THE SOCIAL ROLE OF PREGNANCY

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ABSTRACT

Although pregnancy is an important and common event, the social experience of being pregnant has not been well researched by sociologists. This neglect originates, in part, from the androcentric bias of social sciences in general. As a female experience, pregnancy has either been deemed unworthy of study, or has been so closely identified with being female as to seem inseparable.

When pregnancy has been researched, the focus has usually been upon deviant or pathological aspects of the reproductive process, with only scant attention to the normal pregnancies which are common life events for most women. As an alternative to this perspective, recent research has centered on pregnancy as a normal process, and has been concerned with the subjective experiences of the women themselves.

The objective of the present research was to explore the acquisition of the social identity associated with pregnancy, to determine the norms of this social role, and to present a typology for adherence to the pregnancy role. 43 women from the Greater Victoria area were interviewed in depth during the third trimesters of their pregnancies.

To outline the means the women used to acquire

their socially pregnant identities, Berger and Luckmann's theory of the social construction of reality was used. This theory states that reality is produced by human activity and must be internalized by a society's members for that society to function. By correctly interpreting the physical signs and symptoms of pregnancy, the women proceeded from only being physiologically pregnant to also feeling and acting pregnant. The reality of being pregnant was thus constructed through a social process.

After the women realized their pregnancies, they usually became more comfortable in the role of "pregnant woman" and performed norms of the role. These norms were identified through an inductive approach. To be considered part of the pregnant role, a given behavioural expectation had to be mentioned by at least eighty percent of the women. 22 norms were discovered, which were divided into 5 categories: medical, prenatal, birthing, postnatal, and positive/negative response norms. The medical and prenatal norms were those which the women were aware of, or engaged in, during their pregnancies. The birthing and postnatal norms consisted of intentions and preparations for the future. The positive/negative response norms involved the response of others to the pregnancies.

Although there was considerable consensus on norms concerning pregnancy, fundamental differences became apparent

in the way in which women thought about their experiences. A typology based on these differences suggested three Types of women: the Romanticist, the Conformist, and the Realist. The basic distinguishing characteristic among these Types was their definition of pregnancy as a singular experience: the Romanticist defined being pregnant as special; the Conformist defined being pregnant as scripted; and the Realist defined being pregnant ambivalently, with some special and some ordinary aspects.

While obtaining the objective of the research, to outline the social role of pregnancy, the implications of the study revealed numerous unanswered questions which require further investigation, the most prominent of these being the serendipitous discovery of three values of childbearing. For the women in this group, childbearing is largely voluntary and the reproductive process is seen as being a shared and natural experience.

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CHAPTER ONE

INTRODUCTION

Although parenthood is almost universal, the social experience of being pregnant has received little attention from social scientists. The following study examines the social meanings of pregnancy from the perspective of pregnant women, based upon their experiences with the pregnancy role.

There are three important reasons to study pregnancy. First, reproduction forms a major part of biological sex differences and the basis for alleged gender differences; second, parenthood is almost universal; and finally, it is the means by which the survival of humans as a species is ensured.

Given the importance of pregnancy as a human experience, the neglect of the study of the social experience of pregnancy seems to be without justification. Several suggestions have been put forth as possible explanations for this neglect.

Stewart and Erikson posit that reproductive "... events and processes have been taken for granted and have been so intricately woven into the social fabric, [that] they have not been sifted out as something which merits our

attention and have thus evaded analysis by researchers" (Stewart and Erikson, 1977:33). Yet, they next question why, given the pervasiveness of its existence, the phenomenon has become "...a taken-for-granted reality".

Their first reason is that "...pregnancy and birth are experiences specific to women" (Stewart and Erikson, 1977:33) and, as such, have not been viewed as topics for research. They state that:

> If we define pregnancy and birth as processes which are inseparable from being a woman, as an extension of the female role, and if these processes are so much a part of the definition of woman as to be her presumed nature, then we cannot even perceptually differentiate them as processes significant for study (Stewart and Erikson, 1977:34).

Accordant with this argument, Wortis (1971) views the limitations placed on research through the confusion between biological factors and social psychological factors. She questions the necessity for the acceptance of practices as being necessary and inevitable when they are actually culturally determined.

Subsuming pregnancy and birth under being a woman furthers the neglect of the topic for study as "Sociologists, along with economists, historians, and psychologists, have paid scant attention to women" (Stewart and Erikson, 1977:34). As most members of these occupations are male, their areas

of investigation have reflected male interests. As well, within sociology, areas which reflect female interests are of low prestige. "Thus, the attempt by sociologists to gain prestige and status within their field contributed to the neglect of issues of pregnancy and birth (women's issues) within the field" (Stewart and Erikson, 1977:35).

In addition, by including reproduction under being a woman, "...we still know relatively little about the way in which normal women respond to this life stage [pregnancy] because, until recently, feminine development has been regarded by most personality theorists as unimportant, deviant, or a minor variation of the male-determined stages of life" (Leifer, 1980a:754).

Smith (1975) goes further in her critique of the social sciences. Not only are they male-dominated and male-defined but also, when women's issues are treated within the social sciences, women are the object of the research not the subject. Women's subjective experiences have not formed the underlying foundations for research and theory. She states that "...women have been excluded from full participation in creating the forms of thought which constitute the social consciousness of a society" (Smith, 1975: 365). Proceeding from a viewpoint of the male consciousness, men are seen as the subject and women as the object. Women are:

> thus deprived of the essential basis for developing the discourse out of which symbolic structures, concepts, images, and knowledges might develop which would be adequate to our experiences and to devising forms of organization and action relevant to our situations and interests (Smith, 1975:365).

An additional constraint on the study of pregnancy has been the taboo on the study and discussion of sex. In the period following World War II, societal restraints on the topic of sex lifted somewhat and discussion became more open. However, it was not until the early 1970's that study and discussion of sex became most permissible. Pregnancy, with its connections with sex, also sufferred under this taboo. For example, in earlier times, maternity clothes were designed to hide the pregnancy; during the 1970's, T-shirts became available with inscriptions which drew attention to the pregnancy.

During this same time period, MacIntyre felt that a growing interest from academics and the public on the topic of reproduction and its management was evident. This interest concentrated mainly on the "medicalization of childbirth". She states that given this interest in the topic, the time had now come to explore the area in more detail and offered suggestions as to the possible approaches that could be taken within the social sciences. One of these suggestions is that of the experience of pregnancy and childbirth. She suggests that researchers could:

> seek to explore women's experiences and perceptions of pregnancy and childbirth without necessarily examining directly the maternity care provided. They may seek to explore the social meanings of pregnancy and motherhood, knowledge of reproduction, the impact of childbearing on the woman's life and relationships, the social and psychological changes during pregnancy (MacIntyre, 1977:478).

The present study falls within this category and examines the social meanings of pregnancy for pregnant women. Women are the subject of the study and it is their perspective that defines the social role of pregnancy. Pregnancy is also viewed as a natural, normal life event.

The following are objectives of this research:

1) To specify the means by which women acquire the identity of being socially pregnant;
2) To delineate the social role of pregnancy with the norms which define the role; and
3) To form a typology of adherence to the social role of pregnancy.

To investigate the relatively uncharted domain of the social role of pregnancy, an exploratory and descriptive methodological approach was used centering upon hypothesis-generating rather than hypothesis-testing. "Rather than focusing on particular independent-dependent relationships, this method seeks to discover patterns or systems in the area under investigation" (Leifer, 1980b:6).

Due to the methodology plus the impossibility and impracticality of satisfying the underlying assumptions of randomization, a non-random group of respondents was selected. While not attempting to generate theory, this shares commonalities with Glaser and Strauss' (1967:45-77) "theoretical sampling" in which "...the aim is not to represent the population at large, but rather, to choose a sample in order to learn more about certain theoretical categories" (Leifer: 1980b:7). As such, it is not possible to generalize beyond the group of respondents and, therefore, the results are applicable to this group of white, urban women in stable relationships with the fathers of their babies. On the whole, these women are well-educated and middle class, the majority of whom attended prenatal classes and wanted their pregnancies.

Berger and Luckmann's (1966) theory of the social construction of reality was used to specify the means by which the women entered into the social role of pregnancy. Reality is a production of humans and every society "...constructs, maintains, and modifies a consistent reality that can be meaningfully experienced by individuals" (Berger and Kellner, 1978:179). Through the correct interpretation of their society's signs and symbols of pregnancy, the women proceeded from physiological pregnancy to social pregnancy.

In this study, role was defined as "a cluster of

social norms" and norms defined as "standards of conduct that should or should not be followed" (Labovitz, 1977:105). The norms of the role were gathered through the inductive approach (Jackson, 1966:41).

Using Barton's (1955) method for the substruction and reduction of property-space, a typology of adherence to the social role of pregnancy was formed. The three ideal types differentiated among the groups of women as to their definitions of being pregnant.

CHAPTER TWO

A REVIEW OF THE LITERATURE

Most of the literature available on the perinatal process is concerned with medical management. Within this area, authors discuss briefly the processes of normal pregnancies and deliveries but the main concentration is on the pathology and abnormalities of pregnancy and childbirth (Browne and Dixon, 1978). While not a major substantive area of study, attention had been paid to the perinatal process by the social sciences. However, the majority of research has focussed on "the socio-economic correlates of fertility" and "the psychological parameters of the childbearing process" (Graham, 1977b:81). Thus:

> [We may] know a considerable amount about women's family intentions and contraceptive attitudes, about their psychosomatic symptoms and their infantile attachments, but we know little about the realities of childbearing as women see and experience them in their daily lives (Graham, 1977b:82).

Two bibliographies have been compiled on research done on pregnancy within the social sciences: one in 1974 by Miller, and the other, in 1980, by Lips. Introductions to both of these bibliographies emphasize that the compilations exclude issues related to pregnancy such as contracep-

tion and childbirth except when these topics are directly related to pregnancy in the article. As well, Lips indicates that her bibliography focusses only on normal pregnancy.

Miller's bibliography does not exclude literature on the abnormalities of pregnancy. As such, it is considerably longer than Lips'. Two reasons account for Miller's inclusion of research on abnormalities. First, Miller's bibliography was compiled ten years ago. It has only been recently that interest has been focussed on pregnancy as a normal life experience of women. During the time period for which Miller was collecting articles, research on normal pregnancies was the exception. Second, Miller and Lips appear to differ on their definitions of abnormal. Lips includes literature on the adjustment of women to pregnancy as being within the scope of the normal pregnancy experience. Miller states that within this area "...'normal' pregnancy tends to be defined as the absence of pathology rather than as a routine experience governed by its own rules without reference to moral labels" (Miller, 1973:35). Miller would thus define some of the studies which Lips labels as "normal" pregnancy as abnormal.

Miller's bibliography has three areas of concentration: studies published in the medical journals which focus upon social factors involved with the medical management of pregnancy; social and psychological correlates of pregnancy; and literature designed for the lay consumer. Lips

has excluded most articles on the medical aspects of pregnancy except where specific mention of an interaction between medical and social factors was stated. Although divided into eleven rather than three categories, Lips includes only a further four areas as the additional seven are subsumed under Miller's three areas. The additional four areas are: theoretical analyses, the couple relationship, non-Western customs, and the male side of pregnancy. While covering the same types of materials as Miller, with the exception of the four additions, there is more of a slant towards materials covering the subjective experiences of pregnant women which is mainly due to the later date of publication of Lips.

Sherman (1971) and Grimm (1967) produced reviews on the work in social sciences on pregnancy.

