whatever and I'm LIKE LOOK IF YOU'RE NOT GOING TO TALK ABOUT YOURS, I'm not going to tell you anything about MY symptoms either so but it's a shame, I mean WHY IS IT SUCH A DIRTY THING? Like my friend Sandy said it's natural. It's just totally different though* (Abbey, I_2, p.67).

Most women in the current study did not engage in informative discussions with their mothers about the transition to menopause, even though they desired information, and this is consistent with the literature (Mansfield & Voda, 1993; Walter, 2000; George, 2002). George (2002) found that mothers did not share their menopausal experiences with their daughters, and only a few women could recall what their mother's experience was like. Sheehy's breakthrough book The Silent Passage in 1991 was thought to crack the taboo on the topic of menopause. She cited that very few of the women she interviewed ever learned anything about menopause from their own mothers. Sheehy (1991) attributed the lack of maternal sharing about menopause on extreme prudishness, lack of information themselves, and a shame associated with discussing bodily functions. If mothers imparted any glimpse of their own experience to their daughters, it was usually brief and evasive, downplayed the event, or carried the prediction of an ominous time that should be dreaded. In the current study, most of these daughters felt their mothers did not want to discuss their

menopausal experiences with them, or they were unavailable due to illness or death. Owing to this lack of maternal menopause mentors, it is not surprising that most women aged 35-55 cite 'friends' followed by books, magazines, and then mothers as their source of information about menopause (Mansfield & Voda, 1993).

Lack of informative conversations about perimenopause or menopause with their providers, mothers, and older female relatives, lead the women to seek out friends, 'similar others' or the media to find information. Evans and Avis (1999) note that female friendships have substituted for lack of family availability in contemporary society, however, as previously noted for the women in this study, their lived experience as older first-time mothers placed them out of sync with many women their own age. Consequentially there was a distinct lack of similar others with whom they could share the intimate details of their lives. Mishel (1997) credits the use of 'similar others' as a source of social support, and cites examples from the literature where women with breast cancer used other women patients to reduce uncertainty in the absence of information from their health care providers. Whilst a few of the women were able to make connections with younger women over issues central to mothering, when it came to discussing menopause, the older women felt they had nothing in common with the younger women. Leslie was one of those women, and she felt her transition into menopause set her apart from the younger women. Here she gives an example of the dissonance she felt when the younger women just did not understand what she was going through:

> *There is very much this out of sync. I haven't really found, well I should say I haven't really found the age thing to be an issue with the WOMEN because... it really wasn't. We were all going through similar things with our children. It's funny now that I'm getting into this other age phase with the menopause and almost 50, there does seem to be a little bit more of the separate, the age thing is a little more an issue because they don't know what the hell I'm talking about when I'm having hot flashes. They all think I'm joking because most people say you don't look 50. They think I'm joking when I say I'm*

> *having a hot flash or I'm always hot. Aren't you guys hot? You're making me hot looking at you, you've got on a turtleneck and a sweater and I'm dying with this light jacket. They have no idea what is wrong with me* (Leslie, I_1, p.25).

Several of the women revealed a lack of support and validation for their perimenopausal experience from their husbands and significant others as well. Leslie did not feel she had support from her boyfriend regarding her transition to menopause. He was the father of her child, but at the time of the interviews, she was considering leaving him:

> *He is so self-centered that he is just oblivious to all the stuff I'm going through. Maybe that's the female menopause thing, I don't know.....* (Leslie, I_1, p.37).

Miriam was separated from her husband for over a year, and says he was never interested in what she was going through:

> *I guess he hasn't really been around. I mean, he's been out of the house now a year and four months, and even before that ... like I said, for the last few years I don't feel like he's really cared about how I felt. He doesn't ... he just doesn't relate to things. He's just like in his own world. You know, I don't even think like menopause...like THE TERM even like crosses his radar screen* (Miriam, I_2, p.40).

Shanny felt she was in a mutually satisfying marriage, but she too described lack of support from her husband when she was struggling with perimenopausal symptoms:

> *My husband is a wonderful guy but you know when they say men don't understand, and I say to him all the time I am trying – I don't even want to be in my own body and he'll ask how long does this go on. He's a good man, but he has no sense of what I am trying to say to him. He says you've got to "lighten up", you're too rigid, I say I would like to lighten up. I would like to lighten up. I would like not to be short tempered. I would like to not feel so anxious. He says "you are on edge" all the time". I say I know* (Shanny, I_1, p17).

These findings are consistent with those of Walter (2000, p.123) in which married women noted that spouses were either "uninterested in discussing menopause with them or critical in response to the irritability and mood changes associated with menopause". The uniqueness of each woman's transition to menopause, their lack of

information, and validation, especially by their providers, partners, mothers and other women in their lives, predisposed them to an isolating experience. Unmet desires for information or a perceived inadequacy in present levels of understanding have been shown to heighten levels of uncertainty (Lemaire & Lenz, 1995; Galloway & Greydon, 1996). Social support plays a role in reducing uncertainty in that it provides an opportunity for a person to clarify her situation, "through discussion and interaction with others" (Mishel & Braden,1987, p.55). Through this interaction, information can be obtained that may influence appraisal of a situation, reduce perceptions of lack of control, and put more focus on the positive aspects of a situation, which in the present context, is perimenopause (Mishel & Braden, 1987). Perimenopausal women "who are fully informed about and prepared for menopause are more likely than less informed women to approach the transition with less fear and a greater sense of control" (Koch & Mansfield, 2004, p.183).

It was well established in chapter seven that these women lacked social networks and social support which contributed to the intensity of their mothering experiences. With few exceptions, there was also a distinct lack of 'similar others', or women like themselves, with whom they could interact and discuss their perimenopausal experiences. Lazarus and Folkman (1984) refer to this as a consequence of 'off time' rather than 'on time' events; in the present context it was related to becoming mothers at an older age than expected during the life course. They felt out of sync with younger mothers, women their own age, siblings, family, and friends, and received little reassurance from their husbands, boyfriends, and partners about the physical and psychological symptoms they were experiencing. A lack of social support in all dimensions contributed to a powerfully negative *structure provider.* There was a clear lack of resources to aid women in their interpretation of the *stimuli frame for*

perimenopause: the ambiguous symptom pattern, lack of familiarity with and incongruent experiences during the transition to menopause. This combination may have contributed to the women's appraisal of the transition to menopause as a predominantly negative event.

"So Many Negative Things": Perceptions of Menopause

The interesting point about the women's perceptions of menopause was that there was not a common expectation among them. Pre-understandings ranged from menopause as a normal/natural process to it being a negative event in their lives. The amount of negative perceptions related to menopause outranked the positive comments. Women associated it with "*getting older, having symptoms, having to take medication, causing depression, having a negative public opinion, being emotional, feeling mad, angry, nervous, scared, losing control, irritable, and something they have to get through*". The positive perceptions were that *it was not the end, not about getting old; it was a process, normal and natural.* Leslie was not experiencing perimenopause in a way that she expected because she was not having some of the symptoms she associated with it. She thought menopause was a normal part of getting older, yet she did not feel negative about that. She also admitted that she had other [relationship] issues which were taking priority in her life:

> *I feel like I haven't given it enough um enough power I guess, or something... I haven't acknowledged it enough. And it's not that I'm in denial about it, it's just a normal part of getting older, and I know it's going to happen, I know I'm going through it and I don't really have a problem with it. And I guess in some ways I'm glad that I don't have some of the symptoms that I hear other people have* (Leslie, I_2, p.46).

Miriam also associated hot flashes and severe mood swings with menopause, even though she was not experiencing either of these. This is how she responded to a question from me about her view of menopause:

> *I just picture these women having these like incredible hot flashes and, you know, these severe mood swings. But I think it's really different for everybody. You know, people like will ask me, well, you know, do you feel any different? And, you know, I really don't* (Miriam, I_2, p.39).

Roxanne's experience was not typical, yet her perception was that her health care provider was not receptive or supportive of her requests for help with symptoms. She experienced almost two years of rage, and thought she hated her life and her children. At the time of her interviews, though, she felt she was *coming out of it*, and she was better:

> *I think one of the reasons more people don't talk about it is they feel it's negative- they think there's so many negative things associated with it: getting older, not having your period anymore, not being fertile anymore, and I don't feel any of those things about it. To me, I'll look at it as one less aggravation because my periods have been so awful over the last few years that I'm happy that I don't have them anymore, and I don't feel that this is the beginning of the end or some bad thing that has happened to me. I would actually see it as gaining four more days out of the month that I can actually do things. I don't see it as anything negative but I would have liked to have known that this is what I'm going through* (Roxanne, I_2, p.44).

Shanny was the most symptomatic woman during the time-frame of interviews. She felt she was "*at war*" with her body, experiencing erratic periods, palpitations, night sweats, and hot flashes. Her perception was that everyone she knew was taking something for anxiety:

> *I don't want to do that. I just don't want to do it* [take medication]. *If I thought I really needed to, but I just feel this is something I just want to get through as naturally as I possibly can. I don't know. It's the kind of thing where I look at it like a process like being pregnant and giving birth to a child. Well some day this will end, and I will be past menopause. I'll do this as naturally as I did with my children and do the best I can for myself* (Shanny, I_1, p.17).

Thinking about menopause made Jackie angry. This is what she said during the first interview:

> *I mean it gets me mad, it gets me...I get really angry to think your body's doing this to you* (Jackie, I_1, p.13).

The second time I met with Jackie I wanted to follow-up on her response, because my pre-understandings from the literature were that most middle age women feel neutral about menopause:

> Pat: *...and if, I think this was your quote, "It makes me angry to see your body going through this." Was that...about?*
>
> Jackie: *IT'S A NUISANCE, it's just a nuisance. To think that we have to go through this...you know, and um I think it's probably common. I think that every woman feels that way, you know, when you're having that terrible night sweat and you wake up, and...or you're having hot flashes and, you're all dressed up and you're at a dinner party, and then all of the sudden it's like you start to melt. It's embarrassing...* (Jackie, I_2, p.27).

So, she thought all women consider perimenopause a "*nuisance*". Florence was not looking forward to menopause, and hoped to postpone it as long as possible. I asked her if symptoms of perimenopause had any effect on how she felt about her health, physically, mentally, or psychologically. This was her response:

> *Yeah, I feel...it does symbolize aging to me. I am more aware of the fact that I am getting older. I AM getting close to 50 and I do feel more aches and pains which is more about getting older than about menopause. I think it all comes together* (Florence, I_1, p.13).

I wanted to further explore her views on menopause, so I followed up a few minutes later with a question that asked about her thoughts on this subject:

> *You know what I think about it? I think the later it comes, the better. In my mind, it symbolizes sort of keeping my youthfulness as long as I can. I know some women can't wait to not have their period, but I don't feel that way. Let's postpone it as long as possible is how I feel* (Florence, I_1, p.18).

Mary admitted that as a gynecologist she was biased toward using bio-identical hormones to treat women who are symptomatic in the perimenopause, but she also felt that 'attitude' figures into a woman's experience. She admitted that women just do not know what their menopausal experience will be like, and she has cared for women who look like they have "*mental health issues*" while "*going through menopause*":

> *...I recognise I think that since I know so much about it cause of what I do for a living I think that you know that there's ATTITUDE is everything and I think you have to keep a ...and then you know just don't know how it's* [menopause] *going to be and you just kind of you just kind of deal with it. But and I think some people have much more severe menopausal symptoms* (Mary, I_1, p.10).

Susan thought she was not close enough to menopause yet to have an emotional opinion on it, (but she did); she believed menopause is a combination of changes happening at the same time. She disagreed with my appraisal that the literature on menopause was evolving from the negative, oestrogen deprived, disease representation it has been for many years:

> *I think public opinion is still pretty negative. In our lifetime it won't really significantly change as far as the attitude toward menopause and what you can do to help the symptoms or avoid the symptoms. I think it IS an incredible emotional experience to go through the changes that your body goes through. I think it brings you closer in touch to yourself to, and consequently you want to focus more on your relationships, but I'm not sure that I'm close enough to menopause yet to know how I'm going to feel. If there is an end to it, that would be great whether the end is to take all the natural hormones or whether it is just to let myself go through it and see the end that way* (Susan, I_2, p.34).

Peggy felt scared, nervous and angry about the thought of transitioning to menopause, and how it would affect her life. Abbey's perception of menopause was associated with women's experiences with symptoms. She believed it was because of lack of hormones, and wanted to get it over with. Rosie who experienced surgical menopause thought that menopause can make a woman feel depressed. Sarah is a nurse midwife, and she used the word "*suffer*" when describing women's experiences during the transition to menopause. When asked, she clarified that she does not personally think women suffer with menopause but that she believed it is a common expectation of women:

> *You know, it's been different ...because I already stopped having periods when I had my hysterectomy. ...I think I was a little worried, maybe because I'm in the profession,* [nurse midwife] *of what it might be like for me in terms of hot flashes and things like that, but I didn't have ... I wasn't really dreading it* (Sarah, I_1, p.9).

The women's perceptions of menopause were primarily negative in nature, even when I considered separately the appraisals of the two women who experienced surgical menopause (Rosie and Sarah). This contrasts with findings from Avis and McKinlay (1995, p.45) that women's attitudes toward menopause are "overwhelmingly, positive or neutral". Avis and McKinlay (1995) reported that women with more negative attitudes toward menopause were more likely to report symptoms during menopause. Women were also more likely to have a positive attitude about menopause after they were postmenopausal. Bernhard and Sheppard (1992) suggest that negativism about menopause may arise in societies like the United States in which women are valued primarily for their reproductive abilities, and older women are devalued. Matthews *et al.* (1990) found natural menopause to be a benign event for most women.

Woods and Mitchell (1997) reported findings from a random sample of 131 women aged 35-55 (baby boomers) who were participants in the Seattle Midlife Women's Health Study. Women were born between 1935 and 1955, so this was a slightly older cohort of women than most of the women in the current study. They responded to questions about midlife via telephone interviews. The women alluded to midlife as a time of 'transition', and their most common images of midlife were of getting older, and the aging process. The 'change of life' (a common euphemism for menopause) was mentioned but not as a predominant characteristic of midlife. Rather, these women associated menopause with freedom, and as a time when they have finished raising their family and can focus on themselves. Changing health was only mentioned by a few women. These findings are significant for comparing differences rather than similarities to the women in the current study. Older first-time mothers are in a very different developmental stage, mothering children is their prime focus, and

work is also important, but not their goal. Health maintenance and promotion were very important to them, and this will be discussed further in the next section.

The meaning a person constructs around mental and physical health is connected to "the ways people evaluate and cope with the stresses of living" (Lazarus & Folkman, 1984, p.181). Uncertainty theory (Mishel, 1988) offers some clarity toward understanding the women's opinions of the menopause transition as negative. The event is neutral until appraised; at that point, women will perceive the menopause transition as negative, or view it as an 'opportunity'. This supports the findings in the literature for some midlife women who view menopause as a neutral event. Yet for other women, like the participants in this study, perimenopause was an event that was not initially recognised, and when appraised, the women found it difficult to attach meaning to, or interpreted it incorrectly as something different, or perceived it as negative. Mishel (1988, p.228) states that the appraisal of uncertain situations "involves two major processes: inference and illusion". One characteristic that will influence a person's *inference* of a situation is their personality disposition, particularly a "person's beliefs that they have the skills and behaviors to deal effectively with major life events" (Mishel, 1988, p.229). People with an internal locus of control believe that uncertainty is controllable, and outcomes are dependent on their own behavior. These women would want information about perimenopause and health maintenance; they would be more apt to appraise perimenopause as positive, or an opportunity, and be self-motivated to participate in health promotion activities. Those women with an external locus of control feel they have less control over an event, and uncertain situations, like perimenopause, would likely be appraised as negative particularly in the presence of ineffective structure providers which has already been established in the current study (Strickland, 1978; Lazarus & Folkman,

1984; Mishel, 1988). As previously discussed, specific knowledge related to the transition, and whether that knowledge is positive or negative, communications, social support and context can all have an effect on what a woman will infer about perimenopause.

The second major process which affects appraisal of uncertainty is the crafting of *illusions,* which are "beliefs constructed out of uncertainty- beliefs that are viewed in a particular light with emphasis on their favorable aspects" (Mishel, 1988, p.229). Illusions could be interpreted as a form of denial or avoidance, and for some of the women in this study, may help to explain why they were not eager to learn about perimenopause before they experienced it, preferring to believe that they would be "*forever young*" or discovered the "*fountain of youth*". In order for an appraisal to lead to appropriate and effective outcomes, it must be compatible with what is actually happening, and have implications for effective coping. Mishel (1997) established that uncertainty has a negative impact on quality of life and psychosocial adjustment. Coping strategies are initiated to reduce uncertainty, and when "coping strategies are effective, then adaptation will occur" (Mishel,1997, p.226). Coping is defined as "realistic and flexible thoughts and acts that solve problems and thereby reduce stress" (Lazarus & Folkmam, 1984, p.118). A person's perception and thoughts about her relationship with her environment are critical to coping in this particular model (psychoanalytic ego psychology model). When situations are considered open to change, problem-focused forms of coping are more probable, and people work to manage or alter the cause of the disturbance. Those with a negative appraisal are less likely to utilize "problem-focused coping efforts" (Lazarus & Folkman, 1984, p. 160), and instead use emotion-focused forms of coping. Emotion-focused coping strategies attempt to decrease the emotional distress of the situation

through "avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from negative events" (Lazarus & Folkman, 1984, p.150).

