Biographical 'Disruption' in First-time Mothers' Reflections on the Transition to Motherhood

by

Adrienne Elizabeth Bonfonti Treloar

B.A., Honours, University of Victoria, 2004

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

MASTER OF ARTS

in the Department of Sociology

Biographical 'Disruption' in First-time Mothers' Reflections on the Transition to Motherhood

by

Adrienne Elizabeth Bonfonti Treloar

B.A., Honours, University of Victoria, 2004

Supervisory Committee

Dr. Cecilia Benoit, Supervisor
(Department of Sociology)

Dr. Rachel Westfall, Departmental Committee Member
(Department of Sociology)

Dr. Elizabeth Banister, Committee Member
(School of Nursing)

Dr. Jane Milliken, Outside Member
(School of Nursing)

Supervisory Committee

Dr. Cecilia Benoit, Supervisor
(Department of Sociology)

Dr. Rachel Westfall, Departmental Committee Member
(Department of Sociology)

Dr. Elizabeth Banister, Committee Member
(School of Nursing)

Dr. Jane Milliken, Outside Member
(School of Nursing)

Abstract

The purpose of this thesis was to examine how first-time mothers' experiences during the transition into motherhood reflect biographical 'flows' or 'disruptions' when contextualized within their life course trajectories. I used a qualitative research design with narrative methods of data collection and analysis to explore participants' reproductive life courses. I collected data through in-depth and open-ended questions during face-to-face, retrospective, episodic narrative interviews with a purposive sample of 14 first-time mothers 12-17 months postpartum.

Data indicate that all of the first-time mothers experienced the transition to motherhood as a biographical disruption, but that different types of disruption were evident. The three typologies of disruption identified are: motherhood as a 'fresh start,' a prolonged limbo between life before and after motherhood, and achievement of womanhood or adulthood. Four sub-themes are also evident in the data: weight and body-image, sexual/maternal breast usage, 'advanced maternal age,' and social support provided by participants' mothers.

Table of Contents

List of Tables

Acknowledgements

I would like to thank the members of my thesis committee for their support and suggestions throughout the thesis process. I appreciate all the guidance they have offered along the way, and their genuine interest in my studies. In particular, I would like to thank Dr. Rachel Westfall for her encouragement and Dr. Cecilia Benoit for her guidance and unwavering support throughout my graduate studies.

Thank you to the members of my graduate studies cohort in the Department of Sociology, who have made the journey a friendly and memorable one. I would especially like to thank my 'thesis group': Emma, Annie and Vivian. These three women have provided soothing words during the most stressful times, been great editors, and have been there to celebrate small victories with me throughout the thesis process.

I would also like to thank those who made this research possible. First, I would like to thank the fourteen women who shared their life narratives with me. I appreciate their openness to sharing their personal thoughts and stories so that I could pursue my interest in new motherhood. Second, I would like to recognize the funding agencies (especially SSHRC, MSFHR and BCHRF), whose support has allowed me to focus on my studies full-time.

My family has earned a significant acknowledgement as well. I appreciate my parents, Jim and Bonnie Bonfonti, immensely. They have supported my education since before I could talk, and continue to encourage me in whatever endeavors I pursue. I also appreciate my sister Sabrina, who pushes me to think 'outside the box' and relates to me in a way that only big sisters can.

Last, but certainly not least, I would like to thank my husband, Russ. He has been by my side throughout my undergraduate and graduate studies, and always provided support and encouragement. He is a dutiful editor, willing to read preliminary drafts no matter how rough or long they are, and no matter how late into the night he receives them. He is also the most patient person I know, and is somehow always able to calm my mind and soothe my nerves, during even the most stressful stages of this process.

Dedication

To all girls struggling to define who they are as they grow and explore the world.

And to new mothers, who are embarking on a tireless but exciting new journey in life.

CHAPTER 1:

INTRODUCTION

Becoming a new mother is a reproductive event embedded in personal, social and cultural contexts. Current sociological studies focus on women's experiences during the period of pregnancy and immediate postpartum (Bailey, 1999; Bailey 2001; Miller, 2000; Miller, 2005). Few studies have examined the influence of pregnancy and first-time motherhood upon women's life paths and the potential health outcomes resulting from these events. In this thesis I present a socio-culturally oriented, longitudinal retrospective investigation of new motherhood in order to contribute to the sociological understanding of the experiences of new mothers, and their prenatal and postpartum health. A fuller understanding such as this could inform health care provision and policies, by suggesting why some first-time mothers have a smooth adjustment to motherhood and a high quality of life during the postpartum period, while others face greater struggle and turmoil.

This research is an extension of a recently completed longitudinal mixed-method study, *Social determinants of health and their impact on postpartum morbidity among midwifery, physician and obstetric clients in British Columbia,* (hereby referred to as the *PHS*[1]) (Benoit, Westfall & Carroll, 2004-06). In their study, Benoit, Westfall and Carroll investigate the social determinants of women's prenatal and postpartum health, and question why some new mothers are healthy, while others are not (see Appendix B on page 177 for more details). My research builds upon their investigation with an added qualitative fourth interview conducted with a sub-sample of the *PHS* participant population. While the thesis draws upon data collected in parent study to shed light on

[1] Acronym for Postpartum Health Study

participants' backgrounds and experiences of health and illness, the primary focus is on findings from analysis of the fourth interviews.

The central purpose of my study was to explore how first-time mothers experience new motherhood within the context of their reproductive biographical trajectories and past experiences. To facilitate this exploration I use a longitudinal life course approach within a cross-sectional research design and employ narrative methods of data collection and analysis. I draw upon the concepts of 'biographical flow' (Faircloth, Boylstein, Rittman, Young, & Gubrium, 2004) and 'biographical disruption' (Bury, 1982) to examine whether new motherhood prompts continuity and/or divergence within their existing life pathways. This research is based on the collection and analysis of narrative accounts of 14 first-time mothers in the Greater Victoria Census Area. I collected these accounts through face-to-face, open-ended, retrospective interviews at a single point in time, approximately 12-17 months postpartum.

The *exploratory* nature of this research suited the current lack of understanding of the influence of new motherhood on women's expectations and experiences for their lives. It also enabled participants to shape their own narratives, recognizing the diversity of their experiences and personal backgrounds. I have structured the research design to allow for flexibility, breadth of coverage and the emergence of unexpected phenomena (Palys, 2003, p.72-4). This research is also *relational* (Palys, 2003, p.72), since I consider linkages between themes within data presented. These linkages are derived both from participants' assertions about influences upon their lives and from my analytical observations.

The implications of this research are primarily theoretical, since I hope to make contributions to sociological knowledge of motherhood and women's experiences of becoming mothers, and suggest future areas for related research. I identify social influences upon first-time mothers' experiences and well-being, such as social norms and values, and informal social support. Moreover, by identifying social and cultural elements that appear to influence women's life course, either positively or negatively, I hope that this research may inform discussions about preventative health education for women during the prenatal and postpartum periods. Therefore, this research may also have practical implications for prenatal and postpartum practitioners by assisting in their identification of first-time mothers who are more likely to encounter personal difficulties.

This remainder of thesis is organized into six chapters. In *Chapter 2: Literature Review*, I discuss research and literature pertinent to understanding first-time motherhood for my sample. I describe the procedures I followed for participant sampling, data collection and data analysis in *Chapter 3: Research Design and Methodology*, as well as evaluate the strengths and limitations of these procedures. In *Chapter 4: Sample Characteristics*, I present select data from *PHS* in order to characterize the *PHS* population, first-time mothers within the *PHS* population, and the thesis sample. This chapter provides both an overview of the thesis sample and evaluates its representation of the *PHS* parent population. I present the results this thesis in *Chapter 5: Qualitative Results* lastly. This chapter is divided into two main parts: first, I discuss my findings of three typologies within women's experiences and I explore each of these in turn; second, I present key themes that pertain to all three of these typologies. In *Chapter 6: Discussion*, I situate my research findings within sociological literature concerning life

events, transitions and new motherhood. Last, in *Chapter 7: Summary and Conclusion*, I provide a general overview of the findings of my thesis and suggest possible applications of the data, its strengths and limitations, and future research that could further inform an understanding of first-time motherhood.

CHAPTER 2:

LITERATURE REVIEW

In this chapter I present social scientific research findings and literature regarding several conceptual foundations of this thesis. While there is a large body of social scientific research on the topics explored in this chapter, I focus on sub-sections of them that are pertinent to this thesis. In my investigation of the literature and thesis data I distinguish between life events (as single episodes or occurrences in one's life) and life transitions (a shift or movement from one personal or social space to another), but recognize that they oftentimes intersect.

This chapter includes thirteen sub-sections in which I examine key research and concepts central to the subsequent data analysis and discussion. First, I discuss a life course perspective and its current application within sociological literature. Then, I review current theories of the construction and reconstruction of biographies, identity and one's 'self' during the life course, and continue on to situate the transition to motherhood within such re/construction. Next, I examine literature concerning life events and transitions and their influence upon one's life course, biography and sense of self. I review how events and transitions have been theorized by social scientists, examine the strengths and limitations of their theoretical concepts, and discuss the application of these concepts to the study of new motherhood. I then combine sociological health research with studies focusing on new motherhood to explore the intersection of physical, personal and social elements within experiences of new motherhood. Next, I turn to a more thorough investigation of social scientific literature concerning new motherhood, including: the social construction of motherhood, experiences of motherhood in

contemporary North American society, the influence of body image upon pregnant women and new mothers, and the socio-cultural meanings embedded within breastfeeding experiences. Last, I discuss the application of the literature reviewed to this thesis, with particular attention to the life course perspective and theories regarding life events.

Understanding the Life Course

Biosocial events and transitions throughout the life course work to form a type of life course trajectory. This trajectory includes a person's life events and transitions as well as his/her subsequent experiences and responses to them. In this way, each individual has a life course trajectory unique to the objective content and subjective interpretations of that person's life experiences. Each event or stage in that trajectory can then influence its course and establish the context, resources and experiences that will inform the navigation of subsequent events, stage and transitions. From the longitudinal perspective of a life course approach, "various biological and social factors throughout life independently, cumulatively and interactively, influence health and disease" (Kuh & Hardy, 2002, p.5). This conceptual framework recognizes that social structures are embedded into actions, experiences and expectations of relationships and role norms, and thereby infringe upon individuals' life chances and choices (Halfon & Hochstein, 2002, p.3; Moen, Robison & Dempster-McClain, 1995, p.259). Thus, to better understand women's experiences and health during the transition to motherhood, researchers must recognize the intersection of multiple layers of personal and sociocultural influences, including those of past experiences. Framing health research conceptually within a life course approach provides a powerful tool to explore the interconnections between stages

of an individual's life course trajectory. Moreover, it is a useful way to understand how events and experiences in earlier life stages may influence one's health in later ones. Some researchers apply the life course approach over a larger time frame, while others employ it in a relatively short period of time.

The life course approach has been applied in a long-term time frame by sociological health researchers using qualitative methods as well as those using quantitative methods. Qualitative researchers, including Moen et al. (1995), usually place previous transitions and individuals' varied experiences of them at the forefront of investigation of later transitions, and study direct connections between the past and present. These authors argued that role transitions and their implications for a person's quality of life cannot be understood without knowledge of their previous life experiences and events (*Ibid.*, p.260). They found that social roles and social or material resources used during a past event helped an individual cope with a later situation (Moen et al., 1995), illustrating the significance of earlier experiences for later ones. In contrast to this qualitative application, quantitative health researchers commonly apply this longer term life course approach by looking for connections and correlations between events in the past (such as stressful life events) and more recent experiences of health and illness (see Bartley, Blane & Montgomery, 1997; Halfon & Hochstein, 2002). In their study of depression during the transition to parenthood, Matthey, Barnett, Ungerer and Waters (2000) tested the influence of participants' perception of the quality of parenting they received up to age 16 upon the presence of prenatal and/or postpartum depression experienced by new mothers and fathers' aged 17-45, and found correlations between parent-child relationships and mood among both new mothers and new fathers. Although

the approach to research design differs between qualitative and quantitative researchers, these examples all share a focus on the connection between an individual's past history (often adolescence and early adulthood) and their present health.

Other sociological health research emphasizes a more short-term life course perspective. In these cases, a transition is explored with primary attention given to the course of the transition itself (immediately before, during and a short time after) and secondary attention to life long events, contexts, and personal characteristics. This is most often applied in qualitative research, especially with narrative methodologies, whereby an individual discusses experiences and events before, during and after a transition even though their story is understood and analyzed with consideration for their individual character, life experiences and long term biography. This framework, has been used to study the onset of a chronic illness (Bury, 1982; Faircloth et al., 2004; Kralik, Koch & Eastwood, 2003) and, pertinent to my thesis topic, first-time motherhood (Bailey, 1999, 2001; Miller, 2000). As these researchers have shown, a life course perspective can be a powerful theoretical and analytical tool for understanding an event in a holistic and contextualized manner. As such, a longitudinal life course approach is well-suited for studying life events and transitions because it enables an exploration of the presence of continuity or change. This approach can also facilitate the exploration of impacts of events and transitions upon one's sense of self as it is shaped and then re-shaped in light of events and transitions along an individual's life trajectory.

The Construction and Re-construction of Biographies, Identity and the Self

Self and identity have been explored in many ways within sociological literature, ranging from the construction of self, relationship between self and identity, to

postmodern identity politics. Within sociological health research, some investigators have theorized the onset of chronic illness as facilitative of identity problems (Bury, 1982, 1991; Kralik et al., 2003), while others have focused on the relationship between self and identity and their construction in an individual's life. Concerning the onset of multiple sclerosis, Kralik et al. (2003) have demonstrated the scholarly benefit of distinguishing between self and identity to explore individuals' life transitions. Within their research, the 'self' is the "existential me," and the component that "reflects internal thinking of what it is 'being a person'" (Ibid., p.13-14). 'Identity,' in contrast, is "shaped by external or social interactions with others," and thus, becomes "the label imposed by others on the self, and is the public or knowable aspect of the person… Hence, identity is a dynamic process that evolves from an ongoing interaction between the individual and her (sic) social environment" (*Ibid.*). In other words, 'self' is an internal persona based on one's life experiences and negotiation with one's social world and multiple identities or components, whereas 'identity' is a social persona that includes multiple identities or components (identities of age, gender, ethnicity and many more) that contextualize and frame the self. The resulting 'self' or 'sense of self' is a product of one's negotiation with larger social ideas, norms, values, roles and labels. By separating the concepts of self and identity, one can also begin to recognize multiple identities, as well as explore how those identities may be interpreted, internalized or rejected in the construction of the self. These concepts enable one to differentiate the individual from the social, while still appreciating the relationship between the two. By understanding these concepts in this way, one can also identify when a life event or illness puts forth a new social identity that

conflicts with existing social identities, making it difficult to incorporate or negotiate within the existing 'self' (Kralik at el., 2003).

Sociological research by Corbin and Strauss (1987 in Carricaburu & Pierret, 1995) provides a similar way to break down a related theoretical concept: an individual's biography. These authors argued that a person's biography contains three basic components: conception of self, conception of body and biographical time. Considering these ideas about one's biography with respect to the above distinction between self and identity suggests that there may in fact be four components to biography: self, identity, body and life history. Thus, one's 'biography' encompasses multiple components of personal and social existence, forming a type of road map of an individual's life, including past and present experiences of self, identity and body, changes in each along the way, and major life events or road-markers throughout the life course.

Some of the major road markers that an individual experiences during their life include, among other things, physiological bodily changes and shifts in self or identity. Throughout one's life, a person's body may change for many reasons, including the onset of physical disability, and many such physical changes can be closely related to changes in identity. The onset of stroke, for example, may cause physical disabilities and/or disfigurement, and result in the public recognition and labeling of that individual as a 'stroke survivor' (Faircloth et al., 2004). One other pivotal point of transition between self, identity and body is first-time motherhood. During pregnancy, a woman's body changes dramatically and, in some cases, quite rapidly. These physical changes are observable by others within the woman's social environment and thus, she will usually incur the identities of a pregnant woman and of a mother; identities which then become

part of her social experiences and interactions. Both the changes to her body and her new or altered identities will likely affect her sense of self. Thus, pregnancy may present a physical, personal and/or social transition within a woman's biographical trajectory.

Theorizing Motherhood as a Biographical Transition

Lived experiences of major life events and transitions among individuals and social groups have been studied and theorized both by sociologists and social anthropologists. Childbirth is one of the key life events studied by both of these disciplines, among others, such as puberty and marriage. In her discussion of rights of passage, Anthropologist Kristin Norget (2000) noted that events such as childbirth are "crucial occasions marking critical points of transition in an individual's life" (p.88). Change to social positioning is, in fact, one of the rites that Sociologist Arnold Van Gennep (1960) labeled a *rites de passage* or 'rite of passage.' Using Van Gennep's terminology, Norget (2000) has argued that rites of passage "accomplish various kinds of transformations of status of members of any social group, moving them from one position in the social structure to another" (p.88). Van Gennep (1960) discerned three stages of a transition. First is the stage of separation, during which time an individual is symbolically or physically removed from their existing social context and/or social role(s). Second is a liminal period, during which the individual is symbolically situated outside the society and is subject to new or different rules and expectations of behaviour and movement, where customary societal rules may be suspended. During the final, postliminal phase, the individual is reintegrated into society with a new status and identity (Van Gennep 1960). These phases were initially used to study formal ceremonial rites and to understand the stages involved in ritual ceremonies associated with rites of

passage. However, Van Gennep's theorization of transition and its three component parts also offers a way to understand the transition into motherhood. Using this theoretical framework, there may be a distinct time during which a woman transitions into motherhood through a liminal phase when she is 'in between' life before and after motherhood, in a "'betwixt and between' period of limbo" (Turner, 1967 in Norget, 2000, p.89) or a "neutral zone between identities" (Carter, 2000, p.183).

Many life transitions may involve a rapid progression through Van Gennep's three stages, while others may be more drawn out, such as transition to motherhood. In addition to being socially groomed to become mothers from a young age in contemporary North America, some women may be actively socialized for their roles as mothers during pregnancy and the postpartum period through social interactions, whether formally, such as while attending prenatal and early parenting classes, or informally, when soliciting or receiving advice from others. However, some women may or may not begin to feel they are 'mothers' while pregnant, either because they are still becoming accustomed to the idea, or because there is not yet a child external to their body, to see and touch. In this way, there are conceptual parallels between the transition to motherhood and the liminal phase that Van Gennep (1960) described, roughly corresponding to life during pregnancy and the early postpartum period. Thus, during the liminal phase of this transition, rules and restrictions may include expectations about a pregnant woman's conduct, lifestyle and eating habits, and the suspension of customary rules or expectations may include being excused from physical labour, active employment/work and a slim physique. The post-liminal phase would then include a new personal identity and the social role of a mother, and the beginning of different expectations and norms accorded to this new role

and identity. While the liminal phase may abruptly give way to the post-liminal phase moments after childbirth, it also may linger into the early postpartum period but diminish as the woman re-integrates into society and incorporates her new identity and role as a 'mother' into her self-concept. The speed, ease and nature of the progression through these stages are not fixed, and could depend on many personal and social factors.

While not drawing directly upon the framework and three stages of transition that Van Gennep outlined, the results of some sociological research indicate that new motherhood may mirror its framework. This is especially evident in the work of Fox and Worts (1999), Matthey et al. (2000) and Byrd, Hyde, DeLamater, and Plant (1998). In Fox and Worts' (1999) investigation of the medicalization of childbirth among first-time mothers' birthing experiences, they theorized motherhood as "an important transition point" (p.326), and argued that "as a rite of passage for the woman…medicalized childbirth 'gives birth' to a mother…" (p.331). These researchers emphasized a relatively concentrated view of the transition to motherhood, located in the time and space of labour and delivery, and identified two major foci of this transition: the entrance of a child into the community, and "the beginning of a new role for the woman" (Ibid., p.331). They found that new mothers sometimes experienced "transient depression" and emotional volatility in the initial postpartum period as they emerged from the transition and reacted to their new role and responsibilities of becoming a mother (*Ibid.*, p.340). In an investigation of maternal and paternal postpartum depression among first-time parents, Matthey et al. (2000) argued that "[i]ncreased anxiety and depressed mood are to be expected during important life transitions" (p.76) and demonstrated that pregnancy and early parenting are two such transitions. Their results indicated a temporary decline in

depression between the prenatal period and six week postpartum period which gradually increased only to return to prenatal levels by 12 months postpartum. Byrd et al. (1998) framed their study of sexuality during new motherhood around the idea that "pregnancy, childbirth, and the postpartum period represent a major life transition that usually has a substantial impact on the sexual adjustment of both mothers and fathers" (p.305). The authors found that sexual desires, frequency of sexual intercourse and satisfaction with sexual relationships all plummeted between the second trimester of pregnancy and the first month postpartum, began to increase again by four months postpartum, and returned to their original levels approximately one year after the birth (Byrd et al. 1998 p.307). All three studies demonstrated an experience of transition during new motherhood, and provide evidence for the temporary suspension of normalcy and routine, and the gradual re-construction of a new 'normal.'

Despite the utility of these studies for this thesis, they have limitations that should be highlighted. For example, while Fox and Worts' (1999) insightful analysis adds to an awareness of the socialization of mothers during the birthing process, they fail to adequately recognize women's socialization during pregnancy or even earlier in life. Indeed, understandings derived from this study and the two others mentioned above would benefit from an extended longitudinal approach that recognizes earlier life experiences and how they impact new motherhood. These studies could also be enhanced by a discussion of more social and cultural understandings of the meaning of motherhood in order to understand the conceptual framework from which women approach new motherhood and navigate new identities.

Overall, the research conducted by Fox and Worts (1999), Matthey et al. (2000) and Byrd et al. (1998) contribute to the idea that becoming a mother entails personal and social transitions during a physiological reproductive event. Together, their work suggests that this transition may impact mental, emotional and physical heath status, as well as new parents' patterns and life routines. Their work further suggests that new motherhood entails a pronounced transition period that resembles the rite of passage described above, and that it can take up to a year to complete the transition and establish stability within new roles and routines; indeed, 12 months postpartum appeared to be a significant marker to participants in all three studies. Moreover, the way in which the transition to motherhood was integrated into women's sense of self and into her longer term biography appeared to depend upon her social environment, and past experiences (Fox & Worts, 1999; Matthey et al., 2000; Byrd et al., 1998). To theorize the impact of new motherhood upon a woman's biography during her life trajectory it is necessary examine theoretical constructs put forth within social scientific studies of life events pertaining to health and illness experiences.

Disruption and Continuity in a Woman's Life Course

Periods of biosocial transition and the implications of these experiences on one's self, identity and biography have been theorized in multiple ways within sociological health and illness research; most prominently, as 'biographical disruptions' (Bury, 1982). *Biographical disruptions* include the "kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted" (Bury, 1982, p.169). Biographical disruptions alter social networks and support systems and force a re-examination of an individual's plans for the future. Bury proposed three

aspects of disruption when a chronic illness unfolds: the disruption of taken-for-granted assumptions and behaviours, disruption to explanatory systems inducing a fundamental re-thinking of the individual's biography and self-concept, and disruption to the resources one mobilizes to respond to a new or altered situation (Bury, 1982, p.169-70). In order to explore changes to relationships and other life changes as the situation or illness develops, Bury (1982) began his analysis with the earliest point of an emerging illness. This emergence and development then created a "biographical shift" away from a perceived 'normal' trajectory through predictable steps to an "abnormal and inwardly damaging" one (Bury, 1982, p.171). Although it was initially used to study the onset of chronic illness in general and rheumatoid arthritis in particular, Bury's (1982) concept of 'biographical disruption' has been applied to other research within medical sociology in the last two and a half decades to explore the disruption produced by the onset of other chronic illnesses and conditions, and changes to identities and sense of self at that time (for examples see Faircloth et al., 2004; Carricaburu & Peirret, 1995; and Hydén, 1997). It has also been applied by researchers attempting to better understand how individuals make sense of disruptive events within their biographies (see Bailey, 1999; Miller, 2000; and Riessman, 1993).

Although further applications for Bury's depiction of 'biographical disruption' have wide-ranging potential, it is not without its limitations. His conceptual framework implies that an individual's biography has a generally predictable path, and that disruptions to this path are detrimental to one's sense of self. While it may be a direct result of his conception and development of the concept when studying the onset of illness, he did not critically examine some features of 'biographic disruption' and its

associated impacts. First, he did not deconstruct the 'predictable' nature of life pathways. As such, the presence or absences of 'disruption' for people who do not perceive a predictable pathway for themselves, or those who may anticipate the onset of a condition (as one may in the case of genetic conditions) are not examined. Second, Bury did not consider how else the illness or condition may be incorporated into an individual's biography in a non-disruptive way. Third, he did not consider that some 'disruptions' may be, in fact, quite positive within a person's biography. Finally, while this concept may have useful application to study more than the onset of chronic illness, Bury did not propose how it may be alternatively applied. Indeed, it has great potential within other research for the investigation of other significant life events in general, and more specifically, events and experiences related to *health*, rather than illness. Other researchers have directly or indirectly taken up the second, third and fourth of these arguments. Discussion of the second argument will make up the remainder of this section, and the third and fourth will be addressed in turn in the two subsequent sections of this chapter.

Other sociological researchers have addressed the second shortcoming identified above by challenging Bury's (1982) concept of 'biographical disruption'. Indeed, Faircloth et al. (2004), Carricaburu and Peirret (1995), and Bailey (1999) have all argued that the onset of some conditions may not actually be disruptive to an individual, and have proposed alternative ways for understanding the onset of an illness or other biosocial transitions. Faircloth et al. (2004) acknowledged the value of Bury's (1982) work, but illustrated how some transitions, such as the onset of chronic illness, can be better described as 'biographical flow,' in which experiences represent part of an ongoing

life story rather than deviation from its path. *Biographical flow* involves a continuation of one's previous life experiences, as events are normalized, and integrated into an individual's life narrative and identity, enabling the maintenance of a coherent sense of self before and after the onset of a transition (Faircloth et al., 2004). Within Faircloth et al.'s (2004) research, social stereotypes, social scripts, societal expectations and especially components of previous identity that were similar to the illness experience could establish continuity and end up normalizing the effects of an event or transition. In other words, they proposed that some illnesses can meld into pre-existing biographical contexts with minimal impact on individuals' daily lives. In their own research Faircloth et al. (2004) found that drawing upon ideas about aging can normalize lasting impacts of stroke (such as memory loss), and thus, facilitate acceptance of an event as part of the person's expected biographical trajectory. Furthermore, they found that relationships with others who share a related experience can mitigate disruption by providing knowledge concerning what to expect and how to cope (*Ibid.*, p.253).

Carricaburu and Peirret (1995) have presented yet another view of the transitions related to the onset of illness, proposing that some are 'biographical reinforcements.' These reinforcements work to advance, strengthen or entrench an individual's existing identity. Their research demonstrated that men diagnosed with HIV often found new priorities, fulfillment and values in life, re-thought their present and future, and altered their sexual behaviour; much like the biographical disruption that Bury described. However, the authors also found that these participants facilitated continuity and actually entrenched or 'reinforced' their identities by emphasizing or drawing upon one or more

of their existing identities, such as being homosexual and/or activists in HIV campaigns, and also by mobilizing personal and social resources available to them.

A third alternative to biographical disruption has been put forth in Bailey's (1999) study of first-time motherhood, in which she demonstrated how the concept of disruption may be applied in a more health-oriented setting. She suggested an additional concept: refraction. Bailey (1999) argued that *refraction of the self* occurs when a mother's sense of self is continuous but also altered, as their adaptation to pregnancy and motherhood reveals elements of their personalities hitherto concealed. In this way, some of her participants' aspects of their sense of self or identities became more pronounced, while others receded into the background and became less prominent; none were added, removed or significantly altered.

Together, the theoretical constructs put forth by these researchers establish four different ways to theorize experiences of health, illness and/or transition points in one's biographical trajectory. While each study puts forth different ways to theorize many conditions or events, the above concepts are not without their drawbacks as they have been applied thus far. First, biographical 'disruption', 'flow' and 'reinforcement' are primarily theorized in the investigations above as mutually exclusive categories; only Bailey (1999) and occasionally Faircloth et al. (2004) have explored the experiences under investigation for possible overlap or the complementary coexistence of these concepts. Therefore, these concepts appear as competing narratives or concepts when applied, and as such, the possible existence of two, three or even all four concepts among a particular cohort or an individual's experience has not been explored. When applied independently and exclusively, each conceptual tool does not acknowledge or reflect the

complex and dynamic nature of many biographical transitions. Moreover, when comparing the above studies, a clear distinction between 'changed' or 'disrupted,' and 'refracted' identities remains elusive; as does the basis for distinguishing *new* elements of personalities from those 'previously concealed', or even the point at which elements of an experience that facilitate a 'flow' actually counteract its impacts enough to no longer be considered a 'disruption'.

A second drawback, likely connected to these nebulous distinctions, is that the researchers appear to study some very similar experiences but interpret them very differently. For example, Carricaburu and Peirret (1995) noted that HIV-positive men had to rework their identities, but did not consider this process to be a 'disruption' within the men's biographies. Alternatively, Faircloth et al.'s (2004) demonstrated that aging men may incorporate the lasting physical and mental effects of a stroke into their understanding of their selves, identities and bodies as aging, but this is not discussed as a potential further entrenchment or 'reinforcement' of their biography, despite aging being an existing and expected biographical path. Therefore, as they have been applied thus far, these concepts have considerable room for alternative interpretations of the data by other investigators and as such, may have low inter-rater reliability and easily be applied inconsistently within and between research settings.

A third shortcoming concerns the application of these concepts to date. Other than Bailey's (1999) investigation, the common lens adopted by the researchers has emphasized experiences of illness, to the exclusion of health. While this can be somewhat expected since their three concepts were investigated in studies of the onset of chronic illness, at many times in the research this emphasis had facilitated a dismissal or

failure to recognize components of participants' narratives that focus on health and living instead of illness and death. As a case in point, narrative excerpts provided from Carricaburu and Peirret's (1995) study suggest that while HIV-positive men anticipated illness and death in the future with an expected diagnosis of AIDS, they often focused on living life with HIV to the fullest in the meantime. A further omission is the possibility of typologies within each category. The inclusion of such typologies would make these concepts more representative of the diversity of social and physical experiences and the personal negotiation of them. Additionally, such typologies may be a fruitful method for linking these theoretical constructs and addressing their overlap. 'Biographical reinforcement' and 'refraction of the self' may be two typologies that exist within a larger understanding of biographical disruption. A third issue largely omitted from these investigations is the exploration as to *why* an experience was integrated as it was within a given individual's biography. Within each theoretical concept, this would help to address how or why the experience classified in one category was facilitated in an individual's trajectory, and why another person's similar physical and social experience of the same event may have been negotiated into their sense of self quite differently. Given the current strengths and shortcomings of these concepts, it seems prudent to consider the presence of all of these theories of biographical transitions and the possibility of typologies within larger categories, rather than hypothesize the presence of a single theoretical construct.

The Meaning of Change: For Better or Worse?

The third shortcoming of Bury's concept to be addressed here also speaks to a larger question about change in biographical trajectories: can disruption or changes in life

routines, social roles, physical forms or identities have a highly positive impact on one's experiences, trajectory and sense of self? Overall, the researchers who posit alternative theories to that of biographical disruption have not considered that 'disruptions' may in fact have quite positive influences upon a person's biography, either as a result of the disruption itself or its subsequent impacts. During the onset of a chronic condition, one may find increased familial social support and new support or friendships among support groups of those similarly 'disrupted'. Similarly, Faircloth et al. (2004) have implied that 'biographical flow' is a more positive experience for individuals than disruption, apparently because it does not induce the same unsettling that a 'disruptive' event may cause. The significance of whether an event is more positive or negative is evident in analyses by Bury (1982), Faircloth et al. (2004), Carricaburu and Peirret (1995) and Miller (2000), all of whom demonstrated that whether or not a developing self-concept converges with or departs from earlier identities, there are implications for whether that transition has positive or negative effects on an individual's coping strategies and resultant well-being.

In addition to the general influences and outcomes explored by these authors, even the names of these classifications are inherently suggestive, since the word 'disruption' usually has negative connotations, whereas the word 'flow' implies something that is generally agreeable. However the connotations run much deeper than nomenclature. It is again, pertinent to consider that Bury (1982) was studying the onset of chronic illness when he developed the concept of 'biographical disruption', which one would indeed expect to be an unwelcome event. Nevertheless, when describing biographical disruptions, the author overwhelmingly focused on negative aspects of the

experience to explore the disruption. When investigating the connection between perceived aging and rheumatoid arthritis, Bury (1982) noted:

> …it marked a perceived biographical shift from a perceived normal trajectory through relatively predictable chronological steps, to one fundamentally *abnormal* and inwardly damaging. The relationship of 'internal and external reality' was upset… Commonsense assumptions *lose their grip* and yet alternative explanations do not readily present themselves. (p.171; italics added)

Repeatedly drawing upon terms and phrases like "abnormal" and "lose their grip" *(Ibid.)* connotes an inherently harmful effect, rather than mere difference or divergence from a previous path. While this may be the case overall for his participants, it does not recognize the possibly more positive aspects involved in their experiences.

In contrast to the bleak vision underlying most discussions of 'disruption,' 'biographical flow' is presumed to be quite positive among stroke patients by Faircloth et al. (2004). In their study they drew upon phrases such as "maintaining a sense of a coherent pre-and post-stroke self" and "part of an ongoing life story" (p.244), which both imply a sense of stability, smoothness and ease. They do not recognize the potentially very negative emphasis of this 'flow.' A case in point may be individuals who do not welcome aging, who may not welcome narratives of aging and old age to create biographical flow during stroke recovery. Furthermore, much like Bury's assumption that there is a predictable life path that is inherently positive and that disruptions deviate from that path detrimentally, Faircloth et al.'s (2004) proposal that 'flow' involves "maintaining a sense of a coherent pre-and post-stroke self" (p.244) presupposes that first, there was a coherent 'self' to begin with, and second, that it was a favorable, happy and healthy one that was beneficial to maintain. While the experience of disruption may be, in fact, quite negative, and experiences of flow fairly positive, these should not be

taken as truisms within these concepts, lest it diminish their use and accuracy in further study of the onset of health, illness or life transitions.