Sherman reviews the studies reporting on psychological variables affecting the functioning of the reproductive system. While granting that there is an interaction between these variables and mental and physical symptoms of pregnancy, she states that one of the most commonly held beliefs regarding the symptoms of pregnancy, that of the psychological causes of nausea and vomiting "...appears to have been exaggerated" (Sherman, 1971:195). In summary, she states that the "...conclusions on psychosomatic influences on reproductive functioning will require much more verification" (Sherman, 1971:195).

Grimm critiques research which has studied the psychological and social factors in two main areas. First, to adequately study the abnormalities of pregnancy, "...it would be advisable to have more 'baseline' data on 'normal' emotional reactions in pregnancy" (Grimm, 1967:43). Associations and causal relationships are assumed rather than tested to exist. Second, she criticizes the research on methodological grounds. Most of the research has been retrospective in that women are asked to recall events of the past, a procedure which will introduce the bias of the women's memories. As well, samples have consisted of groups of women who have consulted psychologists, physicians, and psychiatrists for disturbances of their pregnancies. These women would possibly represent extreme incidences of pregnancy symptoms. The research has also proceeded without a control group of non-pregnant women. Adding a control group to the research would ensure that "...one were not simply finding that women with pathology felt worse than those without" (Grimm, 1967:44).

The four objectives of this chapter are to discuss four perspectives used as frameworks within the social sciences for the study of pregnancy and their particular themes with attention given to selected studies within each perspective. The perspectives to be discussed are:

1) Personal and societal problems;

2) Socio-medical;

3) Ethnographic; and

4) Social and Psychological Meanings.

Personal and Societal Problems

This perspective is divided into two areas: problems of pregnancy which affect the pregnant women and problems of pregnancy which affect society. The former is concerned with the pregnant woman's well-being and adjustment to pregnancy and incipient motherhood and with husband-wife marital satisfaction and adjustment as it relates to the pregnancy. The latter is concerned with deviant reproductive behaviour: adolescent pregnancy, non-marital and premarital pregnancies. The studies are not concerned with the aspects of these pregnancies which are similar to non-deviant pregnancies but rather "...the determinants and management of deviance in regard to pregnancy" (Miller, 1973: 10). One component of this area is that of fertility rates, population control and their implications for social welfare.

Within those studies which deal with a pregnant woman's personal adjustment to pregnancy are those which search for variables present during the pregnancy which will predict success in motherhood. Rubin (1967a,b) researched the role of pregnancy in the context of the attainment of the maternal role. The period of pregnancy was seen solely as

the time in which women prepared to be mothers. Role-taking was considered in relation to the development of the self. While various aspects of the process of becoming a mother were outlined, the expectations, rights, and obligations of pregnant women were not discussed.

Funke-Furber completed research in 1978 with the purpose being to determine "...the reliability and validity of instruments which indicate maternal adaptive behaviour during pregnancy and the early childbearing phase" (Funke-Furber, 1978:i). Since psychologists believe that factors present during a pregnancy can influence behaviour post-natally, valid and reliable measuring instruments of these factors are necessary for the use of health care workers involved with maternal care.

Funke-Furber's sample consisted of 76 pairs of parents and their babies. The mothers were interviewed at three time periods pre-natally and four post-natally. In addition, records were kept of the births and the infants were assessed at two separate times. Two instruments were developed from this research: the Maternal Adaptation to Pregnancy Questionnaire and the Mother-Infant Interaction Assessment.

Goshen-Gottstein (1966), Sherefsky and Yarrow (1973), Breen (1975), Leifer (1980), and Entwisle and Doering (1981) all studied the effects of the first pregnancy on motherhood and the marital relationship. The variables

studied included sexual adjustment, marital roles, pregnancy intentions, pregnancy desirability, preferred sex, breast-feeding intentions, pregnancy objective symptoms, pregnancy subjective feelings, conflict and acceptance of pregnancy, motherhood adjustment, marital communication, preparation level, childbirth satisfaction, body satisfaction, emotional attachment, stress, anxiety, and psychological functioning.

Tanzer's 1967 review of the literature on the psychology of pregnancy and childbirth points to three conclusions. First, most of the existing work dealt with narrow investigations of single factors. This approach has led to an insufficient and fragmented knowledge of the psychological aspects of pregnancy. Second, through the use of wording and the substantive factors chosen for investigation, Tanzer saw pregnancy viewed as an illness and a "near-pathological condition". Finally, although the factors are not yet empirically specified, psychological factors are of importance.

The second area within this perspective is that of deviant pregnancies and their management.

Plionis (1975) has reviewed the literature on adolescent pregnancy in seven areas: theory, psychology, sociology, pathology and stress, social problems, medicine, and societal costs. In none of these areas do the researchers study the means by which these adolescents experience their pregnancies in terms of their married adult counterparts.

McKenry, Walters, and Johnson (1979) state that although adolescent pregnancy is a serious social problem and there has been a considerable volume of literature on the issue, "...its utility may be questionable" (McKenry, Walters, and Johnson, 1979:17). They criticize the literature on the following bases:

> ...the range of variables is limited and inconsistent. the use of small, clinical populations, the lack of controls, and unsophisticated methodology have been common problems in research on adolescent pregnancy. Also, the lack of development of theoretical models concerning the etiology of adolescent pregnancy and the behaviour of pregnant adolescents has resulted in a lack of cumulative findings (McKenry, Walters, and Johnson, 1979:17).

Clifford has investigated "...a variety of attitudes as a function of (a) the marital status of the pregnant woman and (b) previous experience of pregnancy" (Clifford, 1962:945). He lists a number of variables which discriminate between the married and unmarried pregnant women. He does not list the ways in which the two groups of women are similar. Miller states that "...most of the research on non-marital pregnancies emphasizes the difference between the deviants and the non-deviants. These studies ignore the possible commonalities of pregnancy regardless of the moral labels attached" (Miller, 1973:8).

An example of the research which concentrates on fertility rates, population control and their implications

for society is Erhlich's Population Bomb (1968) which is directed to a popular audience. Erhlich argues that current fertility rates will lead to the destruction of civilization unless new customs regarding reproductive motivations and behaviours evolve.

Socio-Medical Perspective

The socio-medical perspective is concerned with the relationship between social factors and pregnancy as a health problem. Within this perspective are three categories: the adoption of the sick role, information for medical practitioners, and information for the consumer.

Early sociological research on pregnancy was centred on the question of pregnancy as an enactment of Parsons' sick role. Rosengren, one of the first researchers in this area, attempted to show that intrasocial differences in the adoption of the sick role existed in the United States (Rosengren, 1960-61, 1961, 1962). Using measures of socio-economic status, mobility, stability, and sick role expectations, he received inconsistent and contradictory results. McKinlay criticized Rosengren on methodological grounds. He states that the contrary findings are probably due to Rosengren's "...failure to recognize the differences between the variables under direct study and the covariables" (McKinlay, 1972:572). Since variables which could possibly

have had an effect upon the dependent variable were not controlled, the findings were inconclusive.

McKinlay examined pregnancy in terms of adherence to the rights and obligations of Parsons' sick role. He felt that, although pregnant women do occupy a special role in society, this role cannot be viewed in terms of Parsons' paradigm.

Both McKinlay and Rosengren discuss the vagueness and lack of clarity of the expectations for pregnant women. While they also both agreed that pregnancy is a social role, as specific proscriptions and prescriptions are attached to the behaviour of pregnant women, Rosengren abandoned any attempt to delineate this role and only detailed the factors encouraging the adoption of the sick role. McKinlay summarizes inter- and intra-cultural variations in perceptions of pregnancy. While recognizing that Western industrial society "...provides pregnant women with inadequate, confusing and often conflicting guidelines for role behaviour" (McKinlay, 1972:569), he does not expand these guidelines.

Within the literature on the subject of pregnancy, the majority of the work is concerned with medical management. This literature is oriented to professionals working within the field of the medical management of the perinatal process. Although the authors within this tradition will briefly discuss normal pregnancies and deliveries, the main

focus is upon the pathologies and abnormalities of pregnancy and childbirth.

Browne and Dixon (1978, 11th edition), in their textbook on Antenatal Care, devote thirty chapters of the thirty-six to the problems, abnormalities, and diseases of pregnancy. Browne and Dixon state that the medical attendants' function is a "...a quite proper eager hunt for abnormalities in the pregnant woman..." (Browne and Dixon, 1978:45). This concentration upon the pathological aspects of pregnancy and the accompanying role of the medical personnel is typical of medical textbooks on pregnancy. Literature on pregnancy within the field of nursing has two distinct emphases, methods and psychology, with the emphasis being determined by the date of publication or revision. Maternity Nursing (Reeder, et al., 1976, 13th edition) was originally published in 1929. The first edition concentrated upon the methods of maternity nursing. Through successive editions, revisions were made to update information and chapters were added to include social psychological tactics. However, the main emphasis remains nursing methods. Childbearing: A Nursing Perspective (Clark, et al., 1979, 2nd edition) typifies those texts within nursing with an emphasis upon the psychology of maternity nursing. While some chapters are concerned with the methods of nursing, the focus is upon the application of social psychological principles and concepts by the nurse to aid the maternity patient in adaptation

during various phases in the perinatal process. While less concerned with the pathological aspects than medical textbooks, both areas still deal almost exclusively with nursing methods and social psychological adaptation tactics designed for nursing intervention for abnormalities and emergencies.

A third category within the socio-medical perspective is that which is directed to the consumer. Graham (1977a) discusses the development and dissemination of information on pregnancy from the medical profession to manuals available for midwives, and then to advice books for expectant mothers. She traces the theories about the nature of pregnancy from content analysis of the text of medical textbooks and midwifery manuals and the illustrations of advice books.

Published information was first made available to midwives in 1540 when The Byrthe of Mankinde was published in English. Previous to this, all medical information was published in Latin. For the next 150 years, great resistance was made to these types of publications, to the extent of excluding illustrations and descriptions, on the grounds that "...it was irreverent, and subversive, to publish information about the intimacies of the female body..." (Graham, 1977a:17). This attitude later relaxed and publications contained descriptions and illustrations which were less euphemistic. However, this relaxation was only relative to the previous material. It was not until the 1950's that

material without euphemisms became available. A further lowering of restrictions became evident with the publications of the 1970's.

In the early and mid 1800's, the first advice books specifically written for expectant mothers began to appear. While continuing with the prevalent theories regarding pregnancies as being a period of physical and psychological vulnerability, these books changed the view of the aetiology of such disorders. "They argued that the side-effects which made pregnancy pathological were invariably caused by the mother..." (Graham, 1977a:19). There was thus a break between the advice books and contemporary obstetric texts which advocated medical intervention, not action on the part of the mother to ensure an uncomplicated pregnancy and delivery. The concern was not for the mother's health but for the child's. This originated from widely held views on eugenics and a preoccupation with England's future as needing a strong and healthy population (Graham, 1977a:20).

Early 20th Century advice books, while reflecting the same basic perspective, "...reveal a widening medical jurisdiction over pregnancy..." (Graham, 1977a:21). The writers adopt a more authoritarian style and emphasize that, although the mother is still responsible for the health and well-being of her child, obeying the doctor is of paramount importance. At this period, the concern was with the physical

aspects of pregnancy and little attention was given to the psychology of pregnancy which had occupied earlier writers.