McCormick (2002) noted that it is unclear how uncertainty can be transformed into an opportunity, yet what initially appeared to emerge as a paradox in the current study may be an example of transforming uncertainty into opportunity. While the majority of the women appraised menopause as negative, they perceived themselves as healthy, and participated in many health promotion activities. This could be interpreted as a form of emotion-focused coping, and 'wresting positive value' from a negative event or process. I could also make an argument that despite a negative appraisal of perimenopause, the women were utilizing problem-focused coping strategies in that although they could not change the fact they were transitioning to menopause, they chose instead to pursue behaviors that were directed at helping them cope while at the same time promoting health. The motivating factor for these behaviors seemed to be their parallel appraisal that their health was precious, and their desire to remain healthy, active and available to their child/children despite their older age was of paramount importance to them. This powerful motivation to "*be there*" for their children as they reached important milestones will be discussed next.

***"Being There":* Uncertainty about the Future**

Almost all of the women perceived themselves as healthy, despite aging, chronic health issues, perimenopausal symptoms or negative perceptions about menopause. Many of them claimed to be participating in health promotion activities, like exercise, weight-lifting, healthy nutrition, and regular appointments with their providers. All but one of the women felt strongly that as midlife mothers, they were now more aware that their health was precious, and most of the women felt they were more in touch

with their mortality. Nine of them used the expression "*being there*" to describe their fervent desire to be present for their child/children in the future. Finding ways to "*last longer*" and "*keep up*" with the child/ children was an important focus, and most of them projected how old they would be at particular milestones in their child's life. All but three of the women agreed that mothering young children during midlife motivated them to stay young and healthy. Two who disagreed with this belief confessed that although they agreed in theory, and had good intentions, they did not take the time to care for themselves as they should. The other woman who disagreed stated she did not feel motivated to stay healthy just because she was a mother, and that in any event her husband would be around if something happened to her.

Roxanne was one of four women who were not ready to get old. She was adamant that as a midlife mother she was not ready to "*go to the other side*" which to her meant slowing down, and aging. The following dialogue on health reveals her determination not to get old, and she would do what she could to prevent that from happening:

> Pat: *What effect if any have these* [perimenopausal] *experiences had on your perception of your health: physically, psychologically emotionally or spiritually?*
>
> Roxanne*: I've always been incredibly healthy……I don't have any bad feelings about my health. I have a healthy lifestyle, I ride my bike , I'm very conscious of what I eat, I don't drink I don't smoke…… I have ten years I need to get through, I'm going to be in my sixties when these kids are in college, so I'll be putting them through college on social security, so if anything it's made me more aware that I don't have to get old…… I feel like I'm not on the other side and I won't be on the other side for a very long time…… So I'm not ready to think of myself as old- maybe that's what it is- when I say 'on the other side' is to look at myself any different than I have looked at myself in my thirties and forties. I can't because I don't have a lifestyle to support that thinking…… The kids know, when I go for a walk or bike ride they laugh and say "are you doing that mommy so you stay young?" Cos' I've told them mommy has to exercise so that she doesn't get old* (Roxanne, I_1, p.19).

Shanny was trying to maintain a healthy routine of exercise and eating healthy. She was eating soy to relieve perimenopausal symptoms, and participating in yoga classes.

She was highly motivated despite a low energy level. She wanted to feel good, and be available to her children:

> *Again, just my kids, I don't want to desert them physically and/or emotionally, I want to be there for them. I don't have the energy level I once had. I had a very high energy level. I feel sluggish. I feel sluggish a lot. It's not that I don't do things with my kids. I'm with my kids all the time, but it's not enjoyable to me sometimes. You know to go out and kick a soccer ball. I'm thinking oh, it's like one more thing to do.... So, I do try and balance that with, what am I going to do for myself today that makes me feel good. .....So, it's a constant struggle* (Shanny, I_1, p.25).

Susan was very motivated to pursue activities that would help her "*keep up*", and "*last longer*" so she could be there for her daughter in the future. She was one of nine women who felt that it was critical as the mother, to still be around when their child/children were older. This was shared meaning for the mothers of children with and without disabilities. Susan agreed with most of the women that having a young child motivated her to pursue healthy behaviors:

> *I think I would STILL want to try and stay fit and healthy, but I think it does MOTIVATE you to do things that you think are going to make you last longer in years too, because you want to not only keep up with your kids with what they are doing now, but you also want to stay around for all the life changes that they are going to go through; to share them and enjoy them and help them with them. I have no idea how my daughter's disability is going to affect her in relationships, and whether or not she is going to get married or not. I kind of feel like I am the closest one to her disability, and it can't happen to ME because I have to be around because I'm the one who knows the most about it and is closest to her situation, regardless of all the other professionals that might be helping her. Regardless of my husband's attention to her, you know he just doesn't have the time to devote to learning as much about this disability. So, I feel I need to do it. I need to stay healthy enough to help her through... at least until adulthood* (Susan, I_2, p.21).

Jackie's husband is ten years older than she, and that contributed to her motivation to stay healthy and be there for her daughter in the future. She pointed out that her daughter's grandparents are also older, and suggested that they will not be around to care for her daughter in the future if necessary. As an only child, there will not be sibling support for her either:

> *Definitely, oh yeah, I do* [feel motivated]. *Um, I mean I HAVE to be around for her. You know she's only ten, my husband is ten years older then I am, so she, just her needing me keeps me really focused and keeps me just going. You know, just in general. And um, who else is going to be there for her? You know my parents, you know they're wonderful to her but they're older, and um I'm really the only one. And she looks up to me, so anything I have to do, I'll just have to do it..... It's just the healthier YOU are the better chance you have that you're gonna LIVE LONGER and she NEEDS me. And I want to be there for her, for her prom and her wedding and ...* (Jackie, I_1 p.15).

Miriam wanted to stay healthy to be able to care for her son, and considered herself to be in excellent health. Miriam has long established a lifestyle which included finding time to exercise, eat healthy, and participate in hobbies. When I asked her if having a child aged seven motivated her to stay healthy, this is how she responded:

> *Oh, absolutely I mean, you know, just taking care of myself... I eat really well. Like I said, I exercise, I read. I try to do things that I think are good for me... You know, I take a lot of time for myself as well as take care of him so I can be healthy for him. I was taking a watercolour painting class last year. You know, I mean, like my goals for keeping myself healthy have to do with, like, you know, doing things with him* (Miriam, I_1, p.11).

Susan was 40 when she gave birth to her only child. She worries about the future, particularly because she has a daughter with special needs. Here, Susan gives voice to shared meaning with the other women when she talks about how old she will be when her daughter is still a young woman. She projects into the future and speculates how relationships may be affected because she will be an older mother to her still young daughter:

> *You're going to be old at a young age to your child. I mean when I'm 65, she's going to be 25. Yet, I have step kids that are thirty and late twenties. It's going to be a very different relationship that I have with them vs. what I have with her because she's still going to be a kid and I'm going to be on social security and Medicare* (Susan, I_1, p.11).

Leslie and Peggy worried that they might be a burden to their children in the future because of their age. This is what Leslie had to say:

> *... This was, my big thing is memory I feel like I'm losing it, then dealing with my own mother's issues and worrying about is Kylie going to have to deal with this stuff? ..... And you know again, this is I don't know if this is just*

> *me and my personality or having an older... being an older parent, is realizing how important that is* (Leslie, I_2, p. 45)

A few minutes later, Leslie expanded on her desire to stay healthy:

> *So I'm trying, I'm really trying to make an effort and I think that whether this is menopause or old or whatever but, you know with the age thing....my health, I mean I have to take, I really feel like I have to take care of my health that it's my responsibility for my child because I don't want to have a heart attack or end up with diabetes and all the complications* (Leslie, I_2, p.51).

Peggy worried about being around when her children are in high school, and the loss of her sister at age 40 was a poignant reminder of her own mortality. She does not want to be a burden to her children when they are young adults:

> *I guess the downside is though that you think more too about... sort of I do about the future though too and how I think we talked about this last time a little bit you know how is it all gonna be when, when my kids are in high school and hope, I hope I'm around to see that. I even think that sometimes. Partly because I've lost like my sister died when she was only forty so* [Pat: *my goodness*] *you know I just get scared about that stuff too, so ...am I gonna be around, and if I am around you just want to make sure you're gonna be the kind of mom you really want to be for them, when they're older and when I'm older, or even beyond that too. You don't want to be a burden to them. When they're 25 or something I don't want to be a burden to my kids, so you think about that stuff too* (Peggy, I_2, p.11).

Eight of the women reflected on their own vulnerability and mortality. Leslie's mother did not remember that her daughter turned fifty on her last birthday. Facing some memory issues of her own, Leslie reflects on the possibility that she will not even be alive when her own daughter turns fifty:

> *But I started thinking about gee you know, what's it like to be that age and forget your daughter, your child's 50th birthday and I'm thinking how, you know I can't imagine not remembering what year Kylie was born, but then sometimes when you're doing the math I could see how it could slip by. ..And then I started thinking, I probably won't be around when Kylie's fifty. You know, so then I started thinking oh poor Kylie* (Leslie, I_2, p.40).

During my second interview with Susan, I asked her if there was anything she wanted to say to begin the interview. Increased vulnerability and mortality were on her mind:

> *...My other thought was that how, as you get older and you start facing your own mortality and you start going through middle age, you realise your body is changing, and you're not able to do the same things you used to do. You*

> *have friends that are getting sick and dying; relatives that may be dying at a younger age than what you are at. You start thinking about death more. You start thinking about leaving your child behind because you are more vulnerable than you were fifteen or twenty years ago to disease. You are more vulnerable to keeping ..... so your body doesn't get run down you are constantly struggling to stay fit, stay healthy, and stay at that level so you can be a better parent* (Susan, I_2,p.19).

Susan voiced a fear that she might not have as many years with her children as a younger mother, so she was looking for a deeper relationship with her ten year old daughter:

> *You start praying for, you know, I hope I can live to see my daughter grown. As you get older, I hope I live to see my daughter get married, you know, and then to have kids ..... Your kids are still quite young at that age, you feel like you want to have a deeper relationship with them than if you might have if you were fifteen years younger than that because your thinking you don't know how many more years you have with them – even though life expectancy as it is today, you expect that you are going to live until... you know women live til eighty or so, and you expect that it's going to happen. At the same time, you're more vulnerable because you are older. Vulnerable to disease; vulnerable to the fact that you have more resources so you travel more. You do different things than you would have when you were twenty-five. So, it makes you more vulnerable for things to happen* (Susan, I_2, p. 20).

Miriam worried about her own mortality, and wished she had become a mother younger:

> *I wish I'd started earlier. I probably would have had four kids. But you know, the thing about being an older mom, too, you're always worried about your own mortality, you know, what's going to happen, because ...I'm trying to quick do the math... high school I'll be sixty, you know, but I keep myself so active that hopefully no one will even know how old I am* (Miriam, I_1, p.17).

Monique's perspective was different from all of the other mothers. She felt that she was healthy, but that motherhood in midlife was not a motivating factor for her to pursue healthy behaviors. Here she talked about her health concerns:

> Pat: *Do you consider yourself a healthy person? How would you describe your health, physically, psychologically and emotionally?*

> Monique: *Yeah, I think physically I am very healthy. I have no major medical issues at all* [except] *cholesterol. Emotionally, I can get depressed. I have had problems with depression in my life and that is always sort of a recurring thing I have to keep an eye on and anxiety. I think some of that's inherited,*

> *some of that's a combination of circumstances in different parts of my life. Those have been the major issues for me, more psychological than physical. Physically I'm healthy, it's just sometimes I think I get down very easily... overwhelmed* (Monique, I_1, p.10).

I asked Monique if having a young child motivated her to stay healthy, but she had a different perspective from the other women that did not mirror the need to *be there*:

> *I feel that I am a fit person. I don't feel that all of a sudden I have to get healthy because I have a child. I mean physically healthy, I mean emotionally, I should probably exercise more, um and I try to work on taking more time for ourselves as a couple, you know, but um, no I feel that he's got a big family and if anything would happen to me. I don't really worry about it. I feel like she would be okay. My husband is very good with her so I don't think I have to be careful with that. I don't think I'm going anywhere, and don't have to worry about that, so ...but that isn't an issue for me* (Monique, I_1, p.11).

Monique also had an interesting perspective about "*marking time*" which was different from the other women. Most of the women projected time into the future and thought about how old they would be when their children graduated from high school, college, got married, etc. Their primary focus was on *being there* for the child/children, living longer, keeping up, and staying healthy enough to support and participate in these important events. Most of the women were satisfied with their mothering experiences, and felt they had "*done it all*' prior to becoming mothers. Monique talked about marking time as if "*sands of the hourglass are running out*". Although many of the women wondered what life would be like after menopause, and after the children were grown. Monique expressed fear about not being able to "*live life*" until she is in her sixties. She was 44 when she adopted her daughter, and 47 at the time of the interviews:

> *Yeah, if I get through my forties maybe I'll make it. I do have fantasies of that because I just feel like... AND THEN IT'S HARD WITH WHAT'S INTERESTING IS WHAT I'd always think well I knew I'd have children YOUNG because I wanted to be able to DO things young, but it's funny, when you have kids older, what I'm finding myself doing is actually marking time to how old I'll be when they're a certain age, and then sort of feeling like sands of the hourglass are running out. So it's interesting, it sort of switched from thinking that... I've had friends who married young and had children young,*

and woke up at forty and thought "I want to live life now", you know. Not only do I want it, but now they're living life and I'M actually tied DOWN. So what I find, is I start thinking when Grace is 13, I'm going to be 62, oh my God, I'm going to wake up and I'm going to be in my sixties, what will I have done, will it have been worthwhile, will I enjoy myself? So that's now what I'm sort of... I think of it that way now, which is a little scary (Monique, I_2, p.33).

Susan and Abbey shared a concern that as older mothers, they might have less time with their child/children. They were both mothering children with Asperger's syndrome, and want to be there to take care of them in the future. These women have learned a great deal about their children's disability; they each gave examples of the time and energy they have invested in learning about Aspergers, and meeting the unique needs of their child. They described the toll it has taken on them as mothers which was discussed in chapter six, and here in these two excerpts Abbey worries about who will take care of her children in the future:

I don't sleep well so am I not sleeping well because of that [perimenopause]*or is it because I'm worried about Ryan so much and everything about his future. What if I'm not here? I mean I don't have that LUXURY of extra twenty years or something. Who will take care of him with his issues? So basically, I feel like I never sleep* .....(Abbey, I_1, p.10).

I'll be 50 on Monday so which is like freaking me out a little bit but my friend says it's just a number and I said yeah I know but it's, IT'S A BIG NUMBER IT'S BIGGER. Forty didn't bother me, thirty didn't bother me-fifty is strange to me but the scale has really tipped you know it's really it's really tipping this way now ,but now once the kids were born I did think about a lot. Oh my god I hope I'm here to take care of them...and if I hadn't had a child with Asperger's, I don't know if it would worry me as much but that definitely worries me...making sure I kind of I guess in my own mind I think if I can, if I can make it until they're self-sufficient you know and I'll do everything I can to get them to that point then I guess I'm not to worried about it...but I really didn't think about it before (Abbey, I_1, p.23).

Abbey and Sarah described good intentions to be healthy, but found it difficult to carve out any time to focus on meeting their own health care needs. Abbey expressed shared meaning among the women that they did not feel concerned about the future while they were pregnant. It was only after the child was born that the implications of their age set in:

Always you know it's like I read stuff and I think oh I should be doing that and I should take that vitamin and then I'll go on a FRENZY and go to the health food store and say ok I should be taking you know Chromium for colon aid at night and I need more Zinc or maybe I should take better vitamins but honestly I just don't carve out enough time in my day to even to take the right vitamins. I'll do that later. I don't know, I don't know why I don't it more um I always think well I'll get back to that and a... ... ...I just find a hard time making MYSELF a priority and um I didn't really think about when I was pregnant wow I'm going to be x old you know when they're whatever in high school. Cos' I still felt YOUNG ACTUALLY (Abbey, I_1, p.22).

I asked Sarah if menopause or symptoms had any effect on her health. Imbedded in her response was that menopause and aging are irrevocable partners, but that her larger concern was to be there for her children:

...You know, they come together, being older and menopause, so it's not from menopause but it's just coinciding with menopause. I have arthritis, I have a tough time with my knees, but I just ... I don't have time to really ...deal with it, so I just keep pushing, take some Naprosyn and I keep on going. BUT, I also concern myself, or I am concerned that something not happen to me because of these kids (Sarah, I_1, p.12).

During her second interview, I followed up on the concern that most of the mothers expressed about being available to their children. Sarah agreed with the others that she was more in touch with her mortality, and thinking about the future. Her insight into the future was that older mothers re-create the very lack of social support for their children that they themselves were experiencing. When she becomes an older 'grandparent', Sarah projects that she will not be very capable of extending assistance to her children even if they do not delay parenting like she did:

We have sort of re-created what we've experienced in that respect, that we won't probably, even if they marry in their early 20s and have children, we probably won't be very capable or able to help them much... and that's kind of sad (Sarah, I_2, p.35).