Similar to the study of the onset of health or illness conditions discussed above, women's life transitions often involve an altered sense of self that entails changes, for better or worse (Bailey, 1999, 2001; Miller, 2000; Teitelman 2004). In a study of an the onset of menses, Teitelman (2004) did not draw upon the terminology of biographical disruption, but argued that girls' identities are re-examined and re-shaped during menarche, much like the disruption that Bury (1982) described. She found that menarche entailed an empowering experience for some and disempowering for others, and could also have both positive and negative aspects entwined together. In an analysis of new mothers' identities, Miller's (2000) showed how some first-time mothers have experienced a similar disempowerment to that which Teitelman's (2004) younger participants described. These new mothers perceived limited role status and minimal agency to construct their identities during the transition to motherhood. Bailey's (1999) research of first-time mothers' experiences revealed a more positive and agentic perspective, in which women perceive an increased self-worth, an enhanced social status (being now fully 'adult' as a mother), a justification for more self-attention, and an opportunity to be excused from certain aspects of their pre-motherhood identities. In this way, Bailey's (1999) analysis reveals a potential for manipulation of social and cultural scripts and roles to women's advantage, rather than inevitably feeling outcast or forced to conform as demonstrated in Teitelman (2004) and Miller's (2000) work. However, Bailey (1999) may have over-estimated the degree to which women were actively or freely choosing to embrace new elements of their identities. She did not consider, among

other things, that some elements of the first-time mothers' identities may have been reluctantly accepted or negotiated after an unsuccessful attempt to reject them. Since Bailey (1999), Teitelman (2004) and Miller's (2000) studies were largely exploratory rather than evaluative, assertions as to the nature of the impact are somewhat speculative. Overall, each study does suggest elements of both positive and negative outcomes, identifying a complex transition encompassing personal and social influences and ramifications, as well as both beneficial and detrimental outcomes.

Exploring Motherhood for Disruption and Continuity

The last shortcoming of the initial discussion – the concept of 'biographical disruption' (Bury, 1982) – that will be addressed here is its application in settings other than the study of the onset of rheumatoid arthritis or chronic illness. In fact, evidence for theories of biographical disruption, flow, reinforcement or refraction of the self has been interwoven through several studies of new motherhood. While the researchers have not explicitly engaged with these concepts, they have demonstrated how disruption may be a more positive experience than has been presented in previous research, and provided examples of the application of all of these concepts to research other than the onset of chronic illness.

Bailey's (1999) work is one study that addressed biographical disruption outside a chronic illness setting, and thus, is revisited in greater detail here. Bailey (1999) hypothesized that the transition to motherhood "might be a time when a woman's identity was subject to change as she acquired the new status of motherhood" (p.336), and investigated the idea over the prenatal and postpartum periods. In a sense, she hypothesized the presence of biographical disruption during the transition to motherhood.

Her concept of *refraction of the self* that emerged in her analysis may suggest the presence of disruption *and* flow in participants' experiences, since elements of their personalities may have been *newly revealed* (disruption) but already existed in their personality (flow). Despite the co-occurrence of these attributes, elements of disruption dominate the narratives presented from Bailey's (1999) interviews during participants' third trimesters. This stage of life involved making 'progress' in one's life, taking on increased status, becoming more adult-like, and feeling more responsible, more fulfilled and less selfish. In her postpartum follow-up study, Bailey (2001) argued that several key changes to women's senses of self occurred postpartum, some of which continued on from the prenatal period (such as the confirmation of adulthood), and some that were new (such as feeling more 'feminine' through breastfeeding). Since the transition to motherhood enabled women to actively renegotiate and reconstruct their sense of self and identities as a 'mother,' as well as other components to their sense of self such as identities pertaining to womanhood or femininity and sexuality, Bailey (2001) argued that the changes may not have been merely an effect of the transition, but the transition may have acted as a personal resource for altering one's identities and self. Bailey's (1999) illumination of how some aspects of refraction depended upon physical state (pregnancy or new motherhood) suggests that the source of an identity change may influence how long that change may last. If breastfeeding made a woman feel feminine, she may feel less so once she is no longer breastfeeding. Overall, Bailey's (1999, 2001) studies have implicitly demonstrated that refraction of the self may be a type of disruption that includes elements of 'flow', that motherhood may involve ongoing disruption across the prenatal and postpartum periods but may not be a negative influence, that women may

actively facilitate disruption, and that some identities may be contingent upon physiological events or stages.

In addition to Bailey's (1999, 2001) work, sociological research completed by Miller (2000) have demonstrated how the idea of 'biographical disruption' may be applied or adapted to investigate life events and transitions in general and new motherhood in particular. Drawing upon the idea of 'biographical disruption' to life pathways, Miller (2000) made an analogy to story-telling and plot trajectory. In her investigation, a transition point such as new motherhood was framed as a linear story with a plot trajectory that can be 'lost' during the transition and then 'recovered' as a woman adjusts to her new life and identity. By employing the theoretical construct of 'biographical disruption,' Miller (2000) has complemented Bailey's (1999) work, and provided a sociological example of how one may use the framing concept of biographical disruption within the context of motherhood without pathologizing the biological, personal or social experiences involved in becoming a mother, despite its roots within an illness setting.

Together, Bailey (1999, 2001) and Miller's (2000) work supports the theorization of the transition to motherhood as a rite of passage. Miller's (2000) proposal that an individual's plot can be disrupted, or 'lost' and then 'recovered,' parallels the three phases of transition that Van Gennep (1960) identified. Moreover, both Bailey (1999) and Miller (2000) have demonstrated that the transition to motherhood entailed suspension of some identities or cultural norms and values which then return in the later postpartum period. Therefore, the changes experienced, such as those identified by Bailey (1999), may be temporary changes or disruptions similar to the depiction of the

liminal stage during a rite of passage. In this way, Bailey's (1999, 2001) refraction of the self and Miller's (2000) conceptualization of plot trajectories serve to bring together the ideas of disruption and rites of passage, and demonstrate their application to explore women's experiences during the entrance into motherhood. To further understand the transition to motherhood and first-time mothers' the rite of passage, one must investigate several dimensions of their experiences, including physical, personal and social aspects of first-time motherhood.

Identity and the Negotiation of Self/Body and Public/Private

Miller (2000) argued that becoming a mother is both a public event and a private experience and that it is "positioned at the interface between the biological and the social" (p.322). Her comment resonates with both implicit and explicit themes within the literature on reproductive life transitions, in which self-concept or self-identity are closely connected to one's physical experiences and societal scripts regarding that physicality (Bailey, 1999; Moen et al., 1995; Teitelman, 2004). As a case in point, in their study about the onset of multiple sclerosis, Kralik et al. (2003) separated self, identity and the body to explore the transition to living with MS, and in doing so, were able to demonstrate that body and self are connected. They found that changes in the body facilitate changes both to one's self and one's identity (*Ibid.*, p.17). As a personal, social and biological experience, the transition to motherhood may invoke a re-constitution of all three aspects of the self (personal personae, social identities and the body), including changes that may occur independently as well as in relation to one another, since changes in one component may invoke changes in another.

The interplay between self and body has been researched and theorized in many ways in sociological literature, with some researchers emphasizing the self, others the body, and some the co-construction of the two (Bailey, 1999, 2001; Johnson , Burrows & Williamson, 2004; Teitelman, 2004). Within Bailey's (1999) research, there was a strong connection between self and body for first-time mothers; physical changes to women's bodies during pregnancy served as physical markers of the mental changes women were going through or expected to go through. Some women's bodies served as a reminder of the upcoming birth and related changes to their lives when they had moments of 'unreality' (Bailey, 1999, p.340). Physical changes in pregnancy made some women feel that they had the freedom and agency to behave in certain ways, such as taking up more space in public and putting their physical needs ahead of the needs of others. Unfortunately, Bailey (1999) did not scrutinize this 'freedom' and 'agency,' and thus, has not addressed the nature of this agency. It may be more like a lack of freedom when a pregnant woman is granted more space in public, since it may reflect societal expectations of a woman's 'duty' or responsibility to care for her unborn child. Alternatively, new freedoms and use of space may be contingent upon her pregnancy, and will likely end when the pregnancy is over. This possibility suggests that researchers must distinguish between the agency granted to pregnant women and that of their unborn children, and interrogate the use of terms like 'freedom' and 'agency' when they are 'conferred' or 'granted,' and thus, subject to relinquishment. Nevertheless, Bailey's (1999) results indicate how women's bodies can assist in the construction of the self.

In addition to the connection between self and body, there appears to be an important relationship between the body and the public or social realms of the self.

Teitelman's (2004, p.1299-1301) research on the onset of menses demonstrated that young women viewed menstruation as a physical experience associated with societal ideas about womanhood, gender roles and sexuality. The author argued that that these societal influences have repercussions for young women's self-esteem, sexual subjectivity and sexual agency (*Ibid.*). Indeed, it was during this transition that the young women learned to associate their bodies with sexual potential, reproductive capabilities, shame and danger, and consequently, came to feel less sure of their bodies and selves (Teitelman, 2004, p.1294, 1300). In Bailey's (1999) research this connection between the social and the biological was also present. Her data showed that as the women's pregnancies progressed and their bodies became noticeably pregnant, strangers began to treat them differently in public and their bodies were touched by strangers in a way that was not previously done; as such, the biological was influencing the social (*Ibid.*, p.340). Together, these results suggest an interrelationship between public or social identities and the body, and that each component and their relationship may impact one's sense of self.

Over and above the connection between the social and biological, public elements or social identities within one's sense of self may directly relate to the more internal personal and private components. In her study of first-time mothers' transition into motherhood, Miller (2000, p.320-1) asserted that childbirth and becoming a mother are private and personal experiences, but are simultaneously very publicly defined affairs. Her work illuminates the social and personal elements within the women's transitions and resulting sense of self through narrative methodology in which she distinguishes public narratives and personal narratives. Miller (2000) argued that public narratives dominate or have privilege over individual's narratives in the prenatal period, and that there is

always a potential clash between them because a "public narrative may or may not resonate with the individual experiences of the women themselves" (p.312-3). Public narratives (or social identities and aspects of the self) can create personal struggle, depression and possibly criticism from others if a woman's individual experience does not coincide with larger social and cultural expectations (*Ibid.*, p.320-1). The potential clash here complements Bailey's (1999, 2001) finding that women actively negotiated social identities during the transition to motherhood, and that they resisted or rejected the ones deemed undesirable or incompatible. While public discourse is biologically deterministic, assuming that women naturally know how to be and want to be mothers, Miller (2000, p.317) found that some women in her study did not personally feel that motherhood was innate to them. Women who identified notable discrepancies between their expectations of motherhood (which were based on social interaction, social norms and socialization) and their more personal lived experiences in becoming a mother had concerns about their perception as a competent social actor or a 'real' mother (*Ibid.*, p.320-1). At times, these concerns encouraged women to confine themselves to their homes, shielding themselves from the public eye (*Ibid.*). This is a form of isolation that has been connected to the development of postpartum depression (Mauthner, 1995). Therefore, in the interplay between the personal and the social, one may have the ability to negotiate and reject social identities, but they still have an influence on one's resulting sense of self, and this influence may be detrimental to overall well-being.

The interconnections between biological, personal and social aspects of the self all at once are very prominent in several psychological and sociological studies about women's experiences during pregnancy. Some of these researchers' work has

demonstrated a similar struggle to that which Miller (2000) identified above, and located the site of that struggle at the women's pregnant bodies. However, the way they envision the relationship between these elements seems to differ from one another. Participants in Bailey's (1999) work observed a type of *collision* between public and private. These women found that:

> …their bodies had become 'public property', to be commented upon, patted and prodded, sometimes by people they knew very little or even complete strangers. They described their bodies as being 'invaded', both by these other people and by the baby inside them. (Bailey, 1999, p.340).

Here, it is at the site of the body that the public and private collide, or what Bailey (2000) described as when "the edges of the self become blurred as the body no longer seems to operate as a physical marker of individuality" (*Ibid.*). Similarly, Johnson et al. (2004, p.365) found that "the usual boundaries that surrounded their bodies" were relaxed, along with pre-pregnancy norms regarding personal space and appropriate conduct. In particular, the women explained that strangers touched their bodies too intimately and that doctors also seemed to feel entitled to touch their bodies internally and externally (*Ibid.*). Both of these studies have shown how women's pregnant bodies can be a site of struggle and/or collision between the social and the personal in the construction of experiences and biographies.

In contrast to the apparent collision in which the boundaries between public and private are challenged via the body, further research by Bailey (2001) has also demonstrated experiences of *separation*. She suggested that during the prenatal and postpartum periods, women resisted certain unwanted social identities associated with pregnancy by distancing their minds from their bodies and their bodily changes (Bailey, 2001). In other words, a woman could separate the personal and physical by mentally

rejecting the pregnancy as being 'really hers' or something that was part of her 'inner self' (*Ibid.*, p.125). This division enabled the women to disassociate with their pregnancies and thus, maintain a sense of control over their bodies and their current sense of self (*Ibid.*). However, the effort to divide the personal and the physical here may also provide evidence as to the strength of the connection between social, personal and biological, since women needed to employ strategic techniques such as the separation of mind and body in order to maintain their position of authority and control over the negotiations of their identities and sense of self. In this and other related research such as the work explored above, new motherhood in general, and pregnancy in particular, appears to be a site of struggle for construction of each woman's self and biography. The significance of social influences in this struggle indicates that a rich investigation of a woman's biography and life trajectory is contingent upon an understanding of the social context in which first-time mothers negotiate the physical and personal aspects of their transitions.

The Meaning of Motherhood

To understand the social component of an experience and source of the struggle between the personal, biological and social, one must also understand the dominant public narratives, social norms and values that influence one's motherhood identity. In other words, how is motherhood socially-constructed in contemporary North American society? And how is it interpreted by women in this context? Most of the sociological literature pertaining to motherhood is based on research done with mothers themselves, with little research attempted regarding insights about motherhood and its social and societal meanings put forth and reproduced by other members of society, such as care

practitioners, young women, older women, fathers, and more. Therefore, it is research concerning motherhood that investigates new mothers' experiences directly that will be focused upon in this and subsequent sections. Studies of the *transition into* motherhood are particularly illustrative of the social construction of motherhood, since they emphasize women's experiences as they take on and negotiate new identities associated with motherhood. Overall, research conclusions support the idea that motherhood "represents a life-defining status" (Fox & Worts, 1999, p.326) and "the beginning of a new role" (*Ibid.*, p.331), or a new social identity (Bailey, 2001).

Within research exploring the onset or the transition into motherhood, there is evidence that new mothers discuss a variety of traits and aspects of motherhood identities; some of them favourable and others less desirable. More positive aspects of becoming a mother have featured concepts that emphasize achievement in life and within one's society. In Bailey's (1999, p.344) study of pregnant first-time mothers, one participant noted that she was now a 'real person' among work colleagues. In her later work Bailey (2001, p.116) found that women associated pregnancy with a confirmation of adult womanhood, and as a result, felt more mature, womanly and feminine as their pregnant bodies grew. Interestingly, Bailey found that for some women, these feelings and new identities were enjoyable if temporary, but less attractive when enacting more permanent changes to their statuses. This was the case for women whose work environments made it preferable to be less feminine (*Ibid.*). Nevertheless, for some women these feelings of femininity and womanliness receded at the conclusion of pregnancy but then returned during the postpartum period, at which time breastfeeding served to affirm their womanliness (*Ibid.*). Bailey (1999) identified a tension in women's

interviews, whereby their assertions of womanliness were intermixed with a common theme of feeling like "someone's mum and not a woman" (p.118). Therefore, while some women may delight in motherhood and discover positive aspects to new identities, it may also be a more complicated, mixed batch of feelings with positive and negative elements that wax and wane throughout their transition.

The participants of Bailey's (1999, 2001) work also described much less desirable associations with a motherhood identity. The most prominent of these was the apparent incongruence between work identities and motherhood identities, which appeared to be mutually exclusive and fundamentally conflicting for many women. During the prenatal period, this was a reason for some women to downplay their pregnancy at work in order to control their authority and an identity as a worker, rather than emphasizing their womanhood or motherhood (Bailey, 2001, p.125). Women also feared their upcoming postpartum period because of the maternity leave involved (Bailey, 1999, p.341). The basis for this fear was both from the perception that their society valued a person according to their work, and because of their own emphasis on their work to define 'who they were', which made time off a threat to their societal value and their own sense of self (*Ibid.*). An additional unfavourable aspect of women's motherhood identities postpartum is the apparent clash between motherhood and sexuality. In her later work, Bailey (2001) found that during both the prenatal and postpartum periods, women experienced a "partial erasure of their sexuality", and "difficulty seeing themselves in sexual terms" (p.117). Overall then, investigations of the transition to motherhood suggest that motherhood has been conceptualized as an identity that has the potential to assert one's adulthood, womanhood and femininity, but may also threaten one's work

identity, self-concept and/or sexual identity. Just as an understanding of the related societal context is imperative to exploring new motherhood, so is the recognition that societal meanings are located in a temporal context. Therefore, as social norms, values and expectations change over time, so will the way in which they influence social aspects of new motherhood, and women's personal negotiation with them.

Experiencing Motherhood Today

Some research depicting motherhood in contemporary North America has illustrated how motherhood is located in a social and cultural context that not only informs how motherhood is socially-constructed, but also how it is uniquely infused and shaped by its socio-cultural environment of the time (Fox & Worts, 1999; Letherby, 1994). In this way, motherhood in industrialized societies today can be expected to differ from motherhood in past times or other places. Bailey (1999) argued that less traditional societies in the late modern age "are increasingly dependent on experts in helping us to negotiate *rites de passage*" (p.335). On a similar note, Fox and Worts (1999) explored the medicalization of childbirth and argued that:

> …because medicalized childbirth offers only strictly delimited assistance, it communicates the message that the woman is alone (with perhaps the help of a partner) in her long-term responsibility for the care of the new child. That motherhood is a private responsibility may be the most important message conveyed by medicalization. (p.331)

These researchers argued that the privatization of motherhood in contemporary North America extends to a privatization of responsibilities for childcare, and as such, many women may find that they are given little assistance and instruction in maternity wards, and must learn to feed, change and bathe their babies on their own. This argument resonates with Miller's (2000) finding that women can be excited and eagerly anticipate

motherhood when pregnant but then experience a difficult time in the postpartum period because they felt ill-prepared for life as a mother, felt that they were not in control, and/or found that the reality of motherhood was incongruent with their expectations. The idea that motherhood has been privatized (Fox & Worts, 1999) both builds upon and informs evidence that many women do not necessarily naturally know how to be mothers, despite the biologically deterministic rhetoric that would suggest otherwise (Miller, 2000, p.317).

The privatization of motherhood and childcare appears to have a detrimental impact on some women and their experiences of becoming mothers within contemporary North American society. Fox and Worts (1999) have argued that postpartum depression is one of the costs of privatized responsibility for children. They found that vulnerability and sadness were connected to "the dawning awareness of the enormity of the responsibility they had acquired and the lack of support they were receiving for it" (Fox & Worts, 1999, p.341). Their findings also indicated that 'baby blues' were connected to women feeling "overwhelmed by the responsibilities of motherhood," (*Ibid.*) and to feeling "shocked" and "scared" in the initial postpartum period. Adding to the stress of the situation is a socio-cultural context in which the dominant societal view remains that it is women's primary responsibility to provide childcare (Letherby, 1994), despite the political-economic pressure for even single mothers to work (Bailey, 1999, p.337). In this way, new motherhood involves more than negotiating a new identity. It also requires a redefinition of one's self and the reconstitution of other identities in light of new motherhood. Therefore, identities of motherhood appear to have pervasive influences upon women's sense of self, and have implications for their current and future biographies.

Further contributing to a socially and culturally located understanding of new motherhood in contemporary North America are the biological or physical components of the experience. These may shape how a woman interprets first-time motherhood as she negotiates between socio-cultural ideas about her body and her lived physical experiences. Two themes dominate related social scientific research: body image and breasts. Each of these will now be discussed in turn.

Body Image in Pregnancy and New Motherhood

Sociological and psychological research of women's experiences of pregnancy and the postpartum period offer telling insights into women's experiences of their changing bodies and how those changes play a significant role in their experiences of pregnancy and new motherhood. Weight gain appears to be one change that stands out women's discussions their bodily changes. In their review of studies concerning bodily changes and body image among pregnant women, Johnson et al. (2004) found that there are numerous contradictions within research results. While some studies show that most women are dissatisfied with their bodies during pregnancy and become increasingly dissatisfied as their pregnancies progress, others demonstrate higher levels of satisfaction among pregnant women compared to non-pregnant women (*Ibid.*, p.362). These authors argued that there appears to be no clear pattern of variables influencing body image in pregnancy, but that the literature demonstrated that "body image concerns of first-time mothers are more pronounced than those who have had more than 1 (sic) child" (*Ibid.*, p.364). Research of first-time mothers' experiences has also revealed that weight gain can be interpreted as a positive aspect of pregnancy for an expectant mother; however, there is also a pervasive theme within related studies that women's enjoyment is

temporary and context dependent (Bailey, 1999, 2001; Miller, 2000; Johnson et al., 2004). Overall, studies have demonstrated that weight gain may be more acceptable during pregnancy than other times in women's lives, but the situation is complex and may be inherently linked with more negative body images, such as diminished physical attractiveness.

Among the themes evidenced in research regarding women's experiences during pregnancy, there are two primary benefits asserted by women as well as some minor drawbacks. The most common pleasure associated with women's bodily changes during pregnancy seemed to be their ability to 'opt out' of cultural ideals and pressures to be slender. In her study of first-time expectant mothers, Bailey (1999, p.349) found that women considered pregnancy to be an excuse to put on weight and no longer worry about being slim. Similarly, in subsequent work, Bailey (2001, p.119) found that women often enjoyed their bodies more after deciding that cultural imperatives to be slender 'don't count' when one is pregnant. This position is supported by findings of Johnson et al. (2004, p.367), who argued that expectant mothers construct pregnancy as a means to legitimize the transgression of female beauty ideals "by emphasizing they were not fat, they were pregnant". Therefore, the women expressed relief as the pregnancy progressed and the pregnancy became more obvious, making the distinction between 'fat' and 'pregnant' more evident in public (*Ibid.*). Overall, Johnson et al. (2004) concluded that pregnancy can be a protective factor against body image concerns.

The second positive aspect of bodily changes for expectant mothers draws upon rhetoric of biological determinism, since some women have focused on the 'purpose' or 'function' of their bodies. Johnson et al. (2004, p.366) found that women who drew upon

such discourse were pleased that their bodies were doing what they were 'meant to do' or 'designed to do'. Similarly, Bailey (2001, p.116) found that some of her participants were in awe over their bodies' capability to produce a child. For some expectant mothers then, weight gain and appreciation for their bodies' functions were very positive aspects of bodily changes.

Despite these apparent benefits and protective factors of pregnancy, these same studies have also shown that some women feel less enthusiastic about their changing bodies, and even feared putting on weight in the prenatal period (Bailey, 1999, p.349). Some drawbacks identified include women feeling less attractive, and using negative or disapproving terms to describe their bodies, such as 'fat', 'frumpy', 'bloated' and 'weird' (Johnson et al. 2004, p.366). Furthermore, there is a strong sense that any sense of acceptance gained from their bodily form was temporary, and contingent upon the pregnancy. During the postpartum period there was an immediate pressure to "get back to normal" (Bailey, 2001, p.120; Johnson et al, 2004, p.370).

While some new mothers had greater appreciation for, and/or more functional views of their bodies postpartum, they also expressed sentiments of dissatisfaction with their weight connected to a return to traditional conceptions of femininity and the ideal female form, including a "return to the endless search for slenderness" (Bailey, 2001, p.126). In fact, within the descriptions of women who were in awe of their body after childbirth, many also listed complaints about their attractiveness (*Ibid.*, p.116). Complicating their desires to be both mothers and be attractive is the evidence within this research that conceptions about 'mothers' bodies' are fundamentally in opposition to 'women's bodies' or bodies that are slim, sexy and attractive (Bailey, 2001). Other

research has suggested that there is a perceived distinction between a 'civilized body,' which is self-contained, regulated, dry, proper and cultured, and a 'grotesque body,' which is unregulated, has fluid boundaries and is closer to nature than culture (Lupton, 1999, p.78). From this perspective, women's bodies in general and pregnant women's bodies in particular "tend to be culturally classified as 'grotesque' rather than 'civilized'" (*Ibid.*) because they may leak, be ruled by emotions and be more open to the world. This complex picture of women's body image and bodily experiences during the transition to motherhood, and the social norms and values that influence them, all serve to demonstrate how once again, women's bodies are the site for social and cultural messages and potential conflict and negotiation between self, body and identity. Adding to this already complex picture are women's simultaneous negotiations with breasts and breastfeeding during the prenatal and postpartum periods.

Breastfeeding and the Meaning of the Breast

As an act that incorporates socio-cultural ideas about motherhood and personal experiences of sexuality and the body, breastfeeding can be a controversial aspect of new motherhood. Breastfeeding is infused with societal and public opinions regarding sexuality and discretion, and is embedded within cultural ideas about maternal responsibility and nature. Therefore, breastfeeding requires a woman to negotiate personal preferences, cultural values and societal pressures within her bodily experiences and her decision to breastfeed or not. Two key themes emerge within social scientific research of breastfeeding: discourse about breastfeeding being 'natural', and the distinction between sexual and maternal functions of breasts. Each of these themes will be explored in this section.

In her examination of breastfeeding educational material, Wall (2001, p.594) found that social constructions of motherhood overlapped with discourses concerning nature and women's 'natural abilities' to breastfeed. Educational materials were found to promote breastfeeding as completely 'natural', and demonstrated a clear connection between 'good mothers' and breastfeeding (Wall, 2001). The author also found an implicit message in the educational materials that choosing not to breastfeed risked a mother's commitment both to being a 'good mother' and to ensuring the optimum health of her child (*Ibid.,* pp.604-5). Combining her examination of educational materials with her study of new mothers' breastfeeding experiences, Wall (2001) has demonstrated the impact of these materials upon breastfeeding women. Entwined within the rhetoric of breastfeeding as 'natural' was the idea that since it was natural for women to breastfeed, all women should be able to breastfeed successfully (*Ibid.,* p.593). Therefore, breastfeeding women were expected not to require resources such as professional support, assistance or intervention since they were unlikely to encounter major difficulties or problems (Wall, 2001). From this perspective, difficulties experienced during breastfeeding, lack of desire to breastfeed or lack of maternal gratification from breastfeeding all became relegated to signposts of deviancy and the shortcoming of an individual woman (*Ibid.*, p.599). Wall's (2001) examination of breastfeeding educational materials also illuminated other problems with biologically deterministic discourse. She found that in contrast to what is suggested in the materials, some women's breast milk may *not* be pure or 'nature's perfect food', and that some women may experience major problems nursing and/or may have ongoing breastfeeding difficulties (*Ibid.*). The connection between Wall's (2001) analysis of educational materials and breastfeeding

outcomes is clear in her subsequent review of research concerning women's decisions to stop breastfeeding. She found that some new mothers faced unexpected difficulties breastfeeding and stopped trying because those problems made them feel isolated and unique, as if their bodies had failed and they had failed as mothers (*Ibid.*, p.598). Wall's (2001) analysis, therefore, works both to demonstrate the incongruence between some breastfeeding educational materials and new mother's experiences of breastfeeding, as well as the potential practical implications and health outcomes that may result from this incongruence.

In addition to the prominent discourse about breastfeeding being 'natural' in research investigating women's experiences breastfeeding, the second significant theme in related studies is the tension between breasts being maternal and/or sexual. Some investigators have shown substantial resistance on the part of some new mothers to breastfeed because the mothers felt that breastfeeding had sexual connotations and thus, was an inappropriate act to engage in with one's child (Galupo & Ayers, 2002, p.23). Others have found that some women considered breastfeeding to be a "distasteful" act (Foster, Slade & Wilson, 1996, p.181). Nevertheless, several studies of breastfeeding mothers have reported that women overwhelmingly describe their breasts as 'functional', 'practical' and being 'for their child', and explicitly identify breastfeeding as a non-sexual act (Bailey, 2001; Galupo & Ayers, 2002; Wall, 2001). In her study of experiences of first-time motherhood, Bailey (2001, p.117-8) found that breasts became mostly or entirely practical and devoid of sexuality to breastfeeding mothers. Similarly, Wall (2001, p.598) argued that breastfeeding educational materials try to convince both mothers and the public that when breasts are involved in breastfeeding they are not

sexual. However, by adhering to a series of tacit expectations to keep one's breasts covered, to be discreet in public and 'manage' other people's gazes, Wall (2001, p.598) also found that these materials assigned breastfeeding women with the responsibility for managing the tension between breastfeeding and sexuality. Galupo and Ayers' (2002) study of breastfeeding mothers' narratives indicated that discussions of breastfeeding were inseparable from the dominant social construction of breasts as sexual (p.22) and yet the women considered their breasts either sexual or maternal at any given time, but not both (p.24). These authors also found that participants talked about the functional and practical use of their breasts, and some even viewed their breasts as "milk tools" (*Ibid.*). Galupo and Ayers' (2002) participants almost all identified prominent public disapproval of their breastfeeding, apparently stemming from the public not being able to distinguish the sexual/maternal role of breasts as clearly as the breastfeeding women did. Women also perceived a noticeable increase in public disapproval of their breastfeeding as their infants aged, either because the nursing child is seen as a sexual being, or because the breastfeeding woman is seen as sexual and deriving sexual pleasure from breastfeeding (*Ibid.*, p.24). Clearly then, comfort with breastfeeding appears to be contingent upon the perception of a clear divide in the meaning of the breast as sexual or maternal.

Despite the apparent distinction of sexual and maternal uses of women's breasts among practitioners' views in Wall's (2001) research and in the mothers' opinions in Galupo and Ayers' (2002) work, other studies have suggested that these different uses may not be quite so mutually exclusive for some women. In their study of prenatal and postpartum sexuality, Byrd et al. (1998, p.308) presented a more clinical standpoint and

argued that "orgasm from breastfeeding is a normal response for some women," and that new mothers should be educated and reassured about this physical response. Bailey's (2001) research demonstrated that maternal and sexual uses of breasts may not actually be experienced so differently for breastfeeding women. She found that breastfeeding can be a sensual experience, but that women are hesitant to describe it in this way because they have blurred the distinction between *sexual* and *sensual*, in which case it became "socially unacceptable to articulate sensual feelings toward the child" (*Ibid.*, p.118). It seems that practitioners and breastfeeding women alike, may accept the division of sexual and maternal elements in the act of breastfeeding, as well as provide an alternative understanding of how these elements overlap during breastfeeding.

Whether or not women find breastfeeding natural or sensual/sexual, most studies have suggested that breastfeeding offers personal benefits to women's development and sense of self and identity. Drawing upon feminist discourse concerning women's control over their bodies, Wall (2001) noted that when reproduction, childbirth and childcare have been medicalized, breastfeeding may be the one aspect of new motherhood that remained within women's control and thus, be "an empowering and gratifying experience for women" (p.593). However, the author also cautions that such celebrations of empowerment through breastfeeding can reinforce essentialist gendered discourses about women's presumed ability and success in breastfeeding (*Ibid.*). On a more positive note, Galupo and Ayers (2002, p.27) suggested that some women feel higher self-esteem, competency and accomplishment compared to their lives before motherhood as a result of their breastfeeding abilities.

As these many experiences and discourses of breastfeeding demonstrate, women's breasts take on multiple meanings in pregnancy and especially new motherhood, making them a site for social and cultural tensions about 'good' mothering, maternal responsibility and women's sexuality. Therefore, breastfeeding is more than a mere biological act, and possesses larger societal and political meanings. Breastfeeding then becomes a key component to a rich understanding of women's embodied experiences of the transition into motherhood, and their negotiations of physical, personal and social aspects of the transition to motherhood.

Existing research of new motherhood has generated a dynamic picture of the physical, personal and social elements new motherhood. These studies have pointed out the importance of understanding socio-cultural meanings and societal contexts of motherhood, and demonstrated the significance of body image and breastfeeding in women's experiences of their bodies, sense of self and identities. In my thesis research I seek to combine existing research findings and select theoretical constructs reviewed in this chapter to contribute to some areas of the existing literature. I examine the influence of pregnancy and first-time motherhood not merely upon participants' sense of self, but upon their existing biographies and life course trajectories. I explore the possible presence of both disruption *and* continuity in their transition to motherhood, and evaluate whether *either* construct may have possible positive and negative implications. I also investigate the constructs of 'biographical disruption' and 'flow' and consider possible typologies within these larger categories, in order to recognize the diversity of physical, personal and social experiences that can too easily be subsumed within one or both of these constructs. More generally, this thesis demonstrates how theories of disruption and

continuity may be applied to rites of passage within the life course, as well as to studies of *health* rather than merely illness.

Before presenting the findings of this thesis I first describe the research method and design employed, and then present some general characteristics of the sample population and the first-time mothers upon which those findings are based.

CHAPTER 3:

RESEARCH DESIGN AND METHODOLOGY

In this chapter I focus on the design of this thesis research, including both the intended and actual procedures. I first review literature pertaining to the life course perspective and biographical 'flow' and 'disruption' and discuss how I have employed these theories in this thesis. I then describe the process through which I recruited and selected my participants, and established the final participant sample. Next, I review the data collection procedure that I followed for each participant. I then discuss ethical considerations in conducting this research and my approach to such ethical issues. Then, I provide an overview of narrative data collection and my application of it in this research. I briefly describe the procedures for quantitative analysis pertinent to Chapter 4, and then provide a more detailed description of the qualitative data analysis procedures that resulted in the data presented in Chapter 5. Next, I specify my point of view as the principal investigator of this research. I conclude by evaluating the methodological strengths and limitations of this thesis.