Concurrent with the authoritarian philosophies on pregnancy came the publication by Dick-Read of Childbirth Without Fear. They differred significantly in that "Instead of being simply an adjunct to motherhood, Dick-Read argued that pregnancy was a condition with its own qualitative distinctiveness, where maternal welfare as well as foetal health must be safeguarded." (Graham, 1977a:22). While both argued that pregnancy and childbirth were natural, the authoritarians and Dick-Read disagreed on the definition of "nature" with the former referring to physiology and the latter to psychology. Thus the authoritarians saw natural childbearing as "...something achieved by obedience to a set of inviolable scientific laws, Dick-Read emphasized that personal understanding coupled with medical non-intervention were the prerequisite of natural pregnancy and childbirth" (Graham, 1977a:23). Also Dick-Read included the father in the process with the mother, rather than the doctor being the central figure to the mother.

Dick-Read's philosophy, although first published in 1933, "...with its emotional orientation and its antipathy to medicalized childbearing was largely rejected by the medical establishment of the time" (Graham, 1977a:23) and it was not until the late 1950's that his influence was really felt when new editions of his writings appeared. At

this time, several popular guides incorporating the principles of psychoprophylaxsis were published and rapidly became accepted by both the medical establishment and consumers. However, these new publications were not internally consistent and included ideas from both the authoritarian and Dick-Read's philosophies. They were:

> committed on the one hand to the ideological veneer of natural childbirth, with its orientation to maternal emotion, individual understanding, and medical non-intervention, and on the other to a model of pregnancy which, although consistent with the reality of ante-natal care, systematically thwarts psychoprophylactic goals (Graham, 1977a:24).

From Dick-Read's reprints starting in 1944 and the publication of Lamaze (1958) came a veritable flood of information to the consumer. In Canada, both the federal and provincial governments produced books geared to expectant parents, The Canadian Mother and Child (National Health and Welfare, 1975) and Baby's Best Chance (British Columbia Ministry of Health, 1979). Leboyer produced Birth Without Violence in 1975 and was followed by Berezin's 1980 book The Gentle Birth Book: A Practical Guide to Leboyer Family-Centered Delivery. It soon became possible to obtain books on a variety of aspects of the perinatal process: exercise (Fonda, 1982), midwifery (Davis, 1981), home births (Sousa, 1976), and caesarean births (Wilson and Hovey, 1977). The

only commonality among all of these publications is that they are directed solely to the consumer.

Another section of the literature which is consumer-oriented is that which has an anti-medical focus as exemplified by Forced Labour (Shaw, 1974), Immaculate Deception (Arms, 1975), and The Hidden Malpractice (Corea, 1977). None offer practical solutions or advice to expectant mothers but center upon the terror, humiliations, and indignities that the authors feel women experience within conventional maternity hospitals. Shaw's book documents the dehumanization of a medicalized hospital childbirth while Arms continues with the anti-medical argument but focusses mainly upon the benefits of midwifery, home births, and birthing centres. Corea places her critique within the context of a general criticism of the American medical establishment's treatment of women. She also outlines the dehumanization of the perinatal process with its attendant withdrawal of the control of the birth from the mother to medicine.

Academic treatments of the argument against the medicalization of pregnancy follow the same line as set down by Oakley (1975). She argues that pregnancy, childbirth, and motherhood have moved from being a natural process to a medicalized process. Pregnancy now requires medical diagnosis and treatment. With this new definition of the process, pregnant women must be treated as patients although they are not ill. Along with this treatment of the women as patients

has come a transfer of the management of pregnancy and childbirth from women to men. As well, the intervention techniques brought to childbirth cause a loss of control of the birth from the mother to the doctors. Leading from the techniques comes a necessity for more intervention to overcome the deleterious effects of the original intervention. Motherhood has also moved from being the province of the mother and more experienced women to that of the experts.

Oakley (1976), Chalmers and Richards (1977), and Chalmers et al. (1980) follow different aspects of the same argument against the medicalization of the perinatal process. Romalis in Childbirth: Alternatives to Medical Control (1981) and Lewis in The Politics of Motherhood (1980) further this argument with reference to Canada and Great Britain and offer possible solutions to the problem. Doering and Entwisle (1975) and Post (1981) both suggest alternatives to the system as presently defined. However, they both provide ideas which remain within rather than re-define the present system. Doering and Entwisle posit that more prenatal preparation will relieve the stress of delivering mothers and Post states that allowing a family orientation within maternity care will overcome difficulties that women and their families experience during childbirth.

Ethnographic Perspective

The ethnographic perspective is concerned with anthropological descriptions of reproductive behaviour. As well, sociological ethnographies of folkways that surround the various aspects of reproduction are included within this perspective. The concentration is on ethnographic accounts of cross-temporal and cross-cultural similarities and differences in perinatal attitudes and behaviour. The main concern is with the objective realities of pregnancy with little attention paid to the subjective experiences of the women.

In Kitzinger's 1978 study of mothers and the institution of motherhood, the focus is upon the cultural influences on behaviour that are usually considered to be inherent and unchanging. An examination of the cross-temporal and cross-cultural variations in the customs and expectations surrounding conception, pregnancy, birth, and motherhood reveals that the attitudes and behaviours of the mother and of the society towards her are learned. Although Kitzinger does deal with the subjective nature of the experience from the perspective of mothers more than others working within this area, she is still analyzing the mother as object.

Mead and Newton (1967) contribute an extensive review on cross-cultural variations in perinatal behaviour

through the use of the Human Relations Areas Files and a search of all medical and anthropological literature which contained information on the patterns of cultures in childbearing. They stated that "...the available material is sparse and limited by the professional and theoretical orientation of the recorders" and that "The nature of the data available at the present time makes it impossible to draw any precise conclusion" (Mead and Newton, 1967:151).

The available material was categorized into four broad groups: 1) ways of reacting to children, pregnancy, childbirth, and the transition period; 2) medicine and nutrition; 3) sensory stimulation and body mechanics; and 4) assistance vs. laissez faire in labour management. While complete data was not documented for all the cultures described, Mead and Newton provided the information that had been collected under each group heading.

Raphael (1975) examined the rite de passage of matrescence, becoming a mother. "The matrescent rite de passage can be examined as a biological fact, a cultural event, and as a series of interactions and changed interrelations with other members of the community" (Raphael, 1975:66). She argues that the gap in the anthropological literature, also discovered by Mead and Newton, is due to the ethnocentricity of the ethnographers. Trained in cultures where marriage is considered more important than

motherhood, great attention was paid to the rituals and customs of marriage while the perinatal process was described peripherally.

Jordan attributes a different causal sequence for the gap in the anthropological literature. In the past, and to some degree today, most anthropologists were male. Their androcentric bias closed their eyes to the idea of studying childbirth and its customs, "...male anthropologists themselves subscribe to the notion that birth is women's business and therefore of less importance than puberty rites, warfare, kinship organization, economics and the like" (Jordan, 1981:183). This is an example of the automatic devaluation of the province of women. "In addition, there are many societies in which men are categorically excluded from witnessing births..." (Jordan, 1981:183). As men, the anthropologists would have been denied access to the events of childbirth and would have had to have relied on reports of events. Given that the informants were often themselves male, the accuracy of such reports would also be suspect.

Oakley (1977) also describes the cross-cultural practices surrounding pregnancy and childbirth. She states that "The reasons why a particular culture manages childbirth in a particular way are bound up with the ideology predominating in that culture about reproduction, about medicine and about the role of women" (Oakley, 1977:18).

Busfield (1974) analyzes the effect of ideology on reproduction and shows how the beliefs "...constitute the social reality in which reproduction takes place..." (Busfield, 1974:11). Busfield describes the major points of the beliefs surrounding reproduction and how "...beliefs about what is desirable for the purposes of childrearing form part of the explicit justification for particular aspects of what is held to be desirable for reproduction..." (Busfield, 1974:31). Busfield concluded that "Ideologies play an important part in social controls; they constrain individuals by presenting them with a set of expectations for their behaviour and appropriate rationales that support the expectations" (Busfield, 1974:33). Through her analysis of contemporary English society, this statement is not only true of the relationship between ideologies and behaviour in general but also for the specific relationship between beliefs about children and reproductive behaviour.

Newman (1969), in an unusual documentation of the "old wives' tales" associated with pregnancy and childbirth, argues that "...the intention and the cultural meaning of the communication [old wives' tales] is to symbolize the status of pregnancy and the expectancy of motherhood rather than to communicate useful information" (Newman, 1969:116).

Newman collected the pregnancy beliefs from Negro and White clinic and private obstetric patients during anthropological inquiry in California in 1964. The tales

were responses to the question: "What have you heard about prenatal influences or about how the mother's behaviour can affect the unborn child?" She discovered that the beliefs' content consists of two distinct categories (physiological results and behavioural conditions), they usually take the form of "If X, then Y", and are always expressed by an older experienced female to a primigravida. She states that it is irrelevant to the meaning and function of the tale whether the recipient of the tale believes it or changes behaviour on its basis.

Newman interprets the cultural meaning of the tales as defining the role of the expectant mother. However, the definition of role is very loose. She is not discussing actual attitudes and behaviours that pregnant women are expected to assume but rather the ritual separation of pregnant women from others to "...a state of being supremely female..." (Newman, 1969:116).

Callaway (1978) follows this same idea of being pregnant as being supremely female by saying that giving birth is the most essentially female function. She traces this idea through several cultures and ends with modern Western industrialized society in which she states that "The advances in modern medicine have changed what might previously have been considered the 'biological imperatives' of women" (Callaway, 1978:181). With fewer children and a longer life

expectancy, women may no longer spend as many of their years reproducing. However, at the same time, women are fighting to re-gain control over their reproduction from the medical establishment.

Social and Psychological Meanings Perspective

The social and psychological meanings perspective is concerned with the meanings that pregnant women attach to their experiences. The present research would be categorized within this perspective.

Hubert (1974) briefly outlined the main differences in the ideas and beliefs surrounding the perinatal process in those cultures traditionally studied by anthropologists and in Western industrialized society. While inter-cultural differences may exist between the former, each tends to be internally consistent. However, in Western society, this consistent pattern of beliefs does not exist. "There is a scientific view...but the ideas, beliefs, and expectations held by a large proportion of the population not only do not conform to this view, but are also very diverse" (Hubert, 1974:38). Hubert felt that it was important to discover the nature of the beliefs of pregnant women, how they were acquired, and the divergence of these beliefs not only from the scientific view but also from the reality of the post-natal experience. Hubert interviewed a sample of London

women expecting their first babies on beliefs regarding conception, pregnancy, birth, and motherhood. While Hubert did describe the great variation in the beliefs of the women which were often contradictory to the scientific view, this was not systematically organized to detail the pregnancy role.

Graham (1977a) viewed the ambiguous nature of the pregnant woman as presented in antenatal literature. She performed content analysis on the illustrations, drawings and photographs, in contemporary pregnancy guides for expectant mothers. She states that in three critical areas the drawings and photographs portray a conflicting image of pregnancy and childbirth. These areas are: 1) the nature of being pregnant, 2) the control of the pregnancy, and 3) the context in which the pregnancy is set. A dualistic image of pregnancy is presented. She discusses the discrepancy of health vs. sickness, psychology vs. physiology, and self vs. medical care as being interwoven with the development of antenatal literature. These three dichotomies are presented as existing simultaneously for pregnant women:

> There is ambiguity apparent in the depiction of pregnancy as firstly both healthy and a time of sickness; secondly as physiologically normal and emotionally stressful; and thirdly as both natural and medically problematic (Graham, 1977a:16).

Not only does antenatal literature present a dualistic image of pregnancy but also past research has through the variables chosen attempted to artificially divide pregnant women. In a study of "Women's attitudes to conception and pregnancy", Graham says that the traditional variables used (marital status, parity, social class, and intentionality) have neglected the commonality of the pregnancy experience "...given the common physiological context in which reproduction takes place" (Graham, 1977b:83). In her research, Graham found significant similarities in attitudes and posits that conception and pregnancy are "...a unifying process in which women of differing social backgrounds and psychic constitutions are drawn together in a shared physiological experience" (Graham, 1977:83).