Wanting to *be there* for their children, increased vulnerability and a heightened sense of mortality are consistent with the literature on older mothers. Carolan's (2005) qualitative study with 22 women age 35-48 during pregnancy and postpartum noted that women had similar age-related concerns about energy to keep up, and being there for their children. They also had similar concerns about their own health and

mortality. Reece and Harkless (1996) uncovered the theme of *Mortality/Hastening Time* in their study with first time mothers aged 35-42, which the authors suggested might be unique to older, first-time mothers. These findings are also consistent with what has been written about the normal life cycle (Neugarten, 1968; Lazarus & Folkman, 1984) and the concept of the timeliness of events in a person's life. Not '*being there*' for her child in the future would be considered an 'off time' event, and potentially cause stress or crisis in a woman's life. Hilton's (1994) theoretical definition of uncertainty included not being able to predict the future. An uncertain temporality (in the context of acute illness) disrupts one's usual perception of the present intertwined with the future, and both would be considered when deciding a course of action (Wiener & Dodd, 1993). Based on discourse with the women, and my interpretation of the text, I would argue that this is also true for older first-time mothers.

The women consistently projected time to clarify how old they would be when their child/children would reach certain milestones or transitions, and this parallels the theme *projecting the life plan* described in the work of Benzies *et al.* (2006). The context in the latter study is one is which a woman talked about her intention to become pregnant before she was thirty years old, so that she allowed herself enough time to have more than one child. The authors described *projecting the life plan* as a new theme in the literature which could be useful to health care providers when counseling women about delaying motherhood. The difference is that in the present study the women were already mothering young children at an older age, and there appeared to be a connection between the women's projection of time, and their recognition of health as precious. Older first time mothers in this study used this projection as a motive for health promotion in order to *keep up, last longer, and be*

there for the child when they reached important milestones. It is this uncertain temporality, projection of the life span, and value of health as precious which enabled the women to transform uncertainty into an opportunity for a healthy transition and health promotion.

At the start of the new millennium, there were an estimated 37.5 million women "reaching or currently at menopause" (Center for Disease Control, 2009) yet I could not locate on this website or at the U.S. Census Bureau website specific data related to perimenopause. The government site appears to have aggregated data on women transitioning to menopause and those who have reached menopause, and this theory is supported by the age range for this 'group', which was noted to be forty to fifty-nine years old. This is a wide range of ages, and as this study has demonstrated, women transitioning to menopause have unique needs related to reducing uncertainty, and promoting health. It is worth reiterating that perimenopause has only been recognised as separate from menopause for less than twenty years. A consequence of this has been the absence of research with perimenopausal women, particularly from the perspective of women's understanding and comprehension. The current research answers the call in the feminist literature (Im, 2007) for in-depth qualitative studies on women's menopausal experiences within the contexts of women's daily lives, and related to their own experience with symptoms.

The findings from the current study warrant that health care professionals address the issues of this population of women related to lack of preparation for, and education about the menopausal transition. At least half of the women sought medical care for perimenopausal symptoms, and most were not satisfied with the outcome of those visits. Nurses and other providers could offer private or group discussions which include the incongruous nature of symptoms during the transition to

menopause. Nurses in particular could be a valuable resource to assist women in the transition to menopause, by listening and offering educational opportunities, guidance, counseling, and stress management techniques. Women deserve to hear about the full range of options available to assist them in making an educated choice for managing symptoms and discomforts of perimenopause. Providers who offer anticipatory guidance, are prepared to discuss the research, benefits and potential negative consequences of various options were viewed more favorably by these women. Advancing social networking through classes, support groups, and virtual discussions could also work to lower levels of uncertainty, and foster positive appraisal of the menopause. Just telling women to have a positive attitude toward menopause is clearly not enough to make it so.

Despite a negative perception of menopause, and the lack of support from credible others, this particular group of women placed a high value on their health and health promotion. Similar to the women in the current study, the participants in Musker's (2008) work with perimenopausal and menopausal women focused on activities like nutrition, exercise, and stress reduction that would promote health. Musker's (2008) participants recognised the value of social connections with friends, families and neighborhoods as contributing to their health, which is significant in light of the lack of social support available to the women in the current study. Kafanelis *et al.* (2009) also discovered that the women in their study, aged 43-61 experienced the menopausal transition as a stressful process, which led many to examine their lives, and make positive changes, like incorporating exercise, and utilizing complementary modalities like massage, counseling and diet changes. They spent more time with female friends, asserted themselves at work, and reflected on the significance of their lives. In another study, a group of midlife women aged 40-65, valued health

maintenance through screening, and pursued pap smears and breast health examinations (Meadows *et al*, 2001). These women felt they needed to diagnose their own problems, and tell the physician what was wrong or they would not get what they needed, yet individual efforts on their part were "often met with resistance, denial, equivocation, and dismissal", particularly by allopathic physicians (Meadows *et al*, 2001, p.459). This treatment of midlife women is a lost opportunity for all women, as women's perceptions of good health and positive emotional health have been shown to improve their attitudes about menopause (AWHONN, 2001).

Summary

Chapter eight delved deeply into the women's lived experiences as older mothers and midlife women transitioning to menopause. The major theme *Perimenopause as a State of Uncertainty* conveys the experience of transitioning to menopause as one embodying the three main attributes of uncertainty: probability, temporality, and perception. It was inevitable that at some point the women would experience the transition to menopause and menopause. The absence of a distinct timeline for this transition, and the lack of support from credible sources to guide them through the experience, contributed to the women's perceptions of menopause as predominantly negative. As older mothers, these women also experienced uncertainty about the future, and worried about "*being there*" for their children. The theme *Perimenopause as a State of Uncertainty* was built around six categories which provided substance and support to the concept of *Uncertainty* as a framework for further understanding the meaning of health for midlife mothers during perimenopause.

The first category *"It Must Be Something Else":* Transition to Menopause related shared meaning for the perimenopausal experience as one shrouded in ambiguity, so much so that many of the women were not sure what was happening to them

physically, emotionally, and psychologically. They did not consider this transition to be a major event or turning point in their life, as opposed to marriage, or the birth of their child which was a major event. There was common meaning around the belief that other events in their life took priority, like work, parenting young children, caring for aging parents, or dealing with relationship issues, and some admitted they were simply unfamiliar with what to expect at all as they navigated through this developmental life transition. There was shared meaning in their discourse about feeling unprepared for perimenopause, and most found even their own mothers unwilling to discuss menopause with them. While the women in the current study did not think perimenopause was a major event in their life, they did acknowledge physical, emotional and psychological changes related to 'going through menopause' which were stressful to them. I interpreted these as components of uncertainty or disruptions in the 'structure of their reality' (Selder, 1989); the women engaged in *restructuring*, or created meaning about perimenopause in an effort to decrease the uncertainty.

The range of symptoms they experienced or thought they should be experiencing was confusing to them, and this was discussed in the category *"What is Going On?"*: Unfamiliar with Symptoms. Ten of the women expressed a lack of familiarity with symptoms usually attributed to perimenopause. The onset of their symptoms began at age forty up to fifty years old, and lasted up to six years. During the interviews, women described twenty-five symptoms or behaviors they associated with the transition to menopause. Menstrual changes was identified as the most common symptom they experienced, with irritability, mood swings, night sweats, hot flashes, losing control, various levels of depression, and feeling more emotional as major symptoms they had experienced. Uncertainty about what was going on, and lack of

familiarity with the symptoms they were experiencing, was compounded by the lack of a timeline for how long perimenopause would last. Selder's (1989) theory of life transitions provided an explanation for this. The disruptions in the women's reality structures resulted in a collapse of time, so that they became preoccupied with the event triggering the transition. This created a framework for understanding the women's desire to know how long the transition to menopause was going to last and whether the symptoms were going to get worse, and this interpretation was presented and discussed in the category "How L*ong Will This Last?"* : Uncertain Timeline. Meaning culminated in the construct of uncertainty as theoretical embodiment of the women's transition to menopause. The main attributes of uncertainty were present: probability, temporality and perception which support uncertainty as an appropriate conceptual framework for understanding women's experiences during the transition to menopause.

The category *"It Just Didn't Happen*": Lack of Support from Credible Sources captured the women's lived experience of being unprepared for perimenopause. More than half of the women shared their perception that their physicians and midwives did not provide anticipatory guidance or education about the transition to menopause, and four of those seven women additionally felt their providers were actually unsupportive when they tried to talk to them about symptoms or asked for help. I proposed that health care providers can be viewed as one component of Mishel's concept of "structure providers" (1988, p.22). As credible authorities, they are one resource available to assist women in the transition to menopause. Structure providers and women's cognitive capacity influence the ability of women to perceive the three components of the stimuli frame: symptom pattern, event familiarity and the incongruence of perimenopause. Other components of the structure providers are

education, and social support (Mishel, 1988). The uniqueness of each woman's transition to menopause, their lack of information, social support, and validation, especially by their providers, partners, mothers and other women in their lives, predisposed them to more uncertainty and an isolating experience.

"So Many Negative Things": Perceptions of Menopause reflected the predominantly negative views of perimenopause/menopause which the women held. The amount of negative perceptions related to menopause outranked the positive comments. For the participants in this study, perimenopause was an event that was not initially recognised, and when appraised, the women found it difficult to attach meaning to, or interpreted it incorrectly as something different, or perceived it as negative. It has been unclear in the literature how uncertainty could be transformed into an opportunity, yet what initially appeared to emerge as a paradox in the current study may be an example of transforming uncertainty into opportunity. While the majority of the women appraised menopause as negative, they perceived themselves as healthy, and participated in many health promotion activities. This was interpreted as a form of emotion-focused coping, and 'wresting positive value' (Lazarus & Folkman, 1984) from a negative event or process. I also made an argument that despite negative appraisal of perimenopause, the women were utilizing problem-focused coping strategies in that although they could not change the fact they were transitioning to menopause, they chose instead to pursue behaviors that were directed at helping them cope while at the same time promoting health. The motivating factor for these behaviors seemed to be their parallel appraisal that their health was precious, and their desire to remain healthy, active and available to their child/children despite their older age was of paramount importance to them. This powerful motivation to *be*

there for their children as they reached important milestones appeared to create an opportunity for health promotion.

The women had concerns about the future, and a heightened sense of mortality since becoming mothers. For these reasons, they believed their health was precious, and they had a powerful desire to remain healthy, active and available to their child/children despite their older age. This was revealed in the category *"Being There":* Uncertainty about the Future. Almost all of the women perceived themselves as healthy, despite aging, chronic health issues, perimenopausal symptoms or negative perceptions about menopause. Many of them claimed to be participating in health promotion activities, like exercise, weight-lifting, healthy nutrition, and regular appointments with their providers. The older first time mothers in this study used a projection of the life span as a motive for healthy behaviors in order to be there for the child when they reached important milestones. It was this uncertain temporality, projection of the life span, and value of health as precious which enabled the women to transform uncertainty into an opportunity for a healthy transition and health promotion.

In the final chapter of the thesis which follows, I remind the reader of the aim of the study, summarize the findings and present the limitations of the study. I provide evidence so that the reader may assess the rigour of the study, and finally implications for practice, health care professional education and future research are proposed.

CHAPTER 9

LOOKING BACK AND LOOKING FORWARD

Introduction

In chapters five through eight, I crafted a fusion of both conversations with the participants, and dialogue with the text to create a written interpretation of the participants' lived experiences as midlife mothers, and as women transitioning to menopause. This process led to a new understanding of each woman's life-world as she achieved motherhood for the first time at an older age, and then experienced the transition to menopause as a midlife woman and mother. Gadamer's (1975/2004b) philosophical underpinnings as discussed in chapter three were used to guide the entirety of this study, and as a result, meaning was mutually negotiated through a participative dialogue with the women, and simultaneously with the text. Gadamer's hermeneutic constructs of prejudice or pre-understanding, the hermeneutic circle, dialogue, horizon, fusion of horizons, play, and buoyancy provided the basis for interpretation, and were explicitly and implicitly visible in these chapters. Van Manen's (1990) six methodological themes to guide researchers through a hermeneutic phenomenological human science study (also discussed in chapter three) also influenced data analysis and the interpretation process.

The focus of chapter five, *Achieving First-Time Motherhood at Midlife* was to co-construct meaning around the women's experiences as they sought to achieve motherhood for the first time at age 39 and beyond. These findings were critical in establishing the situated context for the text which followed in chapters six through eight. Chapter six presented a written interpretation of the participants' lived experiences as first-time midlife mothers. The theme *Intensive Mothering* conveys the overarching experience of older first-time motherhood as one replete with

advantages, as well as unique challenges. The women experienced greater fatigue, decreased energy and physical abilities, as well as physical, emotional and psychological symptoms which accompanied their transition to menopause. Chapter seven continued the discussion started in chapter six, with an interpretation of the participants' lived experiences as mothers who were '*out of sync*' with other women, friends and family. The theme *Out of Sync* represents the women's achievement of motherhood at a time in their lives which did not uniformly synchronize with other women, friends and family's experiences of parenthood. As a result, they lacked a sufficient social network and level of social support to help buffer the intensity of their mothering experiences. Chapter eight delves more deeply into the women's lived experiences as older mothers and midlife women transitioning to menopause. The theme *Perimenopause as a State of Uncertainty* conveys the experience of transitioning to menopause as one in which the main attributes of uncertainty are present: probability, temporality and perception. The findings support uncertainty as an appropriate conceptual framework for understanding women's experiences during the transition to menopause.

The women had concerns about the future, and a heightened sense of mortality since becoming mothers. For these reasons, they believed their health was precious, and they had a powerful desire to remain healthy, active and available to their child/children despite their older age. The older first time mothers in this study used a projection of the life span as a motive for healthy behaviors in order to be there for the child when they reached important milestones. It was this uncertain temporality, projection of the life span, and value of health as precious which enabled the women to transform uncertainty into an opportunity for a healthy transition and health promotion.

My intent was to share with the reader the interconnectedness of these four chapters as a vehicle for understanding the complexity of the women's experiences as midlife mothers during a time of overlapping life transitions. This final chapter takes a look back at where I started, and looks forward to sharing the findings through professional opportunities for dissemination. I remind the reader of the aim of the research, the final sample, summarize the findings and present the limitations of the study. I provide evidence to support the rigour of the study, discuss implications for practice, health care professional education and propose suggestions for future research.

Research Aim Revisited

The aim of this research was to understand women's perceptions of their health as they mothered young children while simultaneously transitioning to menopause. This inquiry was inspired by the growing demographics for older first-time mothers which creates a unique phenomenon in which the developmental transition to motherhood is followed closely or overlapped by the biological life transition to menopause, referred to as perimenopause. A scarcity of literature has explored the experiences of older first time mothers, particularly women aged forty and older beyond the first year post partum, and there is even less known from the perspective of women themselves. Similarly, women's experiences of menopause have been addressed in the literature in recent years, yet little is known about the meaning of women's experiences as they *transition* to menopause. The unique experiences of first-time mothers aged forty and older, who were simultaneously transitioning to menopause was not visible in the literature after an in-depth review, and it was this gap in knowledge about women's health which invited this study.

In order to achieve this aim, I conducted a hermeneutic, phenomenological interpretation of the lived experiences of thirteen older first-time mothers who identified themselves as perimenopausal. The final sample consisted of women aged 39-47 when they became mothers, and aged 45-56 at the time of the interviews. They were biological mothers, adoptive mothers, mothers who gave birth and later adopted a second child, one lesbian biological mother and a non-biological lesbian mother. All the women were Caucasian, and had education beyond high school. Two women were single, and ten were married, though one of these had recently separated from her husband at the time of the interviews. One of the lesbian women participated in a commitment ceremony. The median family income was greater than $80,000. Seven of the women were mothering an only child, five were mothering two children, and one woman was mothering three children, including one set of twins. Nine women gave birth to only one child, two women gave birth to two children, and two women never became biological mothers. The children's ages ranged from two to ten years old at the time of the interviews. A summary of the main findings will be presented and discussed next.

Summary of the Main Findings

The findings led to an historical and contextual understanding of women's experiences during this time of overlapping transitions, and four main themes emerged through dialogue with the women and the text. The findings were presented as categories which supported each theme, and represented the shared voices of the women as well as the unique perspectives of those women whose experiences were different from the others. Each chapter included a discussion in the context of known traditions, my pre-understandings and those of the women, as well as a comparison of findings with the relevant literature. A summary of the findings and categories which support the first theme is presented next.

Theme #1 Achieving First-Time Motherhood at Midlife

The first theme, *Achieving First-Time Motherhood at Midlife* constructs an interpretive meaning of the women's experiences as they sought to achieve motherhood for the first time at age thirty-nine or older. This theme is supported by six categories, all of which were critical in establishing the situated context for the text which followed. The first category, "*Not by Choice*": Delayed Motherhood, illustrated the desire of all thirteen women to become mothers. These women did not choose to wait until age 39 or 40 to become mothers for the first time, and the primary reason they cited for delaying motherhood was lack of the right relationship earlier in their lives. The category "*It Didn't Take That Long*": Conception, was an interpretation of the various experiences of these midlife women as they attempted to conceive a pregnancy. Though most of the women expected some reduction in fertility due to their age, eight of the women were surprised when they conceived with relative ease. Ultimately, motherhood was achieved through several different modalities, including natural biology, adoption, alternative insemination, in vitro fertilization, and lesbian partnerships. These were expressed by the category *"A Lot of Ways to Become a Parent*": Paths to Motherhood. Despite feelings of well-being by most of the women during their pregnancies, they perceived that they were considered high risk and treated differently than younger pregnant women by their health-care providers. Anxiety on the part of their providers made them nervous, and they did not like the labels typically ascribed to them, such as elderly primiparas or advanced maternal age, just because they were older. This disparity was embodied in the category "*Unknown Territory":* Pregnancy after age 39. There appears to be a lag between the social context of more women conceiving and delivering healthy babies

in their forties and the norms or parameters which the medical and nursing professions are still applying to these women. This stems back to an earlier time period when mothers having babies in midlife many have experienced a very different set of circumstances and health status than the women in this study. The findings from this study which have captured women's experiences may enable health care providers and nurse educators to refocus or recalibrate the frameworks and norms they apply to first- time midlife mothers.