Socialization and the Life Course

In this thesis there are two underlying foci central to my investigation of first-time mothers' life events and biographies. The first of these is the *explicit* or *direct* messages and information about their bodies, womanhood and motherhood that women receive throughout their lives. Similarly, mothers and peers are also significant sources of information during reproductive events (Brock & Jennings, 1993), and will be examined in the exploration of explicit information or messages aimed at the women during their

development. The second underlying focus of this investigation is the more *implicit* information women receive through social interactions, socialization and their interpretation of more explicit messages. Processes of informal socialization include, among other things, the transmission of indirectly spoken or written information that is interwoven into daily interactions (such as peer relationships, familial role models, and so forth). In these ways, social rules, values and norms are perpetuated and naturalized "by making us think relations that are actually social or cultural are grounded in natural fact.... [The] percepts naturalized by science affect men and women, but as many have observed, women's bodies are a particularly intense focus for scientific and state scrutiny and control" (Martin, 1989, p.152). Hegemonic narratives are significant in the transmission of cultural information about appropriate and accepted ideas, beliefs and values related to sexuality. These narratives are based on the mainstream messages that form dominant ideas, beliefs and values, and in this context, privilege and promote normative conceptions and expressions of sexuality and womanhood. A rich understanding of women's experiences includes both explicit and implicit factors.

In this research I recognize that while formal and informal socialization is imbedded in shared socio-cultural values, norms and beliefs, and macro structures of gender and power relationships, the participants of this research are assumed to be active agents in constructing their social identities and self-concepts. In the process of socialization then, women create their biographies by negotiating with social and cultural messages about breasts, sexuality, womanhood, and motherhood. During this process, participants may have incorporated concepts and ideas that suited their existing identity,

transformed these ideas to better suit their identity, adapted their identity to suit these concepts and ideas, or reject these concepts and ideas altogether.

Investigating Biographical 'Disruption' and/or 'Flow' in the Transition to Motherhood

I employ a life course conceptual framework to understand women's transitions into motherhood within their longitudinal biographies and contexts. Similarly to Moen et al.'s (1995) investigation of women's long-term care provider roles, I will utilize the life course approach with a "focus on the *trajectory* of well-being over the life course in light of shifting role involvements as well as shifting situational and socio-cultural contexts," (p.270, emphasis in original). Framing my qualitative exploration in this way is intended to enable an understanding of the relationships between stages in a woman's life, including those before and after new motherhood. By exploring first-time motherhood as one stage of a longitudinal biographical process, and an experience that may contain elements of biographical concepts such as 'flow' and/or 'disruption,' I will facilitate an increased sociological understanding of the transition to motherhood, and the potential influence of the past on the experiences and well-being of first-time mothers during this transition. Refraction and reinforcement are also both understood here as types of disruption.

To conduct this analysis, I explore the central research question: *how do transitional experiences of first-time mothers illustrate biographical 'flows' and/or 'disruptions' from their previous biographical trajectories?* Since first-time motherhood is understood here as a biosocial transition, *first-time mothers* are defined as women for whom their most recent childbirth experience is their first birth to a live child. Participants with adopted or step-children, or past experiences of abortions, unsuccessful

pregnancies or still-births will still be considered 'first-time mothers', but these experiences will be acknowledged within their biographical trajectories. *Biosocial transitions* are understood here as physiological transitions that are influenced by socio-cultural norms, values and expectations, and exist at the interface of public and private spheres of life. Menstruation, breast development and first-time motherhood, among others, can be considered biosocial transitions. By exploring these participants' biosocial transitions throughout their life course, I investigate how previous biosocial reproductive events as well as social contexts (including social support, and familial and intimate relationships) inform their biographical trajectories. By employing these concepts in my investigation of the research question above, I explore each woman's life course to understand how she has or is navigating the transition to motherhood in light of her previous trajectory, including her self-concept, identity, physical experiences, and social and cultural resources. Furthermore, I investigate *how* and *why* experiences of first-time motherhood came to be constructed as disruption and/or continuous in participants' senses of self and reproductive trajectories, and whether or not that has had beneficial or detrimental ramifications for them during motherhood.

Sampling Procedure and Sample Size

This research provides an in-depth exploration of a non-random sample of women's narratives about the transition into motherhood, with additional consideration given to other reproductive life events and experiences that make up their biographies. The intended in-depth qualitative exploration of sense of self and biographies, disruption and continuity, and physical, personal and social experiences led me to opt for a relatively small sample. A small sample size was suitable for a rich and thorough

investigation of a these aspects of participants' lives. I employed non-probability sampling techniques, including both purposive sampling and convenience sampling (Ritchie, Lewis & Elam, 2003) to recruit a sub-sample of fourteen first-time mothers from the *PHS* parent study described in Chapters 1 and 4.[2]

In consultation with my thesis committee I determined that a sample size of ten to twenty participants would be both large enough to explore a wide range of experiences of reproductive life course events and transitions into motherhood, but small enough to ensure a detailed qualitative exploration of data collected. Ritchie et al. (2003) argue that "the type of information qualitative studies yield is rich in detail, [so] there will therefore be many hundreds of 'bites' of information from each unit of data collection. In order to do justice to these, sample sizes need to be kept to a reasonably small scale" (p.83-4). This more modest sample size was also viable for my personal resources, and would be manageable during data analysis without losing the rich details of women's accounts.

In determining the final number of participants, I continued to interview women until I felt that I had reached a point of theoretical saturation, or *diminishing return*, "where increasing the sample size no longer contributes to new evidence…because [in qualitative data] phenomena need to only appear once to be part of the analytical map" (*Ibid.*, p.83). To determine this point during data collection, I completed ten interviews and then reviewed my interview notes to evaluate whether new ideas and experiences were still emerging. When I thought that I was reaching a point of diminishing return, I completed a few additional interviews in order to be sure of this, as well as to increase the diversity of my sample with regards to age and ethnicity. I completed four additional

---

[2] See also Appendix B on page 177 for details on recruitment of participants for *PHS*.

interviews, for a final participant sample size of fourteen. Some socio-demographic characteristics of these fourteen women will be presented later and compared to the other first-time mothers and sample population of the Postpartum Health Study (see Chapter 4).

The procedure through which I sampled these fourteen participants included both purposive sampling and convenience sampling techniques (Esterberg, 2002; Ritchie et al. 2003). Purposive sampling involves choosing participants strategically in a way that offers particular benefit to the aims of the study, as Richie et al. (2003) described:

> …because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study. These may be socio-demographic characteristics, or may relate to specific experiences, behaviours, roles, etc." (p.78).

The strategic nature of purposive sampling is well-suited for exploratory research (Palys, 2003, p.74) such as this study. I recruited women based on two characteristics. First, since exploring the *transition into* motherhood is the focus of this research, I recruited only *first-time mothers,* according to the definition provided above – i.e. women for whom their most recent childbirth experience is their first birth to a live child. I recruited these first-time mothers with a follow-up questionnaire at the conclusion of participants' third interview through *PPS*. These follow-up questions briefly described the intended research, asked participants if they were first-time mothers, and inquired whether they would like to be contacted to participate in my own study (see Appendix D on page 182). Second, as noted above, I sought to achieve as much diversity as possible within my sample of first-time mothers, including a range of socio-demographic factors (age, ethnicity and income), maternity care styles (certified midwives, maternity physicians and obstetricians), and modes of delivery (vaginal, planned cesarean section and emergency cesarean section). This approach was well-suited to this qualitative research,

since the methodological goal was not to be generalizable, but rather, to explore how different women personally and socially experience the transition to motherhood. This enabled a more thorough investigation into the possibility of different transitional experiences, including the possibility of biographical disruption and/or flow, and positive and/or negative evaluations of transitions experienced.

When I began my data collection stage in June 2006, thirty of the women who had completed their third interview for *PHS* had indicated that they were first-time mothers in their follow-up questionnaires. Of these women, twenty-five indicated that they were interested in being re-contacted to participate in this thesis. After considering their diversity with regards to the factors identified above, participants were narrowed down using convenience sampling, which entails "selection on the basis of ease or convenience" (Jackson, 1999, p.387). In this step, I recruited the first women that were available for an interview, after they reached at least one year postpartum.

Data Collection Procedure

The timing of the data collection was designed to enable participants to partake in 'narrative retrospection' by reflecting back on their initial experiences of first-time motherhood as an experience that is in the past (Miller, 2000; Riessman, 1993; also see *Data Collection* section below for elaboration). Therefore, I waited until at least one year postpartum for all participants; my participants ranged between 12 and 17 months postpartum. After one year or more of motherhood, I expected that women would be able to talk about their experiences of the event, and contrast their initial experiences of new motherhood with more recent ones.

In June and July 2006 I contacted ten participants, all of whom had indicated that they wished to be a participant in my follow-up study and had been a mother for at least one year. Together these ten women represented a fairly diverse group according to socio-demographic variables and maternity care styles. I accessed these women's names, contact information and data through the *PHS* (see Appendix E on page 183 for *Participant Phone Contact Script*). When I phoned each woman I introduced myself, provided them with information about the nature of the interview questions (see Appendix F on page 184 for *Participant Information Sheet)*, answered any questions they had about the interview, and requested their participation. I resorted to alternative participants when initially selected participants had either: 1) moved and changed phone numbers so that the contact information was no longer useable and the *PHS* did not have alternative contact information; 2) were repeatedly unavailable by phone during the data collection period; or 3) were out of town and not planning to return before the end of the data collection period. I provided participants with the option to complete the interview at a time and location that was of the greatest convenience and comfort to them. Locations that I suggested included their homes, an office on the UVic campus, or any other location they believed to be suitable; however, all of the participants opted to complete the interview in their own homes. I then phoned the participant the day before their interview to confirm our appointment.

At the arranged interview, I introduced myself and responded to any questions raised regarding my background, interests, research and coursework. I then reviewed the informed consent form (for more details on ethical agreement, see *Ethical Considerations* below). The interviews generally lasted between one and three hours, including breaks

for childcare and other interruptions as needed. With each participant's permission, the interview was tape-recorded for future transcription. I also took detailed notes throughout the interview, including emotional responses to some topics, participants' demeanor during the interview, and the atmosphere of the interview setting. (For details on the interview guide see Appendix C on page 179 and *Narrative Data Collection* section below.) At the conclusion of the interview, I asked the women if they would like to view a copy of their interview transcripts when they became available, so that they could have an opportunity to add to, delete, or alter something they said during the interview, in order to make them more representative of their experiences. This was done with the understanding that: 1) the narratives belong to participants and are theirs to change if they wish to do so, and 2) that sometimes in narrative retrospection a person can remember an event they believe to be important to their story after the interview (Miller, 2000). Two participants indicated that they did not want to receive their transcripts, and the remaining participants said they would like me to send their transcripts to them by email or mail.

Verbatim transcriptions of all the interview tapes were completed during August and September 2006, both by myself and a hired transcriber who had also worked on the *PHS*. After all interview transcriptions were completed, I reviewed each transcript while listening to the recorded interview and reviewing my written notes from the interview. During this process, I checked for detail and accuracy of interview transcripts, and added comments regarding participants' demeanor, body language and emotions into the

transcripts. I then sent the transcripts to participants via mail or email as they requested.[3] One week after the participants' anticipated receipt of the transcripts I re-contacted them via phone or email to determine if they wished to make any changes to their transcripts. None of the participants requested an opportunity to alter their transcripts; however, five participants expressed their embarrassment over frequent use of verbal cues and fillers such as "like" and "you know?" For these participants, we verbally agreed that their transcripts would be 'cleaned up' and these fillers reduced when I quoted passages of their speech in my thesis. Similarly, a sixth woman did not request specific changes, but commented that her dialect accent made her sound uneducated when reading verbal accounts of her language. Therefore, we verbally agreed that her grammar would be 'cleaned up' when quoting her, but not significantly altered since that would strip her account of her heritage altogether.

Ethical Considerations

This study was approved by the University of Victoria Human Research Ethics Board as an amendment to *PHS*, and all procedures followed in this research were ethically sound according to the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. At the time of the interview, I verbally and visually reviewed the informed consent form with the participant (see Appendix G on page 185), ensured that each participant had adequate time to read the form, and then asked if she had any questions before proceeding with the interview. Their involvement in this research was voluntary and confidential, and each participant had the right to withdraw at

---

[3] For the 5 participants who opted to receive transcripts via mail, I phoned to let them know the package was in the mail, and reminded them of my contact information in case the package did not arrive.

any time, before, during or after an interview. During the informed consent process I also obtained permission from each participant to both tape-record the interview and to make my own notes as well. I continued to use the participant identification numbers assigned in the *PHS* so that their names were not connected to the study data. Their contact information has been stored under lock and key and raw data (interview tapes and notes) have been kept in a separate locked filing cabinet in a locked office. Following final approval and acceptance of my thesis, raw data will be destroyed. In addition to myself and my supervisor, interview tapes were accessible to the transcriber in small quantities after the contact information was separated from the tape,[4] and four transcripts were reviewed by research associates with names and contact information removed in order to perform data validity checks as discussed below (see *Strengths and Limitations* section below).

As specified in the consent form and reviewed with participants, there were two risks to participating in this research. First, there was the potential inconvenience for the participant due to the time commitment involved in completing the interview. In recognition and appreciation of the participants' time and commitment to the study, I provided each woman with a thirty dollar honorarium for participating. Second, there was the possibility that participants would have emotional or psychological responses to the interview questions. In accordance with our informed consent agreement, and in the event that a participant found a question or topic too sensitive or personal to answer comfortably, I would remind her that she may choose to skip questions as desired, or could provide written answers in a sealed envelope (that I would only open after the

[4] The transcriber was given tapes five at a time, and they were kept in a locked drawer in a locked office while in her possession.

interview) if it would create a more comfortable environment for participation. Although it was not my intention to focus on exploring difficult or traumatic experiences, one question pertaining to 'what things had most influenced who they were as a woman or mother' brought up emotional or bothersome issues for three women (see Appendix C on page 179 for *Interview Guide*). These three noted situations were each dealt with according to their unique cases. First, one participant identified her parents' divorce and appeared very upset when explaining why it impacted her. In this case, I skipped the question, and began to probe into more positive aspects of her life, debriefed her for awhile after the interview (at which time she decided to not review her transcripts in order to leave the divorce-related memories in the past), and provided her with an information sheet that included community resources and support services.[5] Second, one participant identified her irregular pap test results, but indicated that she was very embarrassed about it. I suggested she could discuss a different issue, write her response down or skip the question, but she opted to push forward and tell me about the experience. Third, one participant conveyed that her past experiences with an ex-boyfriend had the most impact on her, but that she did not want to discuss it or write it down. Thus, we skipped the question and moved on in the interview. None of the participants seemed to be shy sharing their stories about menstruation, their breasts, their sexuality, or other issues discussed in the interview that would be considered by some to be taboo subjects for typical social interactions. When participants had an emotional response but wished to continue the interview, I provided support without interfering in

[5] This was the same handout used by the *PHS*, designed for and handed out to women who appeared to need professional supports or help during the course of their interviews.

her narratives through appropriate responsive sounds, facial expressions and body language. In some cases, this meant silently nodding my head in recognition of what a participant was saying, while with more openly upsetting anecdotes I would provide verbal responses ("oh no…") and/or indicate concern or sympathy with my face.

Narrative Data Collection

As noted above, I used qualitative methodology for data collection and analysis in my thesis because I believed that it was the best method available to elicit naturalistic, in-depth data, and allow for a representative and detailed understanding of the complexities and interrelationship of social, cultural and biographical factors in the participants' lived experiences (Bailey, 1999; Miller 2000). Collecting narrative data can invite a participant to bring the researcher momentarily into his/her social world to better understand and interpret the life experiences described in the data (Miller, 2000). The qualitative technique of narrative analysis explores the basic story being told, focusing on the way an account or narrative is constructed, the narrator's intention, the nature of the audience, and the meaning of the story being told (Reissman, 1993). It is of particular significance to this research because it allows for the study of meanings and interpretations of participants' experiences and dynamic identities, through its focus on both *what* people say, and *how* they say it. Indeed, Riessman (1993, p.52) argued that how narrators present their stories reveals information about their perceptions and interpretations, including tensions or competing narratives. During data collection and analysis, I relied as much as possible on the participants' views of the phenomena under investigation and privilege their construction of meaning of their experiences.

The narrative data collection for this research included one in-depth, face-to-face narrative interview with each participant (Bury, 1982; Miller, 2000; Riessman, 1993). Face-to-face data collection was most suitable for data collection in this narrative research because it enables a natural 'feel' for interactive narrative story-telling, since "personal narratives are produced in conversation" (Miller, 2000, p.31). Face-to-face interviews can also produce interactions that are private enough for sharing intimate stories with greatest comfort, such as discussing the private and potentially sensitive issues of menstruation, sexuality, pregnancy and first-time motherhood (Teitelman, 2004).

Qualitative narrative methods enable targeted research questions while still allowing for participants to contribute data that may not have been anticipated (Legard, Keegan & Ward, 2003, p.141). As is usually done with narrative data collection, my questions were unstructured and open-ended, and included broad questions about each topic to produce personal reflection with as little intervention as possible. This was done in order to capture experiences as they unfold for the narrator/storyteller (Miller, 2000, p.312) and to give them the flexibility to shape their own narratives. Therefore, I asked an initial interview question about each reproductive event that was open-ended and allowed participants to answer uninterrupted. Once their initial response was complete I used follow-up probes and prompts to gain further detail and clarification after each question. In doing so, I asked more targeted questions, such as, "Can you please tell me more about that?" and "Would you consider that a generally positive or generally negative experience? (Why?)" I stopped probing once I determined that they had described the

nature, content, context and evaluation of each experience or event in their reproductive biographies.

The topics I focused on include: menarche/menstruation, breast development, sexual initiation or early sexual activity, pregnancy and first-time motherhood. First, I asked women several open-ended questions about their current experience of motherhood, and then asked them to contrast that with experiences and events during their initial weeks and months of motherhood. Second, I shifted the focus back in time to puberty and asked an open-ended question about each reproductive event in turn, working forward from menarche to breast development, sexual initiation or early sexual activity, and then pregnancy. Third, I asked women to describe and reflect upon four additional topics and their impact upon their experiences with events and transitions during their life course, including: social support, formal and informal reproductive education, material resources, and changes to their bodies. Fourth, I asked the participants one wrap-up question in order to uncover anything they wished to discuss that had not yet been identified in the interview.

The questions posed (see Appendix C on page 179 for *Interview Guide*) were designed to facilitate a retrospective episodic narrative account, in which each participant was asked about particular topics along their life course trajectories (Summers-Effler, 2004, p.34). Episodic narrative methods of inquiry also offer an approach to data collection that enables the interviewer to concentrate on specific life events or periods as episodic narratives, while understanding the fuller contexts of participants' social worlds and allowing them to shape their own life narratives (Legard et al., 2003, p.141; Summers-Effler, 2004, p.34). In this case, the episodes focused on the topics identified

above, as well as any that a participant believed to be significant in her life story. Retrospective techniques enable researchers to understand participants' experiences and events in their narratives in the context of their life course trajectories (Hydén, 1997, p.51). Using retrospective techniques also enabled me to gain a longitudinal perspective from a single point in time, making data collection sensitive to the time and financial constraints that negated a longitudinal study design for this research. Furthermore, retrospective techniques allow participants to make connections between the events in their lives using their own knowledge and interpretations of their experiences, and in doing so, provide insight about similarities and comparisons across events during their lives.

Quantitative and Qualitative Data Analysis

Data analysis for this research involved three stages, and took place from October 2006 to February 2007. In the first stage I produced descriptive statistics of my sample and its parent population using data from *PHS* and the statistical analysis software package SPSS. While my small sample size (N=14) precludes meaningful quantitative analysis and interpretations, this analysis (see Chapter 4) enables me to describe my participant sample with regards to some socio-demographic characteristics and select health variables from *PHS*. The purpose of this description is two-fold. First, it provides general characteristics of the participant sample of this thesis research. Second, it allows me to examine how this sample compares to all of the first-time mothers within the *PHS* parent population (N=54) as well as to the entire *PHS* population (N=93). As such, this data helps to establish the background characteristics of my sample and contextualize them within their originating sample population.

The second and third stages of data analysis constitute the majority of the data analysis of my thesis. These stages are purely qualitative, drawing upon narrative data analysis procedures, and were completed manually. Narrative data analysis offers a powerful way to analyze both the implicit messages and explicit content of first-time mothers' accounts (Reissman, 1993). In the second stage of this analysis, I explored each participant's reproductive life trajectory individually. In doing so, I looked for key themes within the narratives, and prominent and defining aspects of their biographies. I then explored *whether*, *how* and *why* the five reproductive events in the narrative 'episodes' showed flows within or disruptions to the general course of their biographical trajectory. Once these three elements were clear, I explored the narrative to evaluate whether each instance of disruption, flow or reinforcement was generally positive, negative or neutral. When exploring the transition into motherhood, results of the analysis necessitated further study to understand themes within experiences of biographical disruption, and to establish *types* of disruption.

Determining *whether* a reproductive event in the narrative 'episodes' showed biographical disruption, biographical flow or biographical reinforcement within the general course of their biographical trajectory involved evaluating if an event seemed to reflect one or more of those concepts. To make this determination, I drew upon the definitions of each concept provided above (see Chapter 2) and as such, followed the key criteria laid out by the respective researchers in order to identify and classify each event. A 'biographical disruption' included: shifting roles and/or role involvements, shifting situational contexts, shifting socio-cultural contexts, re-thinking one's biography, re-thinking one's self-concept, altered everyday life routines, changes to current knowledge,

new or altered social networks, and altered plans for the future (Bury, 1982). An instance of 'biographical flow' included: unchanged roles and role relationships, unchanged situational contexts and socio-cultural contexts, events being considered 'normal' or quickly normalized within the trajectory, events being easily integrated into one's self-concept of identity, no impact or minimal impact on everyday life routines, and an overall continuation of previous life experiences and the existing biographical trajectory (Faircloth et al., 2004). For reasons explained in the *Literature Review* above, 'biographical reinforcement' (Carricaburu & Peirret, 1995) and 'refraction of the self' (Bailey, 1999) were kept in mind as possible types of disruption, but were not focused upon in the same way as 'flow' and 'disruption' were.

Exploring *how* an event in the narrative 'episodes' exhibited an instance of disruption or flow meant establishing what elements or criteria listed above were part of the event; that is, determining the way in which the event was a flow or disruption within its trajectory. For example, an event may be characterized by changes to a participant's self-concept, shifting role involvements and altered role relationships, and thus, would be considered a biographical disruption. Despite these clear categories, during data analysis I considered that each event may be characterized by elements of two or all three categories, rather than only one. Indeed, this was sometimes the case. In these cases, I classified each event according to which category it *most* reflected, which was determined by which elements seemed to dominate the participant's experience in her narrative.

Exploring *why* the five reproductive events in the narrative 'episodes' showed a disruption or flow within the general course of their biographical trajectory involved an

investigation into the central reason(s) that the event was experienced in that way. These reasons formed themes within each narrative, and thus, were coded and analyzed thematically. These themes were not usually the same as the criteria listed above, but usually reflected them. As a case in point, 'peer-group membership' was a theme within many of the narrative episodes about the onset of menstruation and reflects the idea of changing role relationships. There were many aspects of the narrative episodes that could have formed numerous themes as well as sub-themes within them; however, only the most prominent themes have been included in this analysis of each event. For this analysis, prominence of a theme was determined by how many participants identified it, as well as the degree to which a participant connected it to understanding her trajectory and life experiences.

In evaluating whether an event was primarily 'positive' or 'negative,' I focused on two aspects of the event. First, I considered the actual *experience* that the participant had; that is, whether the event was enjoyable or unpleasant. Second, I examined the end result of the event to see whether it had any advantageous or detrimental ramifications for that individual within their self-concept or biographical trajectory. Similarly to the data analysis processes described above, events that included both positive and negative aspects were classified as the one that the narrative *most* reflected. Cases in which there were was a balance of positive and negative elements, that is, *neither* were dominant were considered 'neutral.' Furthermore, cases in which there were no clear indications of positive *or* negative aspects at all were likewise classified as 'neutral.'

When exploring the transition into motherhood, a thorough analysis of the data also necessitated thematic analysis within experiences of biographical disruption. This

was necessary to establish *types* of disruption involved in new motherhood that emerged through thematic coding of the narratives. These themes were primarily determined by the narrative episodes pertaining to pregnancy, initial new motherhood and more recent experiences of motherhood. However, the themes were also informed by an understanding of each participant's general identity, self-concept, and themes present throughout the narrative episodes that formed her biographical trajectory. As has been done for the other steps of qualitative analyses outlined above, I also recognized the presence of more than one 'type' of disruption of motherhood. In all of the narratives explored only one typology dominated the account, but in two participant narratives a second type was also evident. In the results presented below, I focus on the typology that dominated the participant's account. Although they were explored in less detail than the primary typology for that participant, secondary typologies are considered supplementary and have been used to complement discussions of that respective type. There was no evidence of more than two typologies in any of the narrative accounts.

Combining all of the above steps to explore *whether*, *how* and *why* the five reproductive events demonstrated biographical flows and/or disruptions, to evaluate whether each was positive, negative or neutral, and to establish the disruption type evidenced in first-time motherhood, involved both analysis of plot trajectories and structural linguistic analysis. To understand each participant's biographical trajectory, I first applied Riessman's (1993) technique of 'plot reduction.' The technique of narrative plot analysis has been useful to identify biographical disruptions within shorter-term conceptual frameworks in previous research (Miller, 2000). In my analysis, I extended this plot to include reproductive transitions and other significant events in their life

course from puberty onwards. I accomplished this by reducing each woman's narrative to its core or 'skeleton' plot, including key reproductive and biographical events[6], and the age at which the event occurred. This allowed me to explore the foundation of each woman's life course. I then began to add details to this plot, including quotations describing the event, and what social support and related education was available and/or accessed at that time. Exploring this augmented 'plot' represented the general 'roadmap' of each woman's reproductive life course.

During each woman's interview, I asked directly for descriptions and evaluations of each event in questions and follow-up probes. However, to contribute to my understanding of participants' experiences, I also analyzed further ideas carried within their explicit accounts. I support Riessman's (1993, p.20) argument that structural features can reveal how narrators want to be understood and can also give insight into women's evaluations of their experiences. To add this layer of analysis to details about the content of each woman's plot, I employed Bell's (1988) structural linguistic model of narrative analysis. This model emphasizes *how* the story is presented, or what linguistic structural elements contribute to meaning and interpretation of the narrative. This analytical tool offered a powerful way to uncover the implicit messages in the explicit content of the narratives.

For the purposes of this thesis, I focused on two linguistic structures: word selection (or word choice) and word repetition (Trudell & Whatley, 1992). *Word choice,*

---

[6] "Key reproductive events" here include the five that were elicited through interview questions as well as additional events related to reproductive functions and/or health identified by the participant, such as beginning of masturbation, date rape, miscarriages, breast reduction surgery, etc. Other "biographical events" include social and demographical events, such as being homeless, getting married, getting divorced, etc.

or a narrator's selection of one word over another, conveys information about the meanings and emotions associated with that event or phenomenon for the narrator (Riessman, 1993, p.37; Trudell & Whatley, 1992). Words like 'scared', 'horrible' and 'dreaded' have negative connotations, while words like 'special,' 'great' and 'looking forward to' indicate more positive connotations. In addition to greatly facilitating the understanding of the women's evaluations of whether an event was positive or negative, *word choice* was used to complement the determination of flow, disruption, reinforcement, and maternal disruption typology based on the content of women's plots. Words such as 'changed' and 'old/new life' suggests disruption, while 'same' and 'normal' suggest flow. *Word repetition* is a narrative device in which some key words or phrases are repeated either during one segment of narrative or throughout a full narrative account. These repetitions can make the meaning of the stated words or phrases more powerful or prominent in the narrative, and therefore, can reveal what ideas are particularly influential or dominant either during one event or that participant's life course, and how that may have changed over time (Riessman, 1993, p.37; Trudell and Whatley, 1992). The descriptions and evaluations that enriched the plot trajectories during this phase of the analysis were furthered also by my interview notes regarding participants' demeanor when discussing or describing their experiences.

Combining the plot trajectory analysis of each participant's life with this structural linguistic analysis created a detailed and dynamic account of each participant's life course, with particular attention and detail of reproductive events. This represented each participant's biographical trajectory. This biographical trajectory was then used to determine how each reproductive event or transition was situated within their life course,

including whether, how and why it was a biographical disruption and/or flow, as well as facilitating my understanding and interpretation of the overall picture of their lives.

In the third stage of data analysis, I completed a cross-sectional analysis of the five reproductive events I set out to investigate: menarche, breast development, sexual initiation, pregnancy and first-time motherhood. To achieve this, I conducted thematic analysis within each event, and identified themes that appeared in several of the women's narratives. Much like the thematic analysis described above in stage two of the analysis, in the results presented here, I focus on the dominant themes that were present, and not the sub-themes or less frequent themes. This comparison between participants' accounts was crucial to understanding the main reasons that each reproductive event was experienced as generally positive, negative or neutral, and as a biographical disruption or flow. Commonalities and differences within their experiences informed my understanding of what elements can have protective effects to buffer a woman's experience so that she may make a transition more easily or more positively, as well as what elements can complicate or be detrimental to a woman during that event or transition. These latter comparisons suggest the commonalities or features of their lives that may facilitate a certain typology of disruption during the transition to new motherhood. Alternatively, understanding the essential difference between narrative accounts by women who share a common biological event but have very different biographical experiences is also important.

I recognize that my own background shapes my interpretation and analysis, and so I have strived to be as reflexive during the research process. I have 'positioned' myself in the research during data analysis and the presentation of results. Therefore, in

the presentation of my analysis I distinguish between participants' views ("she evaluated this experience positively…") and my interpretation of their narratives ("it seems that her experience was quite positive"). In addition to positioning myself within the research this way, I provide an overview of my personal point of view to further facilitate reflexivity in this thesis.

Researcher's Point of View

My personal life experiences have shaped my research perspective and the research proposed here. For the last ten years, I have worked with several organizations that focus on women's health and the status of women around the world, including V-Day, a global movement to stop violence against women and girls. I am concerned about gender inequalities and the relationships between power, status, health and violence. I believe that while 'women' is not a homogenous category, women experience their bodies and their world in a way that is fundamentally different than men. On the other hand, I feel that while women share some biological commonalities and events, the way that they understand and interpret their bodies and related biological and reproductive events can vary tremendously. It is the diversity and richness of these experiences that I seek to better understand through my work and my research. Underlying much of my academic endeavours is an interest in women's power and agency, and a desire to increase women's mental, emotional, physical and sexual health.

Several insights and conclusions based on my academic experiences and work within the Victoria community guide my assumptions and understandings of women's life course experiences. In my undergraduate and graduate studies of menstruation and sexual education, I have found that women's bodies are often sites of confusion,

conflicting messages and disempowerment. For many women, menstruation is an experience that is simultaneously filled with shame and pride; yet it can also be a site of bonding or community building. Furthermore, I have found that formal sexual education curricula are more likely to address reproduction than sexuality, emphasizing young women's significance as potential child-bearers, rather than their sexuality or sexual identities. Therefore, I take a somewhat critical stance toward research concerning women's reproductive events and processes, paying attention to ways that women can be disempowered at both structural and personal levels, as a result of unequal gender relations. However, as an optimist and a woman who hopes to have children in the future, I also believe that women are agents in their experiences, and that any reproductive event or transition can be empowering, liberating, and an opportunity to celebrate womanhood and women's bodies.

Strengths and Limitations of Data Collection and Analysis

By using interviews as my method of data collection, this research was subject to the problems and potential biases common to other such studies. Participants' responses may have been influenced by an *interviewer effect* or *social desirability bias* (Esterberg, 2002, p.86), that led them to answer differently than they may otherwise have, as a result of their perception of my character, skills or research interest, or my social location (and outsider status) as a White, academic, middle-class, young woman that has not given birth. I tried to address this potential bias by explaining to each participant before the interview that I was interested in their viewpoints and that there were no 'right' or 'wrong' responses, and by developing rapport and a degree of comfort and familiarity immediately prior to the interviews. For participants who had not previously met me in

my capacity as an interviewer for the PHS, this sometimes required more preliminary dialogue than for others.

In conducting this research, I attempted to ensure internal validity, representation and consistency in several ways (Lewis & Ritchie, 2003; Palys, 2003). In this research, *internal validity* is understood as an "[accurate reflection] of the phenomena under study as perceived by the study population" (Lewis & Ritchie, 2003, p.274). *Representation* in qualitative research considers "how and by what authority we'll represent our participants through our data and interpretations" (Palys, 2003, p.71). As described above, in this research I provided participants with their interview transcripts and allowed them to make alterations so that their narratives could best reflect their experiences. I have also located participants' voices at the forefront of my analysis by including their perspectives and opinions, and by using verbatim quotes. In accordance with qualitative methods of data analysis and presentation of results, I have included quotes of varying degrees in length. Furthermore, as per narrative methodological practices, some of these quotes reflect a dialogue between the interviewer and participant, and/or present more lengthy accounts to preserve the context in which a given statement was presented (for examples see Miller, 2000; Riessman, 1990). I also worked to keep participants' opinions and insights into their lives at the forefront of this analysis by directly asking women what or who they believe had substantial influences on their reproductive events and their transition to motherhood, rather than merely attempting to infer such information through my analysis. Lastly, I have also strived to be reflexive throughout the research process and presentation of results, to make my assumptions, biases and preconceptions explicit, both as the interviewer and interpreter of this data.