Miller (1973) interviewed 49 primiparous women at various stages in their pregnancies to determine the social meanings of pregnancy to them. The majority of the women were interviewed three times. Miller used four theoretical perspectives to accomplish this task:

> [the] four perspectives (social construction of reality, symbolic interaction, ethnomethodology, labeling theory) are the bases of our view that the social meaning of pregnancy is created and attached to appropriate persons as a result of interaction, and that social pregnancy must be viewed separately from physiological pregnancy if sociological sense is to be made of the pregnancy experience (Miller, 1974:54).

In addition, the concept of "career" was used in the analysis to allow Miller "...to focus on the emergent quality of the social pregnancy identity" (Miller, 1973: 54). The concept of "status passage was used to describe "...the view that careers are passages from one status to another, and that during the career itself the actor has a transitional status in which he is in training for the new identity" (Miller, 1973:55).

Miller divided her analysis into three segments. The initial stage involved separating the women into three groups based on the intentionality of their pregnancies. After this was completed, comparisons were made among the three groups. The first comparisons involved the ways in which the women recognized their social pregnancy identities. The second comparisons involved the different ways in which the careers of the pregnant women emerged as they began to feel "really pregnant". The third stage described the signs and symbols the women used to indicate movement towards the termination of the careers.

Oakley, in her companion volumes Becoming a Mother (1979c) and Women Confined: Towards a Sociology of Childbirth (1980) focusses on the societal expectations and medical management of women as childbearers. Reacting against explanations of reactions to birth and motherhood as being due to the femininity of women rather than their humanity, Oakley conducted a series of four interviews with 54

women during the process of their experiences with pregnancy and early motherhood.

Central to her argument is that childbirth is an event in the women's lives analagous to other potentially disrupting events and should be analyzed in terms of human reactions rather than female reactions. Oakley argues that previous research assumed that "...the responses of women to childbirth must be bound up with (and therefore explained by) the character of their feminine identities" (Oakley, 1980:258). Her counter-argument to this statement is that "Women are 'first and foremost human beings', and they do not cease to have this status because they have babies" (Oakley, 1980:258).

Oakley states that the current style of prenatal education plus the medicalizations of childbirth have fostered highly romantic and unrealistic views of birth and motherhood. Coupled with these views are high technology births and feelings of low control by the mothers to create conditions in which the women are particularly vulnerable to depression. She says that the "...holding and unlearning of unrealistic expectations is especially inimical to self-esteem, and is potentially an influence on the chances of maladaptation and depression following birth" (Oakley, 1980: 281). A discrepancy between expectations and reality as a causal factor for depression is recognized in other areas but not in the study of perinatal attitudes. The great

discrepancies that the women experienced between their expectations of pregnancy, childbirth, and motherhood and the realities of the situations contributed to their feelings of loss of control and identity which led to feelings of low esteem and depression.

Conclusion

In summary, this chapter reviewed the literature on pregnancy in four areas: personal and societal problems, socio-medical, ethnographic, and social and psychological meanings. Criticisms of this literature covered the contradictory and inconsistent findings, methodological biases, foci on pathological pregnancies, and the androcentric bias in the variables chosen for study. With these criticisms in mind, it appears that, although an extensive literature on pregnancy and outcome exists covering many years and in many disciplines, the social and psychological factors illuminating the normal pregnancy remain unclear.

Two trends have emerged from this review. First, researchers are beginning to look at pregnancy as a normal process. They are seeking to understand the attitudes and behaviours of pregnant woman in the context of the reproductive process being a normal life event. Second, the subjective experiences of the women are forming the focal point of the research. The ways in which pregnant women

view themselves and their pregnancies are determining the variables chosen for study and shaping the themes of the research.

Graham's articles, Oakley's books, and Miller's dissertation form the basis for the delineation of the social role of pregnancy. Graham's idea of pregnancy being a unifying process would lend weight to the possibility of there being a social role with common norms for pregnant women. Oakley researched the entire process from pregnancy to childbirth to early motherhood from the experiences of the women in her study. Miller studied pregnancy as a social rather than purely biological phenomenon. Again, it was the subjective feelings of the women which shaped her research.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

The design and methodology chosen for this research were based upon the considerations that the research be hypothesis-generating rather than hypothesis-testing. As such, the design is descriptive and exploratory.

The four objectives of this chapter are to delineate:

1) the sampling procedures used to obtain the group of respondents;
2) the interview schedule with details of its components;
3) the methods used to collect the data; and
4) the methods used to analyze the data.

Sampling Procedures

Typically studies within the sociology of reproduction have concentrated on viewing pregnancy in terms of a single dominant variable, such as the effect of a first birth (e.g., Breen, 1975; Entwisle and Doering, 1981; and Leifer, 1980b) or of being an adolescent (e.g., Plionis, 1975; McKenry, Walters, and Johnson, 1979). Research by Graham states that within this area "...there is little

emphasis upon conception and pregnancy as a unifying process in which women of differing social backgrounds and psychic constitutions are drawn together in a shared physiological experience" (Graham, 1977b:83). The results of this study "...suggested that attention could be usefully focused on the areas in which women, whether primipara or multipara, married or single, planners or non-planners, shared during the pregnancy" (Graham, 1977b:84).

Based upon Graham's statement, there was only one criterion for inclusion in this research. The sole determining consideration for eligibility was that a woman be in the last trimester of pregnancy.

The respondents were forty-three pregnant women from the Greater Victoria area. Four organizations which are involved with prenatal care and instruction (the Victoria General Hospital, the YM-YWCA, the Victoria Lamaze Childbirth Education Association, and the Victoria Society for Alternatives in Childbirth) were contacted and permission was received to speak to their prenatal classes, exercise classes and midwives. Resources did not permit obtaining women who did not use any of these organizations. However, estimates from groups offering prenatal classes indicate that between September 1978 and August 1979 approximately 55 percent of delivering mothers in Victoria were enrolled in classes and that this percentage was rising rapidly.

Since the philosophies of these four groups are radically different, ranging from the provision of the basic knowledge of the delivery to the advocation of home births, it was felt that a wide range of women would be contacted.

All of the women contacted were briefed on the purpose of the research, asked if they wished to volunteer, and informed that they could withdraw permission at any time for any reason. Approximately 170 women were contacted and told of the study.

Upon completion of the description of the research, the women who had decided to participate were asked to complete index cards with names, addresses, phone numbers, and expected due dates. The second contact was made by telephone. At this stage, appointments were made with the women for the time and place of the interview.

Of the 170 women informed of the research, 81 initially agreed to participate. Two withdrew their permission when telephoned, three had moved and could not be located, and two started the interview but were unable to complete it.[1] Twelve women had their babies before their expected due dates and twelve delivered during a period when interviews were not being conducted. A total of 50 women completed the entire interview. Seven completed taped interviews were discarded due to the malfunctioning of the tape recorder which resulted in ruined tapes. The group of

respondents which contributed the data for this study thus consisted of 43 primigravidae and multigravidae pregnant women from Victoria.

The women participating in this study are not representative of the population of pregnant women as they were self-selected from already self-selected groups, prenatal classes. Recent statistics from Statistics Canada and the Canadian Census are not available giving a breakdown of parturient women by demographic characteristics. Therefore, it is not possible to compare the women in this study group to the pregnant population. The following table outlines the demographic characteristics of the women in the group.

TABLE I: Respondents by Age, Education, Marital Status, Length of Relationship, Parity, Gravidity, Planning of Pregnancy, Desirability of Pregnancy, and Length of Pregnancy at the Interview.

	n	%
Age:		
20-24	12	28
25-29	14	33
30-34	14	33
35-39	3	7
Education:		
< grade 12	5	12
Grade 12, occupational training, some university	20	47
University degree(s)	18	42
Marital Status:		
Married	38	88
Living Together	5	12
Length of Relationship:		
1-3 years	23	53
4-6 years	9	21
7-9 years	8	19
> 10 years	3	7
Parity[2]:		
0	25	58
1	15	35
2	2	5
3	1	2
Gravidity[3]:		
1	20	47
2	12	28
3	5	12
4	6	14

TABLE I (Continued)

	n	%
Planning of Pregnancy:		
Planned	28	65
Unplanned	15	35
Desirability of Pregnancy:		
Wanted now	29	67
Wanted sooner or later	12	28
Unwanted	2	5
Length of Pregnancy at Interview:		
20-30 weeks	8	19
31-32 weeks	7	16
33-34 weeks	14	33
35-36 weeks	10	23
37-38 weeks	4	9

Research Instrument

The research instrument consisted of a semi-structured interview schedule. The schedule covered 28 topics with several questions per topic and open-ended probes. The 28 topics are presented in Table II and the entire interview schedule in Appendix A. Four sources were used as a base for the questions in the interview: 1) Oakley's Transition to Motherhood interview, 2) Funke-Furber's Third Trimester Pregnancy Questionnaire, 3) the Medical History Questionnaire of the National Center for Health Statistics, and 4) an author-constructed question on femininity. In addition, author-constructed questions were included to bridge awkward transitions between topics and to include relevant topics not already covered.

Rather than starting the construction of the interview schedule from nothing, Oakley's schedule and Funke-Furber's questionnaire were used as a base. Some questions in both were used verbatim, while others sparked ideas for questions. The selection of the questions from these two sources and the inclusion of the other two sources was based upon theoretical considerations, common sense ideas about pregnancy, and by responses and suggestions from women involved in the pilot stage of the construction. Modifications of some Oakley questions were performed when necessary to avoid terminology and references which were uniquely British.

Oakley, in her companion volumes, Becoming a Mother and Women Confined: Towards a Sociology of Childbirth, focusses on the societal expectations and medical management of women as childbearers. In a series of four interviews with 54 women during the process of their experiences with pregnancy and early motherhood, Oakley sought to reject explanations of reactions to birth and motherhood as having been due to the femininity of the women rather than their humanity. Two of the four interviews were administered pre-natally and the remaining two post-natally. Oakley was contacted and a request was made to obtain copies of the two prenatal interviews. These were received and formed the base for the interview schedule used in this research.

The topics covered in Oakley's two prenatal schedules are similar to the list covered in Table II. However, Oakley devoted more time to the medical management of the pregnancy and less to the expectations of the women. As such, Oakley's questions which asked for details of the women's experiences with the management of their pregnancies were excluded as this was not the focus of the present research. Questions which centered upon the differences which the women had noticed since becoming pregnant and their expectations of their own behaviour and the behaviour of others towards them were included either verbatim or in a modified form.

TABLE II: Topics Covered in the Interview Schedule

1. Age
2. Education
3. Marital status
4. Length of relationship
5. Parity
6. Gravidity
7. Planning of pregnancy
8. Desirability of pregnancy
9. Length of pregnancy at the interview
10. Location of birth
11. Residence
12. Conventional/innovative attitude to pregnancy
13. Conventional/innovative attitude to birth
14. Conventional/innovative attitude to motherhood
15. Importance of motherhood
16. Existence of maternal instinct
17. Definition of femininity
18. Amount, type, source, and search -- pregnancy and birth information
19. Amount, type, source, and search -- baby information
20. Expectations of women
21. Expectations of others
22. Husband involvement
23. Effect of pregnancy
24. Effect of baby
25. Image of future
26. Motivation for motherhood
27. Physical symptoms
28. Emotional symptoms

Three questions were included from the Third Trimester section of Funke-Furber's Maternal Adaptation to Pregnancy Questionnaire. The majority of Funke-Furber's topics in this section of the questionnaire were either duplicated by Oakley's interview schedule questions or were designed to predict the mother's adaptation to motherhood based on attitudes and behaviours of pregnancy. As this adaptation aspect was not a focus of this research, such questions were not included.