The women were aware of potential adverse outcomes related to their age, and this was represented by the category *"Everything was Going to be Fine" and "Just to Make Sure"*: Baby's Health, which portrayed conflicting levels of concern the women expressed about the potential health of their babies, and the decisions they had to make around fetal surveillance. Six of the eleven women who experienced pregnancy verbalized feelings that their baby was going to be healthy; they reflected back on feeling an inner sense that the baby was okay. Although they were aware of concerns (their own or those of others) related to their older age, only two of those particular six women (and only three of the eleven) followed through with amniocentesis, a diagnostic test recommended by their health care providers. It surprised me that eight of the eleven women who gave birth 'chose' not to have amniocentesis, because the information it would yield was not going to affect their decision to continue the pregnancy. They wanted these babies regardless of any problems which would be discovered through prenatal testing.

As stated earlier in this chapter, the women had a strong desire to achieve motherhood, yet just slightly more than half of them wanted a second child. Concerns revolved around whether they were too old, fears of having a child with a disability, worry that they might not be able to conceive or adopt a baby again, feeling like one

child was enough, not feeling like they had a choice in the decision, and questioning whether they had enough emotional reserve to mother two children. Eight of the women expressed a desire to have more than one child, but only two of them went on to deliver a second child. Their desire for more children was embodied in the category *"More of a Fantasy":* A Second Child. Of the remaining six women who wanted another child, two chose to adopt, and two of the women were able to mother more children through their lesbian partnerships. The next section presents a summary of the women's experiences as first-time older mothers.

Theme #2 Intensive Mothering

The second theme *Intensive Mothering* was chosen for its ability to conceptually convey the overarching experience of the older first-time mother as one replete with unique advantages, as well as challenging disadvantages. *Intensive Mothering* was built around six categories, set in the context of each woman's individual life-world, and framed by the larger cultural and societal influences of the 20th & 21st century. The first category, *"Exciting and Almost Immediately Challenging*": Becoming a Mother, relates the participants' initiation into motherhood as a major transition, and primarily a positive experience. There was shared meaning around their pregnancy experience as easy, good or healthy; they enjoyed sharing their birth stories, and had positive recollections and outcomes despite provider anxiety.

Despite how passionately these women wanted to be mothers, or how 'ready' they thought they were, three quarters of them felt unprepared for the life changes that accompanied first time motherhood. This paradox was represented by the category *"Your Life is Changed Forever":* Unprepared for Reality. There was shared meaning for the idea that no one and nothing can prepare a woman for the realities of mothering. The women experienced unfulfiled expectations after the infant entered

their lives; these focused on the centrality of commitment to the baby/child, and an unfulfiled parenting partnership they thought they entered into with their spouse or partner. These realities contributed to intense mothering experiences which at first glance appeared to be very traditional in nature, with the mother as the primary caregiver. Upon deeper reflection, I would propose that they represent the opposite: a third wave of feminism in which these women were finally in a position to weigh their options, and truly make a choice for motherhood.

They expressed very clear ideas about pre-requisites for motherhood, and the kind of mother they wanted to be, and these were represented by the category *"A Good Mother":* Doing Mothering Right. Though they spoke of the lack of explicit guidelines for being a 'good mother', shared meaning confirmed implicit expectations which contemporary society has created to convey the characteristics and behaviors of a good mother. The good mother was invoked by the women with themselves as primary caregiver, focusing copious time, energy and material resources on their child/children. For most of the women, doing mothering right also included mothering differently than they were mothered, and it was with much intentionality that they reflected on their own experiences of being mothered, and set out to do a better job.

The category "It's a Triple Whammy": Older is Harder, embodied the complex issues which emerged as common meaning for older first time mothers. These were the unique challenges which accompanied mothering young children for the first time at an older age, and the women interpreted how their experiences were different from those of younger mothers. In addition to fatigue, decreased energy, and physical ability, the overlapping transition to menopause translated into emotional and psychological feelings along with fears of losing control. These feelings led the women to self-regulate their behavior in an effort to remain in control of their

emotions, in an effort to maintain their standard of good mothering. Another layer of complexity for these midlife mothers included the adjustments they made to their careers in order to establish balance in their life which favored time spent with the child/children rather than work.

Despite the disadvantages, the women were clear that there were also many advantages to starting motherhood in midlife, like financial stability and life experience, and these were captured by the category *"It's Almost a Catch 22":* Older is Better. The women expressed a high level of satisfaction with the mothering role, due in part to the years they spent without a child. They waited a long time to be in a stable relationship, completed their educations, established careers, and were financially stable. They demonstrated a complex ability for differentiation, to think about and offer different perspectives on their experiences as older first time mothers, as part of a process of integration. One very clear example of their integrative complexity was their perception of the elevated level of vigilance with which they watched over their children. The women viewed this behavior on their part as both an advantage and a disadvantage, so it stood alone as shared meaning for this group of women, and was captured in the final category *"Bubble Children":* Hyper-vigilance. A consequence of their maturity, and 'knowing' about people and the realities of 21st century society contributed to their fear of possibly losing their long awaited child. Yet, their abilities for integrative complex thinking allowed them to recognise that excessive control and limits on the children's activities could have a negative effect. This led once more to conscious attempts to control their behavior in an effort to be 'good mothers'. Contributing to the intensity of their mothering experiences was a definite lack of a social network and social support, and this is reviewed now.

Theme #3 Out of Sync

The theme *Out of Sync* represents the women's perception of achievement of motherhood at a time in their lives which did not uniformly synchronize with other women, friends and family's experiences of parenthood. As a result, they lacked a sufficient social network and level of social support to help buffer the intensity of their mothering experiences. *Out of Sync* was authenticated by five categories which provided substance and support to the concept of midlife mothering as an isolating experience. The first category, *"Arrested Development"*: Off-Time Motherhood, acknowledged the non-synchronous reality in which these older first time mothers lived compared to the majority of women who become mothers at a younger age. While friends and family were parenting older children, or adjusting to empty nests, these women were mothering young children, and attending school functions. Their satisfaction with motherhood did not completely obviate how different the context of their life compared to those of their friends and family, or that their children's friends had much younger parents. When viewed from the perspective of an 'idiosyncratic life cycle transition' (Imber-Black, 1989), it became clear that older first-time mothers have no 'available map' to guide them through the experience, little contextual support, and few similar others, which tended to maximize the differences they had with younger mothers, almost to the exclusion of a sense of connectedness with others. This disharmony in life stages resulted in a very thin social network, which was represented by the category *"You Don't Have the Same Network"*: An Isolating Experience. Mothering out-of-sync from members of their social network contributed to the absence of adequate available social support, as characterized by absence of available help from others, lack of reciprocity of services, the lack of similar others, geographical distance, and feeling unconnected to others. The women described their

experiences as isolating, and these were revealed in the category *"Minimal Support"*: From Friends and Family. The circumstances which led to their achievement of motherhood at an older age, also created a context in which their parents became grandparents at an advanced age. Having aging parents created a paradox for these older mothers. Instead of receiving support from the grandparents of their child/children, they instead become the ones having to care for or support aging or ill parents.

The women expressed a perceived lack of emotional support which stemmed in part from the unavailability of older mothers like themselves to confide in, as well as being out of sync with siblings, family, and friends. The lack of meaningful connections with younger mothers, and even women their own age, led the women to seek out older mothers like themselves for social support. Their preference for women who were older mothers like themselves was presented in the category *"I Connect More with Mothers Who Are Older"*: Similar Others. Shared meaning pointed to the value of a connection with even one woman like themselves, and as a result, many of the women voiced an interest in getting together with the other participants in this study.

The final category *"It's Like a Vacation"*: When You Have Support, presented the limited experiences of a few women who felt they had adequate social support, though imbedded in some of these stories were qualifying and slightly ambiguous messages that sometimes the support they received was not always what they needed. The benefits of social networks and social support to well-being and health are clearly articulated in the literature. It therefore makes sense to focus interventions on building the levels of social support for older first-time mothers so that they might gain from both direct and indirect benefits to help buffer the effects of intense parenting. The

next section summarizes the findings from the women's lived experiences as midlife women transitioning to menopause at the same time they were mothering young children.

Theme #4 Perimenopause as a State of Uncertainty

The final theme *Perimenopause as a State of Uncertainty* conveys the experience of the transition to menopause as one shrouded in ambiguity, lacking familiarity with symptoms, and projecting an uncertain timeline. Together with a lack of support from credible sources, these elements contributed to the women's perceptions of menopause as predominantly negative. Further, as older mothers, they expressed uncertainty about the future, and worried about *being there* for their children. This state of uncertainty led them to pursue health and health promotion activities in order to live longer.

While the women in the current study did not think perimenopause was a major event in their life, they did acknowledge physical, emotional and psychological changes related to 'going through menopause' which were stressful to them. I interpreted these as components of uncertainty or disruptions in the 'structure of their reality' (Selder (1989, p. 437), and utilizing transition theory, I expected the women to do some *restructuring*, or create meaning about perimenopause in an effort to resolve the uncertainty. The theme *Perimenopause as a State of Uncertainty* was authenticated by six categories which provided substance and support to the concept of *Uncertainty* as a framework for aiding understanding of the meaning of health for midlife mothers during the transition to menopause.

The first category *"It Must Be Something Else": Transition to Menopause* related the women's perimenopausal experience as one shrouded in ambiguity, so much so that many of them were not sure what was happening to them physically, emotionally,

and psychologically. There was shared meaning in their discourse about feeling unprepared for the perimenopause: ten of the women related that they were unfamiliar with symptoms; eight felt they lacked anticipatory guidance and support from their health care providers, and most found their own mothers unwilling to discuss menopause with them. Eight women were so unsure of what was happening to them that they thought they were experiencing "*something else*". The range of symptoms they experienced or thought they should be experiencing was confusing to them, and this was discussed in the category *"What is Going On?"*: Unfamiliar with Symptoms. Eleven of the women identified menstrual changes as the most common symptom, followed by irritability (7), mood swings (7), night sweats (6), hot flashes (6), losing control (6), various levels of depression (6), and feeling more emotional (5). The women described a prevailing sense of their bodies failing them during the transition to menopause, coupled with a propensity to emotionally lose control over things that normally would not push them 'over the edge'.

Selder's (1989) theory of life transitions provided an explanation in that disruptions in a person's reality structure result in a collapse of time, in which the women became preoccupied with the event triggering the transition. This provided a framework for understanding the women's desire to know how long the transition to menopause was going to last and whether the symptoms were going to get worse. This aspect of their experience was discussed in the category "How L*ong Will This Last?"*: Uncertain Timeline. Not knowing how long perimenopause was going to go on was stressful to them. The women described the ambiguous nature of both symptoms and the timeline during perimenopause, and the extracts highlight this period in their life as a complex transition, in which feelings of uncertainty were embedded. Shared meaning emerged from the dialogue and the text in which the

construct of uncertainty came to light as a theoretical embodiment of the women's transition to menopause. The lack of familiarity with the transition to menopause, the incongruence between what women in this study expected and what they actually experienced, and the variability and ambiguity of symptoms made it difficult for the women to form a cognitive schema for perimenopause.

The category *"It just didn't happen": Lack of Support from Credible Sources* captured the women's lived experience of being unprepared for perimenopause. A significant finding was that more than half of the women held a perception that their physicians and midwives did not provide anticipatory guidance or education about the transition to menopause, and four of those seven women additionally felt their providers were actually unsupportive when they tried to talk to them about symptoms or asked for help. In most cases, the providers did not give the women any anticipatory guidance or education about the transition to menopause until the women broached the topic at an appointment.

In utilizing uncertainty theory to understand women's experiences during the perimenopause, I proposed that health care providers are one component of Mishel's (1988) concept of 'structure providers'. As credible authorities, they are one resource available to assist women in the transition to menopause. Indirectly, education provides more information to help women place perimenopause into the context of their lives, and potentially help them to derive meaning from the experience, which should reduce levels of uncertainty. Inadequate preparation by their providers, including lack of information about menopause and lack of social support (as discussed in chapter seven) can all be linked to greater levels of uncertainty during the transition to menopause. Lack of anticipatory guidance and information from credible sources was not limited to health care providers. Women in the study looked to their

mothers to provide information and guidance about the transition to menopause as well. What most of them discovered was that their mothers did not offer them any information, and when pursued, they did not want to talk about it. Without specific information, the women were left to draw their own conclusions about what their mother's experience with menopause was like.

Lack of informative conversations about perimenopause or menopause with their providers, mothers, and female relatives, lead the women to seek out friends, 'similar others' or the media to find information. However, as previously noted for the women in this study, their lived experience as older first-time mothers placed them out of sync with many women their own age. Consequentially there was a distinct lack of similar others with whom they could share the intimate details of their lives. There was a clear lack of resources to aid women in their interpretation of the *stimuli frame for perimenopause*: the ambiguous symptom pattern, lack of familiarity with and incongruent experiences during the transition to menopause. This combination may have contributed to the women's appraisal of the transition to menopause as a predominantly negative event, and this was presented in the category, *"So Many Negative Things"*: Perceptions of Menopause. The predominance of negative perceptions related to menopause outranked any positive comments. Women associated it with "*getting older, having symptoms, having to take medication, causing depression, having a negative public opinion, being emotional, feeling mad, angry, nervous, scared, losing control, irritable, and something they have to get through*". The positive perceptions were that "*it was not the end, not about getting old, it was a process, normal and natural*".

Uncertainty theory (Mishel, 1988) offered an explanation which clarified understanding about the women's opinions of the menopause transition as negative.

Perimenopause was an event that was not initially recognised, and when appraised, the women found it difficult to attach meaning to, or interpreted it incorrectly as something different, or perceived it as negative. What initially appeared to emerge as a paradox in the current study may be an example of transforming uncertainty into an opportunity.

While the majority of the women in this study appraised menopause as negative, they perceived themselves as healthy, and participated in many health promotion activities. This could be interpreted as a form of emotion-focused coping, and gaining something positive from a negative event or process. I could also make an argument that despite negative appraisal of perimenopause, the women were utilizing problem-focused coping strategies in that although they could not change the fact they were transitioning to menopause, they chose instead to pursue behaviors that were directed at helping them cope while at the same time promoting health. The motivating factor for these behaviors seemed to be their parallel appraisal that their health was precious, and their desire to remain healthy, active and available to their child/children despite their older age was of paramount importance to them.

Nine women stressed it was critical as the mother, to still be around when their child/children were older. This was shared meaning for the mothers of children with and without disabilities. The women had concerns about the future, and were more in touch with their mortality since becoming mothers. All but three of the women agreed that mothering young children during midlife motivated them to stay young and healthy, and they had a powerful desire to remain healthy, active and available to their child/children despite their older age. This was revealed in the category "*Being There*": Uncertainty about the Future.

Almost all of the women perceived themselves as healthy, despite aging, chronic health issues, perimenopausal symptoms or negative perceptions about menopause. Many of them attested to participation in health promotion activities, like exercise, weight-lifting, healthy nutrition, and regular appointments with their providers. The women projected time into the future, and expressed the desire to *be there* for important milestones in their child/children's life, like graduation and weddings. There appeared to be a connection between older first-time mothers' projection of time, and their recognition of health as precious, in that they used this projection as a motivator for health promotion behaviors in order to keep up, last longer, and be there for the child when they reach those milestones. It was this uncertain temporality, projection of the life span, and value of health as precious which enabled the women to transform uncertainty into an opportunity for a healthy transition and health promotion. Having summarized the findings from this study, I now address what I consider to be the limitations of this research.

Limitations of the Study

One of the difficulties in conducting this study included the initial attempts to obtain a sample of older first-time mothers who were aged forty or older when they became mothers. In the end, it was through personal and professional referrals, and recommendations from the women themselves, ie snowball sampling that an adequate and appropriate (Morse, 1991) sample of women were recruited. I was aware of the potential disadvantages of snowball sampling, and I had to remain conscious of how many participants were nurses or other health care professionals, while also maintaining control over snowballing. Though the sample was homogenous for Caucasian, well-educated, financially stable women, these in fact represent the demographics nationally for women who delay childbirth.

This study represents the views of older first-time mothers living in the North East section of the United States. Limited research has been conducted to date with this particular group of women, so further research is needed with larger and more diverse samples of women experiencing delayed motherhood and the transition to menopause. Another limitation in a qualitative study is the role of the researcher herself. Whilst I believe that my contribution to the study as a female, nurse and menopausal woman was primarily positive, the women may have interacted with me in a different manner than if the interviewer had been someone outside of nursing and/or the health field. I was also personally and professionally known to several of the women, and this may have had some influence on their discourse.