To enhance consistency in this research, I have made explicit the criteria and coding schemes used during data interpretation and analysis. This will also allow my readers to evaluate my interpretations and analyses for themselves. Furthermore, in this qualitative research, consistency is most applicable as an evaluation of *inter-rater reliability*, or "the extent to which assessments, judgments, ratings and so on, internal to the research conduct are agreed upon or replicated between researchers, judges, etc." (Lewis & Ritchie, 2003, p.271). I established the reliability of this research in two stages. First, early on in the data analysis process my Graduate Supervisor, Dr. Cecilia Benoit, reviewed three of the fourteen interview transcripts. She and I independently coded these transcripts to look for prominent themes and ideas. We then met and discussed our findings, and through this comparison, found that we agreed upon several key themes that were significant in these three women's stories. The second stage in establishing reliability involved more detailed coding and interpretation of women's stories following my more thorough analysis of all participants' narratives. Two research colleagues, Ms. Emily Arthur and Ms. Annie Kelly, each analyzed two participant transcripts. At least one transcript was selected at random from each of the three types of disruption that I had identified. These researchers thematically analyzed the narratives to determine the key aspects of each participant's life trajectory, and to identify the key features of that participant's transition into motherhood. The results of this analysis were then compared to my analysis of those same transcripts. This comparison indicated that we were in agreement about the major features of each participant's trajectory and transition, as well as the other major themes present in their accounts. There was some minor variation in our labeling of these themes and features within the narratives, but the underlying ideas

were consistent. After this check for consistency and inter-rater reliability, these two researchers were also provided with my full interpretation and analysis of those four women's accounts, including the typology of disruption I assigned to them, and asked to review and critique those analyses. In all four cases, this analytical cross-check confirmed my results, including some minor alterations but no changes to typologies of disruption, their features, participants' placement within the categories, or other major changes.

Within this chapter I have outlined the research design and methodology employed in this thesis. I reviewed processes followed pertaining to sampling, data collection, data analysis and inter-rater reliability. I also identified the ethical considerations involved in the design and implementation of this thesis, and been as explicit as possible regarding my role in the research process. Lastly, I have presented my evaluation of the methodological strengths and limitations of this thesis. In the following chapter I present some quantitative data from *PHS* to characterize my thesis sample and compare it to the *PHS* parent population, before continuing on to Chapter 5 to present my research findings.

CHAPTER 4:

DESCRIPTIVE STATISTICS OF THE THESIS SAMPLE AND SAMPLE POPULATIONS

The following analysis of descriptive statistics is based on results from three waves of interviews with participants from the parent study *(PHS)*, including age, education, income, visible or ethnic minority membership, partnership status, and parity. The purpose of this chapter is three-fold. First, I present descriptive data in order to understand the socio-economic status, demographic and maternity care data of the *PHS* (henceforth referred to as the '*PHS* sample population'). These data will provide the basis for assessing the general make-up of the sample population from which my thesis participants were sampled. Second, I compare these *PHS* characteristics with those of the first-time mothers in the *PHS* (henceforth referred to as the '*PHS* first-time mothers') to determine how first-time mothers in my thesis may be similar or different from the new mothers in the parent study. Third, I present a selection of data available from the *PHS* for the 14 women in the thesis sample, including socio-economic statuses, demographic characteristics and maternity care style. While the intent of this research is not to generalize to the other first-time mothers in the *PHS*, nor to or *PHS* population overall, a comparison of my participants' characteristics and maternity care data with the other groups in the parent study is useful for determining similarities and differences that provide a backdrop for my subsequently presented qualitative findings.

The PHS Parent Population

Using the sampling procedure discussed above (see Chapter 3), I recruited my research sample from the first-time mothers participating in the *PHS*. The *PHS* relied on a non-random purposive participant sample drawn on the basis of four overarching

criteria: 1) residence in the Census Metropolitan Area of Victoria, BC, 2) a current pregnancy, 3) diversity of socioeconomic backgrounds, and 4) choice of maternity care provider. Thus, this sample population included pregnant women who represented a range of ages, ethnicities, educational levels, parity and economic status. The researchers attained the sample by distributing posters and flyers to places that they expected pregnant women would frequent, including physicians and midwives offices, pre-natal classes, ultrasound offices, maternity programs for lower-income women and more.[7] While this non-random sampling technique precludes one's ability to extrapolate from the sample to other pregnant women in the Victoria CMA, the sample was intended to reflect the diversity of social and economic backgrounds and the style of maternity care available through the public health care system in the area.

PHS researchers initially recruited 107 women between October 2004 and the Fall of 2005, with an estimated population-based recruitment rate of approximately 3.8 percent.[8] They interviewed the women at three points in time, losing some participants prior to each stage of interviews. Some of the original 106 women were unavailable for the first interview since they were no longer pregnant, having experienced either a therapeutic abortion or a spontaneous miscarriage. Other participants were lost from the sample at each wave of interviews because they had moved outside of the region, were no longer available through their contact or alternative contact information on file, or had scheduling conflicts. *PHS* researchers successfully interviewed 93 women during their

---

[7] Other examples include: libraries, single-parent resource centres, low income outreach programs and community centres.

[8] This estimate is based on the number of live births in the Greater Victoria, Sooke and Saanich Local Health Authority (LHA) communities in 2005. Geographically, these three communities form an area slightly larger than the Victoria CMA (British Columbia Vital Statistics Agency, 2005)

third trimester of pregnancy, 89 women at 4-6 weeks postpartum, and 84 at the third interview during the 4-6 months postpartum. The *PHS* therefore had a retention rate of 90.3% from the first to the third wave of interviews, and provided an initial sample population base for this study of 84 diverse women from the Victoria CMA. *PHS* participant demographic information discussed in the following section is based on these 84 women (see Table 1 below for details).

Table 1. Population Characteristics.

	Thesis Sample (N=14)	*PHS* First-time Mothers [a] (N=49)	*PHS* Sample Population (N=84)	Victoria CMA (2001) (N= approx. 312,000)
Age at 3rd Trimester (completed years)				
Mean	30.3	29.0	29.5	N/A
Median	31	29	29	N/A
Education				
Highest level of education completed (scale of 1-5) [b]	3.4	3.8	3.7	---
Completed High School (%)	85.7%	93.9%	89.3%	91.1% (females aged 20-34)
Gross Annual Household Income[c]				
Mean	$52,777	$53,788	$54,075	$66,594
Median	$60,000	$54,000	$56,000	$55,529
Own Housing	28.6%	36.7%	41.7%	61.8 %[d]
Ethnicity				
Visible or Ethnic Minority	7%	8.2%	11.9%	9.0% (females)
Aboriginal[e]	0%	2.0%	4.8%	2.8% (females)
Partnership Status: 4-6 Months Postpartum[f]				
In an intimate relationship	85.7%	93.9%	92.9%	---
Living with an intimate partner	78.6%	89.8%	89.3%	---

[a] Here, "first-time mother" refers to women with no previous biological or adopted children, as per PPHS survey design and definition.

[b] This was measured on a scale of 1 to 5, where: 1=Some additional education/training but none completed; 2=Complete Short Certificate Program; 3=Complete Apprenticeship; 4=Complete Diploma Program/trade School; 5=Complete Post-Secondary Degree.

[c] All figures presented here are in Canadian Dollars. "Gross Annual Household Income" was solicited in the Self-Administered section of the questionnaire by the asking participant, "Including your partner and other family income earners in your household,

what was your total annual household income during the last year, (before taxes and not including tips if applicable)? Do not include financially independent room-mates."

[d] This is by household, and is not specific for age or gender.

[e] Includes both Status and Non-Status Aboriginal women.

[f] This was determined through a single question in the self-administered section: "Are you currently in an intimate/love relationship?" with Yes/No response categories.

The women in the *PHS* sample population exhibit a variety of socio-economic and demographic characteristics, and myriad health care experiences. These 84 women's ages ranged from 18 to 43, though the vast majority of them were between the ages of 23 and 35. The sample was slightly less educated than the women in the CMA, with less high school graduates than the larger population. They had a wide variety of annual household incomes, ranging from $2106 to $150,000 CDN, and a mean over $12,000 less than that of the CMA. As could be expected due to the relatively young ages of women in the sample and the high cost of housing in Victoria during the study timeframe, a smaller proportion of these women owned their own homes than the larger Victoria CMA population. The *PHS* sample population included several Aboriginal women, including Status, Non-Status, and Métis women, as well as visible minority women. In this sample the representation of Aboriginal women (4.8 %) and visible minority women (11.9%) is somewhat higher than that of females in the Victoria CMA, in which 2.8% are Aboriginal women and 9.0% are visible minority members.

The majority of the women in the *PHS* sample population share many similarities with each other across variables concerning sexual orientation and partnership status. Most (94.0%) of the women said they were heterosexual, and the remaining 6.0% self-identified as bisexual. During their third interview 4-6 months postpartum, most of the

women were involved in an intimate relationship, though slightly less were living with an intimate partner at the time.

The *PHS* also investigated many aspects of maternity health care, including type of care providers, availability/accessibility of care, satisfaction with care, and details of the births, such as style of birth, people in attendance and several other factors. (See Table 2 below for a selection of these data.)

Table 2. Maternity Care and Birthing Experiences.

	Thesis Sample (N=14)	*PHS* First-time Mothers (N=49)	*PHS* Sample Population (N=84)
Care Provider Style:			
Midwifery Care Only	28.6%	34.7%	34.5%
Midwifery and Physician or Obstetrician Care	21.4%	20.4%	14.3%
Physician or Obstetrician Care Only	50.0%	44.9%	51.2%
Birthing Style:			
Vaginal Delivery	64.3%	63.3%	66.7%
Planned Cesarean Section	21.4%	12.2%	14.3%
Emergency Cesarean Section	14.3%	24.5%	19.0%
Mean rating of satisfaction with the birth across the population (out of 5). [g]			
At 4-6 weeks postpartum	4.7	3.9	4.1
At 4-6 months postpartum	4.6	4.0	4.0

[g] Satisfaction with the birth was determined by asking participants "how would you rate your overall satisfaction with the birth itself, based on your own expectations, and compared to past births if you have other children?" It was measured on a scale of 1 to 5, ranging from "very dissatisfied" to "very satisfied."

Within the *PHS* population, approximately half of the women received care from a physician or obstetrician only, and one third had exclusively midwifery care. The remainder of the participants had both midwifery care and physician or obstetrician care, usually because a woman would begin with midwifery care and end up with additional physician care due to the circumstances of the birth, or complications that arose close to or at the time of the birth. One third of women in the *PHS* delivered their children via

cesarean section, including both emergency and planned c-sections. This c-section rate approximates that of the Southern Vancouver Island Health Service Delivery Area in 2004, where 33.8% of live births were delivered via c-section (British Columbia Vital Statistics Agency, 2004).[9] The majority of the *PHS* sample population rated their overall satisfaction with their birth as "very satisfying" during their *PHS* interview at 4-6 weeks postpartum, but by 4-6 months postpartum rated their satisfaction slightly lower. [10] (For study findings regarding satisfaction with birth and care provider satisfaction, see Benoit, Westfall, Treloar, Phillips and Jansson, (In Press).)

All three waves of the *PHS* included several questions investigating self-reported mental or emotional health,[11] physical health, stress, and fatigue. The research team's quantitative components of the questionnaires included self-rated measurements of all four topics using five-point Likert scale response options. In general, the mean values for these variables among the *PHS* sample population indicate that participants seemed to report fairly good health, both physically and mentally, but consistently reported better physical health than mental health at all three points in time (see Table 3 below for details).

---

[9] The c-section rate of 33.8% for the Southern Vancouver Island Health Service Delivery Area in 2004 was the highest rate of c-sections in British Columbia in 2004 (British Columbia Vital Statistics Agency, 2004).

[10] Despite a similar overall mean satisfaction reported across these two interviews, when asked to rate their satisfaction at 4-6 months more women reporting being "somewhat dissatisfied" and fewer women reporting feeling "neutral" or "very satisfied."

[11] The *PHS* questionnaire included several measurements of emotional and/or mental well-being. On several questions, the research team combines mental and emotional health. In the following discussion I will use the term "mental health" to refer to general measures of mental *and* emotional health.

Table 3. Health Variables at a Glance

Health Ratings (Scales of 1=low to 5=highest)	Thesis Sample (N=14)	*PHS* First-time Mothers (N=49)	*PHS* Sample Population (N=84)
Mean Population Rating: Mental/ Emotional Health[h]			
3rd Trimester	3.71	3.65	3.45
4-6 weeks Postpartum	3.29	3.31	3.43
4-6 months Postpartum	3.50	3.16	3.19
Mean Population Rating: Physical Health			
3rd Trimester	4.00	3.86	3.67
4-6 weeks Postpartum	3.77	3.60	3.68
4-6 months Postpartum	3.57	3.14	3.25
Mean Population Rating: Fatigue[i]			
3rd Trimester	3.64	3.49	3.62
4-6 weeks Postpartum	3.79	3.80	3.69
4-6 months Postpartum	3.29	3.63	3.67
Mean Population Rating: Stress[j]			
3rd Trimester	3.00	2.92	2.95
4-6 weeks Postpartum	2.50	2.84	2.90
4-6 months Postpartum	2.79	2.96	2.96

[h] In the first and third interviews, mental/emotional health and physical health was determined by asking participants "In the last 4 months, how would you rate your (mental or emotional health/physical health)?" During the second interview, "In the last 4 months…" was replaced with "Since your baby was born…" Response categories for mental/emotional and physical health include: 1=Poor; 2=Fair; 3=Good; 4=Very Good; and 5=Excellent.

[i] In the first and third interviews, fatigue was measured by asking participants "In the past 4 months, how often have you felt tired or fatigued?" At 4-6 weeks postpartum, this question began "Since having your baby…" Response categories were: 1=Never; 2=Not Often; 3=Sometimes; 4=Very Often; 5=Always/Chronically.

[j] In all three interviews, stress was determined by asking participants "Thinking about the amount of stress in your life during the last 4 months, would you say that most days are…" Possible responses were: 1=Not at all stressful; 2=Not very stressful; 3=A bit stressful; 4=Quite a bit stressful; 5=Extremely stressful.

Interestingly, participants' ratings for both mental and physical health remained very consistent from their third trimester to 4-6 weeks postpartum, and then dropped significantly by 4-6 months postpartum. (For more information concerning mental/emotional health findings by *PHS* researchers see Benoit, Westfall, Treloar, Phillips and Jansson, (In Press).) The *PHS* sample population also reported considerable

rates of stress and very high levels of fatigue at all three points in time. There was very little variation in stress and fatigue levels across time, other than a slight dip in stress at 4-6 weeks postpartum.

According to the *PHS* researchers' objectives, parity was determined by the number of biological or adopted children that a participant had prior to or during the first interview. According to this definition, 60.7% (N=51) of the 84 women in the *PHS* sample population were first-time mothers, while 28.6% (N=24) had one child prior to their first interview, 7.1% (N=6) had two children, and 3.6% (N=3) had three children.

The PHS First-time Mothers

Comparative analyses between the *PHS* first-time mothers and the *PHS* sample population reveal some interesting similarities and differences. For more detailed comparative data outlining these differences and similarities see Table 1 (Population Characteristics) on page 78, Table 2 (Maternity Care and Birthing Experiences) on page 80 and Table 3 (Health Variables at a Glance) on page 82. The 49 first-time mothers were approximately the same age as the larger *PHS* sample population. The first-time mothers reported more formal education than the *PHS* sample population, evidenced by a higher percentage of high school graduates and a slightly higher mean level of education or training. The first-time mothers reported a slightly lower mean and median income than the *PHS* sample population, and were also less likely to own their own homes.[12] Aboriginal women and visible or ethnic minority members were slightly underrepresented among the *PHS* first-time mothers in comparison to the Victoria CMA

[12] Much like the *PHS* sample population, the mean income, median income and rate of home ownership of the *PHS* first-time mothers are considerably below the Victoria CMA population levels.

and largely underrepresented in comparison to the *PHS* sample population. During their third interview, the *PHS* first-time mothers and *PHS* sample population shared similar overall percentages of women involved in an intimate relationships, as well as those living with their intimate partners during their third interview. However, for both the *PHS* first-time mothers and *PHS* sample population, not all women involved in intimate relationships were living with their intimate partner at that time.

The *PHS* first-time mothers had a similar variation of care provider styles to the *PHS* sample population, though fewer first-time mothers had exclusively physician or obstetrician care, and more had combined midwifery and physician or obstetrician care. Similar to the *PHS* sample population, approximately one third of the *PHS* first-time mothers delivered their children via c-section; however, first-time mothers had slightly fewer planned cesareans and more emergency c-sections. *PHS* first-time mothers tended to rate their birthing experiences with less satisfaction 4-6 weeks postpartum, producing a slightly lower mean satisfaction rating, since more first-time mothers reported being "very dissatisfied" or "somewhat dissatisfied" while less reported being "very satisfied." While the mean satisfaction rates of the *PHS* sample population had decreased slightly by the third interview at 4-6 months postpartum, the first-time mothers' evaluations *increased* slightly by this time, thus, these have similar means of birth satisfaction ratings by 4-6 months postpartum.

In comparison to the *PHS* sample population, the *PHS* first-time mothers reported higher ratings of both mental and physical health during their third trimester. However, the overall mean values of self-reported health indicate that *PHS* first-time mothers did not experience the same consistency of mental and physical health from the third

trimester to 4-6 weeks postpartum as the *PHS* sample population, but rather, had a noticeable decline in both mental and physical health by 4-6 weeks postpartum. Furthermore, these first-time mothers experienced another decline in health by 4-6 months postpartum. As a result of these declines, despite the first-time mothers' initially higher ratings of mental and physical health, they actually fall below those of the *PHS* sample population after their third trimesters. Similar to the *PHS* sample population, the first-time mothers were considerably stressed as well as fatigued; however, they did show a slightly greater variation in their evaluations over time. The *PHS* first-time mothers and *PHS* sample population demonstrate a similar dip in stress at 4-6 weeks postpartum; however, the first-time mothers' temporary decline is somewhat more pronounced than that of the *PHS* sample population. At 4-6 weeks postpartum, the first-time mothers reported their highest levels of fatigue but lowest levels of stress. By 4-6 months postpartum the *PHS* first-time mothers' fatigue drops and stress increases slightly, resulting in mean levels that approximate that of the *PHS* sample population.

Using the sampling methodology described in Chapter 3, a sample of 14 women were recruited for this thesis from the 49 first-time mothers still participating in the *PHS* at 4-6 months postpartum. These 14 women will now be explored and compared to the 49 *PHS* first-time mothers.

Descriptive Statistics of the Thesis Sample

The 14 women who make up the sample for my thesis are a considerably diverse sub-sample of the parent sample population, and have numerous points of similarity and differences from the *PHS* first-time mothers group. (See Tables 1 to 3 above for more detailed comparisons between the thesis sample, *PHS* first-time mothers, the *PHS* sample

population, and the Victoria CMA where applicable.) This study sample includes a wide range of ages, with the youngest participant being 18 years old during her third trimester of pregnancy, and the oldest being 43; however, most of the participants were in their late twenties or early thirties. Twelve of the 14 women had completed high school education and the other two were currently enrolled in a school or training program, making them slightly less educated than the *PHS* first-time mothers. Almost all of these 12 women had gone on to pursue education beyond high school, but some had not successfully completed their post-secondary education or training programs. The 14 women in the thesis sample had a considerable range in gross annual household incomes ($2,106 to $110,000) and had a similar mean income but higher median income level than the *PHS* first-time mothers. Additionally, less than one-third of the thesis sample owned their own home; a lower rate of home ownership than the *PHS* first-time mothers or *PHS* sample population. These 14 women also represent a variety of partnership situations. Thirteen women were involved in an intimate relationship during their third trimester of pregnancy, with 11 also living with their intimate partner, but by 4-6 months postpartum, several of the women were no longer intimately involved or living with their partners. Overall, this sample's partnership status rates are similar to those of the *PHS* first-time mothers. Among the 14 women in the thesis sample, one participant was bisexual and the rest were heterosexual.

Despite my attempt to recruit as diverse a sample as possible, none of the 14 women interviewed for this thesis were Aboriginal, and only one was a representative of a visible minority. The Aboriginal and visible minority women from the *PHS* population were not included in my thesis interviews because only two visible minority women and

one Aboriginal woman were recruited for the thesis after the third *PHS* interview, and two of these women were no longer available during the thesis interviews. Therefore, the thesis sample includes one visible minority woman, and 13 Caucasian women, which under-represents Aboriginal and visible minority women in comparison to the *PHS* first time mothers.

The 14 first-time mothers who I report on in this thesis include women from all three primary care provider groups, with approximately half in the primary care of solely physicians or obstetricians during their deliveries, one third having exclusively midwifery care, and the remainder having combined midwifery and obstetrician or physician care. These 14 women had similar rates of vaginal deliveries to the *PHS* first-time mothers, with approximately two-thirds having vaginal deliveries and one third having a cesarean section. Interestingly, the thesis sample had higher rates of planned cesarean sections and lower rates of emergency c-sections than the *PHS* first-time mothers or *PHS* sample population. On average, the thesis sample rated their births with higher satisfaction at 4-6 weeks postpartum than the *PHS* first-time mothers; indeed, 13 of the 14 rated their births in the highest level of satisfaction category - "very satisfying." Despite a slight decrease in their reported level of satisfaction by 4-6 months postpartum, they still reported higher satisfaction with their births than either the *PHS* first-time mothers or *PHS* sample population.

Although the self-reported health data among the 14 participants in the thesis sample generally reflects the trends among the *PHS* first-time mothers, they do exhibit a few noteworthy differences. The thesis sample shows somewhat higher mean ratings of mental health and consistently higher physical health than the *PHS* first-time mothers.

Nevertheless, the thesis sample demonstrates a pronounced drop in mental and emotional health between the third trimester to 4-6 weeks postpartum, similar to the *PHS* first-time mothers. Despite this decline in their mean self-reported health levels, the thesis sample shows increased mental health between 4-6 weeks to 4-6 months postpartum. This is unlike the *PHS* first-time mothers or *PHS* sample population, which both continue to decline. The thesis sample also appears to be a quite fatigued group, but drops below the levels of fatigue reported by the *PHS* first-time mothers and *PHS* sample population by 4-6 months postpartum. Interestingly, while the thesis sample initially has comparable mean ratings of stress to the *PHS* first-time mothers and *PHS* sample population during their third trimesters, and experiences a drop in stress after the birth. However, the drop in stress by 4-6 weeks postpartum and increase by 4-6 months postpartum show more substantial fluctuations. Overall, in comparison to the *PHS* first-time mothers and *PHS* sample population at 4-6 months postpartum, the thesis sample is least fatigued, least stressed, and has greater mental and physical health.

In summary, while a sample size of 14 cannot be wholly representative of the diversity in the *PHS* sample population, nor the Victoria CMA, the women in the thesis sample do represent a variety of demographic characteristics, socio-economic factors and health statuses. The thesis sample lacks representation of Aboriginal women and has minimal representation of visible minority members, as discussed above. Only a few of these 14 women owned their own housing, and despite a variety of mean annual incomes, they have relatively low mean income level. Within this sample, there is a variety of primary care provider styles and methods of delivery. There is also a range of birth satisfaction rates across the postpartum period, though overall, in comparison to the *PHS*

first-time mothers at 4-6 months postpartum, the thesis sample is slightly more satisfied with their birthing experiences, shows higher rates of mental and physical health, and appears less fatigued and stressed. Lastly, these women also demonstrate diverse individual ratings of mental and physical self-reported health statuses, and a variety of levels of fatigue and levels of stress within their individual responses.

Since the initial sample recruitment for this study took place at the conclusion of the interview at 4-6 months postpartum, it is very possible that women who had more negative birthing experiences or felt more stressed or fatigued were less inclined to agree to a fourth interview, while women with higher satisfaction and less stress were more inclined to participate and continue discussing their experiences. Nevertheless, as the following qualitative analysis will demonstrate, these 14 women's narratives include a great diversity of life experiences.

In this chapter I have focused on quantitative data to provide a general understanding of the thesis sample and the other *PHS* first-time mothers and *PHS* sample population from which the thesis sample was derived. For the remainder of this thesis I focus solely on the 14 women in the thesis sample. In the following chapter I present the results of the qualitative data that I collected from the fourth interview with participants and analyzed for this thesis.

CHAPTER 5:

QUALITATIVE RESULTS

Biographical Disruption and the Transition to Motherhood

Analyzing the life course transitions of participants along their individual trajectories reveals a dynamic path of biographical flows and disruptions as they move from menarche through breast development and sexual initiation into new motherhood (see Table 4 below). What is immediately observable when exploring women's individual trajectories is an erratic pattern of experiences in which one incident of flow or disruption does not necessarily lead to (or prevent) another. Menarche, for example, may be experienced as a biographical flow, and breast development only a short time later may be experienced as a disruption, even with the same social support system, peer group, education and health resources in place.

Table 4. Transitional Events

	Menarche	Breast Development	Sexual Initiation	New Motherhood[13]
Janine	+ Disruption	Flow	Flow	Disruption
Heather	– Disruption	– Disruption	– Disruption	Disruption
Zoe	+ Disruption	+ Disruption	+ Flow	Disruption
Rebecca	+ Disruption	– Disruption	– Reinforcement	Disruption
Lorna	– Disruption	– Reinforcement	– Flow	Disruption
Alisha	+ Disruption	– Disruption	– Flow	Disruption
Carol	– Disruption	Flow	– Flow	Disruption
Caitlin	– Disruption	– Disruption	– Disruption	Disruption
Katie	+ Disruption	– Disruption	– Disruption	Disruption
Denise	– Flow	– Disruption	+ Reinforcement	Disruption
Anna	– Flow	– Disruption	– Reinforcement	Disruption
Ruby	– Disruption	– Disruption	– Disruption	Disruption
Soraya	– Disruption	+ Flow	Flow	Disruption
Ayla	– Flow	+ Disruption	+ Flow	Disruption

[13] "Motherhood" here includes conception, pregnancy, and the postpartum period.

Looking longitudinally at each woman's narrative clearly indicated *why* each transition was experienced as a flow or disruption by that individual. This approach at the same time allowed me to isolate what elements of each woman's experience facilitated this flow or disruption. In addition, structural linguistic analysis and each woman's own evaluations revealed why those transitions were generally a positive or negative experience for each woman. Subsequent exploration of each major transition in participants' trajectories through cross-sectional analysis illuminates themes that enable a rich understanding of experiences of menarche, breast development, sexual initiation and new motherhood. In this cross-sectional analysis, by examining the commonalities and differences within the women's stories, these common 'episodes' in the narratives then reveal what influences can facilitate the presence of 'disruption' or 'flow' during these events. Looking across women's transitions in this way also helps to situate their narratives within their larger socio-cultural context, and demonstrate how personal, social, cultural and physical variables intersect. The following analysis combines these longitudinal and cross-sectional perspectives to investigate first-time motherhood and the experience of these new mothers' transitions into parenthood.

First-time motherhood was by far the most substantial biographical event and transition explored in women's narrative interviews. Participants' stories indicated that it usually had implications for their outlooks on themselves, their bodies and their social environments and oftentimes, involved far-reaching changes to their outlooks and goals for the future. For a few women, their ideas and expectations of their partners changed and they experienced more pronounced family cohesion and new role relationships as they became parents. Many of the women also began to seek different types of social

support, or accepted support they had previously resisted or rejected (most commonly from their own mothers). Most women also identified a new and more positive perspective of their bodies, with greater appreciation for its abilities and functions and more forgiveness of bodily changes such as breast shape and weight fluctuations. Overall, participants' narratives indicate that new motherhood is a life-changing event that has the potential to amend or even transform their existing biographical trajectories.

One key element within women's narratives that highlights the significance of the changes upon the transition to motherhood is the way women often portray a type of disjuncture in their lives in the form of a clear division between life before and after new motherhood. For several women, this appears in their narratives through references to their 'old' and 'new' lives. One example is Ayla,[14] who described to me her initial attempt to continue living her 'old life' this way: "we've tried to sort of keep up our old life as well, like still fit [the baby] *into* our life. But then you come to realize there are some things you just *can't* do that way! [Laughs] You have to *change* some things" (ll.17-20). To Ayla, there was a clear separation between life before motherhood and her life now. Other women spoke of this change in more general terms, including Soraya, who explained that at the current time "life is so different. It's hard to think of anything as being like it was before" (ll.272-3). Indeed, Soraya's narrative demonstrated that her life changed a great deal in new motherhood.

The disjuncture evident in women's lives at the transition to motherhood spurred the question: were these changes an enjoyable or disappointing aspect of first-time motherhood? During their descriptions of their transition into motherhood, some women

---

[14] Pseudonyms are used throughout this analysis in order to protect participants' identities.

expressed a longing for their old sense of independence, or their ability to be spontaneous, to put their needs first, or to do things they used to do. Nevertheless, almost all of these sentiments were expressed as a sense of trading-off their desired 'old' ways, for new enjoyable moments as a mother. For example, Rebecca indicated to me that she didn't expect some of the aspects of new motherhood that she was experiencing, and when I probed about this, she explained:

> Before having [my baby] I was a really busy person, and I remember thinking, 'gosh, like, it's going to be really hard to balance all that stuff when I have a child.' But I just don't! My priority - my *total* priority, is spending time with [my baby]… It's *surprised* me how much those things have just kind of moved to the side for me. And I say that to my friends… "like, don't think about where would a child fit into the life that I'm living now, because you won't want that. Speaking from my experience, you won't want that same life, because your priorities just shift so much." (ll.117-132)

Rebecca drew upon the idea of her old life and new life ("you won't want that same life") to explain her altered lifestyle, but clearly found pleasure in both her life before motherhood and her life now. In this way, she, and most of the other women, described a trade-off in which they have given up or minimized one or more aspects of their life before motherhood but were not left with a void because it was replaced by something in their life as a new mother. Whether that trade-off was considered enjoyable or not, it was unique to the women's negotiation and management of the disruption to their lives.

With all of the women's narratives focusing on change, differences, and 'new lives' it is perhaps no surprise that *all* of their narratives indicate that their transition to motherhood was a biographical disruption in their lives. The most prominent elements of disruption included: re-thinking their biography and/or self-concept, shifting role involvements, different situational contexts, altered everyday life routines, and new or altered plans for the future. Elements that facilitated biographical flow (such as the

continuation of roles, role relationships and situational contexts, events being normalized and integrated into their identities without disruption, and events melding into their biographies with minimal impact on daily life) were *not* significant parts of their narratives, if even present at all. However, as Rebecca's comment above suggests, one should not assume that the aspects of disruption during the transition to new motherhood, nor the overall disruptions that they generate, were necessarily unwelcome or detrimental, contrary to suggestions within the literature explored in Chapter 2.

While all of the women described instances of biographical disruption, a great deal of variety is present in their stories. In fact, women's stories of new motherhood were oftentimes quite different, including variation in how they negotiated their new identity and the changes that were taking place with their bodies. Therefore, as I have suggested in the conclusion of Chapter 2, understanding these women's transitions into motherhood and their associated biographical disruption requires an understanding of different *types* of the disruption experienced.

The 14 women I interviewed demonstrate three main types of biographical disruption. First, four participants' narratives indicate that the disruption of new motherhood was a 'fresh start' in their lives and fostered their conscious effort to improve their lives with new outlooks on their lives and their families. Second, five of the women's biographical disruptions suggest they were personally 'lost' for a (sometimes lengthy) period of time after childbirth, as if they were caught in a liminal stage between life before and after new motherhood. Third, five women's biographical disruptions convey a sense of achievement in their lives, with the onset of a new stage: maturity or adulthood for three women, and womanhood for two others. Despite the clear categories

presented here, these typologies are not necessarily mutually exclusive, and while participants' narratives clearly fit into one type of disruption in particular, a few of their discussions also demonstrate some elements of another type at times. All three types reveal how women experienced their transition, and in doing so, they also suggest different ways that the transition into motherhood can be individually internalized and personally managed. Some biographical details are included in the discussion of each participant's experience, and details about the interview setting are provided in Appendix H (see page 188).

Group 1: Starting Fresh

Four first-time mothers I interviewed all described motherhood as an opportunity for new chances, a new outlook on life and new relationships upon their transition into motherhood. Their transitions reflect a sense of new beginnings or finding a 'fresh start' with new motherhood. For them, the transition to motherhood disrupted their previous ideas and behaviours related to their bodies, their personal perspectives, and their social environments. This fresh start began with the discovery of their pregnancy, and inspired or induced change to their lives according to their individual sources of discontent or desires for change.

Two of these women were the youngest mothers in the sample, had the lowest education and income, and regularly engaged in behaviour that many would consider 'risky' or unhealthy behaviour. Their behaviour included drug use, alcohol use (often in large quantities), engagement in physical confrontations, and involvement with abusive partners or partners who they considered to be irresponsible. Both of these women's

pregnancies were unplanned, and prompted them to make changes in their lives that included withdrawing from their risky activities. Caitlin became pregnant unexpectedly at age 18 and was 19 years old during our interview. She has been in foster care most of her life, and her teenage years were laden with drugs, alcohol, violence and illegal activities. She has not finished high school, and has been unemployed throughout her pregnancy and the postpartum period, relying upon financial support from government assistance and her grandmother. Caitlin described the two years before her pregnancy as follows: "I went down a really bad path. Like doing drugs, drinking a lot – just being really stupid because I was so distraught…" (ll.260-2). Similar to this life story, Heather, who was 22 years old during the interview, grew up moving back and forth between her (divorced) parents' homes. She also did not finish high school and relied upon on government assistance and family for financial support. In her interview, Heather told me about her life of "partying" from a young age, which included drinking and doing drugs throughout her teenage years, mostly with youth who were much older than she was. Neither of these women appeared happy or satisfied with their memories of life before their pregnancies.