Twelve items of the Medical History Questionnaire (National Center for Health Statistics, Series 11: No. 37, 1970) which concern psychological symptoms comprised a measure of emotional stress. The respondents were requested to check the appropriate responses to each psychological symptom with a choice of the occurrence being "occasionally", "seldom", or "never". A standardized measure of emotional stress was used as the emotional symptoms of women during pregnancy has been considered an important variable in past research.

Oakley's schedule contained a checklist of physical symptoms associated with pregnancy. The women were asked to check the frequency that they had been bothered with a particular physical symptom with the response choices being "frequently", "seldom", or "never".

A measure of femininity was provided by the respondents' answer to the question: "On a scale of 1 to 10,

how feminine are you? How do you define femininity?" The replies to the query on the definition of femininity were coded into three categories. The first two categories are taken from Entwisle and Doering's 1975 characterization of femininity as being composed of two factors: 1) social femininity - "the extent to which a female accepts the stereotypically feminine social role" and 2) biological femininity - "how a woman feels about her body and its functions" (Entwisle and Doering, 1981:36). A third category was included to encompass those responses which rejected the word femininity and preferred to discuss themselves in terms of their "humanity".

Data Collection

Interviewing was chosen as the method of data collection for two reasons. First, as Veevers states "Unless one is researching an area which is already quite familiar to social science, one cannot have a great deal of confidence that one is, in fact, asking "appropriate" questions" (Veevers 1980:177). As the social role of pregnancy with its attendant norms and values had not yet been explicated, the components of the role could not be delimited by the structure of the research instrument but must emerge from the data. Second, the problem of acquiescent response set is particularly prevalent when the topic is a sensitive issue

and socially desirable responses would be more likely given on a forced-choice questionnaire. That this would be a problem when studying pregnancy became readily apparent during the course of the interviews. Respondents would initially give the "correct" answer and then qualify and amend their responses in subsequent conversation until they would often contradict themselves.

The second contact with the women, by telephone, was made approximately one week before the interview was to take place. This contact was made to establish a time and a place for the interview. Using the information given by the women at the initial contact, women were phoned in order of their due dates. An attempt was made to interview all the women during their last month of pregnancy. The majority of women were interviewed within three weeks of their due dates with a range of one week to five months.[4,5]

The respondents were offered the option of either their homes or the researcher's home or university office as the location for the interview. All but two of the women chose their own homes giving as reasons their small children under their care and/or their advanced stages of pregnancy. The two women who chose the university office as the site of the interview were both students. All interviews took place between February and August of 1981.

Of the 18 multiparous women, 6 had their children

present during the interview. Although this necessitated interruptions for the women to deal with the requests of these children, it did not interfere with the responses the women gave. The fathers were present for the entire interview on two occasions and for a portion on one. All three of these couples emphasized the "sharing of our pregnancy". The women's responses did not differ from those women whose husbands were not present during the interview, but also spoke of "our pregnancy" and "when we became pregnant". Friends of the mother were also present for two interviews. One of these was discarded due to the tape being ruined. For the other, the woman was obviously nervous about the interview situation and the tape recorder. After approximately 20 minutes into the interview, she became relaxed. Her friend left shortly after this and it was suspected that the friend had been invited to give her courage in an unfamiliar situation.

The interviews began with a brief outline of the voluntary status of the respondents as required by the University's Research on Human Subjects Committee. The women were then asked if they had any questions about the interview before it began.[6] After these were answered, the interview started with questions on the demographic characteristics of the respondents and a description of the house. These were thought to be a non-threatening method of easing into the interview.

The interviews were tape-recorded on a small relatively unobtrusive cassette recorder and generated a total of 82 hours of tape. Although some of the women appeared hesitant at the beginning of the interview, the tape recorder was soon forgotten. Attempts were made to ensure that the interviews appeared as a conversation rather than an interrogation. Due to this, questions were often not asked in the same order as in the interview schedule. Frequently women would anticipate a question or be interested in a topic not yet covered; in these cases, the interviewer would proceed in their direction and then revert back to the "jumping-off" point. If a topic which was not in the schedule was broached by a woman, spontaneous probes were asked to elicit further information.

When the situation was different from the usual hospital vaginal delivery, such as an intended home birth or planned caeserean section, the schedule was amended on the spot to obtain similar data in the different context. Questions were also phrased differently depending on the woman.

The interview schedule was amended and edited throughout the course of the interviews when two situations occurred. First, since the sociology of pregnancy and childbirth is still in its formative stage and the knowledge of the area is not yet complete or exhaustive, when women introduced

topics which were relevant to them, it would be included in subsequent interviews. An example of an addition for this reason was the inclusion of questions regarding doctor "shopping" and doctor interrogation. Second, when the women consistently were disinterested, a topic or question would be excluded. An example of an exclusion under this situation was the topic of the women's family background and sibling relationships. The women appeared confused when this topic was introduced. After further consideration, the topic was dropped from the remaining interviews. As this topic is used in those studies in which the researcher is endeavouring to predict maternal behaviour on the basis of variables present in the mothers' lives, not an objective of this research, it was felt that it would not harm the research by its exclusion.

Data Analysis

As interviews were completed, the tapes were reviewed by the researcher. A compilation of behaviours and attitudes which were potentially the norms and values of the role was initiated at this stage.

The tapes were passed to five student part-time research assistants for partial transcription. The research assistants were supplied with a copy of the interview schedule,

the list of norms and values, and the tapes. They first familiarized themselves with the order and the content of the schedule. Instructions were then given regarding the amount of detail required and the type of ideas to be included. The research assistants were instructed to transcribe verbatim the words of the women when they discussed anything on the list of norms and values, used the words "should" or "expect", or indicated that they were surprised by an event or attitude. Irrelevant digressions were excluded as well as repetitive statements. Some questions required only "one word" or "a phrase" for the answer; in these cases, only the necessary word or phrase was included and all else was ignored. When the schedule was amended on the spot, the words of the interviewer were included in parentheses. Three of the research assistants had previous secretarial training and typed the responses while the remaining two wrote them out by hand.

The responses of the women were recorded, in accordance with the instructions, on 5" by 8" index cards numbered from 1 to 112 in correspondance with the 112 cards of the schedule. All of the interviews were re-arranged and re-ordered to coincide with the organization of the schedule. The taped interviews were thus reduced to one set of 111 index cards for each respondent. At this stage, each interview tape and set of index cards were reviewed

simultaneously by the researcher to ensure the accuracy of the transcriptions and to check for omissions.

Next, the index cards were surveyed to determine if the original list of norms and values were actually those of which the women spoke and if more existed that were not already discovered. It was not necessary for all women to comment directly or voluntarily on a behaviour or attitude for it to be included in the list. Nor was it necessary for all of the women to indicate that they adhered to a norm for its inclusion. Frequently women expressed their awareness of others' insistence upon their participation in a particular activity due to their positions as pregnant women. However, the women declared either their reluctance to do so or their dismissal of the activity as being without reason.

The next stage of the data analysis was the forming of the ideal types of the social role of pregnancy. The components were extracted from the data using Barton's (1955) method for the substruction and reduction of property-space.

Conclusion

In summary, this chapter discussed the research design and methodology used to study the social role of

pregnancy using 43 pregnant women from the Greater Victoria area. A semi-structured interview schedule based on three sources, plus researcher-constructed questions was used to collect the data. Taped interviews were partially transcribed and the norms of the role extracted from the data. The data were then substructed and reduced to form the ideal types of the social role of pregnancy.

CHAPTER FOUR

ACQUIRING THE SOCIALLY PREGNANT IDENTITY

While pregnancy is a physiological event, the social requirements for being pregnant do not generate from the physical fact of the pregnancy. As Berger and Luckmann (1966) state:

> Social order is not part of the 'nature of things' and cannot be derived from the 'laws of nature'. Social order exists only as a product of human activity (Berger and Luckmann, 1966:52).

Pregnant women learn the role of pregnancy with its attendant norms as their identities evolve from that of being physiologically pregnant to being socially pregnant.

The three objectives of this chapter are to delineate:

1) the theory of the social construction of reality as outlined by Berger and Luckmann (1966);
2) Miller's (1973, 1978) application of the theory for the women in her study as they acquired the pregnancy identity; and
3) the acquisition of the pregnancy identity for the women in the present study.

The Social Construction of Reality

This discussion will begin with a short overview of the theory of the social construction of reality as summarized by Berger and Luckmann (1977) and proceed to a more detailed description of the position of roles in socially constructed reality and the internalization of that reality (Berger and Luckmann, 1966).

Reality is defined as "...a quality appertaining to phenomena that we recognize as having a being independent of our own volition..." (Berger and Luckmann, 1966:1) and social order as "...an ongoing human production" (Berger and Luckmann, 1966:52). Berger and Kellner posit that every society "...constructs, maintains, and modifies a consistent reality that can be meaningfully experienced by individuals" (Berger and Kellner, 1978:179). Thus, the reality that individuals recognize as being in existence is produced by the society of the individual.

> Every society has its specific way of defining and perceiving reality - its world, its universe, its overarching organization of symbols. This is already given in the language that forms the symbolic base of society. Erected over this base, and by means of it, is a system of ready-made typifications, through which the innumerable experiences of reality come to be ordered. These typifications and their order are held in common by the members of society, thus acquiring not only the character of objectivity, but being taken for granted as the world tout court, the only world that normal men can conceive of (Berger and Kellner, 1978:179).

Individuals are provided with the typifications by the society with predefined expectations for the ordering of everyday life. "The socially constructed world must be continually mediated to and actualized by the individual, so that it can become and remain his world as well" (Berger and Kellner, 1978:179). The experiences and the ordering of these experiences by an individual are biographically cumulative. The reality of an individual and that individual's society are thus socially constructed.

Roles may be spoken of when

> ...typification occurs in the context of an objectified stock of knowledge common to a collectivity of actors. Roles are types of actors in such a context. ...By playing roles, the individual participates in a social world. By internalizing these roles, the same world becomes subjectively real to him (Berger and Luckmann, 1966:73-74).

Within the context of knowledge, common standards of role performance are available to individuals of a society and especially to those individuals likely to perform the role. As such, individuals are held responsible for adhering to these standards which can be seen as controls on the performance of the role. "Compliance and noncompliance with socially defined role standards ceases to be optional, though, of course, the severity of sanctions may vary from case to case" (Berger and Luckmann, 1966:74).

> By virtue of the roles he plays the individual is inducted into specific areas of socially objectified knowledge, not only in the narrower cognitive sense, but also in the sense of the "knowledge" of norms, values, and even emotions (Berger and Luckmann, 1966: 76).

Thus, by playing a role, an individual is given access to the stock of knowledge specific to that role. Given the biographically cumulative nature of socially available knowledge, an individual is able to store not only the external behaviours of a role but also the internal attitudes.

Socialization may be defined as "...the comprehensive and consistent induction of an individual into the objective world of a society or a sector of it" (Berger and Luckmann, 1966:130). The major agent for such internalization is the primary socialization of the family. However, secondary socialization is primarily responsible for the internalization of the stock of knowledge of roles, "... 'special knowledge' - knowledge that arises as a result of the division of labor and whose 'carriers' are institutionally defined" (Berger and Luckmann, 1966:130). The degree to which the new knowledge is effectively internalized through secondary socialization is related to the degree to which the new knowledge is consistent with that learned through primary socialization. The more continuous that the new knowledge is with the old, the more readily an individual is to accept the new as reality.