It was challenging to write a phenomenological text, particularly when presenting findings and discussion that embodied the philosophical principals and constructs of Gadamer, as well as the phenomenological themes of van Manen. Though I felt confident that I had adhered to these principles during the conduction of the study, it was much more difficult to express myself with written words. Phenomenologic/ hermeneutic research only provides one possible interpretation of the phenomenon, so it is never quite finished. Van Manen (1990, p.31) states that "no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description". In the present study, the lived lives of the women were certainly more complex than my interpretation could ever possibly reveal.

The late addition to my committee of a faculty member with expertise in hermeneutic phenomenology was very positive. Though he was a tremendous help in the final stages of completing the thesis, having a methodologist as part of the team

earlier would have been beneficial. Having just presented the limitations of the study, I will next argue that this study achieved a high level of rigour.

Evidence of Rigour

I believe that there has been methodological coherence throughout this study, as the sample provided a full range of mothering experiences which were explored, and the findings present new knowledge about a cohort of women and older first-time mothers about whom little is known.

I have discussed at length the ontological and epistemological beliefs which have informed this study as well as the philosophical frameworks and paradigms which supported it. I have written about my own prejudices, values and personal insights which factored into the topic, interviews, and interpretations. Methodological decisions and guidelines for analysis and interpretation have been articulated, and thus I have provided an audit trail for the reader. The participants experienced the phenomenon under study, and their stories provided a genuine and meaningful description of it. Women's comments were placed in both personal and historical context, and data collection methods as previously discussed support authenticity, accuracy and completeness of the original data. I provided data from all participants and it was sufficient to enable the reader to judge my interpretation of the data.

I have engaged at length in the reading of transcribed interviews, field notes, drafts of interpretations, feedback from colleagues and committee members. A doctoral supervisor and committee members who are experienced in qualitative research and hermeneutic phenomenology have read the transcripts, notes, interpretations, and provided comment and feedback. An audit trail was created consisting of field notes, documents, transcripts, analysis and interpretations, personal notes, coding schemes, categories, themes, feedback from committee members, and

the final text. I believe that the questions I asked enabled the participants to share their own personal experiences in the context of their life-world, in addition to any theoretical knowledge or pre-understandings they might have had on the topic. Member checks were accomplished during the second interviews when participants were given a chance to correct misinterpretations or factual errors from their previous interview, offer additional information, validate or negate ideas and categories, and offer comment on the interview process. During the second interview, women were asked to confirm or reject ideas or data that emerged during the first interview, to expand on any topic, and were given an opportunity to discuss anything they may not have talked about during the first interview. Any misinterpretations on my part were discarded, and additional data generated from the second interviews were incorporated into a revised text, and disconfirming cases (Patton, 1990) have been represented.

Efforts to gain *affirmation* by the participants, which Munhall (1994, p.189) calls the "Phenomenological Nod", contributed to the rigour and the merit of this research, in that the participants recognised findings and agreed that I had captured the shared or unique meaning of their experience. I received many nods from the women, particularly during their second interview, as we discussed various topics or experiences. In many instances they were able to validate or confirm a similar interpretation of their own experience. However, in some cases, participants expressed different experiences and were unable to give their nod to each idea or interpretation. This is fine in that there may be one lived experience with different interpretive meanings, and these too became a part of the description (Munhall, 1994). I believe I have crafted an interpretation which is rigourous and credible to faithfully represent the important human phenomenon of older first-time midlife motherhood

overlapped with the transition to menopause. Analysis was ongoing with data construction, and this led to verification of ideas and categories with the women. Further, I believe I achieved theoretical triangulation by making conceptual connections between existing theories and those which emerged and were constructed from the data. Connections to existing theories were made, and in the case of 'Uncertainty" a theoretical extension of Mishel's (1983, 1987, 1988, 1990) theory was proposed as a framework for aiding understanding of women's experiences of health during the transition to menopause.

The necessary components of the *Authenticity Criteria* set out by Lincoln & Guba (2000, p.180) which represent "authentic, trustworthy, rigorous, or 'valid' constructivist or phenomenological inquiry..." were established. *Fairness* in this study was reflected in the varying perspectives and voices of all the women participating in the study as well as my own, which will be discussed further below. *Ontological and educative authenticity* were achieved through a raised awareness of both the shared and unique experiences of the participants, and through planned dissemination of findings for professionals caring for women during midlife, healthcare educators, and the public. While I did not actively engage the participants in any form of social or political action, in order to directly satisfy the element of c*atalytic and tactical authenticities,* (social and political action), that is not to say that participation in the study did not create capacity for any woman to feel empowered to make a change in her life. Of all of these authenticity criteria, I would like to focus on *fairness* in particular, as it is represented by 'voice', which is crucial to any discussion of trustworthiness or authenticity. Lincoln and Guba (2000) consider *voice* to be a complex issue in the argument for authenticity. The voice of the researcher was clearly heard in the text as well as the voices of the research participants in their own

words. My own active voice and the consistent use of first person was clear throughout the text. I also utilized a reflexive approach (without succumbing to excessive hyper-reflexivity) to demonstrate how my biases and values influenced the choice of topic, questions, interviews, construction and interpretation of the text. Reflexivity is an acknowledgement by the researcher of her role and influence on the research project (Carolan, 1999), and I would argue that this was thoroughly incorporated. There was the self I brought to this study and the self that I created or was transformed during the process (Reinharz, 1997). How my many selves (researcher, nurse, educator, student, mother, midlife woman, menopausal woman) interacted with the participants and the text was ultimately important to the authenticity of the final interpretation. Reflexivity recognises the relationships I had with the women, the reciprocal nature I had with the text, the interpretive process, and the transformations which took place in thinking about categories and themes. I have made a genuine attempt to represent the participants' voices in a way that did not exploit or distort them. I recognise that although the women and I both shared some control in the direction of conversation, as the person who wrote up the final interpretation, I was in the more powerful position of asking the questions and deciding what appeared in the text. I was conscious of the potential problem in qualitative studies of individual voices reflecting an idea that represents the group, and have in all instances included the voice(s) of a woman (women) who shared a different view, or whose experience was different from the others. I have also attempted to present the women's voices in the context of their lives, and in the greater context of mothering and being a menopausal woman in American society in the twenty-first century.

Lastly, I would argue that this study satisfies Schwandt's (1996) three criteria for evaluating social inquiry. The findings from this research supplement and establish new knowledge about the experiences of older first-time mothers, during their simultaneous transition to menopause. Knowledge of a midlife woman's journey to first-time motherhood, her experiences of midlife mothering, and her perceptions of her health during the transition to menopause have been enhanced. Zestful discussion could now ensue based on the situatedness of delayed motherhood and perimenopause in the twenty-first century. Having discussed the rigour of the study, I now present recommendations for practice, education, and further research.

Recommendations for Policy and Practice

Nurses and other health care providers cannot assume they understand women's perspectives on motherhood or menopause, or presume to know what their health needs may be. In light of the changing demographics for women aged forty and older who are experiencing this unique phenomena in their lives, there is a need to listen to the voices and stories of midlife women who are willing to reveal perceptions of their health during a time in their life when motherhood intersects the transition to menopause. The findings from this inquiry contribute new knowledge for nurses, and other health care providers about the meaning of health and mothering for older first time mothers during a time of overlapping developmental transitions. The women in this study did not choose to wait until they were 39 or older to become mothers; rather for most, life circumstances were influential and stable relationships were paramount in their decisions for motherhood. However, delayed motherhood can affect fecundity and result in undesired childlessness for those expecting to have children, so women need to be informed about potential fertility issues associated with advancing age.

Assumptions about older pregnant women should be promptly reassessed; this was exemplified in this study in that most of the women did not experience infertility, some older first time mothers chose not to risk their pregnancy by having diagnostic testing, because they would not have terminated even if the foetus had a chromosomal abnormality such as Down's syndrome.

The challenges of midlife mothering extend beyond the physical, so in addition to fatigue, decreased energy, and physical ability, the transition to menopause involves emotional and psychological feelings and fears of losing control. Motherhood and the birth of a child were viewed as a major transition in the women's lives, yet despite how passionately these women wanted to be mothers, or how 'ready' they thought they were, three quarters of them felt unprepared for the life changes that accompanied first time motherhood. Whilst this is not unique to older mothers, the significant lack of a sufficient social network and level of social support to help buffer the intensity of their mothering experiences has not been widely disseminated. Older first-time mothers have no 'available map' to guide them through the experience, little contextual support, and few similar others, which tends to maximize the differences they have with younger mothers, almost to the exclusion of a sense of connectedness with others. The benefits of social networks and social support to well-being and health are clearly articulated in the literature. It therefore makes sense to focus interventions on building the levels of social support for older first-time mothers so that they might gain from both direct and indirect benefits to help buffer the effects of intense parenting.

Women's perceptions of good health and positive emotional health have been shown to improve their attitudes about menopause. This particular group of women placed a high value on health and health promotion which provides an opportunity for

health care providers, particularly nurses to improve the care they deliver to mid-life women. At least half of the women sought medical care for perimenopausal symptoms, and most were not satisfied with the outcome of those visits. Inadequate preparation by their providers, including lack of information about menopause and lack of social support can all be linked to greater levels of uncertainty during the transition to menopause. Expansion of uncertainty theory as a framework for understanding the experiences of perimenopausal women is relatively new in the literature. Whilst the concept of uncertainty during perimenopause has emerged as a finding for several researchers, the current study establishes a stronger connection and basis for future work. Health care professionals should take heed to address the issues this population of women raised related to lack of preparation for and education about the menopausal transition. Just telling women to have a positive attitude toward menopause is clearly not enough to make it so. While the findings from a phenomenological study do not solve problems and should not be generalized, they can offer professionals caring for women the opportunity for reflection about how they deliver that care. With this in mind, I propose the following recommendations to inform policy and practice:

- Practitioners need to challenge the assumption that all women desire motherhood, and recognise that women who do want to be mothers delay childbirth for a variety of reasons.
- Practitioners need to provide anticipatory guidance and factual information about conception to women who desire biological motherhood.
- Providers caring for lesbian women can acknowledge that there are unique dimensions for planning conception among lesbian mothers, including which

partner is going to be the biological mother and how conception will be achieved.

- Providers need to review and re-assess long-held assumptions and assignations of risk for older mothers, and that includes refining or abandoning labels such as *elderly primipara, advanced maternal age*, and *high risk* used to describe women thirty-five and older who become pregnant. There is a need to establish guidelines for care based on a woman's age and the evidence available without resorting to labeling women or creating a climate of fear. This may require a change in policy or protocols established for women over 35 years old.
- Health care providers can refocus or recalibrate the frameworks and norms traditionally applied to first-time older mothers and midlife women. Women may not want to pursue diagnostic testing or any procedure that increases the possibility of losing the child. This too requires a shift in thinking about best practices for pregnant women age 40 and older.
- Providers need to be cognisant that the older first-time mother has a strong sense of what constitutes a 'good mother', and she utilizes expert advice to help guide her along the path of intensive mothering.
- Providers working with women and children should recognise that these women self-regulate their behavior in an effort to remain in control of their emotions; in addition to physical assessments, care needs to be taken to discuss the emotional well-being of midlife mothers.
- Prenatal and postpartum education and interventions need to be redesigned to prepare women for motherhood. More preparation and participation in activities of parenting can lead to more complex thinking, and a more positive

adjustment to mothering. Nurses and interested others can develop these programmes.

- Providers should solicit feedback from women about office visits in an effort to hear the client voice, and better meet the healthcare needs of this group.
- Nursing interventions that would foster greater social networks and social support for older first-time mothers may help them interpret the experience of midlife mothering in a more positive light as a result of improved coping, management of stress, and more capable problem solving. This could potentially be accomplished by creating opportunities for women to develop new social network links and by building capacity within community and professional resources, such as hospital supported mother/baby groups, breastfeeding support groups or support groups driven by the women themselves.
- Health care for midlife women should include opportunities to discuss the research, benefits and potential negative consequences of various options for symptom relief during perimenopause. Nurses can provide this opportunity for education and discussion.
- Nurses and other providers should consider offering private or group discussions which include the incongruous nature of symptoms during the transition to menopause, to enable women to make more informed decisions about their health. Nurses in particular could be a valuable resource to assist women in the transition to menopause, by listening and offering educational opportunities, anticipatory guidance, counseling, and stress management techniques.

- Nurses and/or the women themselves can advance social networking and education for older first-time mothers at the same time through classes, support groups, and virtual discussions- these could also work to lower levels of uncertainty during perimenopause and foster positive appraisal of the menopause.

Recommendations for Nursing Education

Educators engaged with student nurses, medical students, residents, nurse practitioners, nurse midwifery students and students in other health professions are teaching future health care providers how to care for older pregnant women, midlife mothers, and women transitioning to menopause. Care must be taken not to pass on the biases of the past which carry a negative message about pregnancy after age 35 or perpetuate the medical model of menopause. This can be accomplished through a commitment to the triangle of best practice which includes current research, clinical expertise and patient/client preferences in establishing a plan of care for women who delay motherhood and for women transitioning to menopause. With this in mind, I propose the following recommendations to inform education:

- Foster the education and development of a new generation of healthcare providers who do not promulgate an environment of ageism, particularly in the care of women.
- Educators should refocus or recalibrate traditional pedagogies for teaching and learning as they apply to older first time mothers and perimenopausal women. Revised paradigms should be drawn from current research evidence, women's experiences as well as clinical expertise in order to educate current and future healthcare providers and the public in ways that promote the health and well being of midlife women.

- Educators should critically appraise the choice of textbooks and other academic reading material for students which casts a negative bias on the care of midlife women.
- Encourage educators to engage in further research and scholarship within the academic and clinical communities which is focused on the discovery of new knowledge about the care of older first time mothers and midlife women transitioning to menopause.

Recommendations for Future Research

Further research is needed with this older cohort of first-time mothers to explore their mothering experiences, and the transition to menopause. In addition to building knowledge upon which to base education and healthcare for this group of women, the women themselves need opportunities to tell their stories as to date their voices have not featured prominently in research studies. Future studies with midlife mothers should include women who adopt as well as single women and women in lesbian partnerships. Mothering experiences should not be marginalized for those women who are not in traditional relationships. I would recommend more than one interview in future qualitative studies with women. Conducting two interviews with each woman was incredibly valuable; it allowed me time to develop a relationship and 'rapport' with the women. As a result, they appeared much more relaxed and open during our second meeting. They enjoyed talking about their birth experiences, or how they came to be mothers. Here, Florence recalled those first moments after the birth of her daughter:

> *Mothers love to talk don't they? It's fun to go back through it. I remember just the bliss that evening of being with my husband and the new baby and all our friends who were there were singing as she came out. They were singing, oh it was so beautiful, sort of welcoming her. I remember the next morning feeling just energized, excited* (Florence, I_1, p.7).

The interview process was a positive experience for them. At the conclusion of her second interview, Florence expressed in words what most of the women implied during their interviews or said to me after the recorder was turned off:

> Pat: *Is there anything else you would like to talk about?*
>
> Florence: *No, it's been fun actually just to think about it, and think about a little bit more of what it means, parenting in my forties, being a perimenopausal woman. (laughing) Because I don't HAVE those opportunities, like I said, I have one other friend, oh and I forgot, I have a number for you, one other friend in her forties.* [Pat*: oh excellent*]*Other than that, everyone else is in their thirties that I know who's parenting* (Florence, I2, p. 42).

Many questions remain about how we care for midlife women during pregnancy and perimenopause. Future studies could be based on the pedagogical approaches to women's health for nurses, physicians and other care providers both in the United States and in other countries. The effectiveness of feedback provided by women about their appointments with healthcare providers could be measured. Uncertainty theory could be further explored as a framework for understanding women's experiences during the transition to menopause with a diverse sample of women. These could be women who became mothers at various ages, as well as childless women. Interventions could be designed using uncertainty theory as a framework with the aim of reducing uncertainty during perimenopause.

A Possible Human Experience

Van Manen (1990, p.58) suggested that "phenomenology always addresses any phenomenon as a *possible human experience*. It is in this sense, that phenomenological descriptions have a universal (intersubjective) character". I would argue that in the final text, I have provided sufficient information related to the participants involved, in context but without compromising their identity, to enable the reader to judge whether the findings are transferable to them in a similar situation

or at least be recognizable to someone who is a midlife mother who has stepped over the threshold into the transition to menopause.

Conducting this study was an amazing journey for me. I felt privileged to listen to the stories these thirteen women shared with me and dialogue with them about their experiences. Interventions based on the shared lived experiences, and common meanings of the participants will provide the most effective base for meeting the health care needs for many midlife mothers. The shared voices and unique experiences of some of the women also stress the importance of individualizing care for clients. The readers will ultimately decide if I created a capacity for understanding women's experiences around this phenomenon.

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Appendix A

University of
NEW ENGLAND

Dear Practitioner, June 30, 2004

My name is Patricia Morgan. I am an Assistant Professor at the University of New England in the Department of Nursing, and the coordinator of the associate degree programme. I have been a nurse for 27 years, and am currently working toward a PhD in nursing at the University of Wales, Swansea, through an international collaboration with The University of New Hampshire. My clinical nursing experiences have been in the areas of obstetrics, newborn care, and gynaecology, with a special interest in menopause. My current study is aimed at understanding what the experience is like for midlife women who are mothering young children, while also experiencing symptoms of perimenopause.