Within these two women's considerably bleak descriptions of their pre-motherhood years, they seemed to stop to reflect upon those years with marked criticism. Heather noted to me, "I didn't have any idea… I don't know – I didn't take anything seriously until I got pregnant anyways" (ll.803-4). Indeed, for both of these women, the news of their pregnancies brought a new outlook on life and generated a new sense of direction. Caitlin expressed the motivation for change this way: "my pregnancy with my son was very…well, having him and everything was great. He kept me – through my

whole pregnancy and so forth – he kept me from doing a lot of stupid crap. And I figured that was my scapegoat,[15] right there" (ll.272-5). Thus, for these two women, as well as the other women whose narratives of motherhood reflect a 'new start', the changes in their lives were not a direct result of the pregnancy itself but rather, the *opportunity presented by* their pregnancy. This, and their critical reflections on their past lifestyles, both suggest that there must also have been a desire for change, or at least, a source of discontent that enticed these women to seize the opportunity or motivation that their pregnancies facilitated. For example, Heather explained to me the following:

> H: It [was] just a chance to get everything together in my life, you know what I mean? Yeah, I really turned around my whole life.
>
> I: Was it sort of like a fresh start for you?
>
> H: Yeah, yeah, exactly, actually. It puts a lot of things in perspective, you know? (ll.115-121)

For Heather, it was her pregnancy that put things into perspective, but the 'chance' to get everything together was more of a reason, rationale or motivating factor to do so rather than any actual ability gained from pregnancy. In other words, it wasn't the pregnancy that "turned around [her] whole life" but her choice to use pregnancy as a vehicle to do so. Moreover, the changes in these women's lives that began with pregnancy, turned into new perspectives which then evolved into changes in many or most other areas of their lives.

One aspect of Caitlin and Heather's lives that changed as a result of their new outlooks was their withdrawal from involvement with drugs, alcohol, violence, and the peer groups connected to such behaviours. Before her pregnancy, Caitlin's life and relationships involved violence and physically abusive peers that she began to handle

---

[15] Participant's use of the word "scapegoat" here is interesting. It is possible that she meant that her pregnancy was her 'motivation' or her 'excuse' to change.

differently. She now had a very different response to interpersonal violence: "[Now, I would] run the other way! [Laughs] Or walk the other way – just laugh and go away… [Whereas] before I had my son, I would've beat the shit out of him" (ll.423-6). Similar to this new approach to role involvements and routines, Heather disassociated from her 'partying' friends, and the corresponding consumption of drugs and alcohol. She happily explained her new peer group and lack of substance abuse in her social environment to me as follows:

> I've got this little being to look after now – he's my number one. It's never been like that for me – I've always seemed to have these piss-tank friends, or you know drunken friends. And so it's just been a lot different, like I have to go to a lot of mom and babe groups to meet other first-time moms, so that I'm surrounding myself around the right kind of people, and kids for him to play with, and all that sort of thing. (Heather, ll.19-25)

In this passage Heather indicates that she was continuing to withdraw from her previous risky behaviour, and that a large part of her fresh start included finding different situational contexts and role involvements for herself.

Both Caitlin and Heather also changed their role involvements and expectations of intimate partners. In this process, both of these women broke up with their previous boyfriends (and the babies' biological fathers) and began new relationships that they considered more supportive and mature. As Caitlin described her new relationship and dating partner it became clear that he is a considerable source of support to her: "It's great. He's really down to earth… He knows how to be supportive of everything I do, and everything I think of doing or saying… I don't fight with my boyfriend now *at all*… [and] if I'm going through a bad day or whatever, he's there, one-hundred percent" (ll.412-16; 371-2). As she began to address here, not only has Caitlin changed peer groups and found a new partner, she also now sought different qualities and had different

expectations of a boyfriend. Similarly to this story, Heather described her feelings about her renewed relationship with a past boyfriend who was helping her to prioritize her baby boy, her life goals and her education. Moreover, Heather found that she and her partner now both have focus in their lives and attempt to include each other in their pursuits. Indeed, Heather made it clear in her narrative that she has established new plans for her future, altered her role involvements and related socio-cultural contexts to pursue them, and in doing so, has integrated an intimate partner into her life that fits with and contributes to, her fresh start.

In addition to more supportive partnerships, the women in this sub-group also became more accepting of social support than they had been during any other transition in their lives. In many earlier life transitions, they found that support wasn't offered or available; moreover, in some cases they were simply not interested in the support that was accessible to them. Heather explained it this way: "community supports weren't offered. Help from my mom or help from friends were offered all the time constantly, I just wasn't interested – I had my own things going on" (ll.516-18). However, once they were pregnant, both Caitlin and Heather were offered support from friends, family and community resources which they accepted during pregnancy and continued to draw upon in new motherhood. These women both became much more aware of support programs available to them, and became very resourceful in finding emotional and material supports for themselves and their new infants.

In addition to the way that these two women began to think differently about themselves, their relationships and their support systems when they became pregnant, they also began to feel like their bodies, self-concepts, social identities and social roles

were perceived differently by themselves and by others in their environments. Both of them described this quite positively; for example, Heather explained how this change was one of the enjoyable parts of her pregnancy:

> I loved being pregnant!... It was just awesome! Everything about it… I was just really really happy throughout the whole thing. And people were you know, happy around me. And it was like all the little things, like I was able to save up money, and you know I'd go into a busy bus and I'd always get offered a seat… Yeah, it was a *lot* – like, a *lot* of fun. And him kicking around in there, and he gets the hiccups, and – it was just you know, out there. It was just a lot of fun. (ll.386-396)

Clearly pregnancy was a positive time for Heather. This passage also illustrates how her perception of her body changed, as well as how there can be a supportive and enabling relationship of change between individual aspects of disruption (self-concept, life routines, etc.) and social aspects (role involvements, situational contexts, etc.). While Caitlin similarly found happiness in pregnancy and new motherhood, she described a much more resistant social context than Heather, since Caitlin's new self-concept and role involvements were not necessarily supported by those around her. She explained this to me as follows:

> C: Some people think that [motherhood has] changed me – in a good way. Other people think that I've destroyed my friendships with other people because I'm a mom and I can't do the same things that I used to do. Not that I want to *do* any of those things but, you know…
>
> A: Okay, and what do you think?
>
> C: I think I love being a parent. And I wouldn't give it up for anybody. No matter what somebody had to say about it. (Caitlin, ll.573-81)

In this case, Caitlin's fresh start persisted despite challenges to its success or longevity fostered by her social environment. An additional challenge was her financial inability to move to a new neighborhood, which Heather was able to do. In fact, Caitlin's continued social/living environment is the only element present in these two women's stories that

represents an element of 'biographical flow'. Therefore, Caitlin's fresh start had to be created and maintained from her existing physical location and prior living situation, which included neighbours who were part of her previous peer group. Nevertheless, she disengaged from those social relationships despite the ongoing situational context of which they were a part.

While Heather and Caitlin's 'fresh starts' involved major changes to their previous patterns and lifestyles, two other women's pregnancies initiated new beginnings that were less radical but still significant in their biographies. Soraya was a 39 year-old new mother when I interviewed her. She had completed a post-secondary degree program but was unemployed during her pregnancy and the postpartum period. She had many difficult years as a child and teenager largely because of her parents' divorce, after which she moved to a new city to live independently before the age of legal adulthood. Anna was a 35 year-old community support worker with a high school degree. She felt that she did not get the support she needed from her mother during adolescence and young adulthood, and often pointed to this lack of support when describing and evaluating reproductive transitions preceding pregnancy. Soraya and Anna were two of the oldest women I interviewed for my thesis. Both had long term common-law partners, and had planned their pregnancies with their partners ahead of time. For them, pregnancy brought new happiness, personal direction, and a chance to mend relationships with their mothers.

As Soraya described her life from young adulthood onward, it became clear how influential her parents' divorce had been on her life experiences and transitional events.

When I asked her to tell me about what she thought most affected who she was as a woman or mother, she immediately identified this divorce:

> …their divorce is symbolic of a bad relationship, where children are raised in an atmosphere of tension and disagreement…and the resulting fallout, which, in our case was, I was left with a mother in poverty. Which was quite shocking. I was left with a parent who was unable to care for me. And left with some pretty scarring perceptions about the world [participant starts to cry] and about people in the world…a total loss of security… It was really hard not to be angry. Well, I can't say it was hard not to be angry – I *was* angry. I was bitter. I was dark. I was twisted. (Soraya, ll.789-95; 550-2)

As this excerpt suggests, Soraya's discussion of previous life transitions seemed overshadowed by memories related to this divorce, such as reaching menarche without her mother around to celebrate with or explain what was happening. Moreover, she connected her early sexual experiences and relationships to her attempts to find support, stability and security in her life. Life just prior to pregnancy had improved from that of young adulthood, including a supportive relationship with her common-law spouse. Nevertheless, Soraya also discussed her responsibility for the loss of her relationship with her best friend, how she oftentimes feels depressed, and how she has had to draw from her partners' example in order to focus on the positive aspects of her life so as to not "wallow in you know the bleakness of it all" or "get sucked into negativity" (ll.731-2; 822).

Soraya's narrative about her pregnancy and new motherhood was very different than these descriptions of her previous life. She enjoyed and found new respect for her body, and her self-concept changed a great deal and spread to changes in her situational contexts, life routines, and eventually her role involvements. In fact, Soraya explained how she began to feel better about herself even when she believed she had become pregnant but tests had indicated that she had not. Once she determined that she was

indeed pregnant, her outlook on herself and her life improved even more drastically. She described this transition to me with considerable delight, outlining how she came out of her depression, became more active, and took the remaining five months of her pregnancy to spoil herself and be spoiled by others. After recounting her new found happiness during pregnancy, Soraya continued her narrative with a description of her improved outlook on life and new approach to relationships. In addition to these more personal and social improvements in Soraya's life, she also described a more positive approach to her body. Nevertheless, it was a somewhat ambiguous description in which she was both critical of her body and very loving of it at the same time:

> It's an inverse scale of: as my body becomes less attractive, I feel better about it, and more confident in it… Now I think my body is probably at it's ugliest that it's ever been, and I can still find pleasure in it, and revel in it…and just try to love it…love myself. It's hard now, but it's easier than when I was 18, to love my body. (Soraya, ll.618-625)

Despite the conflict identified here, she did appear to have found a new appreciation and love for her body during the transition to motherhood.

In addition to these developments and new personal outlooks, peer relationships and her body, Soraya also described how pregnancy and new motherhood were a chance to re-connect with her mother for social support in a way that she had not been able to do during previous reproductive events in her life. In fact, after she re-engaged this relationship, she found that it was an enjoyable role relationship and provided added social support. This became clear when she noted to me that "my mom and I had a really good time together when I was pregnant, because I think my hormones were all really nice, and leveled out, and we just got along really really well" (Soraya, ll.404-6). Indeed, Soraya's narrative indicated that pregnancy provided an impetus to renew family bonds with her sister and parents that had long been absent. This development altered her social

support network as well as her situational contexts and role relationships. Moreover, it contributed to a growing sense of stability she was forging during pregnancy and the postpartum period.

Unlike this family history, Anna, the fourth woman to describe new beginnings or a 'fresh start' with new motherhood, had a steady, dual-parent family to rely on while she was growing up. Nevertheless, she put forth a similar lack of stability and support to that described by Soraya; instability that Anna largely attributed to her poor relationship with her mother. Much like the prominence of divorce in Soraya's narrative, Anna's sentiments about her mother's lack of support during young adulthood appeared throughout her narrative. She described their relationship earlier in life this way:

> I didn't really like the way my mom was, and she knows herself too – she's apologized to me many times. And we have a good relationship now, but we didn't have a good one growing up, and it was more *her* – she was a young mom and insecure in what she was going through, and what she did to me, and the way she treated me and interacted with me; she felt like she wasn't a good mom. (Anna, ll.201-7)

Later in the interview, Anna returned to these thoughts to elaborate further, and noted that "She wasn't really there for me the way I always wanted her to be – [which was] more like a friend, but also like a mom, but not so strict and where I didn't feel like I could tell her stuff, which was the case" (ll.493-6). Indeed, Anna's descriptions of her transitional reproductive experiences expressed disapproval of her mother's inability to provide the information and support that Anna felt she needed during that phase in her life However, now, as a mother herself, Anna has found the common ground to be able move past these former deficiencies and has forged a new relationship with her mother. She also explained to me that having a child had allowed her to create the loving and supportive family she felt that she did not have when she was growing up. In this sense,

Anna's transition into motherhood gave her the chance to pursue the family, familial relationships and supports that she had desired for a very long time.

Similar to Heather and Caitlin, Anna had also found a new sense of purpose or direction for her life during the transition to motherhood. She described a sense of increased happiness as a new mother that was similar to Soraya's feelings during and after her transitional experience. Anna connected her happiness to new motherhood this way:

> I felt like I needed it, and that there was always a kind of an emptiness over the last 10 years. Something was missing, you know? Like I wasn't – I was *happy*, but I wasn't… like, I'm *really* happy now. I feel like there's some kind of purpose in my life now too, to have this little girl to care for. (ll.155-9)

For both Anna and Soraya, increased happiness and re-forged security and familial relationships were key to understanding their transitions into motherhood, and the personal and social implications of that transition.

Both independently, and as a group, all four of these women's narratives have indicated that the transition to motherhood was a biographical disruption that entailed positive life changes or a chance for new beginnings. In all cases, it was not the physical experience or transition that was most vital to these new beginnings, but how the women personally and socially interpreted and engaged with the news of their pregnancies and experiences of new motherhood that motivated change. In other words, any of the alterations to their lives could have been made at any point prior to the transition, but pregnancy and the expectation of motherhood appeared to give these women the personal motivation and new perspectives on life to establish a foundation for new beginnings, and an incentive for change. Unfortunately, not all of the participants found such positive changes in the transition to motherhood. For others, pregnancy and new motherhood

induced a very different sense of disruption from that which Caitlin, Heather, Soraya and Anna described.

Group 2: Surrealist Limbo

For five of the women I interviewed, the transition into motherhood was experienced as a biographical disruption that dislocated their sense of self and disturbed their previous ways of life including their role involvements, situational contexts and life routines. In many ways, their narratives reflect a state of limbo or a liminal phase (Van Gennep, 1960) between two distinct stages in their lives and biographies – before and after new motherhood. During this liminal phase their life trajectories or biographical 'plots' were temporarily lost. At times, the women described this phase of new motherhood as a surreal experience in which they experienced a type of reality-check and/or disbelief over being a mother and having a child of their own to care for. For all five of these women, their sense of disruption did not necessarily set in when they determined they were pregnant but rather occurred at the point when the transition to motherhood began to require alterations to each individual's current sense of self, social identities and general way of life. From that time onward, the women's descriptions of new motherhood repeatedly drew upon words like 'lost,' 'confused,' 'surreal' and 'difficult.' The termination of this liminal phase was as individually timed as the onset of disruption, but in general connected to the time at which they were able to re-engage with prior aspects of their lives that were central to their sense of self and their ways of life before new motherhood.

One of the women whose narrative suggested that she experienced a period of limbo is Denise. Denise was 24 years old when I interviewed her. She had a high school diploma and was pursuing a career in the military. She became pregnant unexpectedly after a visit with her partner during their long-distance relationship, but remained involved with him while pregnant and eventually married him. When she reflected back to her life upon finding out she was pregnant, Denise remembered enjoying and even treasuring her "care-free" and "self-centered" way of life, which became one of her reasons for considering her options carefully before deciding to have the baby. Her decision-making process early on in her pregnancy involved evaluating her life situation, her ambitions for herself and her expectations for her relationship. As such, her sense of disruption was virtually instant once she found out that she was pregnant:

> …once I found out I was pregnant, I didn't even tell [my partner] for like maybe a month, because I wasn't sure what I wanted to do. And so, like I *really* thought about *not* having the baby. And it just seemed so *surreal*, that I was having to actually consider this! Like I wasn't done university, I was just living on my own, being carefree, being selfish. (Denise, ll.388-94)

Denise's subsequent decision to continue the pregnancy and her partner's support for that choice prompted her to reflect upon and re-evaluate her plans for the future and her biography. This decision involved not only biographical disruption, but also a loss of some important aspects of her life and confusion within her sense of self. Her experience of disruption and her related perception of feeling lost continued through her pre-natal period, with some sickness and weight-gain for which she was not prepared. She described this with a tone of distaste: "I didn't feel like myself at all. I felt as if I was trapped in a different body. And so I didn't really enjoy being pregnant…" (Denise,

ll.459-61). Her narrative also indicated a connection between physical disruption and biographical disruption.

Denise's feelings of overall disruption and limbo continued into new motherhood after childbirth and she spent a great deal of time explaining to me how life seemed very different for her now. In addition to the surreal experience during pregnancy, life at home with a newborn child transformed her surrealism into a sense of total instability and confusion:

> Bringing him home was like, terrifying. Because all of a sudden you have this person to care for, and he's *your* responsibility. And like the first few days… I kind of felt… lost. Like, 'what was the meaning of life?' Like I felt all these really deep issues, and I had no answers for them. I wasn't prepared that way. Not that anybody would ever be I don't think. I don't know… (Denise, ll.9-15)

Her feelings described above were concurrent with many other hardships she mentioned during our interview: feeling isolated from her friends and other adults in the initial postpartum period, having to forfeit an appealing employment opportunity, being forced to cease interaction with work colleagues, lacking friends in her neighborhood outside of work, and feeling unable to continue with her basic life routines like showering or talking on the phone when desired. In this way, Denise did not experience altered role involvements and situational contexts, but was temporarily removed from her existing ones. Overall, Denise's narrative indicates that the disruption to, and temporary loss of her sense of self and biography began when she found out that she was pregnant, continued to build as the pregnancy progressed, and peaked during the initial postpartum period.

Despite the increasing prominence of Denise's withdrawal from her previous life trajectory and biography, she eventually did recover her 'plot,' though it was an altered

path to the one she was previously pursuing. As Denise went on to explain, life became more enjoyable to her again once she was able to re-engage in the activities that asserted her independence, which she sometimes considered "self-centered." For her, this meant reaching a stage in her child's development where she could begin to work part-time, and spend time doing things independently. She explained her eventual change in her feelings about motherhood this way:

> I was starting to feel really… housebound, and like I wasn't doing anything for myself. So I chose to do a marathon, because that was just kind of like a challenge for me, and had nothing to do with [my baby]… Now I feel like I'm back on track, like I can kind of have my own life too. And now that he's a little bit older, he doesn't need me as much… Whereas before it was like… I felt I had to be there *all* the time. And also I'm starting to do more stuff for myself again. Whereas when he was younger, everything was about him basically. (Denise, ll. 68-73; 39-49)

As Denise continued her explanation of what she is doing for herself, she began to describe her life with a new sense of normalcy, as if she emerged from her liminal phase and found a new 'plot' and sense of self in which there was room to recognize both her role as a mother, and her other personal interests and desires.

Unlike the immediacy of Denise's lost plot trajectory, for two other women, Alisha and Katie, the sense of surrealism and experience of disruption from their previous ways of life did not begin during pregnancy, but once they brought their newborn children home. Katie was a 31 year-old Customer Support Manager with a post-secondary degree when I interviewed her. She became pregnant quite quickly after she and her husband first attempted to conceive. Before taking maternity leave late into her pregnancy, Katie worked full-time and valued her independence and ability to plan and organize most elements of her life. Alisha was a 33 year-old single mother and fitness instructor with a post-secondary degree. Before becoming pregnant unexpectedly in an

on-and-off relationship with her boyfriend, she was very career-oriented and focused on improving aspects of her health, including diet, mindset, lifestyle, and relationships. Both Alisha and Katie described their respective pregnancies as very positive experiences and connected this evaluation with their ability to maintain pre-pregnancy living and working routines until very late in their pregnancies. Katie explained this to me with a sense of enjoyment and control: "My pregnancy was really good; I wasn't sick, I could still work… I was happy, and I never got headaches, and it was just, I don't know, it was just a very positive experience" (ll.361-5). Alisha also enjoyed her pregnancy, and continued her pursuit of optimal mental, physical and emotional well-being. These two women's stories have some noticeable similarities and will be explored here together.

Before taking time off to take care of their newborns, both Alisha and Katie had full-time jobs and lives in which they valued their sense of control and organization. Therefore, for them, it was bringing home their babies that sparked a major disruption to their biographies and a loss of their plot trajectories. They both described a sense of confusion and loss of control during this time. Katie explained her feelings about it this way:

> It's so exciting, but it's so frustrating. It's the most difficult job I've ever had in my life! [Laughs] I think it's because you can't really control the environment…like you are reactionary, and I'm the type of person that's very planned and organized, and I kind of control everything around me. But having this child – no way am I able to do that, because he dictates what goes on. So it's been difficult that way… For the first three months you're in chaos, you've never been a mom before, you don't even – you know, there's no manual when you have a baby, 'this is how you do it'… And for me the most overwhelming thing was giving up my independence, because… before I went back to work, twenty-four/seven I was with this child, right - it depended on me… and there was *no* schedule right, which I had a hard time with. (ll.9-15; 29-37; 43-45)

As this excerpt illustrates, it was the feeling of confusion and disruption to Katie's taken-for-granted knowledge, her life routines and sense of structure that destabilized her plot; disruptions for which she had no known way of managing or coping.

Alisha's narrative demonstrated a similarly destabilized plot trajectory as Katie, due to an absence of structure and the life routines that working had previously provided her with. She described her experience of new motherhood as follows:

> The first three to four months was a *huge* adjustment. It was frustrating for me not having the structure of work, and having to *find* my own structure – that was a real challenge for me. And that has been a challenge in the past - to find my own structure. But once we got into a *routine*, I actually really enjoyed it. But it was still really boring [Laughs]. (Alisha, ll.50-4)

Much like the passage from Katie's story above, this excerpt also indicates the importance of routine for Alisha, and the significance of work to her way of life. Both of these women's narratives about the initial postpartum period focus on the challenge imparted from the loss of the routine and structure that were imperative to their previous biographies and maintaining their 'plots.' As such, their transitions into motherhood necessitated a new way of life, and new ways in which to understand themselves and their plots.

Similarly to Denise's story above, once Alisha and Katie were able to re-engage with previous aspects of their lives that were central to their sense of self, namely, their independence and structure, they began to emerge from their liminal phase. For Katie, this emergence began at approximately nine months; for Alisha, it was around four months postpartum. However, they both only seemed to have completely found a new sense of self, including a stabilized plot and biography, about one year into motherhood, when they began working again. At that point, they also began to explore how to be

mothers in addition to being independent women and employees. Katie explained her experience this way: "It started getting better once he wouldn't be so attached to me. And so the older [he] got, the better it got. Now I mean… at least I *have* an evening and I *have* some of my own time. Whereas you know, for the first good - the first three months you have no time to yourself" (ll.38-43). Much like the independence that was key to Katie's adjustment here, Alisha found her new plot and stability when she returned to work, which provided her with time to herself, familiar routines and a structure for living again, this time as a mother. She described the transition to me this way:

> Al: [Around] 5 or 6 months, really through to when he was a year old was pretty good, because I was starting to work more, and I started working at the [community centre]… and it gave me a lot more structure – at least a base structure that I could work around… You know, ever since I started working it's been fantastic… I felt a sense of sense of normalcy and self - my sense of self came back, I think around the same time that I started working again.
>
> Ad: And was that *because* you were able to start working again, do you think?
>
> Al: I think so. Yeah. [Laughs] I've always been very connected to my work, particularly what I do now – I'm very connected to it. And so yeah, it gives me a lot of personal satisfaction. (Alisha, ll.56-60; 72-5; 78-88)

As this passage and the complementary experiences of Katie and Denise suggest, it was not necessarily the act of returning to work that seemed to end the liminal phase and establish a new plot. These three women's transitions to a new life and sense of self as mothers required a re-engagement with previous ways of living and understanding themselves; thus, working was the opportunity to reconnect with aspects of their former way of life that were key to their individual self-concepts and biographical plots, whether it was care-free and more self-centered living, independence and control, or employment and daily routines. In some ways, the re-engagement with previous aspects of themselves

reflects an element of biographical flow; however, life up to that re-engagement was *very* different than their previous experiences and elements that were continuous were minor components in their narratives in comparison to their emphasis on what had changed as a result of new motherhood.

The last two women whose narratives reflect a temporarily lost plot and resulting limbo or liminal phase during the transition to motherhood are Carol and Ruby. During several stages of analysis of their narratives about motherhood, their stories were initially quite challenging to understand and situate within the analysis. This difficulty primarily resulted from these two participants' tendency to float in and out of thoughts and describe stories back-to-back that were somewhat contradictory. Finally, it became clear that these women's experience of the transition into motherhood were difficult to understand because the women were still transitioning, or perhaps just beginning to emerge from their liminal phase and re-engage with their previous sense of self and way of life. Carol was a 35 year-old community health worker with some training beyond her high school degree and living in a fairly isolated, rural area of Victoria. When she and her husband began trying to have a child together, they had been married for several years and were already raising her husband's children from a previous marriage. Ruby was a 35 year-old woman who also has some training beyond her high school degree but was unemployed during the prenatal and postpartum periods. She is a visible minority member who emigrated from South America to Victoria four years ago. She and her husband began trying to have a child shortly after their marriage. She became pregnant after only one attempt, despite being initially worried that she would be unable to conceive. Both of these women were full-time, stay-at-home mothers, and seemed happy during their

interviews and in their descriptions about their current lives. However, both also had little structure in their lives and were challenging for me to interview since they had difficulty with time management and scheduling, as well as being able to focus during the interview. Their narratives of the transition to motherhood and their experiences of liminality will be explored together.

When she described life as a new mother, Carol did not make comparisons with life prior to pregnancy and childbirth very much, and thus, it was difficult for me to determine what key aspects defined her plot trajectory. She did make clear her very blunt, pragmatic and matter-of-fact approach to life. When she discussed new motherhood her narrative included similar experiences of momentary surrealism to what Denise, Katie and Alisha described:

> [Laughs] There are times when I still look at him and go "Oh-my-God, he's mine! Like, I can't believe he's mine!" [Laughs] Yeah I, I don't know. It's just – he still is – like sometimes I go in and just watch him sleep, and have a little quiet moment just watching him. And have that thought – "there he is, he's mine…" (Carol, ll.44-8)

These moments of disbelief occurred several times during our interview session. Carol described a more negative body image and a disengagement from both her sense of womanhood, and the physical, mental and emotional aspects of her relationship with her husband. However, these sentiments were mixed within other comments in which she told me that more recently she was becoming more accepting of her body, reviving her feeling of womanhood, and re-cultivating her relationship with her husband. Carol described these changes with a certain amount of joy and satisfaction, both with regards to her sex life with her husband, "now I'd say we're back to a healthy sexual relationship" (ll.227-8), and to her body and womanhood, "I mean it's taken me a little while to get adjusted to [my body], and…I'm starting to feel more like a woman I guess

now, [Laughs] again!" (ll.463-5). Despite these noticeable steps to establish a new 'plot', Carol seemed to be at the end of a liminal phase, rather than beyond it. This was evident primarily through her demeanor during our interview and through her continued sense of disbelief over being a mother and having a child of her own.

Ruby was living a very different life than Carol when I interviewed her, and also had quite a different personality. Nevertheless, both appeared to be very strong-willed women who now seemed to be slightly struggling with who they were and what their plans for themselves were. When I asked Ruby to describe her understanding of her current identity to me, she thought about it a long time, and then replied:

> My… who I am now. Hmm… I feel like, [Laughs], you know like a wife, and a mother, and I don't feel very beautiful. I don't feel very – I feel very strong still, like I feel like I could accomplish something if only I had the time. But I make up a lot of excuses for myself so I don't get things done the way I should. Like the exercise, and the personal accomplishments - I always put them on the back burner. But I always feel like I can run and win a marathon or something if I really put my mind to it. I have always felt very strong. (ll.824-31)

This passage hints at Ruby's dynamic personality, in which she was at once open and honest but also shy, confident but also self-conscious, and ambitious but not following her ambitions. In related passages of her narrative, she also described a former lifestyle in which she seemed to float from one relaxed activity to the next, following her whims and desires. However, this lifestyle was now disturbed by two things. The first of which was her child's energy and noise-level; indeed, during our interview, the energy levels between herself and her son contrasted noticeably. She did not seem bothered by her son's energy, but instead was able to laugh at his rambunctious behaviour, and explained to me that "lately I've just been getting used to very loud noises," (Ruby, ll.61). The second factor that has disturbed her lifestyle became evident at several points in her

interview when she repeatedly identified a type of invasion of her personal space and lifestyle since bringing her baby home from the hospital. She associated this with continuous visits by her family members in general, and her mother-in-law in particular. In fact, her mother-in-law's visits, and her displeasure with them, seemed key to understanding her life as a new mother, and is a repeated theme in her narrative. She explained this to me in several different ways at different points in her story, including early in the interview when she discussed challenges she had faced as a new mother:

> she would come over and she would more want to just sit and gossip all the time, and I feel like it's a bit of a… I feel a bit crowded with that, you know? And… I think that was probably one of the main things, like emotionally or something for me. Because I used to feel as if, you know, I kind of like my own space at my own time a lot. (Ruby, ll.84-2; 91-6)

Ruby returned to this source of discontent numerous times after this initial explanation, including a subsequent comment, "I like my space a lot especially because I just want to do things on my own impulses… I like to just pick myself up and go. But generally whenever she comes I just get this closed-in feeling and I feel crowded and like I have to go somewhere!" (ll.127-33).

Throughout her interview, Ruby was clearly content as a new mother most of the time, but as these and other passages indicate, she very much needed her personal space and ability to act on her impulses to feel relaxed and mentally and emotionally settled. While she noted that she was beginning to get used to her child's loud noises, she did not yet have a strategy for coping with the persistent unwanted visits by her mother-in-law. Overall, it seemed like Ruby had not yet regained her sense of control and freedom in her life, or recovered her 'plot' by adjusting to new role involvements, situational contexts, social networks and life routines.

In addition to these five women, a sixth participant, Lorna, whose transition into motherhood will be further discussed in the subsequent section, also described a loss of her plot trajectory in her narrative and complication of her biography. However, unlike the five women whose narratives have been explored above, Lorna's liminal phase was very brief, lasting only a couple weeks. She explained the feelings that she had during that time this way: "…I remember the first couple of weeks I thought 'ohh…'… the days seemed so long, and I seemed so lost, and so out of my element, and…yeah, it was a tough first couple of weeks. But then it just gradually got better and better and better" (Lorna, ll.20-24). Like Alisha, Katie and Denise's stories, the sense of dislocation and limbo Lorna described faded or became more manageable once she identified and relieved the primary source of her sense of dislocation. For her, the primary destabilizing force was breast-feeding, and as such, she believed that her ability to cope was directly a result of stopping breastfeeding; "that's when we felt sort of the calm after the storm. Well, it wasn't really a storm, and I don't want to make it sound bad, but yeah, we just sort of felt then, 'okay, we can do this, yeah'," (Lorna, ll.37-9). Therefore, while the first three women emerged from their liminal phase and found a new plot once they were able to re-engage with aspects of their lives prior to pregnancy, Lorna was able to do so only when she alleviated the source of her limbo or plot dislocation.

Interestingly all six of these women who experienced or were still experiencing a sense of surrealism, lost plot, or limbo between life before and after new motherhood, had diverse personalities and socio-economic backgrounds. However, they also shared a few common elements in their transition to motherhood. First, all of these women described a type of withdrawal from society or social engagements, whether intentional

or by circumstance. Ruby and Katie were simply more comfortable with limited social involvement or interactions with family or the public during their initial months of motherhood. In fact, Katie was unwilling to draw upon the social support available to her and her husband in the initial few months, despite the independence that such support could provide her with and her desire for such independence at the time. She reflected:

> I mean [my husband and I] both have both sets of grandparents in town so we have people to come and look after him. And we get to get out and do other things. I think it's really important to still be able to be who you are, and be independent and be able to do things that you enjoy doing. I mean that was what was the hardest in the first three months – because I wasn't ready to let other people help in that sense and take care of him. (Katie, ll.469-75)

In this case, she described a combination of situational isolation due to maternity leave, and intentional isolation, as a result of her reluctance to utilize her available supports systems. Other women were isolated more by situation than by their specific intentions. Alisha found herself severed from society as a single mother on maternity leave from work and without family in town. Carol was isolated as a full-time stay-at-home mother in a remote rural location. Denise found herself without friends, family or transportation and a husband who shipped out with the military reserves shortly after the birth. As one would expect from the five women's desires or situations in which they tended to be left alone with their infants, they described fewer sources of emotional and social support during the transition to motherhood than most of the other participants. Therefore, availability and access of social support seem to be one key factor that could have facilitated a prolonged feeling of limbo.

An additional aspect of similarity among these women was that, while most of them expected to become mothers at some point in their lives, their pregnancies all happened somewhat unexpectedly. All of their desires to be mothers were quite

noticeable. Alisha's statement was not unusual for the group, "I've always imagined being a mom" (ll.153), nor was Katie's similar comment: "I never saw my life without children, from as far as I can remember. That's just kind of you look at your life and there's certain points of progression, and that was you know I was someone that was getting married, and having kids" (ll.173-7). However, none of these five women were expecting to conceive when they did. Carol was the only woman of these five who was perhaps expecting to conceive; however, she explained that it was not so much a concerted effort to become pregnant, but rather no longer taking the means to prevent it. Katie and Ruby were both actively trying to get pregnant, but did not expect to conceive as quickly as they did. In fact, Katie expected that it would take likely a year, but instead became pregnant within one month. Ruby and Lorna both thought that they were unable to become pregnant or had limited fertility due to their interpretations of past health experiences. Ruby explained with a tone of amazement: "we talked about having a baby but I told him I didn't think I could. And then he said, 'well you wait and see!' [Laughs] And first try it was just that. It was almost like, just the one time he tried" (ll.190-3). The other two women in this group, Denise and Alisha, were both taking hormonal birth control pills and were caught off-guard by unexpected pregnancies. This common feature of surprise suggests that these six women may have all had less time to become accustomed to the idea of new motherhood than they needed, or required an adjustment period before being able to find themselves and their personal paths again.

In addition to the women who described 'fresh starts' and prolonged 'liminal phases' as a result of new motherhood, a third typology of disruption emerged within the

thesis data. This third group of women presented a transition to motherhood that was quite different than the stories examined thus far.

Group 3: Maturation and the Achievement of Adulthood or Womanhood

The third and final type of disruption that the transition into new motherhood generated among this sample was a very positive sense of achievement along their life course or plot trajectories, reflected in five women's narratives. Much like the "points of progression" that Katie identified above, the stories within this third group suggest that motherhood indicated progression and was a type of accomplishment that marked their transition into a new stage in their lives. Three of the women described this new stage as maturation or full adulthood, and the other two highlighted a fully realized feeling of womanhood.