Acquiring the Pregnancy Identity: Miller

Miller's 1973 study "Pregnancy: The Social Meaning of a Physiological Event" describes the construction and maintenance of the social identity of pregnancy. The data were obtained by taped interviews with women during the first, second, and third trimesters of their pregnancies. This study was discussed previously in Chapter Two. Her 1978 article "The Social Construction and Reconstruction of Physiological Events: Acquiring the Pregnancy Identity", based on the same data, focusses on the initial entrance into the identity.

The aim of Miller's paper is to examine the idea that "...all identities are acquired through processes of social construction of reality which may be independent of 'objective' reality" (Miller, 1978:181) and that a "... special effort is exerted by society to insure that social and physiological pregnancy do occur simultaneously" (Miller, 1978:183).

Initial Physical Symptoms

Miller identifies "...three patterns of entry into physiological pregnancy...true planners, sort-of planners and non-planners" (Miller, 1978:186) and further states that:

> Not only did the ways in which the women in the sample gained entry into pregnancy careers vary in terms of intentionality, but the type of decision to become pregnant affected both how the women became socially pregnant and how they became 'really' pregnant ... The true and sort-of planners constructed their identities as the 'signs' occurred; the non-planners reconstructed their identities once their 'illnesses' had been diagnosed as pregnancy... (Miller, 1978:187).

Miller's non-planners initially identified their physical symptoms as illness, although these physical symptoms were identical to those experienced by the true and sort-of planners which were correctly interpretated as being indications of pregnancy. Miller points out that:

> No constellation of physical signs inevitably or invariably means anything or the same thing. Only by locating events in meaningful contexts do actors come to attribute common-sense obvious interpretations to these events (Miller, 1978:187).

Therefore, the non-planners, lacking the anticipation of the true and sort-of planners, did not immediately recognize their illnesses as being pregnancy. This was in spite of all of the women, regardless of intentionality of the pregnancy, reporting that they were aware of the common physical signs of pregnancy before they became pregnant.

Becoming "Really" Pregnant

Fetal movement and "getting bigger", both physical events, were used by the women as an affirmation of the

"realness" of the pregnancy, a social construction. In addition, other physical signs along with the continuing validation of other people with whom the women interacted were taken as evidence of the new identity. "Maternity clothes were used not just as a rational solution to a need for larger-sized clothing, but simultaneously to reveal and conceal the new shape" (Miller, 1978:197).

The women in Miller's study changed from being only physiologically pregnant to being socially pregnant in a process which involved the correct interpretation of physical signs plus the social construction of these signs into the pregnancy identity. "The pregnant women tentatively recognized their new identities but awaited further confirmation of their new status before they acknowledged their identities as fully 'real'" (Miller, 1978:198).

Since the movement from being physiologically pregnant to being socially pregnant is brought about by the correct interpretation of signs, it would be possible for women to misinterpret these signs. It would thus seem that social pregnancy is separable from physiological pregnancy. Miller (1978:182) describes the possible combinations in Figure I:

FIGURE I: Identities produced by presence/absence of physiological and/or social pregnancy

		Physiologically Pregnant: Yes	Physiologically Pregnant: No
Socially Pregnant	Yes	Normal Pregnancy	False Pregnancy
	No	Undiscovered Pregnancy	Non-pregnancy

Acquiring the Pregnancy Identity: Present Study

The framework used to present the data on the acquisition of the pregnancy identity from the present study is based upon that which Miller had developed using Berger and Luckmann's (1966) theory of the social construction of reality.

Initial Physical Symptoms

For the majority of the women in this study, the first indications of pregnancy were physical signs and symptoms, with the most common being a late or missed period. However, this alone was not sufficient proof of pregnancy as the women were aware of other factors which could delay or interfere with menstruation. To fully convince the women of

their pregnancies, a missed period must be accompanied by sore or swollen breasts, nausea or vomiting, and/or cramps. In addition to these physical signs, some women had been graphing their temperatures daily as a means of ensuring or avoiding conception. For these women, another indication of pregnancy was the lack of a decrease in their temperatures after ovulation.

Intuition

A smaller group of women felt intuitively that they were pregnant from the moment of conception. This feeling was described as a "gut" reaction which could not be adequately explained. One woman, typical of this group, stated that:

> In a way, I felt different. I can't describe it, physically different but not ill. It's not something that I can say what it was. I just knew and felt that "this is it". It's not really a sensation that you can put a finger on, just an intuition.

All of the women except one felt either physically or intuitively pregnant before visiting their doctors. One woman, whose physical symptoms were masked by an irregular menstrual cycle and a bout with the "flu", was unaware that she was pregnant until her doctor suggested a pregnancy test as a possible explanation for her prolonged "flu" symptoms.

Differing from Miller's research, the intentionality of the pregnancy had no effect on the correct interpretation of the physical signs of pregnancy. The one woman that did not correctly interpret the signs stated that her pregnancy was planned.

Medical Confirmation

In Miller's research, true planners were much more likely to identify themselves as pregnant before medical confirmation than the sort-of planners and non-planners. The latter were frequently surprised by the outcome of the pregnancy test.

The correct interpretation of the physical signs is the first stage in the transformation from being physiologically pregnant to being socially pregnant. The next stage in the process is to visit a doctor for the medical confirmation of the pregnancy. All of the women except for one attended their physicians at this point although they stated that they knew that their pregnancies existed. There were two explanations by the women for the necessity for a pregnancy test.

Approximately half of the women felt that they could only suspect their pregnancies, that the pregnancies would not be confirmed until a test was positive and the doctors pronounced them pregnant. There was a suggestion from the women in this group to feel that their own judgement

as to whether they were pregnant was not sufficient and they could not announce their pregnancies to their relatives and friends until they had received medical confirmation. They explained their decisions to have tests as "just to be sure".

The other group of women, equally as convinced of their pregnancies, felt that people expected them to have the tests done. They had already informed others of their pregnancies and were at a loss to explain why the test was necessary. They frequently stated that they already knew that they were pregnant and were not at all surprised when the results were positive.

Only one woman did not receive medical confirmation of her pregnancy. Expressing sentiments similar to the second group, she felt that since she knew that she was pregnant, was aware of health and nutritional requirements for pregnancy, and was not suffering from any problems, it was not necessary for her to visit her doctor. She did not go to her doctor until she was entering her fifth month of pregnancy at which time she felt that she should make arrangements for the birth.

Becoming "Really" Pregnant

Consistent with Miller's research, at this stage in their pregnancies, the women were now physiologically pregnant with official medical confirmation and a new social

identity of "pregnant woman". They began to assume the role of pregnancy by learning and/or performing the norms of the role. However, none of the women felt "really" pregnant.

The feeling of being "really" pregnant occurred for the women when two physical events took place. These events were simultaneous for some or extremely close together in time for others. They were an awareness by the women of the movement of the baby and when they "showed". An additional cue to others of their new identity was the donning of maternity clothes which, for most of the women, was closely related to the above two physical events.

Typical of the response of the women regarding the movement of the baby and the obviousness of pregnancy was:

> I felt really excited when the baby moved because I thought I really am pregnant, it's really there. Up until then, I never really believed I was pregnant no matter what the doctor said. I was at that point where people no longer looked at me wondering if I'd gained weight and was just getting fat. They could tell that I was pregnant.

Although many of the women did not need to wear maternity clothes because their regular wardrobes accommodated their increasing size, many felt a great relief when maternity clothes were worn. One woman spoke of first donning her maternity clothes and the relief of putting on a "uniform":

> At first, you have enough of a tummy that you can notice the difference and people are not saying that you've put on weight but you get the feeling that they're looking at you and thinking that you're getting fat. Well, when you put on your "pregnancy uniform", it immediately tells them "I'm pregnant". I'd rather that they think that than that I'm fat.

At this point, the women had completed the transformation from physiological pregnancy to social pregnancy. In addition, they now felt "really" pregnant and were more comfortable in engaging in the norms of the role.

Conclusion

In summary, this chapter described the assumption of the role of pregnancy for the women in Miller's study and the women in the present study. The women proceeded from physiological pregnancy to social pregnancy via the correct interpretation of their physical signs and symptoms. Through socialization, the women knew that medical confirmation was necessary to validate their new role. Thus, their identities as "pregnant women" were socially constructed through the meaningful symbols of society.

CHAPTER FIVE

THE NORMS OF THE SOCIAL ROLE OF PREGNANCY

The concept "role" has had several different definitions within the literature. In the present context, role is defined as "a collection of rights and duties" which are specified by "a cluster of social norms" and norm will be defined as "...standards of conduct that should or should not be followed" (Labovitz, 1977:8). There have been very few studies which have been designed to measure a social role. "Many social scientists simply assume the nature of social roles and then test the possible implications of their preconceptions" (Labovitz, 1977:105).

The norms of the social role of pregnancy were gathered through the inductive approach (Jackson, 1966:41). The initial list of norms which were included in the interview schedule were compiled through theoretical considerations, common-sense ideas about pregnancy, and previous studies (e.g., Baric and MacArthur, 1977). This list was modified and extended throughout the course of the interviewing. Newcomb (Jackson, 1966:41) suggested that to determine the norms of a mother's role "...fifty percent of the informants [should feel] that a particular behaviour was necessary". In the present research, the arbitrary criterion for the inclusion of a norm was that eighty percent of the

women should mention the behaviour. In fact, for the majority of the norms included in the study, one hundred percent of the women felt that it was a necessary standard of conduct for pregnant women.

Since the definition of norms used was "...standards of conduct that should or should not be followed", the women did not have to perform the norms for them to consider them to be desirable standards of behaviour. For example, many women mentioned that pregnant women should be more conscious of their diets as to nutrition but, when questioned further, they revealed that they had made no modifications in their own diets.

Very frequently the norms were phrased similar to Cancian's definition of ranking norms, "...shared beliefs about what actions and attributes bring respect and approval from oneself and others" (Cancian, 1975:7). Thus, the norms were not just phrased "Pregnant women should..." or "Mothers-to-be should..." but more frequently as "To be a good mother, pregnant women should...". An example of this would be the norms that mothers should breastfeed their babies. This was usually phrased in terms of "A mother who cares about her baby will nurse" or "Good mothers breastfeed their babies".

The minority of the norms could be considered to be membership norms as Cancian uses this concept, "...standards for including or accepting a person within a group or

social position" (Cancian, 1975:3). An example of this would be the norm that pregnant women should regularly attend their doctors. For the women in this group, there is no variation in this norm. All attend their doctors as part of being a pregnant woman.

The first stage of the analysis was to extract from the taped interviews a complete list of possible norms. These norms were then divided into five categories. The tapes of the women were then reviewed to determine if the women had mentioned a particular norm. In addition, each category had extra spaces for responses which had not been included in the original list.

The five categories of norms which define the social role of pregnancy were medical, prenatal, birthing, postnatal, and positive/negative response norms. The medical and prenatal norms were those which the women were aware of or were engaged in at that stage in their pregnancies. The birthing and postnatal norms consisted of intentions for the future and preparations. The positive/negative response norms involved the responses of others to the pregnancies.

The norms relating to the health of the women during their pregnancies were the most easy to obtain from the respondents. When the women were asked, "Did anybody tell you anything you should or should not do during your pregnancy? Who? What did they say?", the most frequent

responses involved the health of the women and their babies. Norms of the other categories were taken from the data but were not in response to a particular question. The keyword for locating a norm in the data was "should". Therefore, responses in which the women mentioned statements such as "During pregnancy women should..." or "I should be doing..." or "Fathers should..." were classified under the appropriate category of norm.