This is a qualitative study, which will involve 2 interviews of about 1 hour each with women who meet the study criteria. I have received ethical approval for my study from The University of Wales, Swansea, and The University of New England, and would like to begin data collection this summer. I am looking for women who were 40 years or older at the time of their first delivery, who are currently mothering children aged 12 or younger, as well as experiencing symptoms of perimenopause.

I am contacting you because I believe your practice could provide an opportunity for me to make a connection with the women I would like to interview. I am asking for permission to post a flyer (in your office), inviting women to participate in this study. I will provide my business cards so women would know how to contact me if they are interested. I can certainly be flexible in my approach to reach out to these women and would consider any suggestion that you might have that would work better in your setting.

Once women contact me, I will send an informative letter to them (copy enclosed), and arrange a mutually agreed upon time and location for the first interview. In order to maintain confidentiality of the participants, no one except myself will have access to the identities of the women in the study. Their identities will be coded to a master list which no one will have access to except myself. The master list will be stored in a locked file drawer in my home office. Pseudonyms will be substituted for the participants' real names and used to completely anonymize the data.

There is little understanding about the occupation of mothering, let alone how it may change or be affected by other overlapping life transitions. Few studies have explored the mothering experiences of women who give birth after the age of 35 years, particularly for those women who are mothering while simultaneously experiencing symptoms of perimenopause. There is a need to hear the voices and stories of those who are willing to reveal what it is like to be a midlife mother. I

anticipate that the findings from this study will inform health care practice in order that physicians, nurses and others can be more effective when caring for midlife women, and be better prepared to help promote healthy responses to the transitions of motherhood and menopause.

I have enclosed a response card, and respectfully request that you will consider extending me this privilege. Thank you for your time.

Patricia Morgan, RN,MS,BSN
Department of Nursing and Health Services Management
Associate Degree Coordinator
Blewett 228 Westbrook College Campus
or
18 Leavitt Farm Lane, York, Maine 03909
207-363-2326 (home) 207-752-0189 (cell)
Pmorgan4@maine.rr.com

Appendix B

WOMEN NEEDED
FOR RESEARCH STUDY ON
MIDLIFE MOTHERING

Aim of study: to understand what the experience is like for women who are mothering young children while also experiencing symptoms of perimenopause.

Researcher: Pat Morgan is an RN with her Master's Degree in Nursing. She is an Assistant Professor at The University of New England in the Department of Nursing, and the coordinator of the Associate Degree Programme. Her clinical expertise is in women and infants' health, with a special interest in menopause. This study is being conducted as part of her doctoral studies for a PhD in nursing.
Time commitment: 1-2 interviews lasting about 1 hour each.

Criteria for Participating in this study:

1. You delivered or adopted your first baby at 40 years of age or older.
2. You are currently mothering one or more children aged 12 or younger.
3. You are experiencing any of the symptoms of perimenopause listed below.
4. You are willing to talk with me about your experiences of childbirth, parenting, and health.

Symptoms of perimenopause may include any of the following:

- changes in the menstrual pattern or amount of bleeding • hot flashes
- night sweats • headaches • dizziness • palpitations
- changes in mood or memory • anxiety • decreased sexual desire
- vaginal dryness •sleep disturbance • urinary incontinence.

If you are interested in sharing your experiences with me, and you meet the criteria listed above, please call me at 207-752-0189 (personal cell phone), email me at Pamorgan@une.edu or write to me at The University of New England, Westbrook College Campus, Blewett 228, 716 Stevens Ave., Portland, Maine 04103. I will answer any further questions you may have.

Appendix C

University of
NEW ENGLAND

Hello,

My name is Patricia Morgan. I am an Assistant Professor at the University of New England in the Department of Nursing, and the coordinator of the associate degree programme. I have been a nurse for 27 years, and am currently working toward a PhD in Nursing at the University of Wales, Swansea, through an international collaboration with The University of New Hampshire. As part of my studies, I am conducting research for my doctoral dissertation. My nursing experiences have been in the areas of women and infants' health, with a special interest in menopause. My current study is aimed at understanding what the experience is like for women who are mothering young children, while also experiencing symptoms of perimenopause.

As a health care professional, I think it is time to hear the voices and stories of those of you who are willing to reveal to me what it is like to be a midlife mother. As a participant in my study, I will meet with you individually at least 1-2 times, for about one and one half hours each, and ask you to share your experiences with me. For the purposes of data collection, and with your permission, I will audiotape our discussions. Your identity will be protected. The knowledge gained from this study may be very illuminating to nurses and other health care providers, and will provide a base for meeting the needs of other women with similar experiences.

If you are interested in sharing your experiences with me, and you meet the criteria on the following page, please call me at 207-752-0189 (personal cell phone), email me at Pmorgan4@maine.rr.com, or write to me at The University of New England, Westbrook College Campus, Blewett 228, 716 Stevens Ave., Portland, Maine 04103. I will answer any further questions you may have.

Thank you for your time

Patricia Morgan, RN,MS,BSN
Department of Nursing
Associate Degree Coordinator

CRITERIA FOR PARTICIPATING IN THIS STUDY

1. You delivered your first baby at 40 years of age or older.

2. You are currently mothering one or more children aged 12 or younger.

3. You are experiencing any of the symptoms of perimenopause listed below.

4. You are willing to talk with me about your experiences of childbirth, parenting, and health.

Perimenopause is the gradual transition from menstruation to menopause. It includes the period of time immediately prior to menopause, and the first year after menopause lasting about 4 years. Perimenopause is the medical term for being in or going through menopause. Symptoms of perimenopause may include any of the following:

- changes in the menstrual pattern or amount of bleeding
- hot flashes
- night sweats
- headaches, dizziness, palpitations
- changes in mood or memory
- decreased sexual desire
- vaginal dryness
- anxiety
- sleep disturbance
- urinary incontinence.

College of Health Professions
UNIVERSITY CAMPUS 11 Hills Beach road, Biddeford, Maine 04005-9599 Phone 207-283-0171. Fax 207-282-6379
WESTBROOK COLLEGE CAMPUS 716 Stevens Avenue, Portland, Maine 04103-2670 Phone 207-797-7225

Appendix D

University of
NEW ENGLAND

Dear (name deleted), August 19, 2004

Thank you for responding to the call for research participants for this study. I enjoyed speaking with you on the phone. I have enclosed the formal *letter to participants, and criteria for participating in this study,* which will provide you with more information about what I am doing. As we discussed on the phone, the criteria have been set to include women who delivered their first baby at forty years or older. I have spoken to my research supervisors who have advised me to stick with the original criteria for now. I will hold on to your name and contact information for a future study. From our brief conversation I was impressed that you have an important story to share; hearing it might spark an idea for another research project.

I have enclosed some flyers as well. If you can think of any women who meet the criteria, I would appreciate it if you would pass on the information to read and consider.

Thank you again for your interest in this study, and I hope to one day meet you.

Please feel free to call me at 207-752-0189 (personal cell phone), 797-7688x4273 office or email me at Pmorgan4@maine.rr.com, or write to me at The University of New England, Westbrook College Campus, Blewett 228, 716 Stevens Ave., Portland, Maine 04103. I will answer any further questions you may have.

Thank you for your time

Patricia Morgan, RN,MS,BSN
Department of Nursing
Associate Degree Coordinator

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716 Stevens Avenue, Portland, Maine 04103-2670
Phone 207-797-7225

Appendix E

University of
NEW ENGLAND

Dear (name deleted), September 12, 2004

Thank you for responding to the call for research participants for this study. I enjoyed speaking with you on the phone, and look forward to meeting with you in a few weeks. I have enclosed the formal *letter to participants* for you to read, which explains in a little more detail what this study is about. As I mentioned on the phone, I must follow research protocol and give you 2 weeks to reconsider your intent to participate. In speaking with you, this may work out well, since your children will be back to school. I will be happy to meet you in (place deleted) as you suggested. I will call you in a few weeks to set up a time convenient for you. I have also included the criteria for the study, and some flyers in case you can think of any other women who might be willing to participate.

Please feel free to call me at 207-752-0189 (personal cell phone), 797-7688x4273 office or email me at Pmorgan4@maine.rr.com, or write to me at The University of New England, Westbrook College Campus, Blewett 228, 716 Stevens Ave., Portland, Maine 04103. I will answer any further questions you may have.

Thank you for your time

Patricia Morgan, RN,MS,BSN
Department of Nursing
Associate Degree Coordinator

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Phone 207-797-7225

Appendix F

SAMPLE QUESTIONS FOR INTERVIEWS

1. What was it like to have your first baby at age 40 (or whatever age she was)?

2. Tell me what it is like to be a mother at this point in your life?

3. Perimenopause is the term used to describe *going through menopause.* Can you tell me what it's been like to go through menopause?

4. What effect (if any) have any of these experiences had on your physical, psychological, emotional, or spiritual health?

5. What effect (if any), has your health had on your ability to mother your child (children)?

6. What advice would you give to a very good friend who asks you if she should have a baby at 40 or older?

Appendix G

INFORMED CONSENT FOR PARTICIPATION IN STUDY

This is a study of the experiences of midlife women who are going through menopause while mothering young children.

The purpose of this study is to understand what it is like for women to experience two life transitions at the same time: mothering and menopause. You have been invited to participate in this study because you delivered or adopted your first baby at age 40 or older; you are mothering a child age 12 or younger; and have identified yourself as someone who is experiencing symptoms of perimenopause. You are in a unique situation, and I believe there is a need to hear the stories of women like yourself who are willing to reveal what it is like to be a midlife mother.

Please read through the following information before signing:

You will be interviewed by the researcher, Patricia Morgan for approximately 1 hour, at a time and place mutually convenient to yourself and the researcher. In order to fully capture your experiences and views about going through the menopause and mothering young children, this might require more than one meeting. You may withdraw your consent to participate at any time. The researcher will maintain confidentiality of your identity.

The personal nature of the topic and the sharing of information with the researcher may trigger some discomfort for you. You will be responsible for any costs associated with future counseling or medical care. There is no direct benefit to you from participating in this study, and there is no compensation being offered for your participation. Your decision to participate in this study is completely voluntary. It is your responsibility to decide how much or how little of your experience to share with the researcher. Participation in this study is in no way connected to your health care by your provider. In fact your provider will not be aware of your decision to participate or not.

You will be asked to agree to have the interviews audio-taped. Data and audiotapes will be stored in a locked drawer in the researcher's home office during the research phase. The tapes will be destroyed 5 years after conclusion of the project. Written data and reports, which will be anonymized, will be retained by the researcher, possibly for future use in another study. All future references to data obtained from this research will be presented anonymously. The researcher plans to use information gathered from this study in her dissertation submitted to The University of Wales, Swansea for fulfilment of the requirements for a PhD in Nursing.

The researcher intends to use data gathered from this study in future publications. Ethical approval for this study was obtained from The University of New England and University of Wales, Swansea. The researcher, Patricia Morgan will be guided in this research by Dr. Joy Merrell, her supervisor at The University of Wales, Swansea, and Dr. Dorothy Rentschler, her supervisor at East Carolina University.

1. I have received information that the University of New England Institutional Review Board for the Protection of Human Subjects has approved the use of human subjects in this project.

2. I have received an explanation of the scope, aims, and purposes of this research project, and the procedures to be followed.
3. I have received a description of any reasonable foreseeable risks or discomforts associated with participating in this research, have had them explained to me, and understand them.
4. The investigator seeks to maintain the confidentiality of all data and records associated with my participation in this research. All data and tapes will be stored at the researcher's home in a locked drawer. Only the researcher will have access to my original identity. A pseudonym will be substituted for my real name, and used to completely anonymize the data. The researcher's supervisors in this study will have access to the anonymized data only. Tapes will be kept for 5 years after completion of the project anticipated to end in 2008. At that time the tapes will be destroyed. The anonymized data will be retained by the researcher for possible future use in another study.
5. I understand that my consent to participate in this research is entirely voluntary, and that my refusal to participate will involve no prejudice, or penalty. I understand that my health care provider will have no knowledge of my decision to participate or not participate in this research.
6. I further understand that if I consent to participate, I may discontinue my participation at any time without prejudice, penalty, or loss of benefits to which I would otherwise be entitled.
7. I confirm that no coercion of any kind was used in seeking my participation in this research project.-
8. I understand that The University of New England, The University of Wales, nor the researcher is responsible for the cost of any care required as a result of my participation in this study.
9. I understand that if I have any questions pertaining to the research including my rights as a research subject, I can call Patricia Morgan@207-221-4273 or Dr. Rentschler @ 252-328-5450, and be given the opportunity to discuss them.
10. I understand that I will not be provided financial incentive for my participation by the University of New England or the researcher.
11. I certify that I have read and fully understand the purpose of this research project and the risks it presents to me as stated above.

I,_____CONSENT/AGREE to participate in this research project.

Signature of Participant _____

Date_____

Appendix H

~~ne~~

8th March 04

Dear Patricia,

Ethical Approval: Women's Perceptions of their Health Through Life Transitions: Mothering Young Children During Perimenopause

Firstly, please accept my apologies for the length of time it has taken to respond to your application. As I think you are aware, there has been an internal re-organisation of the ethics framework within the School of Health Science and this has taken a little while.

I am please to say that we see no ethical objections to your study. The only question we would raise concerns the storage of the tape recordings of the interviews. You state that these will be destroyed on the completion of the study, but you do not define when this will be – when you have, been examined, or when you have graduated, or when you have published articles or a book etc. In our view it is good practice to preserve original data for a reasonable period after the research, as long as it is stored securely and that participants know how long it is to be stored for. This allows proper response to any challenges to your analysis once the work is in the public domain, and may allow secondary analysis of what will be valuable data in an under-researched area.

I would be grateful if you would clarify this point, but otherwise we would be happy to approve the study and wish you well with the research.

Yours sincerely,

Dr Paul Wainwright
Reader in Humanities and Health Care

Appendix I

Date: 5/18/04

To: Patricia Morgan

CC: Joy Merrell/Dorothy Rentschler-External, Faculty Sponsor

IRB#: 20040331MORGP

Status: Approved
Status Date: 5/18/04

Proposal Expiration Date: 5/18/05
Review Level: Expedited

Project Title: **Women's perceptions of their health through life transitions: Mothering young children during perimenopause (PhD dissertation)**

Submission Date: 3/31/04

The Institutional Review Board (IRB) for the protection of Human Subjects in Research has reviewed and approved the use of human subjects in the protocol for your study.

Approval for this study expires on the date indicated above. At the end of the approval period you will need to submit a project report with regards to the involvement of human subjects. If your project continues to be active at that time you may apply for an extension of the IRB approval.

Prior to implementation any changes in your protocol, you must submit them to the IRB for review and gain written, unconditional approval. If you experience any unusual or unanticipated results with the regards to the participation of human subjects, report such events to the IRB within one working day of the occurrence.

The IRB wishes you success with your project.

Nona Spear
Chair UNE Institutional Review Board

Appendix J

University of
NEW ENGLAND

To: Patricia Morgan

From: Ronald P. Morrison, Chair
Institutional Review Board

Date: 5/18/2005

Project Title: **Women's perceptions of their health through life transitions: Mothering young children during perimenopause (PhD dissertation)**

The Institutional Review Board (IRB) for the Protection of Human Subjects in Research has reviewed the materials you submitted in support of your request to renew IRB approval of the use of human subjects in the protocol for your study. Approval has been renewed.

Approval for this study expires on the date indicated below. At the end of the approval period you will need to submit a project report summarizing the involvement of human subjects. If your project will continue to be active beyond the expiration date, you must apply for an extension of the IRB's approval one month prior to the expiration date.

Prior to implementing any changes in your protocol, you must submit them to the IRB for review and gain written, unconditional approval. If you experience any unusual or unanticipated results of consequence to the human subjects in your research, you must report such events to the IRB within one working day of the occurrence.

The IRB wishes you success with your project.

IRB#: 20040331MORGP
Submission Date: 3/31/2004
Review Level: Expedited
Status: Approval Renewed
Status Date: 5/18/2005
Proposal Expiration Date: 5/17/2006

Hills Beach Road, Biddeford, Maine 04005-9599
Phone 207 283-0171 • Fax 207 294-5125

716 Stevens Avenue, Portland, Maine 04103-2607
Phone 207 797-7951 • Fax 207 797-7953

Appendix K

Dear Pat,

I am delighted to inform you that the SHS research ethics committee approves the change to your sampling protocol.

Could you possibly send me a copy of the approval from the Ethics Committee at New England so this can be stored with your application? Thanks in advance

Regards,
Steve

(Prof) S.D.Edwards
On behalf of SHS REC

Appendix L

To: Morgan, Patricia

From: Nona Spear, Chair
InstitutionalReview
Board

Date:
10/10/05

Project Title: Women's perceptions of their health through life transitions: Mothering young children during perimenopause (PhD dissertation)

The Institutional Review Board (IRB) for the Protection of Human Subjects in Research has reviewed and approved your request for modification to the protocol for your study.

Approval for this study expires on the date indicated below. At the end of the approval period you will need to submit a project report summarizing the involvement of human
subjects. If your project will continue to be active beyond the expiration date, you must apply for an extension of the IRB's approval one month prior to the expiration date.