The three women who felt more mature and adult-like as a result of their transition to motherhood identified several ways that their lives were in some way advanced by it. This was accomplished in their narratives through frequent references to advancements in their lives within areas such as relationships with intimate partners, life experiences, and their infrastructure for handling motherhood. None of these three women identified a sense of immaturity prior to motherhood, nor the need to fill a void in their lives. Nevertheless, all of their stories highlight accomplishment and gain while emphasizing their perception of their maturity and/or a new 'adult' status connected to motherhood.

One of these women was Lorna, who was discussed above regarding her temporary lost plot and dislocated sense of self after becoming pregnant unexpectedly at

age 42. When I interviewed her at age 43, she was a language instructor with a trade school diploma in addition to her high school degree. During her life story, she made it clear to me how happy she and her husband were before their child, with a "full" and "very adventurous life together" in which they did not feel like anything was missing. Nevertheless, when they found out they were going to have a child they immediately began to take on new roles, and "imagining each other as 'mother' and 'father'" (Lorna, ll.94-102). In fact, these new roles and role relationships were just the beginning of how motherhood changed her life.

As her story continued, it became clear that Lorna's daily life, routines, situational contexts, socio-cultural contexts and social networks all began to change during the later stages of her pregnancy and continued into motherhood. She and her husband returned to Canada and planned to stay at least for awhile, they gave up living in a camper and bought a house, found new friendships, and after childbirth Lorna began to interact with other mothers and attend mothers' groups and community parks that she had previously not explored. But there are two things that appeared to be most significant to her transition. The first of these was the advancement of her intimate relationship into a new stage, which she discussed at several points in her narrative. She described to me how they are "seeing different sides of each other" and has found it a very positive process, but one that nevertheless involved redefining their relationship. The second key aspect of her transition was the expansion of her self-concept and promotion of her sense of adulthood. She made this connection quite early in her narrative when she described her feelings about new motherhood to me and commented:

> …I marvel every day in him, and how I am as a mother. You know, I really – yeah, I feel more mature. It's changed me, not just physically in

> giving birth, and in my body, but yeah, I've seen a different side of me, and it's been a nice side to see. So it's sorta like yeah, discovering a whole new part of yourself. So yeah, it's been, it's been a most welcomed experience. (Lorna, ll.8-15)

Overall, Lorna approached motherhood in a very exploratory way, and seemed to contemplate the impact it had had on her and her life, and had shown her new sides of herself, her partner, her body and her life in general.

Another participant with a story quite similar to Lorna's was Janine, a 32 year-old full-time secretary with a trade school diploma in addition to her high school education. Her narrative portrayed a story of a full and established life, in which she owned her own home since her early twenties, and has been married for over seven years. Her story was most reflective of 'biographical flow' than any other woman in the sample, based on her comments about how their lives have not changed that much from life before having a child. However, her narrative also indicated some very different roles, routines and plans for the future. Interestingly, Janine emphasized several times that she did not feel compelled to have a baby in order to feel complete:

> I was never the type of woman that *had* to have a baby… we didn't *have* to have her - which I think is what's made her that much more fun is – it wasn't a big desperate thing for her – I didn't need to have a baby in order to feel complete or, as a woman, or anything like that, or to add to my life, or to hold my marriage together, or anything like that! It wasn't a necessity - I didn't *have* to have her, so she's just been that much more fun - that she's basically - we've just *added* her into what we were doing, which was pretty good as it was. (ll.99-110)

Despite this insistence on prior personal fulfillment, Janine seemed to be even *more* fulfilled in some ways now that she was a mother, especially feeling that she finally had created the close-knit family that she wanted when she was growing up.

An additional significant part of her disruption was that similar to Lorna, Janine found life without a child to be quite happy and fulfilling, but found that her self-concept

had become more 'adult' or mature as a new mother. She connected her personal experiences and transition into motherhood with her perceived social expectations of women and mothers, and for that reason, now found that her social identity and subsequently her sense of self suggested that she was more 'adult' than before motherhood. In her explanation, Janine situated her understanding of herself within a social commentary about life progression and achievement:

> it's just made me feel more, I don't know, like an adult I guess… To try and explain that… you just kind of feel more grown up – more like an adult. I noticed that people *outside* of things took me more seriously when I got married, like the banks, "oh, you want some more money? Okay, well we can give you a loan *now* –if you're married we'll do this, as opposed to we wouldn't before." And then all of a sudden when you have a kid, people just kind of think 'oh, okay well their marriage has now been… justified to the world, you know, [because] now they have a child or whatever.' So I think from outside, I don't know, I guess people kind of think you're worth more. (ll.990-1011)

While openly critical of a higher social valuation of mothers here, Janine clearly identified her own sense of feeling more "grown up" than before motherhood. It was unclear whether this was a result of personal exploration or her internalization of her public persona as a mother. Nevertheless, motherhood had clearly brought a transition into a new way of understanding herself, her place in the world, her husband and their relationship.

The third woman who described her transition into motherhood as a progress marker or new stage of adulthood was Rebecca. When I interviewed Rebecca she was a policy analyst with a post-secondary degree. She was 28 years-old and had a planned pregnancy with her husband of three years. Like Lorna and Janine's stories above, Rebecca found that motherhood brought a sense of maturity and growth for herself and her relationship with her husband. Also, just as these other two narratives revealed, it

was not marriage, full-time employment or home ownership that fostered Rebecca's feeling of maturity or adulthood, but rather, new motherhood. For her, motherhood and adulthood focused on a new, more self-confident approach to her life that was rooted in her feeling successful as a mother, which prompted a sense of achievement and accomplishment, and which then improved and advanced other areas of her life. After she reflected upon her long-standing lack of self-confidence, she explained how motherhood had enabled her to cope with and transcend those feelings:

> I just think that at least now when I get that nagging in the back of my mind, like 'maybe I'm gonna fail,' I feel like – I say… I've like accomplished some[thing], and [so] being a mom is something that has really helped my self-confidence, because I just feel like I've done a good job. Like I – the way that [my baby] is really happy, and… well-adjusted… and she's not super-high maintenance, and all of those things. I think that's kind of what I wanted my child to be like. And I mean it's mostly *her* you know, but I do feel like I've had a role in enabling her to be like that. And so that's been a nice confidence builder for me as well. So I guess I *feel* successful. So [now] when I get that nagging feeling I can kind of fight it now. (Rebecca, ll.902-12)

Rebecca's feelings of success had been critical, not only to advancing her sense of self, but also to other areas of her life. She noted that her relationship with her husband had now grown and improved with her new found ability to communicate and the strength to work through difficulties together. As this narrative, as well as Lorna and Janine's demonstrate, the transition to motherhood can be experienced as a sense of progression, and enable new development for the personal aspect of their sense of self, and their social identities and relationships, including their understandings of their roles and standing within their marriages, jobs, and larger social environments.

Much like these three women's experiences of advancement or accomplishment, two other women also described a type of movement towards a new stage in their lives, but instead of discussing adulthood, they focused on their achievement of a new or

heightened sense of womanhood. Within their narratives, motherhood brought a new self-concept or understanding of themselves and their roles that made them feel like 'women,' or more 'womanly' and/or 'feminine.' Through their stories, they suggest that motherhood can be experienced as an accomplishment unique to women, particularly through their connections between motherhood and womanhood via their bodily experiences.

One of these two women was Ayla, a 27 year-old receptionist with a trade school certificate in addition to her high school diploma. For her, the changing shape of her body with pregnancy, childbirth and motherhood had altered how she felt about her physical form, as well as her ideas about herself as a woman. She brought up this feeling several times in her narrative, such as when she discussed her breasts since she began breast-feeding and at one point said, "I feel overall my body – more of a *woman*, because this is the purpose of a woman really, and I'm just even more comfortable with my body, even though it's changed" (ll.237-40). Her new self-concept and outlook on her body can be further understood through her reflection at the conclusion of her narrative, at which time she noted:

> …I would say becoming a mother has been the most major change in my sexuality, or like development as a woman. It's just made me more aware of my body, and more aware of everything my body can do. And because I haven't had any major health concerns or anything like that, I sort of took my body for granted. So now I'm still very comfortable with my body, and even more appreciative of it now. (Ayla, ll.613-20)

As this passage demonstrates, motherhood and development as a woman did not simply co-occur; rather, motherhood inspired and enabled that development and her subsequently altered self-concept and biography. In fact, as Ayla's story indicates, the changes to one's body that accompany motherhood can facilitate a strong feeling of

womanhood, suggesting that some women connect their passage into motherhood with that of womanhood.

The second woman to discuss a connection between motherhood and womanhood or femininity was Zoe, who clearly identified a passage into womanhood in her narrative of new motherhood. Zoe was a 29 year-old mother of twins, who worked as a health care provider with a post-secondary degree. She had looked forward to becoming a mother since grade school, and would have preferred to have children earlier in her life were it not for her husband's desire to delay parenthood, and her subsequent fertility problems. Zoe had always connected her womanhood and processes of menstruation and breast development to her ideas about motherhood. Furthermore, her conception of womanhood and motherhood were so tightly intertwined in her mind that, in her early twenties, when fertility complications arose, they began to undermine her feeling of femininity. In fact, when reflecting upon influences on who she was as a woman or mother, she immediately pointed to the fertility problems, and sadly told me:

> …when I was having trouble conceiving… I felt kind of defeminized because of that. And I felt that there is really a connection between my ability to conceive and carry a child, and to give birth and be a mother. [It] was a huge you know, a huge view on who I was as a person, and how I was as a female. (Zoe, ll.125-30)

As this passage indicates, Zoe's womanhood was a very tenuous achievement, contingent upon her fertility. As such, this remained a source of sadness for her, knowing that conceiving more children would not likely come easily. Nevertheless, Zoe said she also enjoyed being a mother and has found that motherhood made her feel 'womanly'; in particular, when she was lactating and breastfeeding. She also identified some discontent in over motherhood not being "storybook perfect" or the "fairytale of how [she thought] it was going to be," (Zoe, ll.87; 373), and which she had pictured from a young age.

Nevertheless, becoming a mother was the realization of her life ambition, and a source of affirmation of her womanhood after years of feeling defeminized by infertility. Furthermore, she said she very much enjoys her new role as a mother, a new stage of her biography, and her altered situational context and life routines that resulted from it.

In addition to Ayla and Zoe's stories of womanhood, part of Soraya's narrative also contributes to an understanding of the experienced connection between motherhood and womanhood. Soraya's narrative was explored above as a 'fresh start' in her life after years of depression, weak familial relationships and negative feelings about her body were all overturned through her transition into motherhood. During her discussion of breast development, she recalled that during young adulthood she appreciated her small breasts and the freedom that her smaller size brought, but she now viewed her breasts very differently. In a new outlook fostered by motherhood, the breasts that came with motherhood and breastfeeding gave her access to a 'culture of womanhood'. She described this feeling to me this way:

> Now I feel like, well now I have women's breasts. Now I have the breasts of a woman, which hang down, and they provide milk, and you wear a bra - like my mother and my sister and every other woman in my family, who almost all have large breasts, except me. So I'm now a part of that culture. (Soraya, ll.222-6)

This description illustrates how her understanding of womanhood involved both a culture, and a physical form, and how the physical form is central to the routines and group membership of that culture of womanhood.

Overall, these six women all found a sense of accomplishment when they became mothers, whether it was an achievement of maturity, adulthood or womanhood. The women who found maturity or adulthood through motherhood did so by connecting their self-concept as a mother to their relational roles or social selves, while the women who

found a sense of womanhood connected motherhood to their bodies or physical selves. All of these women located their transition into motherhood within a socio-cultural context. Together, their narratives highlight ideas about development and progress, and the explorations of their identities, their bodies, their relationships, and their social and cultural locations.

In addition to the three typologies of disruption proposed and explored thus far, there are also several themes within these 14 women's stories that contribute to an understanding of their transitions into motherhood. These themes also provide insight about the impact of new motherhood upon the women's life pathways.

Other Key Themes in the Transition to Motherhood

There are four main additional themes present in women's narratives that contribute to an understanding of their transitions into motherhood. For the most part, these intersect all three types of maternal disruption discussed above. The first two themes were identified in the literature reviewed in Chapter 2, while the latter two appear to be elements of new motherhood that have largely been left unexplored in social scientific research thus far. The first of these themes is body weight, including weight gains and losses, and related discussions of body image. The second theme is women's interpretation of the new role of their breasts during the transition to motherhood, particularly with regards to breastfeeding. The third theme deals with the women's views on aging and the significance of a woman being of 'advanced maternal age.' The fourth and final theme explores how the mothers of many participants played an important role in their pregnancies and postpartum period, often being their most substantial or desired

source of support. Together, these prominent themes add to the understanding of the transition into motherhood, and how socio-cultural constructions of motherhood can intersect with and infuse each woman's individual experience and her resulting sense of self. As such, these four ideas illuminate not only some of the personal issues at play in new motherhood, but some larger societal issues as well. An exploration of each of these four themes make up the remaining qualitative findings for this chapter.

Weight and Body Image during New Motherhood

Although participants were not prompted to talk specifically about their weight, every woman that I interviewed focused on weight gains and losses when I asked about changes to their bodies during their lives. Furthermore, many of them commented that pregnancy was a very difficult time as a result of the associated weight gain. Rebecca, whose narrative of motherhood demonstrated her perception of achievement of maturity or adulthood, explained her feelings to me this way:

> … getting pregnant was kind of *hard*, because I've always been a fairly weight-conscious person, and then to see like the scale just going up and up and up…I remember my midwife one time – because I made a comment about 'I was getting *fat'* and she was like '[Rebecca], you're not getting fat, you're growing a baby!' She kind of had to make that point with me… It's just weird, because your whole life you're, you know as a girl you're just kind of conscious of weight stuff, and then to see the numbers just…and I just kept on thinking 'god, how am I going to lose all this weight?! How am I going to lose all this weight?!' (ll.814-24)

A similar feeling of discontent was voiced by Denise, whose sense of self was dislocated during the transition to motherhood until she was able to live more care-free and self-centered again. Denise described her displeasure at pregnancy-related weight gain as feeling trapped in another body above (see "*Group 2: Surrealist Limbo*" section above).

When she generated her description, she used words such as "bloated", "huge" and "disgusting" to depict her pregnant body.

In contrast to the feelings of displeasure expressed by Denise and Rebecca, other women expressed appreciation for their bodies during pregnancy. Two such women were Carol and Lorna, who both found joy in the growth of their pregnant bellies. Carol's transition to motherhood had dislocated her sense of self, but she seemed to be beginning to emerge from her liminal phase when I spoke with her. She happily described her experience of her body during pregnancy to me this way: "I enjoyed it, actually. I really did. I liked the belly. [Laughs] It was neat, to watch it grow and to know that that little guy is in there… It was neat to watch it grow, and to be there, and to rub it and to see it, and yeah, I liked it" (Carol, ll.489-93). Similar to this, Lorna, whose narrative about transition to motherhood reflects two weeks of temporary limbo and then a sense of achievement of adulthood, and who has had weight fluctuations throughout her life, outlined her experience of pregnancy with joy and excitement:

> …it was wonderful. It was like this stomach finally had a purpose! [Laughs] It was big, but you know - because when I was sometimes fatter and - especially when we traveled in other countries, the little Thai women, little Vietnamese women would go "when's your baby due?" – "Oh, there's no baby there, I'm just fat," You know? So finally when I was pregnant it was like "yes! The baby is due in April!" Yay! And it was wonderful to watch my belly grow... (ll.595-602)

Clearly, Lorna and Carol approached the changes to their bodies during pregnancy much differently than Denise and Rebecca. This may be related to their body size throughout their lives or that just prior to pregnancy; indeed, Denise and Rebecca have noticeably smaller frames and body sizes than Lorna or Carol. However, their narratives suggest that their dis/pleasure was more closely related to whether and how the women actively engaged with their "growing bellies" as a *symptom* of pregnancy, or as a "neat" or

"wonderful" part of it. Associated with the former idea is a desire to relieve or recover from the symptom, while with the latter notion, weight gain was explored as part of the process of growing a child.

As the women's narratives of their changing bodies proceeded into the postpartum period, they began to evaluate particular features of their bodies, such as their hips (Janine) and breasts (Alisha and Soraya), and conveyed an overall sense of purpose and function for their bodies (such as Denise and Ayla). They indicated that they liked or appreciated certain aspects of their bodies more after childbirth, and in their explanations, depicted pregnancy and childbirth as a physical accomplishment. Janine, who found a sense of achievement of adulthood in the transition to motherhood, credited her long-standing ample hip width with the ease of her labour and delivery, and so evaluated her body with much more emphasis on its purpose and capability than its esthetic properties. Similarly, Denise described to me how her feelings about her body have changed: "I don't look at it as esthetically anymore, I look at it more of – of what I'm able to do… So it's gone from more of like, you know esthetics, to um… ability… and performance" (ll.953-4). Some narrative excerpts cited in the previous sections also express similar positive evaluations of their bodies based on function and performance. Soraya, who found a new beginning for relationships and a fresh start in many areas of her life during new motherhood, commented that she felt better and more confident in her body. Ayla, who described a sense of achievement of womanhood with new motherhood, also noted that she felt this way, and explained that she was more aware of and appreciative of her body and its capabilities after childbirth.

Unfortunately, unlike these stories of increased appreciation, most of the other women in the sample described a more view critical view of their bodies and a related diminished sex appeal. In particular, lasting physical reminders of pregnancy and breastfeeding were repeatedly identified and criticized; including, scarring and altered breast shapes. For Carol, this was just one negative aspect of a generally satisfied or happy body image, and she noted, "I mean [my body has] changed a bit – I have my caesarean scar, and I'm a little heavier than I was before I got pregnant… But yeah, I find myself feeling *better* about my body now, after pregnancy" (ll.458-9; 462-3). While Carol clearly had some things she did not like about her body, overall she seemed quite happy with it. Caitlin, whose transition to motherhood facilitated a radical fresh start in her life, also noted a general feeling of satisfaction with her body; however, her breasts became a prominent source of discontent after breastfeeding:

> I like my body the way it is. Nothing's wrong with it. The only thing that needs to change is my breasts, because they're fucking gross. I'm sorry! I could roll them up in my socks! [Laughing] It's been that, or use them for my belt. I just don't like them. But everything else is good" (ll.518-21).

Unlike the localized dissatisfaction Caitlin identified here, several of the other women (including Zoe, Anna and Ruby) described more widespread displeasure, which made them critical of their bodies overall. Additionally, all five of these women suggested that their bodies were less sexually attractive than before they were pregnant. Zoe explained, "my breasts are saggier and you know I have sort of a bigger belly, and… yeah, I guess I don't really feel as physically attractive as I used to" (ll.690-92). This is particularly interesting because Zoe's narrative intimates that she achieved womanhood during her transition to motherhood, further suggesting that womanhood and sex appeal have quite different and possibly even conflicting criteria. In contrast to Zoe's clearly negative

outlook, Anna, whose narrative portrayed a fresh start during her transitions to motherhood, described more internal conflict within her body image. She outlined the changes to her body with an emphasis on the impact of breastfeeding, which had left her with breasts that "are not the breasts you see in magazines." However, Anna was also able to find pride in her breasts by emphasizing their function, much in the same way described by Denise and Janine above regarding their bodies overall. Anna explained her feelings to me this way: "they're *my* breasts, and you know even if they have a few stretch marks on them, or they're more saggy then they used to be… in some ways it's a reflection that I'm a mom, and you know they serve that purpose, and we're born with breasts for that purpose" (ll.352-9). Therefore, Anna seemed able to deflect her criticisms with this emphasis on capabilities and function, much like a strategy or technique for finding acceptance. This new view of her breasts contrasted markedly from Caitlin's description of her breasts above, and demonstrates how different personal negotiations of similar physical phenomena may vary greatly between new mothers, and have a direct impact upon their resulting body image and sense of self.

Overall then, women's evaluations of their bodies, including ideas about function and capabilities, weight gain and breast shape, have an important role in understanding their experiences of pregnancy and the transition into motherhood. Furthermore, they appeared to be influential on their physical experiences as well as the related social identities that contribute to these women's sense of self. Again, what was important was less physical changes and weight or breasts shapes and sizes than how the women internalized and negotiated those changes, and incorporated their impressions into their body image and self-concept in new motherhood.

Breast Use and the Interpretation of Breasts among First-time Breastfeeders

The second theme in women's narratives about their transition into motherhood concerns the changing role of their breasts in their self-concept and life routines. This was evident in many women's stories and can be categorized into two main sub-themes: first, the identification of considerable difficulty with breastfeeding, and second, different interpretations of the role of their breasts and contemplation about or changes to patterns concerning the "division of labour" of their breasts as they began to breastfeed.

During the postpartum period, all of the women in this sample except for Janine chose to breastfeed their babies, and a few (including Rebecca, Katie and Lorna), found it *much* more challenging than they had anticipated. In fact, when I asked the women about the challenges faced during new motherhood, these three women immediately identified breastfeeding. Their lack of expectation or anticipation of this challenge also added further difficulty to Katie and Rebecca's experiences. When she described her challenge, Rebecca explained:

> …there are just a lot of things that you expect will be so easy as a mom [like] breast feeding. You think 'oh breast feeding is so natural and easy' and God, it is *not*. And that was one of the hugest issues for [my baby] and I during the first few months of her life. Like we had a *really* hard time with breast feeding, and you know she wasn't latching, I wasn't producing, and it became like a cycle and we persevered with solely breastfeeding, exclusively breastfeeding, and it worked out. But oh-my-gosh! I had *no* idea that that could be as much of an issue as it was. (ll.36-45)

Rebecca's preconception of breastfeeding as "natural and easy" resembled Katie's surprise at her difficulty breastfeeding as well. Katie's narrative revealed that her first year of motherhood was experienced as a limbo, but that she was able to emerge from her liminal phase once she began to rely upon her support network more and return to work.

When addressing breastfeeding as "really difficult" and her "biggest challenge" during new motherhood, she contrasted her very positive preconception of breastfeeding her baby to her lived reality of the experience:

> He was never a really good breast-feeder, so that was really frustrating from the sense that everybody talks about breastfeeding, how wonderful it's supposed to be – and *no*! It wasn't that wonderful. It was hard! And it was, you know, for me it was the most difficult thing. And it was painful, and you know he was hungry, and you're doing it all the time and you just, you kind of… it's difficult because you know it's the best thing for them, but it's something you really don't want to be doing. And then it got better. (Katie, ll.82-94)

In this passage, Katie also identified an incongruence between what she felt was best for her child, and what she wanted to be doing, which may have contributed to the loss of her biography and the dislocation of her sense of self.

Unlike the unexpected difficulty with breastfeeding experienced by Rebecca, Katie and a few others, Lorna had been forewarned about difficulties breastfeeding due to breast reduction surgery earlier in life. Nevertheless, Lorna's suspicion that it would be a challenge did not seem to noticeably reduce its mental or emotional impact on her. In fact, when I asked her about challenges during new motherhood she began immediately identified breastfeeding: "it was just a *real* challenge, because…it just consumed me" (Lorna, ll.70-1). She then listed numerous tactics that she used to improve her milk supply and increase her baby's weight gain, including natural supplements, prescription medication, an at-the-breast supplementer, a breast pump, and a wealth of community resources. The struggle did not subside until she stopped breastfeeding and, as explored in her narrative above, at that time "that's when we felt sort of the calm after the storm….we just sort of felt then, 'okay, we can do this, yeah'" (Lorna, ll.37-9). This was also the point at which her experience of limbo subsided and her narrative began to shift

its emphasis towards an achievement of adulthood. Lorna and Katie's stories did not suggest that breastfeeding caused an experience of limbo, but rather, if one is already experiencing a sense of personal and/or social dislocation, difficulties with breastfeeding may be a contributing factor in this respect.

Difficulty breastfeeding was only one aspect of the women's narratives about the role of their breasts in new motherhood. The second sub-theme that contributes to an understanding of the role of women's breasts in the transition to motherhood is that many women found a need to physically and mentally manage their breasts when they began to breastfeed. In particular, their breasts had generally played a sexual role in their lives hitherto, and they now faced having to establish whether and how they would continue to do so while they were breastfeeding. When they discussed this subject, many of the women laughed and joked with me, while others appeared more perplexed by the situation they were describing. Alisha, whose narrative suggested that new motherhood induced a state of limbo that subsided once she had the structure of returning to work, described this as a type of rewarding transition for her breasts. She had shifted how she thought about her breasts but found joy and appreciation in their new role: "… it was a strange feeling when I was first breastfeeding because they were always a sexual thing, and so for them to be a nurturing thing, it actually took time… and I remember thinking about it… that I'm actually producing this in order to give life…" (Alisha, ll.899-905). Although other women contemplated the new function of their breasts in a similar manner, *how* each of them managed the new role of their breasts differed. Some women, including Rebecca, Alisha, Carol, Caitlin and Denise, accepted their breasts playing these two roles simultaneously during their breastfeeding period, while others, including

Heather, Zoe, Anna, Ruby and Ayla, appeared to need or desire a clearer demarcation of function. For the five who allowed their breasts to carry both sexual and feeding roles, they often used unfavourable words such as "weird" "strange" and "tenuous". Ruby, whose narrative was explored above and reflected an on-going liminal phase, allowed her partner to touch her breasts sexually during the initial postpartum period but became uncomfortable with her physical and emotional feelings and thus, soon opted out of sexual play of her breasts:

> My breasts are still sensitive and then it makes me kind of cross-wired, because you get - you do get all the feelings just like you know, when [my baby is] having the breast, so it just kind of makes my mind go all weird, you know? [Nervous laughter] And I don't like my husband to touch my breasts anymore because of that. Because it makes me feel kind of like, cross-wired, because I don't know like how I'm supposed to feel about it you know. (ll.49-55)

In contrast to Ruby's experience here, other women found it easier to disengage their sexual feelings and thus, were able to maintain the dual roles of sexual and functional breasts. Denise put it this way:

> It's like basically they're only sexual if we're having sex and then they're brought into it by touching or whatever. But sometimes I might even just keep my bra on. That's so sad! [Laughs]… And I think [my husband] is kind of hesitant to touch them too, because he sees them as so functional. Like for me, the issue of having to take them out in public, I overcame that. But then *he* sees them out all the time too – as totally functional, like just feeding [the baby]. So that's probably desensitized him I think, to thinking of them as sexual. (ll.299-301, 303-8)

While Denise allowed her breasts to be both functional and sexual, she appeared to not consider them to be very sexual, despite their intermittent role in sexual play. Many other women described a similar lack of sexual feelings about their breasts, as well as their partners' hesitation to incorporate their breasts into sexual activities. Therefore, while some women's breasts were de-sexualized by breastfeeding, their breasts continued

to be a part of their sexual identities. Interestingly, while it was not exclusive to them, all of the women whose transition to motherhood demonstrated a temporary liminal stage are included in this group of women who maintained dual roles of their breasts.

Like Ruby's comments above, many of the women described an internal negotiation with this issue. However, in contrast to her, and others who incorporated these two roles for their breasts, Heather, Zoe, Anna and Ayla found the two roles to be at odds, and were uncomfortable attempting to maintain both roles. Ayla stated that "because I'm still breastfeeding so much, I don't feel I *can* do both roles right now with them" (ll.250-2). The clear division established between the sexual and breastfeeding roles that their breasts played sometimes reflected a division of labour. Moreover, their stories often conveyed a type of transfer of ownership from their partners or themselves, to their infants. Anna light-heartedly explained the transfer in usage of her breasts this way:

> They're providing food for my baby, so right now – over the last year I've felt quite different about them, where it's like okay my husband [Laughs] – my husband always jokes like "oh daddy used to be able to play with those, and now he can't anymore! [Laughing] – They're not for daddies!" – And *that's* right! It's like you know, when you're nursing all the time you just… it's *different* now. They don't have the same purpose, you know?... So in that sense it's quite different now. (ll.338-49)

Here, Anna appears to thinks of her breasts quite differently since becoming a mother and breastfeeding. Similarly, Heather and Zoe withdrew their breasts from sexual activities and reassigned sole ownership and accessibility of their breasts to their children. Heather, who began a fresh start in her life at the onset of her pregnancy and was involved with a new boyfriend, described the exclusion of her breasts from sexual activity with him this way: "My boyfriend now – he'll do whatever, and I'll just be like "you know, [grimacing noise] ehrmmm" like "move back!" You know? [Laughs]… My

boobs are all for him – my son" (ll.266-70). Similarly to how Heather and Anna 'give' their breasts to their child, Zoe had happily done this for over a year and a half when I spoke with her. However, she had also begun to feel like she would like to regain ownership of her breasts for herself. She explained her feelings and division of breast roles to me this way:

> I don't like that part because I don't really feel like there is any - like I have this – I feel like my breasts *are* my children's [Laughs]. And so there's like no sexual connection with that for me, like there hasn't been since they were born… I'm still breastfeeding now. And yeah, I think I'm feeling more ready to have my body back… It's not there at all, um, and so maybe that will come back once I stop breastfeeding. (Zoe, ll.215-16, 223-8)

Much like what Zoe indicates at the end of her story here, several other women ended their comments with speculation that, once they stopped breastfeeding, it was conceivable that their breasts could be re-introduced into sexual play. Zoe and Ayla, both of whom described the transition to motherhood as an achievement of womanhood, divided the roles of their breasts in this way. Therefore, the division of the two roles may have contributed to these two women's sense of womanhood, but alone was not enough to cause it. Indeed, those who divided the use of their breasts are also included those who found a fresh start with new motherhood.

Negotiating 'Advanced Maternal Age'

The third theme present in women's narratives is their expectations and ideas about the age at which they intended to or desired to become mothers. Four women (Janine, Heather, Katie and Ayla) expressed an explicit desire to have children before age 35. For Ayla and Heather, this was simply a general cut-off, as Ayla explained, "I'm not one of those people who really have like a timeline or anything, like 'okay I'm going to

be a mother by this time'… But I didn't want to be like 35 or 40 having a child…" (ll.99-103). However, for Janine and Katie, the age of 35 was a very particular cut-off point which stemmed from the 'advanced maternal age' label placed upon expectant mothers aged 35 and over within the current health care community. Janine explained that the timing of the conception of her first child was instigated to coincide with her turning 30 years old, and at her current age of 32 she now felt the need to begin trying for her second child very soon in order to give birth before turning 35. Similarly, Katie said that medical labels for expectant mothers aged 35 and over influenced the timing of her and her husbands' attempt to conceive:

> I think [the timing] just puts a little bit of rush on – like I turn 33 this month – on when we have the next one, because I don't want to be getting too old to have a second. Like I've always said 'well, 35 is the cutoff – not anymore kids over when I hit 35.' You know, you have to go in for more testing and you're actually called an "elderly parent" you know when you hit 36, yeah, you're an elderly parent! So, as far as that is, I mean, we'll probably have our kids closer together because I'm older. (ll.92-3, 200-6)

Janine and Katie's comments indicate that it was not the medical complications that create the cut-off point they have set, but instead, it was concerns regarding the medical labels and perhaps a stigma associated with being labeled 'an elderly parent' or being of 'advanced maternal age'.

Almost all of the women in the sample who *were* aged 35 or over also brought up the issue of age at some point during their interviews, though they had different things to say about becoming a mother at their age than the four women who considered age 35 to be a cut-off. In fact, when they discussed their desires to be mothers, Lorna (aged 43), Anna (aged 35) and Ruby (also aged 35) often reflected upon their age, and what age was desirable to have children. They suggested that their age was beneficial to their

experience of motherhood because it allowed them more time for personal development. Ruby outlined her belief that younger mothers would have a more difficult time than older mothers, because "just imagine how frustrating it might have been for them, because they probably take [their ability to bear children] for granted. And a lot of young people don't have that extensive personal growth" (ll.929-32). Similar to Ruby's idea of "extensive personal growth" here, Anna noted her belief that she was better off than she would have been at her initial intended age of motherhood at 25. Anna explained to me that she "didn't want to be too old to have children" and further elaborated that "now that I think back, it's probably better that I had her at this age, you know?... It happened at 35 probably because I was probably ready at that age; more mature you know, knowing better what I want out of life, or knowing myself better too" (ll.125-33). Building upon Ruby and Anna's ideas about "personal growth," being "more mature" and "knowing myself better," Lorna also described her feelings about the advantage of having a child later in life:

> I think that having a child at this age can be a real…*easier* transition I think, because you're more stable in who you are. And I'm in a great relationship for so long, and we have a great chunk of money behind us, so there were none of those pressures that I think sometimes when you're younger, and you're renting an apartment, and you're with a guy you don't know or were just married to – I think that adds a lot more stress on the whole experience of parenthood. (ll.744-51)

Together, these narratives show that there are many angles to anticipating the optimum age for becoming a mother, in addition to physical or medical ideals, such as: knowing who you are as a person, what you want out of life, and having some infrastructure in place such as savings or a long-term relationship.

It is unclear what impact that age, or the anticipated or ideal age of becoming a mother had on whether their transition to motherhood was experienced as a temporary

limbo, a fresh start, or an achievement of womanhood or adulthood. In fact, the four women who identified 35 as a cut-off age were each from a different typology group, as were the three women who discussed being over age 35 and those who did not mention maternal age at all. However, these stories have demonstrated the impact that medical labels can have on women's decisions about becoming mothers during their lives, the stigma that an 'advanced maternal age' label may carry, and what aspects to the timing of motherhood that older women consider relevant.

Mothers Helping Mothers

The fourth theme that is quite apparent in women's discussions is the importance of their own mother's roles for social support during pregnancy and postpartum period. Some women, (such as Janine, Zoe and Lorna), had close relationships with their mothers throughout many of their life experiences and transitions. Others had on-and-off or estranged relationships during young adulthood (including Denise, Anna and Soraya), or were not close to their mothers at all for a variety of reasons (such as Caitlin and Alisha). Regardless of their relationship before pregnancy, and despite the participants' age or marital status, almost every participant responded to my question about social support by first identifying the crucial support that their mothers provided.