Medical Norms

Seven norms comprised the list of medical norms:

1) to modify the pregnant woman's diet;
2) to continue or to start exercise with an emphasis on pelvic exercises;
3) to quit or reduce smoking;
4) to moderate or abstain from alcohol consumption;
5) to avoid over-the-counter or prescription medication;
6) to add supplemental vitamins or minerals to the diet; and
7) to attend regularly a doctor.

These norms were grouped under the heading medical since they were all concerned with the health of the women during their pregnancies. While many additional norms concerning health were mentioned, the criterion of eighty percent

of the respondents advocating an item was not met and they were thus excluded from the list. In most cases, only one or two of the women brought up these additional items. They covered such things as avoiding recreational drugs and substances emitting toxic fumes, such as paint and fibre-glass. With increased knowledge of the placenta's ability to pass both positive and negative substances to the foetus, women are more aware of substances which, if in their circulatory systems, could be passed to their babies and possibly cause harm. Conscious of the possible implications for their babies' health and development, the women felt that being cautious and avoiding activities which would involve such dangers would be wise. As most people do not regularly use such substances, women who did not encounter these items pregnant or not pregnant would be unlikely to mention them which would account for this precaution not receiving advocations by eighty percent of the respondents.

When the women were asked "Did the doctor give you any general advice about pregnancy?", the first response was that they had been told to "watch your diet". None of the women said that they were surprised by this and all had been expecting to be told something about diets for pregnant women. However, the majority did not receive any practical advice from their doctors on what exactly was meant by "watch your diet". Most assumed that the doctors were aware that they knew what was meant but as one 25 year old primigravida

stated:

> She asked me if I kept to a good diet but didn't ask about what I ate. She doesn't really know me and who knows, maybe I think chips and candy are part of a good diet, some people eat all that junk.

All of the prenatal classes which the women attended also emphasized the necessity of the women keeping to a nutritionally sound diet, but as the previous woman said:

> They tell you in the prenatal classes exactly what you're supposed to be eating. But it's a little silly by then. Everybody in the class is about seven months or more pregnant, so it's too late to be doing anything about your diet.

Few of the women made any radical modifications in their diets. Most stated that they had always felt the necessity for a sound diet and therefore thought that their diet was already adequate and that there was no need for any changes. The few who did make changes in their diets said that the changes were very minor, just the reduction or elimination of what they described as junk foods.

All of the women felt that there was no need for them to alter their normal exercise programmes with the exception of two very athletic women. These two women did reduce their exercise from their pre-pregnancy amounts. One, a field hockey player, felt that the game could be too dangerous

and the other, a runner, stopped running marathons for the last few months of her pregnancy. None of the women were told by their doctors to stop exercising or sports with the general advice being that as long as there were no problems, the women could continue. Some women who had done little or no exercise previous to the pregnancy were advised not to start a strenuous exercise programme then but were told that prenatal exercise classes, such as those available at the Y, would be beneficial. However, the only women who took advantage of these types of classes were ones who had been involved with exercise and sports previous to the pregnancy.

Very strong feelings were held by the women on the necessity to quit smoking or drinking. All said they were aware through their doctors and the British Columbia government advertising campaign that smoking and drinking were considered to be harmful to pregnant women and their babies. A 30 year old multigravida, a non-smoker and occasional drinker prior to her pregnancy, expressed the common feeling of the anti-smokers and drinkers as:

> If people can't give up that (smoking and drinking) for nine months to have a healthy baby or at least contribute to a healthy baby, I think there's something the matter with them. It makes me very angry to see a girl come to Lamaze then have to duck out to have a cigarette. It really upsets me because I think "poor child".

The women who did not give up smoking and drinking during the course of their pregnancies felt the need to justify themselves in a manner similar to the following 30 year old primigravida:

> Well, I feel both of those topics are so controversial. I don't think there's a lot of evidence to support the fears people have about alcohol and smoking. To smoke or to drink in moderation seems to be harmless.

Some of the women who had continued to smoke and drink, while professing views similar to the above woman that the evidence against both was not yet complete, did do so against the wishes of their husbands and friends. One woman, whose husband was within hearing but not sight during the course of the interview, indicated by signals that she had seen the researcher's cigarettes and wished to borrow one without her husband's knowledge.

Similar to the previous two norms, the proscription of smoking and drinking, the next two norms are closely related in that they both involve the ingestion of chemicals. All of the women were aware prior to their pregnancies that pregnant women were to avoid over-the-counter and prescription medication. Also they knew that the diets of pregnant women were often supplemented with additional vitamins and minerals. Tragedies involving the use of over-the-counter and prescription medication have been well documented in both

the print and audio-visual media. As such, the women felt no hesitation in following the doctors' advice that they should both be avoided. Most did state that previous to their pregnancies they had not taken many of these medications and therefore, it was no problem to not take them now.

Although all of the women were told that they should take supplemental vitamins and minerals, some went against their doctors' wishes in this regard. They felt that since their diets were more than adequate and that they had modified their diets to include such items as more milk for additional calcium, there was no need for the extra vitamins and minerals. Also, they thought that since many substances which were previously thought to not pass through the placenta did actually do so, it was better to be safe and not include anything in their diets which might prove to be not only unnecessary but also harmful to the baby.

All of the women except one went to their doctors for medical confirmation of their pregnancies even though many shared the thoughts of the one woman who did not attend for confirmation that it was not necessary. Congruent with their feelings regarding going for medical confirmation were their thoughts on regularly attending the doctor. Many thought there was no necessity and that prenatal checks should be made in a way in which the pregnant woman would not feel like and be treated like a sick person. However,

even whilst holding such ideas, the women still attended their doctors. One reason for this was expressed by a 25 year old multigravida:

> I know it wouldn't be my fault but people would still act that way. Some people still think that miscarriages and problems are because the mother didn't look after herself properly and I'd feel guilty if anything went wrong.

Prenatal Norms

Six items were uncovered during the interviews which comprised the prenatal norms:

1) to tell others of the pregnancy before it is obvious;
2) to attend prenatal classes;
3) to read books on pregnancy;
4) to prepare a nursery for the baby;
5) to prepare all baby accoutrement; and
6) to select names for the baby.

Again, other items were brought forth by individual women but the criterion of eighty percent of the respondents mentioning them was not met. These included such items as purchasing toys for the child and playing music or talking to the pregnant woman's abdomen.

The first norm of the set of prenatal norms is the obligation to tell others of the pregnancy before it was

unnecessary to tell. In no case was the husband in the situation of being coyly told of impending fatherhood, all were aware that it was a possibility. All except four immediately told their relatives and friends who, on the whole, acted in the manner that the women had expected. None of the women reported being surprised by anyone's reaction to their announcement.

Three of the four who did not immediately tell others did so due to possible problems with the pregnancy. Since there was a chance of miscarriage or that the pregnancy be terminated, they felt it would be easier to wait until the pregnancy was established before notifying others. The fourth, while experiencing marital difficulties, felt that until that was resolved and the decision to continue the pregnancy made, it was better not to announce the pregnancy.

One of the women who did not announce her pregnancy directly after medical confirmation states that she "...hid it until we were sure...". Her response that it was necessary to hide the pregnancy in a covert manner indicates the feeling that the women had that others should be informed as soon as possible.

As the majority of the group of women in the study were contacted through prenatal classes, it would appear that a bias exists in the data for assuming that prenatal class attendance was a norm of the role of pregnancy. However, it was not the actual fact of their attendance which

constituted the basis for the inclusion in the list of norms, rather, the judgemental reasons for doing so. Assuming that no physiological change in the state of pregnancy has occurred in the past ten years to support the rapid increase in the number of classes available and the direct encouragement of the medical profession to women to attend, would lend support to the notion that the increase and encouragement were based on social reasons.

In fact, over half of the women stated that both themselves and their husbands were either bored or disappointed with the classes they were attending. That they continued to attend was associated with their reasons for going originally, "...good mothers go to prenatal classes, it's better for the baby...". When one 29 year old multigravida was asked as to why she had decided to attend prenatal classes, she responded:

> I don't really know. The doctor said that it was a good idea and all my friends are going. I didn't go with the first one. They weren't that common then. I guess I'm going because that's what you're supposed to do.

The classes with which the women were most satisfied were those which were taught by a mother, the feeling being that anything that could be said by somebody who had never experienced pregnancy or birth could be readily obtained from a book. The personal aspect of the experience most

attracted the women to the lectures taught by the mothers.

All of the women interviewed in this study had done some reading on the process of pregnancy. However, the type and quantity of the reading was widely diverse. The minimal amount done by the women comprised two popular books, Baby's Best Chance and A Child Is Born. Some of the women read far beyond the scope of these two books.

Baby's Best Chance: A Perinatal Manual for Parents is a 1979 publication of the Ministry of Health, British Columbia. It is distributed free to all expectant parents enrolled in Public Health prenatal classes or attending Public Health clinics and is available for a nominal charge through the Ministry of Health. Written mainly in point form, it follows the pregnancy from conception to birth with an additional two chapters on child care. A practical rather than descriptive book, Baby's Best Chance assumes that the parents' knowledge of the childbirth process is virtually non-existent and endeavours to correct this deficiency. The father is not only included but is encouraged to be involved. There is an emphasis upon the parents' ability to manage and control the pregnancy and birth with expert advice. Due to the distribution and availability of this book, it would constitute the minimal level of reading for a pregnant woman in British Columbia.

A second popular book is Nilsson's A Child is Born

(1977) which contains a complete photographic record from conception to delivery. In utero photographs of the embryo and fetus distinctly sets this book apart from others on pregnancy. Women who stated that their husbands were relying on their wives to tell them of anything they needed to know and were therefore not reading the books which the women had, reported that their husbands were interested in the photographs in A Child is Born.

The women who read the larger amount of books on pregnancy read mainly in two specific areas. The first area was that in which the books were similar in tone to Baby's Best Chance but contained far more material and did not assume that the parents knew nothing of the process. The second area included books which focussed on separate aspects of the process. Thus the women were reading books devoted to the nutrition, exercise, medical management, and general physical and psychological well-being of the pregnant woman.

Another aspect of the norms of pregnancy is the preparation of the baby's nursery and accoutrement. The majority of the women were preparing a room specifically for the baby, although these same women would deny the necessity for such as indicated by one 27 year old primigravida:

> I know a baby doesn't really need a room just for himself but the other choice is putting the crib in our room and I don't want that. It's the same with the decorating. I know I'm doing it for myself. The baby won't care about the wallpaper or colour of the paint.

The few women who intended that their new baby would either share a room or, more usually, remain in a crib in the parents' room initially were multigravidae. This can be explained as being partially a function of limited household space with two or more children and being partially due to the more experienced mothers endeavouring to create a more convenient baby-care environment for themselves. Those multigravidae who intended separate bedrooms for their children were often placed in the position of evicting an older child from a more accessible, for the mother, to a less accessible room. This added to the preparation for the new baby as often extensive decorations and renovations were being done to compensate the older child for the move. Explicit efforts were being made to avoid the older child becoming jealous or resentful of the expected baby.

Those women who did not intend to have a room solely for the baby reported that friends and relatives reacted quite strongly against this plan. From the statements of the women, it appears that siblings sharing a room is more acceptable than the baby occupying the parents' bedroom. When siblings share, it seems to be a matter of the usurpation of the older child's space and the possible inconvenience incurred with the different sleeping and waking patterns of the two children which causes the objections of people to this arrangement. Thus, sharing a room was felt

to be a tolerable compromise of the ideal situation. However, the women received the impression that having a baby in one's own room was in some way improper and that efforts should be made to remedy an intolerable situation.