Prior to implementing any changes in your protocol, you must submit them to the IRB for review and gain written, unconditional approval. If you experience any unusual or unanticipated results of consequence to the human subjects in your research, you must report such events to the IRB within one working day of the occurrence.

The IRB wishes you success with your
project.

IRB#:20040331MO
RGP Submission
Date: 3/31/04
Review Level: Expedited
Status: Approved
Status Date: 5/18/04
Proposal Expiration Date:
5/17/06

Appendix M

Personal Data Survey

1. Date of Birth_____ Age now_____
2. Age at first delivery_____

3. Last Menstrual Period_____

4. Age when perimenopausal symptoms started_____

5. Which of the following symptoms have you experienced? (Circle letter)

    a. Changes in menstrual pattern or amount of bleeding
    b. Hot flashes
    c. Night sweats
    d. Headaches
    e. Dizziness
    f. Palpitations
    g. Mood changes
    h. Memory loss
    i. Decreased sexual desire
    j. Vaginal dryness
    k. Anxiety
    l. Sleep disturbance
    m. Urinary incontinence

6. Ages & genders of Children_____

7. Are you taking Oral contraceptives? _____
 if yes, circle one of the following:
 for contraception 1
 for hormone support 2

8. Are you currently taking Hormone Replacement?
 If "Yes", what are you taking ?

		Brand	Dose
Estrogen (oral)	1	_____	_____
Estrogen (patch)	2	_____	_____
Estrogen & Progesterone	3	_____	_____
Progesterone	4	_____	_____
Testosterone (ie Estratest)	5	_____	_____
Other	6	_____	
Not Sure	7		

9. How long have you been on hormones? Circle one

Less than 3 months	1	1-2 years	4
3-6 months	2	More than 2 years	5
6-12 months	3		

10.Ethnicity

White	1	Native American	4
African-American	2	Hispanic	5
Asian/pacific Islander	3	Other	6

11. Annual Family Income

Under $10,000	1	40,000-59,000	4
$10,000-20,000	2	60,000-79,000	5
$21,000-39,000	3	Over 80,000	6

12. Current Relationship Status:

Never married	1	Divorced	4
Married	2	Living Together	5
Separated	3	Widowed	6

13. Highest Education Level:

Eighth grade or less	1	Bachelor's Degree	4
High School/GED	2	Advanced Degree	5
Some College	3		

14. Present Occupation (s)_____

Stay at home mom	1
Work outside home part-time	2
Work outside home full-time	3

Appendix N

Examples of Initial Data Analysis

Transcript: Participant #5 Susan	Meaning Units
Susan: So, it's been a pretty rocky road raising her and I thought well if this happened when, I'd had her when I was 18; I don't know where I would be with this, ((laughs)) because you are a kid yourself. You just don't have the patience and the strength and the resources to devote to dealing with a disability that's so multifaceted. I feel fortunate that we are at a place in our lives that we can afford to have these professionals for her and that we are that much more experienced in life to know how to go about approaching things. There are a lot of advantages to that (Susan, I_1, p.4).	Perception is that she can deal better with the challenges of motherhood because she is 'older'. Advantages: age, money, life experience
Example #2 Susan: It's not the kind of experience that anybody wants to pass up. I think at age 40 you are so much more capable emotionally of handling a child. You have so much more to offer based on what you've been through in life that you're much more capable of being a better parent that you are at 20 or 25 even, but not to say there aren't good parents at that age, but they have to offer... their experience up until then, and you have to offer your experience up til 40. There are advantages and disadvantages (Susan, I_1, p.12).	Older mothers are more capable emotionally of handling a child. Older mothers have more to offer, and are capable of being better parent because of more life experience. There are advantages and disadvantages to having a child after 40
Example #3 Susan: You start thinking about death more. You start thinking about leaving your child behind because you are more vulnerable than you were 15 or 20 years ago to disease. You are more vulnerable to keeping ..... so your body doesn't get run down you are constantly struggling to stay fit, stay healthy, and stay at that level so you can be a better parent (Susan, I_2, p.19).	As older parent, she is facing own mortality Her body is changing Thinking about death more, and having to leave your child behind

Transcript: Participant #9 Monique I #2	Meaning Units
Monique: I find that most of the mothers my age, the mothers I've met who are my age are either stay at homes or they are professionals who have seriously cut back, and that is the second thing they do maybe part time. One woman is a lawyer, and she does it one day a week. She had two girls back to back, and that's her life, so the others stay at home. I don't think I really connect with anybody. I really haven't had the time (Monique, I_2, p.26).	She feels disconnected from mothers her own age because they stay home with child or work part time. She doesn't feel connected with anyone.
Pat: So if you had the choice and from what I've heard – to see if I'm right about what I've heard, you really don't want to stay at home. Monique: No, No. I can't.	Implies that what she does at work is more important and gratifying than mothering
Pat: You really like working and like that stimulation. Monique: Yeah, yeah. I couldn't be home cleaning all day and arranging play dates. I couldn't do that.	
Pat: You're feeling that you've go to find a balance here somehow, but you really want to pursue your career. OK- that's what I thought I heard (Monique, I_2, p.26).	She confirms that I have got it right.
Monique: When I think about that (not feeling fulfilled) I feel kind of bad, because one woman was single, and she was miserable until she adopted her child, and now the whole world revolves around her, but she's so happy to be a mother, that the rest is not really that important. I think oh my God to find that peace, I don't know, for me I can't be there, you know. I mean I love her dearly, but mother be all, I mean I can't, that can't be all for me. Pat: You want both, yeah, I see it as you want both (Monique, I_2, p.33).	She feels bad because motherhood doesn't fulfill her.

Transcripts: Participant #11 Peggy Interview #2	Meaning Units
Pat: Can you share your views about menopause?	
Peg: I'm scared ((laughs)), I don't want to do it. Well part of... I'm hopeful that it won't be too bad for me. ((short laugh) But I am, I'm really nervous about it, because I do feel like, my life is somewhat complicated, and to throw into that all this stuff that's supposedly going to be affecting me and my emotions and my health. You know, I'm hoping that I can deal with it ok and handle it alright. I'm concerned about that (Peggy, I_2, p.20).	She is scared and nervous about menopause.
Peg: I also get <u>mad</u> because it's not fair...I mean we have to go through all the... having your period, menstruating and all that, then you have to go through having a child, being pregnant and all that, and now we have to do this?! So part of it, you know I'm mad about it too (Peggy, I_2, p.21).	Mad that women have to "go through" menopause.
Peg:I also have concerns, like I don't know enough about it yet to look into, I know some people do their replacement hormone therapy and all that, so there's a lot of decisions and things to be made. My life right now, is you know I've had this toothache for at least 3 weeks, and I can't call the dentist yet because I don't feel like I can squeeze in a time to <u>go to the dentist</u>!	Lack of knowledge
Peg: So yeah I do have concerns about it's going to affect my ability to do what I do, as a working person and as a mother and a wife at home, you know, I hope I can do it all (Peggy, I_2, p.21).	Uncertain if menopause will affect her ability to do what she does.

Appendix O

Examples of Revised Data Analysis with Feedback from Committee

Susan: So, it's been a pretty rocky road raising her and I thought well if this happened when, I'd had her when I was 18; I don't know where I would be with this, ((laughs)) because you are a kid yourself. You just don't have the patience and the strength and the resources to devote to dealing with a disability that's so multifaceted. I feel fortunate that we are at a place in our lives that we can afford to have these professionals for her and that we are that much more experienced in life to know how to go about approaching things. There are a lot of advantages to that (Susan, I_1 p.4).

My analysis: Her perception of mothering is that it's been a 'rocky road' in context of daughter's problems. Perception is that she can deal better with the challenges of motherhood because she is 'older'. Advantages: age, money, life experiences.

Supervisor #1 feedback: More life experience is an advantage; has resources to cope with a disable child.

Example #2

Susan: It's not the kind of experience that anybody wants to pass up. I think at age 40 you are so much more capable emotionally of handling a child. You have so much more to offer based on what you've been through in life that you're much more capable of being a better parent that you are at 20 or 25 even, but not to say there aren't good parents at that age, but they have to offer... their experience up until then, and you have to offer your experience up til 40. There are advantages and disadvantages (Susan, I_1, p.12).

My analysis: Older mothers are more capable emotionally of handling a child. They have more to offer, and are capable of being better parent because they have more life experience.

Supervisor #1 Some of this conflicts with other things she says. What is the reality? Is perception that whatever age a woman has a child is the best age?

Supervisor #2 Yes- she agrees that there are advantages and disadvantages. Her (Susan's) subjective perspective is that older mothers are more capable emotionally; how does one know that?? She contradicts herself in this section.

Example #3 Susan: You start thinking about death more. You start thinking about leaving your child behind because you are more vulnerable than you were 15 or 20 years ago to disease. You are more vulnerable to keeping ..... so your body doesn't get run down you are constantly struggling to stay fit, stay healthy, and stay at that level so you can be a better parent (Susan, I_2, p.19).

My analysis: Thinking about death more, and having to leave child behind. Feels more vulnerable to disease

Supervisor #1: Increased awareness of own mortality

Supervisor #2: Fear of dying

Appendix P

Example of Data Analysis: Organizing Data From Each Set of Transcripts Under Possible Themes and Categories

Transcripts: #5 Susan, File Categories and Themes

Possible Theme 'UNCERTAINTY'

Category B. UNCERTAIN TRANSITION TO MENOPAUSE

I. UNFAMILIAR WITH TRANSITION TO MENOPAUSE

I have not gone through menopause yet. I am 51 going to be 52 in September and I probably started experiencing some symptoms I would say 5 years ago, and it wasn't until recently that I realised what they were. I've had a lot of anxiety attacks, and I'm not sure if they are as much related to menopause as they are to [daughter's] situation with her disability. It's probably both, but I've also had borderline high blood pressure too, so now those are the issues I am dealing with (Susan, I_1, p. 4)

Analysis: Supervisor #1- lack of awareness of symptoms; consistent with literature

I haven't missed any periods yet. I think menopause comes late in my family. When I ask try to ask my mother she says I really don't know (Susan, I_1, p.6).

Analysis: Pat- seeks mother's perspective

I think anything that can be done to prepare you for menopause would be good because I don't think there is anything that prepares you right now. Not that I've seen. Maybe there are some doctors' offices that do, but I don't even think, I mean there are so very few books out there on what to expect. Of course, when you're pregnant, you're wanting to read as much as you can because you are so excited about having a baby. You don't feel that excitement about menopause so you're not running out there trying to find every book you can about menopause because you're so excited about it. You only turn to books on menopause when you are having symptoms, and you start thinking okay something is happening to me. Could it be menopause? You don't have the same enthusiasm for it, so I think the more that the doctors' offices talk to you about it, the more... and support groups would be great too (Susan, I_2, p.37).

Analysis: Pat- Menopause isn't as exciting as pregnancy so women are not trying to find books about it until symptomatic

Analysis: Supervisor #1-These women definitely were experiencing symptoms of perimenopause which literature supports, while parenting young children.

Appendix Q

Example of a Sample Worksheet used to Organise Data according to Categories and Possible Themes (Note: this was not the final interpretation)

PARTICIPANT #

Theme # 1 UNCERTAINTY
- A. Uncertainty about Pregnancy & Motherhood
- B. Uncertain Transition to Menopause
  - I. Unfamiliar with symptoms
  - II. Experiencing perimenopause
  - III. Perceptions of Menopause
- C. Uncertainty about the Future

Theme # 2 INTENSE MOTHERING
- A. CHALLENGES
  - I.Transitions
  - II. Being an older mother
- B. Stress
- C. Meeting Own Needs
- D. Perceptions of Motherhood
- E. Mothering differently from own mother
- F. Effect of Health on Mothering
- G. Social and Cultural context for Mothering in the 21st century
- H. Advantages of being older mom
- I. Joys
- J. Vigilance
- K. Guilt

THEME # 3 LACK OF SUPPORT
- A. Out of Sync
  - i. Lack of Support from aging parents
- B. Seeking Support from other mothers
- C. Lack of support from partner

Appendix R

Example of a Participant Summary

July 30, 2008 This process facilitated bringing main meaning units together into possible categories which led to eventual theme formation. This also facilitated comparison of data across the sample and collaborative analysis process with committee.

REVISED SUMMARY ON PARTICIPANT # 5 SUSAN

Referred by a friend. Initial contact by phone from me to her, letter sent. Cooling off period respected. First interview March 31,2005 1.25 hours. Second interview May 9,2005 1 hour. Age 51 at time of interview. Married @37. Her second marriage, Husband's second marriage and he had 3 children. He was 46 at time of this birth. She was 40 at birth. Daughter age 10. Identifies 5 perimenopausal symptoms. White married female living with husband. Has step-children who are older (20s)Income >$80,000. College Graduate. Susan expressed uncertainty about having a child with this husband, but as she approached age 40 felt it was "last call". Conceived easily. Child always was difficult, and teachers suggested testing her in grade 1 (6 years old). Experienced perimenopausal symptoms x 5 years before recognizing what they were. She felt she has had little preparation for menopause and like many of the other mothers, her own mother was not helpful with information. She has sought professional help for symptoms, both traditional and non traditional. Her primary symptom is panic attacks, and "feeling loss of control". Questions whether she will take Hormone Therapy and just keep periods going in order to feel good. She is motivated to stay fit and healthy to "last longer" and be around for her daughter. Susan thinks about her own mortality more, and feels increased vulnerability to disease. She is looking for deeper meaning and quality of time in relationships. Feels motherhood is a "don't miss" experience. She wants to be a different mother than her mother. One of her prime focus during the interview was describing the challenges of mothering a child with a disability "Aspergers"- feels this has become her "calling and career". She has no social support, is lonely, with a "very thin network".

THEME # 1 UNCERTAINTY

A. UNCERTAINTY ABOUT PREGNANCY & MOTHERHOOD

- Uncertainty about conception, whether to have a child
- Uncertainty about outcome due to high risk status
- Last call
- Uncertainty about child's health & diagnosis

B. UNCERTAIN TRANSITION TO MENOPAUSE

I. UNFAMILIAR WITH TRANSITION TO MENOPAUSE

- Uncertainty about symptoms, how she will address these
  ((these women definitely were experiencing symptoms of perimenopause which literature supports, while parenting young children.))
- Uncertain what her mother or family experience has been with menopause

- "I'm not sure"

II. EXPERIENCING SYMPTOMS

- Seeks help with symptoms: traditional and nontraditional.
- There still has to be something to help those things
- Primary symptom panic attacks. Loss of control with panic attacks. Other: weight issues, body composition changing. Heart palpitations, dizziness
- Lack of control over body/symptoms, not in control of situation, lost control of self, baby controlling you
- Fears loss of control
- For menopause, there is nothing

III. PERCEPTIONS OF MENOPAUSE

- It might be better to keep periods going
- Menopause is not just one thing. Looking at it holistically.
- I think public opinion is still pretty negative
- I think it is an incredible emotional experience to go through the changes that your body goes through. ((Guilt fear and struggle intertwined))((yet this contradicts what she says in first paragraph of this section))
- I think it brings you closer in touch to yourself ((a time of introspection))

C. UNCERTAINTY ABOUT THE FUTURE

I. MOTIVATED TO STAY HEALTHY: "Last Longer" Being Around, Stay Around

- Motivator/incentive to maintain health for sake of the child- as well as her own sake
- Motivated to stay fit & healthy. Important to her perception of being a better parent. ((Consistent with other interviews)) "last longer"
- "I have to be around"
- "I have to stay healthy"

II VULNERABILITY

- Uncertainty about the future. Looking for a greater meaning in the experience.
- Facing mortality
- Increased awareness of own mortality
- Thinking about death more, and having to leave child behind.
- Feels more vulnerable to disease
- Fear of dying, experiences losses
- Looking for quality of time since quantity may be less than younger mother
- Interesting concept of vulnerability and wanting deeper relationships with family members-notion of making the most of time available
- She attributes wanting deeper more meaningful relationships with child to less focus on herself and recognition of importance of meaningful relationships. Sense of increased vulnerability to injury, disease, death. Time with child is

precious. Unknown factor of mom's life expectancy. Maybe she will have less time with her child than a younger mother?((Interesting perspective))

THEME # 2 INTENSE MOTHERING

A. CHALLENGES

i. Transition to motherhood

- Realization that life is changed forever by baby.((Despite husband's warnings, she didn't realize how a baby would change her life)) ((accepting change; do they go into it with eyes wide open or because it is their last chance?))
- Most difficult job in the world, but wouldn't have missed it for anything. ((transformation, this changed her life. No one- nothing can prepare one for experience of parenthood))
- It's tough
- Infant didn't sleep, parents didn't sleep
- Demands of motherhood felt immediately. Daughter was labeled from beginning)) Check Reva Rubin's Theory.
- Defends her choice to not work outside the home. Expectations of society- doesn't value 'stay at home mothers'.
- Low energy makes it difficult to keep up with the schedule with mothering responsibilities))
- Hints at relationship issues here. Going separate ways because of demands of mothering

ii. Being an older mother

- Her perception is that older mothers have bigger and more complicated lives which makes mothering more difficult
- Don't miss this experience
- Body changing and can't do things used to do
- Being old when children are still young
- More vulnerable to disease
- Increased awareness of own mortality
- Thinking about death more and leaving child behind
- Looking for quality of time since quantity may be less than younger mother Interesting concept of vulnerability and wanting deeper relationships with family members-notion of making the most of time available))((She attributes wanting deeper more meaningful relationships with child to less focus on herself and recognition of importance of meaningful relationships. Sense of increased vulnerability to injury, disease, death. Time with child is precious. Unknown factor of mom's life expectancy. Maybe she will have less time with her child than a younger mother?))((Interesting perspective))
- Less energy than 10 years ago
- Older moms already have the house and career
- Having a child may make career impossible to do
- Her perception is that it's been a "rocky road" in context of daughter's problems, but that her age, and social financial position are an advantage over being a younger mother.

iii. Mothering a child with disability

- Daughter's disability has become mom's mission her career
- Her perception is that it's been a "rocky road" in context of daughter's problems, but that her age, and social financial position are an advantage over being a younger mother.
  ((Her experience is compounded by having a disabled child, so her time is extensively taken up with researching info, finding services and resources for her child which is probably no different from other parents with disabled children, except that she has the resources to do this-financial and intellectual))
  Does the older mother take more time to read about this?
- Her reward is improving daughter's life.
- This is her "calling"
  ((Had disabled child last- child needs a lot of time and attention, yet other children at college possibly more challenging if step children had been younger))
- no respite

C. MEETING OWN NEEDS

- Needing to spend more time on self adds to stress of the day
- Spending time she can not afford on fighting aging

D. Perceptions of Motherhood

- Most difficult job in the world, but wouldn't have missed it for anything.
- Her perception is that every woman wants to be a different mother than their own mother was.
- You want to cover the bases that she didn't, but sometimes you end up neglecting what they covered.
- Similarity: my children are very important to me
- Different: My children aren't my everything either.
- Mother's priorities were kids and religion, relationship with God. Husband less important
- My relationship with husband was very important, ((I))would have been complete without a child.
  ((Beliefs about motherhood have changed. Now that she has a child- wouldn't go backwards. Used to think she would be fine without a child
- My life is broader than my mother's and in some ways it hinders parenting because you are involved in too much. Helps parenting because you can give your kids so much different perspective.
  Her perception is that her life is so different as a mother than her mothers was))((Is this her perception or reality?))