Heather told me that her mother "was the biggest support" she had during the prenatal and postpartum periods. When I asked her to expand on this, she did so with a tone of gratitude and reverence, "…*every* kind of support. She helped me out financially a bit, she helped me with getting things for [my son], and just being there. She was my coach too. So yeah… yeah, and in fact I don't really know where I'd be without her" (Heather, ll.457-60). Comments like this one were evident in the narratives of many of

the participants, even in those who were married, or had a long-term partner who lived with them. Interestingly, many women with steady partners or husbands still placed greater emphasis on the support given by their mothers. On such woman was Zoe, who continued to be particularly grateful for her mother's role during her pregnancy and initial postpartum period. She first mentioned this to me when she said, "My mom was definitely…yeah, my mom was my main support absolutely…yep, she was huge" (ll.436-7). When I asked her to elaborate on this, she thoughtfully replied:

> My mom was huge, because not only could I talk to her, I felt like I could talk to her about everything like, from you know, my relationship with my husband, to how I was feeling, and all of that. But also she would actually like help me with stuff, like help me clean the house when I couldn't, and take me shopping, or do the shopping for me, and stuff like that, so that was, that was absolutely huge. I actually feel like I couldn't have really gotten through it without her. (Zoe, ll.450-6)

Zoe's mention of the opportunity to discuss her spousal relationship may be one reason why mothers played a more central role for social support than their partners or husband; however, this was clearly not the only reason why their mothers were such an asset to their social support network. In fact, the women's stories suggest that this trend is more connected to their mothers' unwavering dedication to providing whatever type of support was needed, whenever it was needed. Therefore, the significance of the role of their mothers may be one reason that a re-engagement with their mothers was a key component to Anna and Soraya finding a fresh start in new motherhood. Additionally, having mothers that they were not in contact with, or otherwise unavailable to them, may have contributed to temporary or longer term limbo experienced by Alisha, Carol and Denise. Again, this may have added to the occurrence or duration of their liminal phase, but was likely not enough to directly cause it, since it was not identified by the women in

their descriptions of new motherhood, and was not a component of the narratives of all of the women who experienced limbo.

Table 5. Occurrence of Major Themes[16]

Participant	Motherhood	Weight & Body Image Postpartum	Breasts Postpartum (Sexual and/or Functional)	Maternal Age
Janine	Achievement: Adulthood	Improved - functional	---	Cut-off at 35
Heather	Fresh Start	---	Division	Cut-off at 35
Zoe	Achievement: Womanhood	Less Attractive	Division	---
Rebecca	Achievement: Adulthood	---	Both	---
Lorna	Achievement: Adulthood (& Temporary Limbo)	---	---	Over 35 (likes it)
Alisha	Limbo	---	Both	---
Carol	Limbo	Less Attractive	Both	---
Caitlin	Fresh Start	Less Attractive	Both	---
Katie	Limbo	---	---	Cut-off at 35
Denise	Limbo	Improved - functional	Both	---
Anna	Fresh Start	Less Attractive	Division	Over 35 (likes it)
Ruby	(still) Limbo	Less Attractive	Both → Division	Over 35 (likes it)
Soraya	Fresh Start (& Achievement of Womanhood)	Improved	Both	---
Ayla	Achievement: Womanhood	Improved - functional	Division	Cut-off at 35

Overall, women's weight gain and changing body image, the negotiation of the conflicting roles of their breasts, views about aging and 'advanced maternal age', and their own mothers' roles in their social support systems are all key themes that add to the

[16] This table summarizes how participants described additional themes regarding new motherhood, as presented in this Chapter. Women whose narrative did not include a particular theme is represented by "---".

understanding of the transition into motherhood in several ways. First, they suggest some elements that may contribute to or facilitate the three types of transition into motherhood demonstrated in the women's narratives. Second, they reveal what aspects of motherhood that these women found key to their experiences, and thus, provide further depth and understanding of their transition to motherhood. Lastly, these themes help elucidate some of the larger societal issues at play during this significant life and reproductive transition, regardless of transition typology, such as views about mothers, breasts, sexuality, aging, and maternal-child ties. In particular, women's stories speak to standards of body size and attractiveness, a conflict between 'sexy' bodies and mother's bodies, the role and impact of age classifications and medical labels, and long-term implications that maternal care or bonding and related social support may have for women into adulthood. Therefore, these themes also show how socio-cultural constructions of motherhood and larger social concepts intersect with each woman's individual experience and impact upon her sense of self during first-time motherhood. These ideas will be returned to and elaborated upon in the next chapter, where I undertake a discussion of the qualitative findings presented in this thesis.

CHAPTER 6:

DISCUSSION

In this chapter, I discuss the qualitative findings of this thesis presented in the preceding chapter, in relation to the literature presented in Chapter 2. I first address an understanding of the 'self' and revisit the theoretical construct of 'biographical disruption', and then apply thesis findings to the existing understanding of motherhood within social science research.

Understanding the 'Self' when Motherhood entails Biographical Disruption

This research has explored how and why first-time mothers' transitions into motherhood illustrate instances of biographical 'flows' or 'disruptions' from previous biographical trajectories, and has found that all of their various experiences of new motherhood reflect biographical disruptions. A review of Faircloth et al.'s (2004) concept of biographical flow in light of these women's stories indicates that it would, in fact, be very difficult to find a story that reflects this type of continuity. Even though, as Faircloth et al. (2004) has argued, the event or transition may be part and parcel of their biographies and as such, be expected or anticipated that way, it still presented a disruption to all of these women. Sometimes the reality of motherhood was not what a woman expected, even if she eagerly awaited and anticipated the birth of her child – a finding of other researchers as well (see for example, Miller, 2000). Also, new motherhood sometimes brought with it changes in women's relationships, routines and sense of self. Moreover, oftentimes new motherhood *was* normalized into a woman's biography, but it took time and sometimes personal struggle to get there.

Nevertheless, it remains useful to reflect upon the idea of biographical flow in the study of new motherhood by using its core aspects to understand how the transition can be made smoother for women. Faircloth et al.'s (2004) finding that relationships with others who shared a similar condition can facilitate 'flow' resembles the thesis participants' tendency to seek support from their own mothers during first-time motherhood. Faircloth et al. (2004) proposed that one way 'biographical flow' could be created was by information sharing, since people going through a transition could learn what to expect and acquire coping strategies from those who have already been through the event. For the 14 women explored in this thesis, this may also be the case, and it points to the possible benefit for first-time mothers to have relationships with their own mothers, or even with other new mothers in the prenatal and postpartum periods. Therefore, this support and knowledge sharing may provide health benefits, so it is important to professionally facilitate these ties when they do not already exist.

Understanding the transition to motherhood as largely a biographical disruption, with recognition that 'disruption' may have beneficial or enjoyable aspects, brings to light several unique aspects of the transition. This includes, but is not limited to, the onset of change and negotiation of this change within the women's daily lives and ongoing biographies. In this thesis, motherhood proved to be a disruption to participants' existing biographies in several ways, including: altering their taken-for-granted knowledge, such as their existing identities and expectations of what motherhood would be like; inducing a re-thinking of their biography and self-concept, by understanding themselves as mothers, even for the women who expected to be mothers at some point; and mobilizing new or different resources, such as beginning to seek out and rely upon

their mothers for significant social support. Bury's (1982) observation that people may often withdraw from social relationships during biographical disruption also reflects some of the women's stories, such as Ruby's desire for isolation and Katie's refusal to leave the house during the initial postpartum period. Overall, this conceptual framework offers a useful way to understand the transition to motherhood, and possibly other life changes that include changes to one's body, identity and sense of self.

My findings also support Bury's (1982) idea that the notion of 'biographical disruption' provides a way to research the interaction between experiences of illness and wider social structures, as well as health. Drawing upon Gidden's (1979 in Bury, 1982) concept of a 'critical situation' in which one can learn about day to day situations and routine settings when those settings are disturbed, Bury's (1982) framework of 'biographical disruption' translates the idea into a concept applicable here. First, for the women in the 'fresh start' disruption group, pregnancy served to highlight aspects of their biographies which were sources of discontent in their lives, such as abusive relationships and unhealthy lifestyle patterns (Heather and Caitlin), or a lack of connection with their own mothers and desire for family stability (Anna and Soraya). For women who experienced a pronounced state of limbo or liminality, the transition to motherhood underscored what aspects of their lives were very important but taken-for-granted thus far, such as the ability to live carefree, self-centred and act on their impulses (Denise an Ruby), and the importance of formal paid employment, control and structure in daily routines for their sense of self and fulfillment (Katie and Alisha). The women may have already been aware of these taken-for-granted elements of their lives, or they could have been highlighted by another disruptive event, but in their existing narratives and

biographical trajectories, the disruption that motherhood brought seems to have been the catalyst for them to be emphasized in these ways.

These women's experiences of disruption also illuminate social and cultural ideas such as how they understand womanhood and adulthood. The women in the achievement disruption group were clearly 'adults' and 'women' already according to many different definitions; however, their internalization of social norms and values, particularly those pertaining to gendered expectations of women to become mothers, constructed ideas about life progress being tied to motherhood. Likewise, all of the women's experiences bring to light other social and cultural influences on the women, such as their negotiation with ideas about weight, breasts, and the 'ideal' age at which to become a mother. These ideas will be further explored below. In brief understanding how and why the transition to motherhood was experienced as a disruption for the participants in this study provides insight not only to their own stories of new motherhood, but aspects of the transition to motherhood more generally and to larger social and cultural ideas at work for women and new mothers.

The women's experiences and narratives at the same time supports the idea put forth in Chapter 2, that "identity refraction" (Bailey, 1999) and "biographical reinforcement" (Carricaburu & Pierret, 1995) may in fact be two aspects of biographical disruption, rather than alternatives to it. Stories like Janine and Ayla's, in which motherhood brought out their feelings of adulthood and womanhood, resemble Bailey's (1999) participants' experiences of refraction of aspects of their identities. Furthermore, Bailey's (1999) finding that such refraction may amount to a revolution in their lives during new motherhood aptly describes the 'fresh start' embraced by Heather and Caitlin,

whose lives after new motherhood were drastically different from those before pregnancy. Nevertheless, these changes all entailed disruption.

'Biographical reinforcement' was also found in the women's narratives above, but not in the way that Carricaburu and Pierret (1995) found for their participants. One would expect that becoming a mother would 'reinforce' the biographies of women who looked forward to being a mother (and sometimes were actively trying to get pregnant); however, this was not the case in most of the women's stories, usually because the reality or lived experience of pregnancy and motherhood was not what they expected it would be. New motherhood did seem to reinforce other aspects of the women's lives, particularly those that were key to their sense of self. For Alisha and Katie, the lack of formal employment during maternity leave at the end of their pregnancies and during the early postpartum period emphasized the importance of their work to the maintenance of their sense of self. Carricaburu and Pierret (1995, p.81) also suggest that reinforcement may involve reorganizing biographies so that an event or the onset of a condition appears as just one more step in a biographical path. There is some evidence of this in the stories of women in this thesis who focused on progression in life and the achievement of womanhood or adulthood, including Zoe and Rebecca. Although the stories of the women whose narratives demonstrated achievement via motherhood do indicate progression of their lives, identities and senses of self, they still presented disruptions since they involved an unexpected pregnancy, a different experience of motherhood than anticipated, or new identities and altered relationships. Nevertheless, these experiences, again, are more usefully understood as *elements* of disruption, rather than a different concept altogether. The ideas of reinforcement and refraction do offer insight into the

personal process of becoming a mother for some women as outlined here, but not for all of the women and may have limited ability to recognize the variety and depth of changes that may take place during major life events and transitions such as motherhood.

The separation of body, identities and self-concept in previous research also has merit in the understanding of the transition to motherhood offered here. Some of the women's narratives explored above have demonstrated an explicit negotiation between their social environment and their perception of their 'selves'. Moreover, their emphasis on weight gain pointed to one of the ways that their bodies provoked changes in their public persona or identities and their overall sense of self during pregnancy and the postpartum period. In this way, this research supports Kralik et al's (2003) finding that changes to one's body produces changes in one's self and identity, and provides an example as to how their analysis of the onset of chronic illness is applicable to understanding the transition to motherhood as well. My study also supports Bailey's (2001) related finding that bodily changes can be a resource to renegotiate one's social position. This is evident during pregnancy for some women, such as Heather, who found joy and higher social valuation when obviously pregnant, and the postpartum period for others, such as Ayla and Soraya, who embraced their new figures as 'mother's' bodies or 'more womanly' bodies.

The separation of body, identity and self also works to better understand the experiences of the women whose narratives reflect the limbo typology of disruption. There are useful connections to be made between these women who experienced an extended or ongoing liminal phase into the postpartum period, with research by Bury (1982), Kralik et al. (2003), Carricaburu and Pierret (1995) and Miller (2000). Bury

(1982) has argued that when faced with chronic illness, keeping the illness separate from the 'self' can be a cultural resource to manage the situation by enabling an individual to temporarily hold it at a distance (or else accept the full burden of responsibility for it), until the condition manages to invade one's life anyways. Similarly, Carricaburu and Pierret (1995) have reported that the battle to 'lead a normal life' may involve an individual denying their chronic illness or condition. In other words, these authors suggest the separation from the body and the self, or identity from the self (Carricaburu & Pierret, 1995). Their arguments reflect the way that the liminal women carried on with their lives as usual, until their later stages of pregnancy or initial postpartum period when their current ways of life and sense of self were eventually disrupted. Women within this liminal phase disruption typology also reflect Kralik et al.'s (2003) concept of "diminished self" when they were not able to initially reconcile their new identity (as a mother) with their current identities (for example, the working identities of Alisha and Katie). For this reason, the women's experiences within this thesis also reflect Miller's (2000, p.316) argument that when new mothers cannot locate their individual identity narrative within unpredictable experiences postpartum or related public narratives in their social environment, they may 'lose their plot' trying to make sense of their new identities. Overall then, there is a useful overlap between studies of identity, the body and self, research of the onset of chronic illness, and an understanding of the transition into motherhood.

Towards an Understanding of New Motherhood

My findings support and to some extent challenge several of the ideas and key themes evident in previous findings of sociological and psychological studies of new

motherhood. The themes that will be revisited here in light of the preceding analysis include: confirmation of adult womanhood, the use of breasts, body weight, and rhetoric about what is 'natural,' maternal age, and the loss of one's 'plot.' At times, a particular disruption group may reflect or challenge findings of other researchers and, elsewhere, it is the stories or individual women or even those of almost the whole sample that does this.

It is primarily the work of Bailey (1999, 2001) that gives evidence for the confirmation of adult womanhood. In her research, new mothers described feeling more womanly as well as more adult (Bailey, 2001). In the narratives analyzed above, six women's stories supported this claim, but the other eight did not. Thesis participants who did not discuss feeling more 'adult' or 'womanly' may have in fact felt this way, but did not discuss it during their interviews. Therefore, I suggest that while it may be a significant aspect of becoming a mother for *some* women, it may not be as prominent within or even part of other women's transitions. Furthermore, the women who did identify these feelings did not describe mature womanhood and adulthood as a virtually united advancement as Bailey (2001) has. In fact, in Janine's story presented above, she explicitly stated that having children does *not* make one a 'woman.' Instead, the women in this study who described feeling more feminine focused on bodily changes influencing their sense of self, while those who described the onset of adulthood focused on their social identity and position. Since these two experiences of 'progress' or achievement (womanhood and motherhood) appear to emanate from different sources, it is understandable that they did not necessarily appear together within participants' narratives. Nevertheless, all six of these women described new motherhood as a type of

achievement and marker of progress in their lives and development of themselves. Therefore, while some women's narratives support Bailey's (1999; 2001) overall argument that women connect motherhood to life progress and achievement, this thesis challenges the idea that motherhood necessarily provokes feelings of womanhood and/or adulthood.

The second key aspect of other research concerning new motherhood is the role of breasts and women's conceptualization of their breasts and this role during new motherhood. My findings support the ongoing struggle breastfeeding women face in negotiating sexual and maternal roles of their breasts (Galupo & Ayers, 2002). Findings by Bailey (2001, p.118) indicate that women viewed their breasts functionally and comment that their breasts were now 'for' their children, while Galupo and Ayers' (2002) study suggested that although all of their participants shared this functional view of their breasts, some also continued to assign them a sexual role, even if sexual pleasure was only experienced by their partners and not themselves. In this thesis, I suggest that when the women speak of the use of their breasts it resembled a transfer of ownership – an argument built within these study participants and supported by Bailey's (2001) participants' stories.

This thesis also supports and builds upon Galupo and Ayers' (2002) finding that some women may allow their breasts to play both sexual and nurturing roles, but that only some and not all women found this sexually-based touching void of sexual pleasure. Therefore, I suggest that there may be three loosely separated categories of women: those who only want or are only comfortable with their breasts to playing a maternal role during breastfeeding, those who permit their breasts to fill both roles but find the feelings

of sexual pleasure mostly belong to their partner, and lastly, those whose breasts play a sexual role and they are able to find some pleasure in it. However, this thesis (and the lack of evidence in previous studies) indicates that this third group may be the rarest. This rarity is likely related to Bailey (2001) and Galupo and Ayers' (2002) finding that sexual pleasure derived from breastfeeding is considered morally and socially inappropriate. This may be because those women who did find sexual feelings were uncomfortable with this and withdrew from sexual use of their breasts (such as Ruby). Alternatively, this may be because the women feared stigma or outside judgments of those feelings as inappropriateness, and thus, were less likely to disclose their feelings in an interview. Overall, my findings indicate that breastfeeding may be a difficult biosocial transition on its own, in which a new mother must engage with the biological changes to her breasts and the personal and social roles and meanings embedded in breasts and their use.

A third prominent theme of research of new motherhood is the way that women begin to discuss weight and weight gain during the prenatal and postpartum periods. My findings have not demonstrated that some women enjoy pregnancy as an excuse to put on weight as Bailey (1999) found. Instead, some of the participants' narratives in my study reflect Johnson et al.'s (2004) work in which participants tended to emphasize that they are not fat, they are pregnant. In fact, this thesis indicates that this *may* particularly be the case for women who felt that they had some excess weight before pregnancy. Thus, my findings do not support those of other researchers that pregnancy may be a time to challenge ideals of slenderness imposed on women's bodies (Bailey, 1999, 2001; Johnson et al., 2004). Instead, my results indicate that if there is an existing dislike of

excess weight (such as that described by Lorna and Rebecca) their pregnancy may enable a temporary alternative interpretation of that body shape. More generally, my thesis reflects the variety of women's interpretations of body weight found by both Bailey (1999) who reported that some women enjoy the excuse to put on weight while others fear weight-gain, and Johnson et al. (2004), who found striking contradictions in related literature and demonstrated the presence of both enjoyment and dislike of weight gain during pregnancy in their own study. My thesis provides examples that support both of these, since some participants were clearly disturbed by weight gain during pregnancy either initially (such as Rebecca) or in later pregnancy (such as Denise), or else found joy in their expanding bodies (such as Lorna and Carol). Moreover, by comparing these women's different interpretations of somewhat similar biological changes, I have been able to once again demonstrates that it was not the biological change itself that induced a particular experience during pregnancy; rather, it was how a woman interpreted her biological change and how she negotiated those biological changes with personal experiences and biography and related social values and expectations.

There are also parallels between related research and my study findings concerning women's experiences of weight during the postpartum period. I provide further evidence to Bailey's (1999) finding that women may discover increased purpose and value in their bodies as a result of new motherhood. While this was not a common thread across all of the women's narratives, it was a very prominent feature to some of their experiences, such as Denise and Janine. My findings also indicate that unrelated (or not explicitly related) to experiences of weight gain during pregnancy or decisions regarding the role of their breasts when breastfeeding, some women did not find a greater

appreciation or outlook on their bodies during the postpartum period. Instead, some women focused on or exclusively discussed their criticisms of their bodies postpartum, including their body shapes and sizes (such as Caitlin), their decreased attractiveness or sex appeal (such as Zoe and Ruby), and their lingering excess weight (such as Carol). These women's criticisms of their bodies during the postpartum period were not necessarily at the exclusion of appreciation for their bodies' abilities, and sometimes their descriptions included elements of both (such as Denise and Janine). Neither their positive nor their negative interpretations of bodily changes during the postpartum period seem to correspond to with any one category of disruption found in the preceding analysis, and instead, can be found within all three.

The fourth theme within related literature that overlaps with results from this thesis is the use of rhetoric concerning what is 'natural' for women; in particular, the 'naturalness' of becoming a mother, and of breastfeeding. Results of Miller's (2000) research in which not all women – even those who eagerly anticipate motherhood – naturally knew how to be mothers, is echoed in this thesis. This is evident across all of the typologies of disruption, including Zoe and Rebecca, as well as most of the women in the limbo group (in particular Alisha, Katie, Denise and Ruby). However, while these women's narratives suggested that they were attempting to figure out how to be mothers, it was probably more likely that the women were trying to figure out how to be themselves *as* mothers, and for the liminal group, how to be themselves *and* be mothers. In other words, the narratives revealed these women's endeavour to find their own niches and identities compatible with their existing identities and self-concept. These same women's narratives also find support in other studies (Miller, 2000) that show women's

expectations of motherhood often do not coincide with their lived reality of it (especially for Zoe and Katie), and that women may isolate themselves when they find such inconsistencies until they learn to manage motherhood a bit more (especially like Katie and Ruby). However, the experiences of Zoe, Katie and Ruby suggest that while this isolation may relate to fear of being perceived as a competent social actor (as Miller, 2000 argued), it may also reflect their loss of control over their environments and a resultant attempt to establish some element of control again, even if just within one's home.

Wall's (2001) finding that health care providers and new mothers expect that breastfeeding is 'natural' is also present in my research. No participants took up discourse concerning whether breast-feeding was 'natural' in comparison to bottle feeding, but Katie and Rebecca clearly identify their preconception of breastfeeding as a 'natural' capacity of women's bodies, and thus, expected that it would be "so natural and easy" (Rebecca, l.38). Moreover, akin to Wall's (2001) conclusion, a stark contrast between expectations of ease and 'naturalness' and lived realities of breastfeeding difficulties can lead to self-blame and frustration, which was indeed prominent in Katie, Rebecca and Lorna's stories of breastfeeding. I propose that in a culture where breastfeeding is not openly welcomed in public (Wall, 2001), it is unreasonable to assume that an innate biological drive will inform women about breastfeeding strategies. My findings support the idea that women may not naturally know how to be 'mothers' especially in the initial postpartum period, nor find breastfeeding 'natural' or easy. Again, a need to be socialized into these roles may be one reason that participants sought

relationships with their own mothers, since they may have been considered 'experts' or at least veterans in these areas by the first-time mothers.

The fifth theme in my research to be addressed in this discussion is the identification of expectations about age and motherhood. This topic appears to be understudied at the current time. In Miller's (2000) research of first-time mothers, she drew attention to "the existence of public and lay definitions about what are perceived to be appropriate periods in life when pregnancy is anticipated or expected" (p.319). She also speculated that women may find conflict between their experiences and this perception due to factors such as life situation and age, which is supported by one of her participants who believes that others may be critical of her becoming a mother "quite late" in her life (age 29), (Miller, 2000, p.318). Similarly, Bailey's (1999) research showed that "The right time and the right place were both seen as important to the decision to have a baby" (p.345). However, in her subsequent discussion she did not specify age as a factor in determining 'the right time,' which had more to do with physical location, stability/settlement and home-ownership (Bailey, 1999, p.345). In Lupton's (1999) research, the triple screening for birth defects and medical label of 'high risk' for women over age 35 was a very negative experience for pregnant women. Lupton (1999) described the detrimental mental and emotional impact upon women going through pregnancy or considering pregnancy at 35 years or older, in a social context emphasizing maternal responsibility for minimizing risk, and a medical context in which these women are considered 'higher risk' and thus, are singled out for needing expert advice, additional testing and self-regulation. Participants in my thesis sample were particularly aware of the significance of age 35, possibly because they are a fairly

educated group, or because women in their thirties may have discussed the issues with their physicians. However, it also seems likely that with the rising age of women having children both in public and in popular media (such as Celine Dion), this issue may be a growing issue of interest among first-time mothers or women considering becoming mothers. As Lupton's (1999) work has indicated, the moral and social responsibility for expectant mothers to minimize the health risks to herself, her fetus, or both, can be a pervasive socio-cultural discourse within private, public and medical settings.

The sixth and final theme that will be discussed here is the liminal phase that five of the participants evidenced in my research. In Chapter 2 I outlined Van Gennep's (1960) concept of a "rite of passage" in which there is a middle stage between identities and social positioning that involves a period of liminality. This aptly described the stories and experiences of Denise, Alisha, Katie, Carol and Ruby during the initial postpartum period and even into the later months of their first year as a mother. The temporary nature of this limbo supports Fox and Worts' (1999, p.340) argument that women have an emotional reaction to their experience of becoming a mother, and Miller's (2000, p.322) conclusion that women may lose the plot of their stories during the initial postpartum period and work to re-forge or recover them during the postpartum period. I have argued above that what is especially noteworthy is *who* was inclined to feel that they lost a significant part of their self-concept when pregnancy or childbirth disrupted their previous ways of life. In particular, for Alisha, Katie and Denise, the structure, routines and fulfillment of full-time employment was a key part of their self-concept and understanding of their lives. Therefore, I argue that full-time maternity leave for one year may not best facilitate the transition and mental health of new mothers who

have long derived their sense of self from their employment. This suggestion resonates not only with my study, but also with Bailey's (1999) finding that some career-oriented women sought to continue working at least part-time after the birth of their child because they felt they had "invested part of their selves, and not just their time, into their workplace" (p.342). Indeed, in a society in which women have become increasingly educated and more involved in full-time employment, the shift to a full-time stay-at-home mother may be too drastic and even detrimental and, as a result, contributing to her sense of disruption rather than mitigating it.

In addition to the six themes proposed above, I propose that this thesis has possible applications within research of motherhood and health care practices pertaining to prenatal and postpartum health. In the following chapter I address these potential applications, review strengths and limitations of this thesis, and put forth related issues and questions for future research.

CHAPTER 7:

SUMMARY AND CONCLUSION

This is the final chapter of this thesis. I begin this chapter by proposing some ways in which this thesis may have applications for both social scientists and health care practitioners. I then review the strengths and limitations of this thesis. With consideration of these strengths and limitations, I then put forth suggestions for further research. I conclude this chapter with a brief summary of the thesis and some final thoughts about its implications for understanding health during first-time motherhood in contemporary North American society.

Possible Applications of the Research

Results from this study support some arguments and suggestions put forth by other sociological and psychological health researchers regarding the potential application of qualitative research findings to improve the health status of individuals as well as health care policy and practices. The first area of possible improvement is in the preparation of women, and particularly expectant mothers, about what to anticipate and how they may find that their lives change during new motherhood. Byrd et al. (1998) have argued that "accurate information can help couples feel more comfortable during transition periods before and after childbirth" (p.305), suggesting that counselling may relieve anxiety and enhance adjustment (p.308). The researchers point out the value of preparatory guidance, assisting new mothers in anticipating the variety of things that they may experience, rather than new or expectant mothers relying upon a more generic image of motherhood put forth in education materials (Wall, 2001) and public narratives

(Miller, 2000). My findings suggest that expectant mothers be counselled in particular about the possibility that they may experience very different feelings about their bodies, social roles and public personae, and confusion within their self-concept. Essentially, I proffer that the professional and public image of motherhood be redressed and expanded to include a wider range of experiences, feelings and sensations that may all be considered 'normal' rather than deviant. This wider range of 'normal' could include the possibility that a woman does not naturally know how to mother or breastfeed, that the sexual and maternal usage of breasts may be a tenuous territory, and that a mother is not necessarily an undedicated mother if she remains employed through the postpartum period.

My findings may also offer benefits to practices in health care for new mothers through care practitioners' increased understanding of first-time mothers' experiences. When discussing the application of research into stroke survivors' experiences, Faircloth et al. (2004) argued that knowing how an individual interprets the event as part of their life course "can be an invaluable tool for health practitioners… treating all [patient] experiences may gloss over some important aspects of [their] experience, resulting in poorly designed interventions, and in turn, poor outcomes for particular people" (p.258-9). Indeed, as my findings have shown, some first-time mothers may have very different health care needs during the prenatal and postpartum periods as others. Knowing how each woman is interpreting her experience may assist in meeting that woman's individual needs and assist in facilitating a smooth transition into life with the added identity of 'mother.' Women who continue to go about their ways of thinking and living in current roles and routines without much disruption (as Alisha and Katie did) and those who

become pregnant quickly or unexpectedly (such as Denise and Ruby) could be better supported in engaging with the idea of themselves as mothers so that they are largely accustomed to the idea before childbirth. Additionally, women who have long-standing areas of discontent in their lives could be encouraged to embrace pregnancy and new motherhood as a turning point to 'start fresh' in their lives. These suggestions are contingent upon the acceptance of the idea I put forth above: that these women's lived experiences were not directly caused by their physical experiences and processes, but rather, were the product of each woman's interpretation of physical and social elements within her existing and newly developing sense of self. Some of these suggestions may overlap existing efforts to intervene or counsel women within programs such as Best Babies[17] or some prenatal classes. However, I suggest that these efforts be more systematically employed within healthcare policy and practice, such as incorporating counseling into prenatal and postpartum care for all women.

Overall, the practical application of this research can be best understood as further insight into the possible ways that women interpret their bodies, their social worlds and their self-concepts, adding to the understanding to findings put forth in research of new motherhood (such as Bailey, 1999, 2001; Byrd et al.; Miller, 2000; and Wall, 2001). My thesis indicates new ways to approach understandings of biographical events and more detailed understandings of biographical disruption, to add to research by others studying

---

[17] Best Babies is principally funded by the Public Health Agency of Canada, and is a locally sponsored program at select cities in Canada. The program intends to offer support and programs for expectant and new mothers. In the City of Victoria, the primary task of the Victoria Best Babies program "is to support behavior changes that will improve maternal and infant health outcomes" (Fernwood Neighbourhood Resource Group, 2007).

changes to biographies in the context of health and illness (such as Bury, 1982; Carricaburu & Pierret, 1995; Faircloth et al., 2004; and Kralik et al., 2003).

Strengths, Limitations and Future Research

This study has sociological, and possibly medical, merit for a fuller understanding of first-time motherhood and the transition that women experience when becoming a mother, and has numerous strengths.[18] I have strived to privilege the participants' voices so that this research best reflects their stories and their individual negotiation with the transition to motherhood. I have attempted to maintain the individuality of their lives and experiences within the larger framework of the typologies put forth. Furthermore, the combined longitudinal and cross-sectional approach, employed not only for data collection but also to the stories explored and analysis presented above, keeps the women's experiences situated within their individual life histories and wider socio-cultural contexts. Therefore, the results presented here take into account women's individual lived experiences as well as their intersection with larger social, cultural and political realms.

Despite these strengths, the thesis is not without limitations. Since this analysis is based on a sample of only 14 women in the Victoria CMA, it almost certainly does not include all of the diverse possibilities of disruption typologies that first-time mothers will experience. Furthermore, there may be some women for whom the transition to motherhood has indeed been experienced as an uninterrupted flow, and their experiences are not represented here. While this sample has considerable variety across several variables, it lacks the diversity that an inclusion of more visible minority members and

[18] For a discussion of methodological strengths and limitations, see Chapter 3: Research Methodology

Aboriginal women would have enabled. As such, their experiences are also not reflected here. Moreover, since this study has a small and non-random sample, it is unclear to what degree the experiences presented and analyzed are representative of other women in the Victoria CMA. Overall, I do not believe that these limitations detract from the accuracy or theoretical and practical utility of this research. However, they do restrict my ability to make generalized statements about other first-time mothers, either in the Victoria CMA or larger geographical or socio-cultural areas.

In order to build upon this research and seek further understanding of first-time motherhood and new mothers' experiences of transition, continued research in this area would be highly beneficial. First, additional qualitative research with other first-time mothers could explore more women's experiences for additional typologies of biographical disruption (or even biographical flow). Second, an additional qualitative investigation of new mothers who already have one or more children, could explore whether the typologies evidence here are unique to first-time mothers, or apply to new mothers more generally. Third, qualitative research exploring the transition to motherhood based on data collection with persons surrounding first-time or new mothers would be a useful comparison to further understand the socio-cultural context of new motherhood; particularly from those providing social support to new mothers. Fourth, a longitudinal study involving an intervention, or an institutional ethnography within a healthcare setting would be of use to explore whether and how typologies such as a 'fresh start' could be or already are being facilitated by health care providers. Lastly, a mixed method and longitudinal study that qualitatively explores for transition typologies while quantifying socio-demographic, personal and health variables would contribute much

insight to this subject. This would enable the possible identification of predictive variables to disruption types, and with a large enough randomized sample design, regression models could be developed to explore and to help explain relationships between socio-economic indicators, patterns of biographical flow and disruption, and health outcomes.

Concluding Remarks

The narrative data collection techniques of interpersonal, open-ended, retrospective episodic interviews provides a beneficial way to understand women's life course development, through stories that naturally unfold, present unanticipated topics, and retrospectively integrate events into a biographical trajectory. By using a multi-stage analysis that integrates retrospective and thematic cross-sectional analyses as well as plot reduction and structural linguistic analyses of participants' narrative descriptions, I have explored both the content and embedded interpretations of first-time motherhood. Additionally, I have investigated how women integrate their experiences of pregnancy and new motherhood into their identities, and thus, have demonstrated how first-time motherhood is generally experienced as a biographical disruption. Furthermore, I have also delineated the many ways in which disruption can be experienced, including those which are quite positive (including a 'fresh start' and achievement of womanhood or motherhood) and those which are more disorienting (such as prolonged liminality). I have also suggested here that there are some commonalities within typologies that may identify how they arise, as well as some commonalities and differences across all of the participants' narratives that illuminate some larger social and cultural issues at play in the transition to motherhood.

Understanding personal, social, cultural and political aspects of motherhood has great challenges, not only because there is much diversity between women, but also because larger societal meanings and understandings of motherhood change over time as a society itself changes and evolves over the years. When suggesting that women's experiences be taken into account within health care provision and a wider societal image of motherhood, I am making several arguments about future understandings of motherhood. Health care provision is based upon medical science and the generally static scientific understandings of women's bodies which, in and of themselves, do not fundamentally change over time; however, the societal context in which their biology exists does change. In fact, the socio-cultural context of biology can change quite markedly over a period of only one or two decades. And as I have demonstrated in this research, a woman's personal experience in becoming a mother can at times involve negotiating both biological and social transitions. Therefore, in order to understand the transition to motherhood and provide health care that best meets the needs of new mothers, we must continuously work to reconfigure our understanding of women's biological processes in light of the ever-changing societal context in which they exist.

FUNDING

I would like to thank all of the organizations that have contributed financial support to the pursuit of this thesis. This research has been jointly funded by the following organizations:

British Columbia Health Research Foundation (BCHRF)

The Michael Smith Foundation for Health Research (MSFHR)

The Social Sciences and Humanities Research Council (SSHRC)

The Sara Spencer Foundation

The University of Victoria

REFERENCES

Bailey, L. (2001). Gender shows: First-time mothers and embodied selves. *Gender and Society, 15*(1), 110-129.

Bailey, L. (1999). Refracted selves? A study of changes in self-identity in the transition to motherhood. *Sociology, 33*(2), 335-352.

Bartley, M., Blane, D., & Montgomery, S. (1997). Socioeconomic determinants of health: Health and the life course: Why safety nets matter. *British Medical Journal, 314*, October 22, 2005

Bell, S.E. (1988). Becoming a political woman: The reconstruction and interpretation of experience through stories. In A. D. Todd, and S. Fisher (Eds.), *Gender and discourse: The power of talk* (pp. 97-123). Norwood, NJ: Ablex Publishing.

Benoit, C., Westfall, R., & Carroll, D. (2004-2006). Social determinants of health and their impact on postpartum morbidity among midwifery and physician clients in British Columbia. Michael Smith Foundation for Health Research, Canadian Institute for Health Research, Health Canada National Network on Environments and Women's Health, a Centre of Excellence for Women's Health funded by Health Canada.

Benoit, C., Westfall, R., Treloar, A., Phillips, R., Jansson, M. (In Press). "Social factors and postpartum depression: A mixed methods longitudinal study." Journal of Mental Health.

British Columbia Vital Statistics Agency. (2005). Appendix 1: Statistical summaries by Health Authority , Health Service Delivery Area, Local Health Area, and Community. *Selected Vital Statistics and Health Status Indicators Annual Report, 2005.* http://www.vs.gov.bc.ca/stats/annual/2005/index.html. Accessed July 3, 2006.

British Columbia Vital Statistics Agency. (2004). Figure 11: Cesarean Sections by Health Service Delivery Area, British Columbia, 2004. *Selected Vital Statistics and Health Status Indicators Annual Report, 2004.* http://www.vs.gov.bc.ca/stats/annual/2004/index. Accessed December 6, 2006.

Brock, L.J., & Jennings, G.H. (1993). Sexuality education: What daughters in their 30s wish their mothers had told them. *Family Relations, 42*(1), 61-65.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health and Illness, 23*(3), 263-285.

Bury, M. (1991). The Sociology of chronic illness: A review of research and prospects. *Sociology of Health and Illness, 4*, 167-182.

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health and Illness, 4*(2), 167-182.

Byrd, J.E., Hyde, J.H., DeLamater, J.D., & Plant, E.A. (1998). Sexuality during pregnancy and the year postpartum. *The Journal of Family Practice, 47*(4), 305-308.

Carricaburu, D., & Pierret, J. (1995). From biographical disruption to biographical reinforcement: The case of HIV-positive men. *Sociology of Health and Illness, 17*(1), 65-88.

Carter, J. (2000). African religions. In R. Scupin (Ed.), *Religion and culture: An Anthropological focus.* Upper Saddle River, NJ: Prentice Hall.

Corbin, J., & Strauss, A. (1987). Accompaniments of chronic illness changes in body, self, biography and biographical time. *Research in the Sociology of Health Care, 6,* 249-281.

Esterberg, K.G. (2002). *Qualitative methods in social research.* Boston, MA: McGraw-Hill

Faircloth, C.A., Boylstein, C., Rittman, M., Young, M.E., & Gubrium, J. (2004). Sudden illness and biographical flow in narratives of stroke recovery. *Sociology of Health and Illness, 26*(2), 242-261.

Foster, S.F., Slade, P., & Wilson, K. (1996). Body image, maternal fetal attachment, and breastfeeding. *Journal of Psychosomatic Research, 41*(2), 181-184.

Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A contribution to the Sociology of Birth. *Gender and Society, 13*(3), 326-346.

Fernwood Neighbourhood Resource Group. (2007). Victoria Best Babies. *Programs.* http://www.fernwoodneighbourhood.ca/programs.html#vbb Accessed June 30, 2007.

Galupo, M.P., & Ayers, J.F. (2002). Negotiating the maternal and sexual breast: Narratives of breastfeeding mothers. *Journal of the Association for Research on Mothering, 4*(1), 20-30.

Giddens, A. (1979). *Central problems in social theory*. London: Macmillan.

Halfon, N., & Hochstein, M. (2002). Life course health development: An integrated framework for developing health, policy, and research. *The Millbank Quarterly, 80*(3), 433-479.

Hydén, L. (1997). Illness and narrative. *Sociology of Health and Illness, 19*(1), 48-69.

Jackson, W. (1999). *Methods: Doing social research* (2nd Ed.). Scarborough, ON: Prentice-Hall Canada Inc.

Johnson, S., Burrows, A., & Williamson, I. (2004). 'Does my bump look big in this?' The meaning of bodily changes for first-time mothers-to-be. *Journal of Health Psychology 9*(3), 361-374.

Kralik, D., Koch, T., & Eastwood, S. (2003). The salience of the body: Transition in sexual self-identity for women living with multiples sclerosis. *Journal of Advanced Nursing 42*(1), 11-20.

Kuh, D., & Hardy, R. (2002). A life course approach to women's health: Does the past predict the present? In D. Kuh, and R. Hardy (Eds.), *A life course approach to women's health*. NY, NY: Oxford University Press.

Legard, R., Keegan, J., & Ward, K. (2003). In-depth interviews. In J. Ritchie, and J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 138-169). Thousand Oaks, CA: Sage Publications.

Letherby, G. (1994). Mother or not, mother or what?: Problems of definition and identity. *Women's Studies International Forum, 17*(5), 525-532.

Lewis, J., & Ritchie, J. (2003). Generalising from qualitative research. In J. Ritchie, & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 263-286). Thousand Oaks, CA: Sage Publications.

Lupton, D. (1999). Risk and the ontology of pregnant embodiment. In D. Lupton, (Ed.), Risk and sociocultural theory: New directions and perspectives (pp.59-85). Cambridge, UK: Cambridge University Press.

Martin, E. (1989). The cultural construction of gendered bodies: Biology and metaphors of production and destruction. *Ethos, 54*(3-4), 143-160.

Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2000). Paternal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders, 60,* 75-85.

Mauthner, N. (1995). Postnatal depression: The significance of social contacts between mothers. *Women's Studies International Forum, 18*, 311-323.

Miller, T. (2005). *Making sense of motherhood: A narrative approach*. Cambridge, UK: Cambridge University Press.

Miller, T. (2000). Losing the plot: Narrative construction and longitudinal childbirth research. *Qualitative Health Research, 10*(3), 309-323.

Moen, P., Robison, J., & Dempster-McClain, D. (1995). Caregiving and women's well-being: A life course approach. *Journal of Health and Social Behaviour, 36*, 259-273.

Norget, K. (2000). Ritual. In R. Scupin (Ed.), *Religion and culture: An Anthropological focus.* Upper Saddle River, NJ: Prentice Hall.

Palys, T. (2003). Research objectives. In *Research decisions: Quantitative and qualitative perspectives* (3rd Ed.). Scarborough, ON: Thomson Nelson.

Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage Publications.

Ritchie, J., Lewis, J., & Elam, G. (2003). Designing and selecting samples. In J. Ritchie, and J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers*. Thousand Oaks, CA: Sage Publications.

Summers-Effler, E. (2004). Little girls in women's bodies: Social interaction and the strategizing of early breast development. *Sex Roles, 51*(1-2), 29-44.

Trudell, B., & Whatley, M. (1992). Equity principles for evaluating sexuality education materials. In S. S. Klein (Ed.), *Sex equity and sexuality in education*. NY, NY: State University of NY Press.

Teitelman, A. M. (2004). Adolescent girls' perspective of family interaction related to menarche and sexual health. *Qualitative Health Research, 14*(9), 1292-1308.

Turner, V. (1967). *The forest of symbols: Aspects of Ndembu ritual*. Ithica: Cornell University Press.

Van Gennep, A. (1960). *The rites of passage*. London: Routledge & Kegan Paul.

Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender and Society 15*(4), 592-610.

APPENDIX A:

EXTENDED THESIS ABSTRACT

Background: The transition into motherhood is shaped by personal, social and cultural contexts. Current sociological studies of postpartum health and the transition to motherhood focus on women's circumstances and mental health during the period of pregnancy and immediate postpartum. Few studies have examined influence of new mothers' experience during these times upon her life course biography and trajectory or 'life path'. This thesis reports on research that theorizes biographies during life course events and transitions, and studies which explore first-time motherhood experiences. A socio-culturally oriented and retrospective investigation of the transition to motherhood would contribute to the sociological understanding of motherhood, the transition into motherhood, and prenatal and postpartum health. A more complete understanding could inform health care provision and policies, by suggesting why some first-time mothers may approach new motherhood with ease and a high quality of life during the postpartum period, while others face struggle and turmoil, hindering their ability to take care of themselves and their newborn.

Aims: In this thesis I examine how first-time mothers' experiences during the transition into motherhood reflect biographical 'flows' or 'disruptions' when contextualized within their life course trajectories. I identify the key factors that have had positive/negative impacts on first-time mothers' experiences and that are commonly part of new motherhood. This will allow a better understanding of the social factors that can affect new mothers' well-being during the postpartum period, and make it possible to identify specific areas for concentrating further research concerned with first-time mothers' well-being.

Methods: Retrospective qualitative research design, using narrative methods of data collection and analysis to explore the life course narratives of a purposive sample of 14 first-time mothers approximately one-year postpartum. To investigate first-time motherhood I interviewed women who gave birth to their first child 12-17 months prior to the time of the interview. I used open-ended questions to collect episodic narratives about participants' reproductive events and prior transitions.

Results: Qualitative analysis revealed that all of the first-time mothers experienced the transition to motherhood as a biographical disruption, but not in the same manner. Three different typologies of disruption presented themselves in the narratives: women who found a fresh start with new motherhood, those whose difficulty adapting to motherhood prompted a prolonged limbo between life before and after new motherhood, and last, those who expressed a sense of achievement of either womanhood or motherhood. Four sub-themes were also observed across the participant sample: concerns about weight and body-image, sexual and/or maternal usage of breasts, the significance of being of 'advanced maternal age', and the role of participants' own mothers in providing social support.

Acknowledgements: This research was supported by research grants from the British Columbia Health Research Foundation (BCHRF), the Michael Smith Foundation for Health Research (MSFHR), and the Social Sciences and Humanities Research Council (SSHRC), the Sara Spencer Foundation and the University of Victoria.

APPENDIX B:

POSTPARTUM HEALTH STUDY OVERVIEW

The Postpartum Health Study is officially titled *Social determinants of health and their impact on postpartum morbidity among midwifery, physician and obstetric clients in British Columbia.* It is a longitudinal mixed-method study in which Drs. Benoit and Westfall investigate social determinants of women's prenatal and postpartum health in Victoria, BC, and examine why some new mothers are healthy, while others are not. Their primary objective is to identify some ways in which social determinants of health affect women's mental, emotional and physical well-being in the postpartum period.

The participant sample of this study includes 93 women who were recruited because they were currently pregnant, living in the Victoria Census Metropolitan Area, and interested in being part of a study on the social determinants of postpartum health. Participants were recruited over approximately one year (October 2004 – November 2005) using posters and flyers distributed through the offices of maternity care providers, ultrasound clinics, and pregnancy outreach and support services. This sample is intended to be diverse, and include of the two main primary maternity care styles in Victoria: certified midwives, and maternity physicians (including general maternity practitioners and obstetricians), as well as the variety of ages, ethnicities, and levels of income and education, in the Greater Victoria Census Metropolitan Area.

Data was collected through a series of three interviews: (1) in the third trimester of pregnancy, (2) at 4-6 weeks postpartum, and (3) at 4-6 months postpartum. The longitudinal design is allows the researchers to track changes in the participants' self-report physical and mental health over time. At each interview participants were asked

both closed and open-ended questions. A resource sheet with contact information for related health organizations was given to any woman who showed signs of physical, mental or emotional distress during an interview session. The open-ended portion of the interviews were tape-recorded and transcribed.

I am acquainted with many of the participants that were recruited for this thesis research, since I conducted between one and three interviews with approximately 35-40 of the 93 Postpartum Health Study participants.

APPENDIX C:

INTERVIEW GUIDE[19]

Social determinants of health and their impact on postpartum morbidity among midwifery, physician and obstetric clients in British Columbia: WAVE 4

"A lot of my academic and extracurricular activities have revolved around women's lives and their experiences of their bodies. I have studied menstruation, sex and sexuality, pregnancy, mothering and women's reproductive health for many years. What I am now doing in my graduate thesis work is exploring how these issues may or may not be linked within a woman's life. Therefore, in this work I am investigating the transition to motherhood. My goal is to see how women's experiences as first-time mothers are situated within the rest of their reproductive life course. By 'reproductive life course' I mean the biological and social experiences and events that you had as you physically matured from a girl to a woman (such as menstruation and breast development), and those that you are now experiencing as you embark upon motherhood. I want to get a sense of what these experiences were like for you at the time that you were experiencing them, and how you now reflect back on them. I would like to begin with your most recent experience of becoming a mother, and what the transition has been and/or is like for you."

"…Do you have any questions before we begin?"

1. **Can you please tell me about what first-time motherhood has been like for you?**

   → Can you give me an example of a typical experience of being a mother for you?

   → Can you give me an example of a challenge you have faced during the first year of motherhood and how you managed it?

2. **a) Did you ever imagine you would become a mother? (When?/Why?)**

   b) Has motherhood been how you expected it to be so far? (Why/why not?)

3. **Now I would like to turn to some of your earlier experiences. How do you think that motherhood might be linked to your experiences with female biological changes you have experienced earlier in your life?**

   a. Menstruation: How would you describe your thoughts about your first period? About menstruation as you matured? Now?

   b. Breast Development:

---

[19] This interview guide was adapted according to each participant's background, and to her responses during the interview.

i) How would you describe your early experiences with breast development? How did that change over time?
ii) Since becoming a mother, have you breasts played a dual role, being both sexual and nurturing?

c. How would you describe your experiences of early sexual activity?

d. How would you describe your experience of getting pregnant? And of pregnancy?

4. **Social support from people like parents, friends or places like community resources during these times of biological change has been shown to be helpful for some people. They may be places to get information, or in some other way make an experience or transition less stressful. What kinds of social support did you have during these stages in your life?**

→ How have these sources of support changed over time? (Why do you think they did/did not change?)
→ How would you describe the social support system available to you now, as a first-time mother?
→ Are there one or two individuals who stand out in your life who were there for you when you needed social support?

5. **Now I'd like to ask you about sex education you had growing up, and I'm thinking here about both formal sex ed, like school programs or information from doctors, and informal sex ed, such as information shared by friends or family members or information you received via media. With these two types of sex education in mind, can you please describe to me what your sexual education was like growing up?**

→ Was it useful to you when you received it? (How/Why?)
→ Did you feel you had the right kind of knowledge when you had your first sexual experience?
→ How useful do you think it really was, knowing what you know now? (How/Why?)
→ What do you think would have made your sex education more helpful or effective for you?

6. **Can you please tell me about some of the dating or intimate relationships you've had in your life?**

→ How have your sexual relationships changed over time? Why/not do you think they changed in this way?

7. **a) How would you describe the changes to your body since the onset of puberty to the end of adolescence, and after experiencing pregnancy and childbirth?**

b) Sometimes our ideas about our body are different than our actual bodies. How do you think your ideas about your body have changed over time?

8. **Often our sense of self is connected to our physical appearance and experiences we have as we age. Can you tell me about your 'sense of self' – or 'who you were' around puberty, during adolescence and into early adulthood?**
   → How do you think that your sense of self changed or evolved over time as you physically developed?

9. **Looking back across time in this way, what experiences do you think most affected who you are as a woman and a mother?**
   → Any people or events in particular? (Who/What?)

10. **Sometimes material resources can make the difference between whether we are successful or not in coping with life events that can be stressful, such as those we have been discussing, (like starting to menstruate, becoming sexually active, etc.). By material resources, I mean such things as enough money to pay for birth control pills or hygiene products, adequate housing, childcare, and so forth.**

    Did you have any difficulties accessing the resources you have needed? Or were there any that were missing for you?

11. **Is there anything about your biological changes or mothering experiences that you would like to add to what we've discussed?**

12. **Do you have any questions for me?**

Thank you for participating!

APPENDIX D:

PARTICIPANT RECRUITMENT FORM

Postpartum Health Project

Participant follow-up sheet (to be completed at the Wave 3 interview)

Name _____ Participant ID _____ Interviewer _____

1. We are very interested in learning more about your experiences with health and parenthood. If funding becomes available, additional waves on interviews may be added to this project. Would you be like to be contacted if the study continues on?

□ Yes, I would like to be contacted regarding further participation in the study, should it continue on beyond the third wave of interviews.

□ No, I would not like to be contacted regarding further participation in the study.

2. As an addendum to the existing project, Adrienne Treloar (nee Bonfonti) is conducting further interview-based research into the reproductive experiences of first time mothers. For Adrienne, this research will meet part of the requirements of a Master's degree in Sociology at the University of Victoria. If you are a first time mother, would you like to be contacted regarding this project?

□ Yes, I am a first time mother, and I would like to be contacted regarding this project.

□ No, I am a first time mother, but I would not like to be contacted regarding this project.

□ I am not a first time mother.

3. A summary of the research findings from The Postpartum Health Project will be made available to you in the Autumn of 2006. Would you like to receive a copy?

□ Yes, please send me a paper copy in the mail. (Please provide your full mailing address.)

_____

_____

_____

□ Yes, please send me an electronic copy by email. (Please provide your email address.)

_____

□ No, I would not like to receive a copy.

Thank you for participating!

APPENDIX E:

PARTICIPANT PHONE CONTACT SCRIPT

"Hello, this is Adrienne Bonfonti calling from The Postpartum Health study at UVic…"

[If I was their PPH interviewer:] "…You may not remember me, but I was your interviewer for those three interviews about your pregnancy and postpartum health."

[If I was NOT their PPH interviewer:] "…We've never actually met, since (name) was your interviewer for the three interviews about your pregnancy and postpartum health, but I have been working on the project since it began almost two years ago."

"I'm calling today because at the end of your last interview you responded 'yes' to being a first-time mother and interested in participating in one more interview about the reproductive experiences of first time mothers. I'd like to give you a bit more information and answer any questions you may have, and then set up an interview if you are still interested in participating."

Information to be covered during this conversation:

- Purpose of the interviews: to ask open-ended questions about their past and current reproductive experiences, to learn about the potential linkages and significance their experiences have on their health and transition into motherhood.
- Questions will cover: experiences with breast development, menstruation, early sexual activity, pregnancy, childbirth and first-time motherhood.
- Details of the interview process:
  - interviewing after at least 12 months postpartum
  - face-to-face, one-on-one interviews
  - 60-90 minute interviews
  - interview time, date and location of convenience to participant
  - tape recording of interviews
  - $30 honorarium to thank them for participating.
- Review of major aspects of informed consent: anonymity, confidentiality, right to withdraw, and use of the data.

"Do you have any questions or would you like further explanation about anything?"

Once all of the participant's questions are answered, complete

"Participant Information for Wave 4"

APPENDIX F:

PARTICIPANT INFORMATION SHEET

Participant Information for Wave 4

ID#_____

Name: _____ Phone Number: _____

Alternative phone number: _____ (Specify:_____)

Email address: _____

Address: _____

Alternative contact method: _____

Child's date of birth: _____

Main style of maternity care during pregnancy/delivery:

- ☐ Midwife
- ☐ Physician (Mat. Dr. or OB/GYN)

Desired/approximate date of interview: _____

Comments: _____

_____

Interview date: _____ Interview time: _____

Interview Location: _____

☐ Interview Completed

APPENDIX G:

PARTICIPANT CONSENT FORM

Participant Consent Form

Respondent ID Number:_____

Social determinants of health and their impact on postpartum morbidity among midwifery, physician and obstetric clients in British Columbia: WAVE 4

What is the purpose of the continuation of this project?

You are being invited to continue participating in the study entitled *Social determinants of health and their impact on postpartum morbidity among midwifery, physician and obstetric clients in British Columbia,* currently underway in the Department of Sociology at the University of Victoria. This research project examines variation in the health and well-being of childbearing women in the Greater Victoria area. The study is continuing to examine variation in women's mental and physical health, and the social elements that contribute to that health status, through a fourth interview with a sub-sample of women. This fourth interview will add a narrative element to the project, and help us to better understand the full context of your pregnancy, birth and entrance into motherhood. We aim to do this by looking more closely at your earlier years, including social and physical development in young adulthood, and at how you have come to understand your body and its more recent changes as you entered into motherhood.

Who is being asked to participate?

You are being asked to participate in this study because you are a first-time mother, and have completed the first three interviews involved in this research project. By "first time mother" we mean that the pregnancy and birth that have been the focus of your first three interviews represented your first sustained live birth.

What does participation involve?

Your participation will involve one face-to-face interview that will be approximately 60-90 minutes in length. This interview will take place approximately 18 months after the birth of your child. The interviewer is prepared to conduct the interview at your home, at a private office provided by UVic, or another location for your convenience and comfort.

What are the benefits in participating in the study?

Your participation in the study has potential benefits (1) to you, (2) to society, and (3) to the state of knowledge. First, we believe that you will likely feel empowered by having the opportunity to "tell your story" about your young adulthood and experiences that can effect your postpartum health. Second, you will likely find it beneficial to know that

your stories and experiences will be combined with those of other first-time mothers in order to produce better general knowledge of maternal health. Third, this research has the potential to advise policy development in social and health services so that health-related resources can better meet the physical, mental and emotional needs of first-time and new mothers. Additionally, this fourth interview has the potential to advise social and health services for future parents to best allow for an ease of transition into motherhood.

Are there any risks or inconveniences involved?

Some of the questions in this study cover potentially sensitive topics which may remind you of difficult past events, or for which you may feel uncomfortable sharing the information. To address this, the interviewer will remind you that you do not have to answer any questions that you do not want to. Should you feel too uncomfortable with any question, simply express your desire to the interviewer to skip any such questions. Alternatively, if you feel more comfortable submitting an answer in written form, the interviewer will provide you with paper, a pen, and an envelope to seal your answer in, making your answers only accessible to the researchers after the interview. Answering in this manner will provide privacy, but your answers will still be linked to your file.

The study may also inconvenience you due to your time commitment to the interview. As a way to compensate you for this inconvenience in participating, and to thank you for your contribution, you will be offered a small honorarium of $30 at the time of the interview. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to continue participating in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Is your participation voluntary?

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data collected in earlier interviews will only be used in analysis if you agree to this. If your withdraw part way through the interview, we will not use the data collected in that interview unless you indicate that it is okay to do so.

How important is your privacy?

The pseudonym and code number used for the organization of data and publication for the first three interviews will be maintained for this fourth interview. Your confidentiality and the confidentiality of your data will continue to be kept in a locked filing cabinet and on a password protected computer. This information will only be accessed by members of the research team. Further, only transcribed data will be retained, while raw data (interview tapes and notes) will be destroyed at the end of the data collection period.

How will the information be used?

The above researchers plan to use these data only for research purposes. This sub-project will form the basis for the Master's thesis of the researcher, Adrienne Bonfonti. This data will also be used for comparative purposes with the data collected in the first three interviews. It is anticipated that the results of this study will be shared with others in a variety of ways, including: directly to participants, via published articles, presentations at scholarly meetings, and via the Internet.

Who are the researchers?

The principal investigator for this project is Cecilia Benoit, a faculty member in the department of Sociology at the University of Victoria, who you may contact if you have further questions: Phone: 721-7578; or Email: cbenoit@uvic.ca. The researcher for this fourth interview will be Adrienne Bonfonti, a graduate student in the Department of Sociology at the University of Victoria, who you may also contact if you have further questions: Phone: 995-8426; or Email: abonfont@uvic.ca. Other continuing members of the research team are Rachel Westfall, a post-doctoral fellow, (Phone: 472-5116; Email: rachelw@uvic.ca), and Dena Carroll, an aboriginal health consultant.

How is this study being funded?

This fourth interview is being jointly funded by the Social Sciences and Humanities Research Council of Canada (SSHRC), the Michael Smith Foundation for Health Research, the British Columbia Health Research Foundation (BCHRF), and the Sara Spencer Foundation.

Who do you contact if you have any further questions?

In addition to being able to contact the researcher and interviewer through the above contact information, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

_____	_____	_____
Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX H:

INTERVIEW SETTINGS

The following entries describe my prior involvement with each participant through the *PHS*, and provides details about the setting in which the narrative interview for my thesis research was completed. This includes a description of who was present, the atmosphere of the interview, the length of the interview, and some information about the participant's demeanor.

Alisha

Since I was Alisha's interviewer for all three of her *PHS* interviews, we were already somewhat familiar with each other. I interviewed Alisha on the sofa in the living room of her two-bedroom apartment, with her 16 month old little boy playing on the floor in front of us and her two cats sleeping peacefully at our feet. The interview lasted almost three hours in order to accommodate several stops for infant care, including breastfeeding, diaper changes, and an upset stomach. Throughout the interview, Alisha was cheerful and talkative, despite touching on some very sensitive subjects in her stories.

Anna

I knew Anna a little already since I was her interviewer for the first two of her *PHS* interviews. I interviewed her at the kitchen table of her modest log house. Her daughter was just over 13 months old, and was actively watching the interview progress from her highchair while chasing blueberries around her highchair tray. During the interview we stopped a few times so that Anna could breastfeed her daughter and prepare her lunch. Anna was very talkative about some aspects of her life and was able to provide elaborate details and anecdotes; yet, she was also somewhat shy and more vague about other areas.

Ayla

I did not know Ayla before arriving at her door for her interview, since I was not her interviewer for any *PHS* interviews. We chatted briefly before the interview, giving me the opportunity to ask about her daughter and family and to answer her questions about

myself and my thesis work. We completed the interview at the kitchen table by a patio door overlooking the ocean. During the interview, her daughter, who had recently turned one-year old, played among a sea of toys spread over the large living room floor nearby, and occasionally came over to play with the tape-recorder or show Ayla or I one of her toys. Ayla was a very upfront woman, who did not appear shy at all during the interview, even when her husband came home for lunch and was in the room while she was describing some of her past dating relationships.

Carol

I conducted all three of Carol's *PHS* interviews, and was very familiar with her personality and family situation. She was a difficult participant to book for this interview, and had one cancellation and one missed appointment before I successfully interviewed her on my third attempt. I interviewed her at the kitchen table of her large log house in a remote area of Victoria. The television was on in the adjoining living room, though we were alone in the house other than her baby, now 15 months old, who sat in his highchair at the table with us chewing on Cheerios. Most of Carol's responses were very brief and required much probing, reflecting her matter-of-fact, pragmatic approach to life. Despite the on-going probing, this was the shortest interview, taking only about 45 minutes to complete.

Caitlin

I did not complete any of Caitlin's *PHS* interviews, and so introduced myself and my research to her before beginning the interview. Caitlin lives in a small house with her grandmother in a low-income neighborhood in Victoria. We completed the interview on the outside porch so that she could continue to smoke during the interview. Her son was 13 and-a-half months old, but I did not meet him, since he was asleep inside the house for the duration of the interview. Caitlin was not shy at all, and shared many life stories with me in great detail. She was also a very emotional and expressive woman, who changes from very angry, to scared, to upset and then embarrassed as her stories take her back through the emotions she felt in the past. The interview took a little over an hour to

finish, but I stayed about another 20 minutes to chat with her about her experiences and my research after the interview.

Denise

I was Denise's interviewer for her first and second *PHS* interview, and so, before the interview began, we chatted briefly about what we had each been doing since our last meeting. I interviewed her at her living room table, where I had also completed our prior interviews. She lives in an apartment on a main road where, at times, the traffic noise forced her to speak loudly over the cars and occasional siren. Her son was almost 14 months old, and was sleeping for the first half of the interview. For the second half, Denise's son snuggled into her lap, listening quietly to her voice with only an occasional fuss. Denise was very open with me about everything she has been through in her life, including her very honest reflections about herself, her life and her family. Our interview was almost two hours long, with only a very brief interruption to bring her son out to sit with us.

Heather

I completed Heather's first and second *PHS* interviews, so we already were somewhat familiar with each other when I came to interview her again. We completed this interview on the living room sofa in her new basement suite where she was living with her 13 month-old baby boy. Her son played with his toys on the floor in front of us and wandered back and forth from us, to his toy box, to the adjoining kitchen and back again. However, his favourite pastime during the interview was playing with Cheerios or the informed consent form on the coffee table in front of us. The interview took about an hour. She was very open with me about most of her experiences, but was hesitant to discuss troubling people and past events that she wished to leave out of her narrative.

Janine

I conducted Janine's second and third PPH Study interviews with her, so she was already familiar with me and my research background when I came to interview her this time. Her daughter was now 17 month old, and Janine was excited to tell me that she was

pregnant with a second child, and that that particular day was her and her husband's sixth wedding anniversary. Her daughter slept soundly in the bedroom adjacent to the living room, where we settled in on the over stuffed sofas for an interview that lasted almost two hours. At one point during our discussion of menstruation, her husband came into the room to use the computer and we stopped the interview briefly as Janine gestured to me that she wanted to wait until he left the room again.

Katie

I did all three *PHS* interviews with Katie, and we immediately began chatting about her family and the progress of the *PHS* and my graduate studies when I arrived to interview her for this thesis. We completed the interview at a small table in her living room. Her son was 15 and-a-half months old during this interview, and was playing amongst a sea of toys on the floor around us. He was very interactive and wanting Katie's attention, which necessitated pauses in the interview 10-12 times in the first 30 minutes. At that point, Katie's husband came home and interacted with us briefly before taking their son into another room so that we could continue the interview uninterrupted. Katie was very open with me about her life, and seemed to have a good time telling me about her life experiences.

Lorna

I did not complete any *PHS* interviews with Lorna, and so we were unfamiliar with each other at the beginning of the interview. Therefore, we chatted about her family, her plans for the summer, my studies and my role in *PHS* before turning to the formal interview questions. I interviewed Lorna in the overstuffed chairs facing each other from across the living room of her large home. On the carpet in front of us, there were toys scattered around the floor and her 15 month old son was happily playing among them. There was a technical problem with the tape-recorder that began about 2 minutes into the interview and continued for 10 minutes before I noticed it. Using my notes about her responses to the questions we had covered during those 10 minutes, we re-visited those questions and ended up covering her responses in even more detail the second time. She had a very

calm presence throughout the interview, appearing thoughtful and reflective, but also cheerful and open to discussing whatever topics I asked her about.

Rebecca

I did all three *PHS* interviews with Rebecca and had great rapport from the time I entered her home for the interview. As we had done during previous interviews, we completed the interview at her dining room table in her small but very nice home. Her 15 month old daughter was napping in another room for the duration of the interview and woke just as we were finishing. We paused the interview about half way through for approximately 20 minutes because she noticed that I was wearing an engagement ring and wanted to chat about my engagement and show me the photos from her recent wedding. She was cheerful and very talkative for the duration of the interview, though she specifically identified some topics that made her shy or less confident when discussing them in her responses.

Ruby

I did not conduct any of Ruby's *PHS* interviews. While Ruby did not seem hesitant to talk, she did seem somewhat shy, and so we spent about 20 minutes talking about my research background, my personal situation and my background before beginning the interview. We completed the interview at a small dining room table located in the family room of her small apartment. The apartment was a somewhat chaotic environment for the interview, with a television on in the background, several (unanswered) phone calls, and a hard-wood floor that amplified her son's movements and vocalizations. Her son had just turned one year old, and was actively playing with his toys around us during the interview, occasionally coming over to breastfeeding with his mother for a minute or two before returning to his toys. Ruby seemed unaffected by the atmosphere, remaining relaxed throughout the interview, and calmingly telling me many stories about her life and reflecting on how it has unfolded.

Soraya

I did not conduct any of Soraya's PHS interviews, and so we were initially unfamiliar with each other when I arrived. It was difficult to navigate across her front porch and through the house to her kitchen because these areas appeared to be undergoing renovations. We sat at the kitchen table and chatted informally while she finished her lunch, and then began the interview. Part way through the interview her husband and 13 and a half month old son came in from playing in the backyard. We paused the interview briefly so that Soraya could introduce me to her husband and son, and also, so that she could tend to her son's diaper change and make him a snack. Throughout the interview she was noticeably emotional when discussing many subjects, so we took the interview quite slowly, and also chatted informally for almost a half hour after the interview was over.

Zoe

I conducted all three of Zoe's *PHS* interviews, and had met her twin sons and husband on all three occasions. Just as with the previous interviews, Zoe and I went to a spare room their basement suite to complete the interview, but had only moderate privacy for part of the interview, since her husband arrived home and occupied the adjoining room of the quiet home. We were interrupted only at the conclusion of the interview, when her 17 month old boys awoke from their nap and were crying for her attention. She was very open about almost all of the topics, and was quiet only a few times, appearing somewhat shy when recounting a few of her stories and reflecting on them.