E. MOTHERING DIFFERENTLY FROM HER OWN MOTHER

- ((She wants to give to her child what she didn't have growing up))
- Her perception is that every woman wants to be a different mother than their own mother was.
- You want to cover the bases that she didn't. but sometimes you end up neglecting what they covered.
- Similarity: my children are very important to me
- Different: My children aren't my everything either.
- Mother's priorities were kids and religion, relationship with God. Husband less important
- My relationship with husband was very important, ((I))would have been complete without a child.
  Beliefs about motherhood have changed. Now that she has a child- wouldn't go backwards. Used to think she would be fine without a child
- My life is broader than my mother's and in some ways it hinders parenting because you are involved in too much. Helps parenting because you can give your kids so much different perspective.
  Her perception is that her life is so different as a mother than her mothers was))((Is this her perception or reality?))

F. EFFECT OF HEALTH ON MOTHERING

- Perception is that her menopause experience must affect how she mothers, but can't identify how.
- Trying not to relay message that she is "sick"
  ((affect on mothering seems to be self-limiting and linked closely to severity of symptoms. Validates other women's statements that 'insignificant things' upset her.))
- Husband's perception is that she has less patience because she is older mother

G. SOCIAL/CULTURAL CONTEXT

- Different: My children aren't my everything either.
- Mother's priorities were kids and religion, relationship with God. Husband less important
- My relationship with husband was very important, ((I))would have been complete without a child.
  ((Beliefs about motherhood (being childless) have changed. Now that she has a child- wouldn't go backwards. Used to think she would be fine without a child))
- My life is broader than my mother's and in some ways it hinders parenting because you are involved in too much. Helps parenting because you can give your kids so much different perspective.
  Her perception is that her life is so different as a mother than her mothers was ((Is this her perception or reality?))

H. ADVANTAGES OF BEING OLDER

- more life experience is an advantage
- has resources to cope with a disable child

- Her perception of mothering is that it's been a 'rocky road' in context of daughter's problems. Perception is that she can deal better with the challenges of motherhood because she is 'older'.
- Advantages: age, money, life experiences.
  ((yes advantages & disadvantages))((some of this conflicts with other things she says. What is the reality? Is perception that whatever age a woman has a child is the best age?
- Her subjective perspective is that older mothers are more capable emotionally; ((how does one know that?? She contradicts herself in this section questioning whether disability is linked to maternal age))

J. VIGILANCE

- She supports idea that older mothers are more vigilant.
- Her perception is that younger parents don't 'care' about the same risks. ((This is consistent with comments from other interviews.))((Interesting perception)) ((could be tied in with the idea of 'premium children'- these older mothers can't replace a child as readily as a younger mother??))

THEME # 3 LACK OF SUPPORT

A. OUT OF SYNC

- She didn't even get help from her older stepchildren.
- Perceived loss of freedom;
  ((conflict of role expectations or societal norms))
- She left work after marriage for a more traditional role- spending more time with husband. Having a child made that more difficult- not spending as much time with him affects marital relationship
- Child altered relationship with husband
- Doesn't have same network of support as younger mothers
- She "has no one"
- She confirms that she also feels out of sync with friends and doesn't feel comfortable asking them to care for daughter
- No support, lonely job of mothering
- Thin support network: parents older, friends kids older, lonely

B. SEEKING SUPPORT FROM OTHER MOTHERS

- Confirms other mother's statements that it is difficult to make friends or form a network at school with younger parents
- Value of self help groups
- Comfort in talking to other mothers. Hospitals and churches could do more. Feeling connected over a common bond is invaluable
- Need to connect with others who shared similar problem with daughter/child
- Support networks; need for connection
  ((Sees school as source of support. Does she expect doctors to provide the help she is looking for? Interesting women often talk to other women about most intimate things-maybe just does not know the other women very well))

TRANSITIONS & TURNING POINTS

- 30- divorced
- 37 married and acquired stepfamily
- 40 pregnant (had remarried)
- 50- husband retiring
- challenge of step parenting teenage children
- When daughter was 3 years old trying to juggle things in her life

ADAPTATIONS

1. Life with stepfamily. It wasn't about me anymore, but it couldn't revolve totally around them either. "Parenting" Nothing prepares you for parenting
2. Deciding whether to have a child together.
3. Parenting changes your life forever. Realization dawns that life is changed forever.
4. Loss of control after having been accomplished and competent in other areas of your life. Feeling clueless and helpless as parent. Feeling inept.
5. Trying different approaches, functioning without sleep or less sleep
6. Finding survival methods. Adaptation is about survival.

Appendix S

Sample of Development of Themes with Supporting Categories & Data

In my computer file, this list was followed by the analysed transcripts which supported these Meaning Units and this Category. This computer folder contains Meaning Units and Data (transcripts) for all 13 women that I felt represented a lack of preparation for menopause and the other categories which ultimately comprised the *"It Just Didn't Happen": Lack of Support From Credible Sources and Perimenopause as a State of Uncertainty Theme.*

Theme: UNCERTAIN TRANSITION TO MENOPAUSE

Participant: ROXANNE

Category: LACK OF PREPARATION FOR MENOPAUSE

Meaning Units:

- To know it will end
- More information about time frame.
- Variety of symptoms
- Thought she had something else
- There must be something wrong with me!
- This is physical and not emotional
- I'm not angry at the world or my kids or my situation
- Wants more dialogue with women
- More one-on-one dialogue with women about their experiences
- It's like coming out of a depression
- "There's a light there now…"
- Can't relate it to anything I've ever been through before, but I do feel so much better.
- (Let's) not let it be this deep secret that we're going through quietly by ourselves.
- Felt dismissed by doctor
- Needed more support and assessment
- Discuss study findings to help understanding
- Knowledge of menopausal process would have helped her cope
- Provide anticipatory guidance
- Negative associations with menopause prevent people from talking about it
- The actual diagnosis of menopause or not menopause isn't what is important. It's feeling supported with what is happening and knowing it won't last forever.
- "Out the door on your own"
- What are the options
- Needs validation

Appendix T

Samples from Reflexive Journal

September 15, 2004 Journal Entry

I was very excited when the first woman called me. Unfortunately, she did not meet criteria for participation. Her response was very positive and encouraging, and my spirit was renewed that this was a meaningful study. I felt sad that I could not include this woman who was so eager to share her story with me. The next woman who called did qualify and now I was really excited! When I told her we couldn't meet for two weeks she laughed and asked " why- so I can grow older?"

Five more women have contacted me. One of these women emailed me and feels like this is a very good study- "more information is needed". I am faced with a decision of who to include and exclude. It seems to be splitting hairs to exclude women who were almost 40 at delivery- if they are symptomatic and mothering young children. I want to include them. I would like to back off the age requirement to 35 which is when the 'experts' consider them to be 'high-risk' physically and call them 'elderly'. Then if a woman is perimenopausal and 40- something with a young child I can include them. I am interviewing participant #1 today.

September 15, 2004 Reflexive Journal Participant #1 Roxanne 1.5 hours

Sunny cool day. I interview this participant at her home on. It was a beautiful home, nice furniture, and nicely decorated. Roxanne sat on one couch and I was on the other couch. She curled up with a blanket over her legs. She made continuous eye contact, seemed relaxed, but became teary several times when speaking about mood swings. "Someone should warn you about this". Teary at end when speaking about mood swings. "It isn't fair to the children." Later off tape, she said she kept a journal during these years, and remembers a really bad day when she had to lock the kids in their room and call her husband home. Session lasted 1.5 hours. She agreed to meet again in 2 weeks. We hugged at end of meeting. (She never did share her journal with me)

Today's interview went well. I recognized her from (name of place) and she me. I reassured her that her participation and everything she said would be confidential and anonymous. She chose Roxanne as her pseudonym. As her story unfolded, I felt reassured that this was a vital study and sharing results will be beneficial to women and professionals. I probably nodded my head too often. I meant it as a sign that she should continue to speak, but there were times that I agreed with what she was saying. For instance- she was talking about feeling mean, and that she is not a mean person. I was reminded of an interaction with my oldest son a few years ago when he told me I was "always in a bad mood". I did not think of myself as frequently in a bad mood. I could understand what she said about needing sleep or feeling irritable.

At the end of the interview I asked her to think about what she had shared, and what meaning they hold in her life. We discussed her concept of 1. "going over to the other side"- giving up- as she referred to her cousin getting old
2. mood swings

3. getting her needs met
4. body image
5. journal entries a. bad day, b. good day & c. average day. How did she feel? How did kids respond??

I need to go back to ethics committee for permission to use journals, poetry, art work... as data. Then, ask Roxanne to give me a sample of a bad day, good day and average day of mothering.

I have read *The Study of Life History: Gandi by David G. Mandelbaum (1973).* I like the 3 procedural suggestions he makes for developing a frame of reference for life histories. I think there is some application here that I can use during the second interview with these women. 1. Dimensions 2. Turnings and 3. Adaptations may be useful in the collection and analysis of data for my study. These women all share the same 'Dimension' of midlife mothering while experiencing menopausal symptoms. Asking them about 'turnings or major transitions' may help them delve deeper into the meaning of their experiences as midlife mothers. Mandelbaum states that 'Adaptation' is a built-in-process, in that each person must alter established patterns of behavior to cope with new conditions. I will try it and see what happens.

10/5/04 Doctoral Meeting with Dr. Rentschler & Professor Merrell at UNH

- The aims of this study point to a qualitative study.
- All decisions so far are supported
- Discussed an audit trail; Field work relationships from journals will be included in methods chapter
- Do data survey at end of interview; send copy of demographic sheet to IRB
- Discussed using "The Spike" F3 or F5 key on computer to find extracts in text
- When writing up analysis and findings, use:
    - 4 out of 5 women
    - Most women
    - The majority of women
    - The readers need to know that the findings came from a range of women

We reviewed preliminary analysis of interview #1 & 2 with Roxanne

Journal Entry: October 20, 2004 Interview with Participant # 2 Shanny

It was a beautiful, clear sunny day. This participant drove to meet me, approximately 1 hour. She has relatives in the area. She is very friendly with outgoing personality. We met downstairs in my church office building. There were no interruptions, but we could hear noises upstairs for the first half hour. Consent form signed and she chose pseudonymn. She verbalized permission to use actual name (but I did not use it). "I'm willing to share any of this."

She was a very talkative participant. I explained what was expected: first session purpose is to hear her story from conception to present time. I will ask some broad open ended questions, but will talk very little. She talked very fast and gave examples to clarify her points. She made eye contact but sometimes she looked off to the side

while talking. I felt at these times that she wasn't particularly speaking to me. She became teary at times.

I didn't have to ask many more questions- actually only one toward the end. She was very thorough and covered every topic on my list as if she was reading my mind. At the end I thanked her for coming and sharing her story; also for being so honest. She said " I feel good. Someone wanted to hear my story." She is willing to meet again and drive to see me. I offered to drive to her town but she said no- she wanted to come. She also asked me if I was writing a book. She said I should- it would be a best seller.

Journal Entry: November 2, 2004 Interview with Participant #3 Rosie

Rosie offered me coffee and she made muffins. We sat at the dining table near the kitchen, across from each other. She started talking immediately, before I even started asking questions. Her 6 year old daughter was home from school because it was election-day. The daughter came out shyly to say hello and intermittently she came out for something to eat, among other requests. Rosie put her in the family room to watch a movie.

I had a feeling during the interview that Rosie was 'holding back', perhaps because her daughter was around. She would at times look around her to see if her daughter was listening. Rosie overall was less spontaneous than the first two participants, and needed more prompting with questions. Rosie had a hysterectomy which put her into immediate menopause. She was not immediately put on hormone replacement, and states she went "mental".

At the conclusion of our first meeting, she commented to me that "this was good", and was willing to meet me again. I asked her to reflect on what she had told me, and gave her a few things to think more deeply about. We set a date for our next meeting. She reacted to the term 'subject' at the bottom of the consent form so I will change it to 'participant'.

Appendix U

Sample of Research Field Notes and Preparation for Second Interview

RESEARCH FIELD NOTES Roxanne- 9/15/04 1.5 HOURS

Sunny cool day. I interview this participant at her home. It was a beautiful home, nice furniture, and nicely decorated. Roxanne sat on one couch and I was on the other couch. She curled up with a blanket over her legs. She made continuous eye contact, seemed relaxed, but became teary several times when speaking about mood swings. "Someone should warn you about this". Teary at end when speaking about mood swings. "It isn't fair to the children." Later off tape, she said she kept a journal during these years, and remembers a really bad day when she had to lock the kids in their room and call her husband home. Session lasted 1.5 hours. She agreed to meet again in 2 weeks. We hugged at end of meeting.

Notes made during interview
She is not ready to be on the other side
Mothering keeps her young
Mood swings were her most disturbing symptom
If she can get her needs met (sleep), it is easier to meet kids needs
Harder to get back to sleep if interrupted
Body image decreased after delivery. Body doesn't snap back at older age.

Ideas or main points that emerged from first interview:

- The adoption was huge. (she was 47) "Everything that was going on with my life combined with mood swings was making it very difficult in the house. Menopausal symptoms made it difficult."
- I felt very bad for the kids. I told my doctor that
- PMS is one week out of the month, this was PMS all the time. Why am I so angry? I bled all the time. Everyday was impossible (period)
- Slightly easier to manage now. Night sweats- but they're not all the time. Last year on occasion, now stopped.
- I'm not a yeller. I wish people would prepare you.
- I'm embarrassed and ashamed that I was (like that)(crying) for 2 years, really really bad.
- Those were really really hard(those 2 years).
- I blamed it on (daughter) coming. The kids & stress.
- Things that would have rolled off my back would send me off the edge.
- I don't know anything about menopause
- Health: "Always incredibly health" Don't have any bad feelings about my health.
- I have 10 years to get through. It's made me realize: I don't have to get old!
- Cousin who had child young felt she was "done". "She's on the other side- I'm not ready to be on the other side" (old)
- My health is precious to me. Healthy lifestyle.
- Mood swings affect ability to mother children.
- Decreased sleep & decreased energy= decreased mothering abilities.
- Need for sleep.

- Life is in control before having children @ 40
- Changes from 40-45 huge!
- What did I do before kids? Be prepared to step it up.
- Self limited
- Decreased sex- drive is lower, kids are good excuse, his drive is normal
- Body Image- does a number to it. Breasts

Constructs to pursue at second interview: (after listening to tapes from first interview and reading transcripts)

- Ask her to reconstruct the details of a day when "everything going on in your life combined with your mood swings to make it difficult in the house"
- Explore the meaning of "not ready to be on the other side. Why is her cousin on the other side?"
- Explore body image
- "I'm embarrassed and ashamed that.....2 years really really bad...I felt very bad for the kids"
- Getting her needs met
- Anger
- In control before kids, how does she feel with kids?
- What have been kids responses to her mood swings?
- How could someone have prepared her for this experience?
- Meaning of mothering at this point in her life?
- Major Turning Points in her life? Major Transitions?
- Adjustments? Adaptations? Every person must alter some of her established patterns of behavior to cope with new conditions (survive) change your ways to maintain continuity.