The preparation of the baby accoutrement was one behaviour which for obvious reasons did differentiate between the primigravidae and multigravidae. Most of the multigravidae had clothing and furniture left from previous children. For them, the preparation consisted of mainly washing clothing and taking furniture out of storage. Some expressed guilt for not being able to purchase new items for the baby and all bought at least one thing for the baby which would not be passed on from an older brother or sister.

The same woman that had stated that she was preparing the nursery more for herself than for the child expressed similar feelings about the baby's clothing:

> I swore that I wouldn't go out and buy all the cute little things that are in the stores and I guess I haven't gone to the extremes that some people do. But, after I bought the basics last month, I'm still doing some more shopping. I know it's for me to show the baby off. At least I haven't bought the really commercial things, clothes for a baby with cartoon characters on them.

All of the women, except two, intended to select a name for the baby before it was born. The two exceptions intended to see what the baby looked like before a name was

chosen, stating that they didn't want an inappropriate name to be given to the child if she or he didn't suit it. These two women reported negative reactions to their plans with the feeling being given that they were being remiss in their duties. Upon learning of the women's plans to select a name for their babies after the birth, people acted as if the women were not sufficiently interested in the child to have chosen a name.

The remaining women chose names based on euphony, a pleasing meaning, after a friend or relative, or they "... just like that name...". Those women whose pregnancies were well advanced and who were still deliberating between two or more possibilities felt that others were wanting them to make a choice. It seemed that people felt a child should be named immediately after birth and that names should be ready. It was therefore a duty of the expectant parents to have selected names.

Birthing Norms

Four norms were mentioned by the respondents which concerned the actual births:

1) to read books on the birth process;
2) to discuss plans for the birth with the father and the physician or midwife;
3) to practice and use psychoprophylaxsis for the birth;

4) to plan for the father to be in attendance at the birth.

The women were in three groups defined by the location and participants for the birth: 1) in a hospital with a physician, 2) in a hospital with a physician and a midwife, and 3) at home with a midwife and doctor on-call. The women performed the norms in slightly different ways depending on the which group they belonged; e.g., different books were read depending on whether the birth was planned for hospital or home. However, these four norms were the only ones mentioned by at least eighty percent of the women.

Some of the books read on pregnancy were also used for the reading on childbirth as the books would contain sections on both topics.

Baby's Best Chance and various childbirth manuals are used in the prenatal classes in Greater Victoria. While extensive bibliographies of reading material are distributed in the classes, other than Baby's Best Chance, parents are expected to search out, obtain, and read only that material which interests them. All prenatal classes in Victoria are based on the Lamaze method of psychoprophylaxis with varying degrees of emphasis placed upon the need and importance of it.

The women who read beyond Baby's Best Chance consulted a large number of other childbirth manuals. As well they read in another related area. A new body of literature directed to the consumer has emerged in recent years in

response to dissatisfaction with current medical practices (e.g., Berezin, 1980; Sousa, 1976). Based on the work of Dick-Read (1944), Lamaze (1958), and Leboyer (1975), they emphasize the psychological aspects of pregnancy with psychoprophylaxis advocated as a means of "natural" childbirth. This literature calls for drastic revisions of delivery practices from an extreme of returning to home births to family-centered labour and delivery rooms and birthing centres. A less ambiguous image of pregnancy and birth is presented with the aim of a "shared experience" for the mother and father and a "natural" birth without medical intervention.

All of the women reported that they had at least read the minimal amount of reading on childbirth. Husbands of women read in similar quantities relative to their wives. However, in no case did the husbands read the same amount or more than their wives. The women responded that they felt considerable pressure to read from friends, relatives, and medical management personnel. One 31 year old multigravida expressed this sentiment as:

> Everybody's always pushing books at you. I'm not much of a reader but they make you feel guilty if you don't want to read about the birth. I don't remember this happening before. Even if you look in the bookstores, there's shelves of books now on all this stuff.

The childbirth manuals which the women were reading plus the prenatal classes which the women were attending all emphasized the need for the expectant parents to fully discuss and plan the births of their babies if they wished to maintain control of the delivery. All the women regarded having the control of the birth in their own and their husbands' hands as an important goal. One 29 year old multigravidae compared her past experience with what she hoped would occur this time:

> I'm afraid of losing control because it can be so overwhelming from what I can remember with my first one. It's an easy thing to talk about and go through these classes but then it's another thing to do what they say you're supposed to do. I intend to be much better prepared this time. We've both talked to the doctor about what we want to happen. Last time, he didn't even see the doctor about the pregnancy at all.

The majority of the women felt that by attending prenatal classes, they were planning the birth. However, actual plans as to how the delivery was to be ordered and what procedures and medications were acceptable to the parents were made by only a minority of the parents.

Another norm which is directed to the birth of the baby is that of practising the breathing exercises. Since all of the women intended to use psychoprophylaxis to aid them in their deliveries, a competent command of the skills involved is necessary. Few of the women mentioned

that they were practising these skills but all stated that they were necessary to learn. A second time mother characterized the first time mothers as not taking the classes or the exercises seriously enough:

> We went through the classes with the first one but I think it went in one ear and out the other. We have been watching the other first time couples in our class and they take it so lightly. Maybe they practice at home but I doubt it, maybe they are all serious but they don't know that it's hard work and you need to know what you're doing if you're going to do it the way you want to.

Although this woman singled out the first time mothers as being less serious about their exercises, there was no difference between the primigravidae and multigravidae in the entire group. Some of the multigravidae in the group did not use psychoprophylaxsis for their previous children and were equally unaware of its benefits or the necessity for practice as the primigravidae.

All of the women except one intended to have the fathers of their babies in attendance at the births. The one father who was going to be absent was due to an unavoidable conflict with working hours. None stated that their husbands needed to be persuaded to be at the birth.

On this particular issue, rapport between the researcher and the respondents suffered somewhat due to the strong feelings of the women. Often misinterpreting the

question "Why is your husband going to be at the birth?" as an indication that the father's attendance was objectionable in some way, they argued quite strenuously that it is not only the right but the duty and obligation of the father to attend. Some women became almost belligerent at the thought that some people would imagine that there was a choice in the issue. When the question was clarified to indicate to the women what were their personal reasons for wanting their husbands with them, the women became co-operative once more.

Postnatal Norms

Three norms were found to exist which involved preparation for postnatal concerns:

1) to read books on baby and child care and development;
2) to discuss with the father and friends the care and development of the baby; and
3) to intend to breastfeed and to prepare for such.

These three norms were classified as postnatal as the behaviour to which they are directed will only occur after the birth. Again, no other items reached the criterion of eighty percent acceptance.

The amount of reading done by the women on the care of their babies did not nearly approach that of the

reading done on pregnancy and childbirth. Whereas all women had read at least the minimal amount in the latter area, the majority of women had concentrated on obtaining but not reading such books as Dr. Spock, often as a gift. The second group, much smaller than the first, had accomplished extensive literature searches for material less traditional than Dr. Spock. These women were more likely to have conducted the search at their own initiative in libraries and bookstores and less likely to have received the books as gifts or to have received suggestions from others. The topics of the books ranged from in-depth coverage of breastfeeding and parenting to discussions of child development and educational theories.

Clearly the majority of the women felt that there was no necessity for learning about the care of babies. This came from all of these women without reference to their previous experience with babies or children or to their parity. The general feeling was that mothering is a skill which will come "naturally" when the need arises. Books such as Dr. Spock are necessary only for use as a reference to determine the baby's progress or to know when to call the doctor.

A response which typifies this attitude is that of a 23 year old primigravida:

> I think there's a maternal instinct. Mothers know what each cry means, sense what their babies want.

The husbands of those women who did extensive reading in this area followed the same pattern as in their pregnancy and childbirth reading. Since the people in these relationships typically valued the sharing of the experience, the fathers had usually read nearly as much as the mothers. Since these couples assumed that all fathers would be involved in child care equally with their wives, they would, therefore, need to be equipped with the same knowledge. The only discrepancy between the two reading patterns arose with those husbands of the women who had read only a little on child care. These husbands had usually read little or nothing on pregnancy or childbirth and relied on their wives or the prenatal class to supply them with the relevant information. However, their interest and reading was intensified on the topic of child care. Now, the men would initiate the search for material as pointed out by a 27 year old primigravida:

> What he's interested in most is what it's like after, looking after the baby. He was disappointed that there wasn't much about that in the prenatal classes, so he found his own books.

While reading and learning about pregnancy and childbirth was a very clear normative requirement of the role

of a pregnant woman, the expectations for reading about the potential roles of parents seemed much more vague. None of the women reported any expectations from others that reading beyond Dr. Spock type literature was required nor were any negative reactions incurred by the women on their lack of preparation through reading. It was clear that while obtaining a reference book was necessary, it was not expected to be read until the need arose. While it cannot be said that not reading about child care is a norm of the pregnancy role as expressed by "Pregnant women should not read about child care.", it could be stated that such reading was to be avoided as being unnecessary and possibly harmful. The majority opinion held that, at best, such reading provided the pregnant woman with a confusing picture of childrearing from all the different experts and, at worst, could possibly smother the "natural" parenting instinct.

Concurrent with the lack of in-depth reading on child care came the lack of discussion between the parents about the child's rearing. Few parents had discussed the principles, values, and practices they wished to incorporate in their childrearing. The majority had not gone beyond speculation on their future child's sex and possible physical characteristics and most had discussed the baby's appearance solely within the context of jokes as evidence by the following 22 year old primigravida:

> All we've talked about is that he'll be a big kid with big feet since we're both so big.

However, overwhelmingly the women felt that communication between the parents would facilitate easy childrearing and that good parents should "talk things over with each other".

One assumption implicit in the lack of discussion between the parents could be that since the women will be responsible, with few exceptions, for the care of the child, discussion would be superfluous. Actual thoughts on such aspects of child care as the division of labour, discipline, education, and the parents' values were not raised. Although most women felt that their husbands would be involved, to some degree, with child care, practical discussions had not occurred. Even between those couples who had read extensively and assumed that the husbands would share equally, talks regarding their plans for their child remained minimal. Some women had thought about the difficulty of involving their husbands in feeding, since all except two intend to breastfeed, and planned to express their milk to enable the father to be included. However, none mentioned talking about this with their husbands. The nearest that the women indicated that they had come to discussing childrearing practices were joking statements about who would change the dirty diapers.

As stated earlier in this chapter, it was not

necessary for the women to actually participate in the behaviour for it to be a norm of the role. Of all the norms associated with pregnancy, the discussion between the parents as to the future child's upbringing was the least likely to be enacted. This was in spite of the fact that while the women frequently stated that one joy of having a child is the "molding and teaching" of that child and that communication between parents is a desirable standard of conduct, they had not specifically discussed with the fathers exactly how the child was to be molded and what the child was to be taught.

A competing explanation to child care being the women's responsibility for the lack of discussion could be the factor of immediacy. For these women, in their last trimesters of pregnancy, the immediate challenge is the birth. All attention is focussed upon the labour and delivery. It is possible that after this hurdle has been overcome, discussion will be directed to the care of the child.

Of all the norms defining the social role of pregnancy, the norms requiring women to intend to breastfeed their babies most clearly qualifies to be a ranking norm as defined by Cancian (1975). The women attached very strong overtones of judgement regarding the worth of a mother to the decision to breastfeed or not. The two women who had decided to bottle feed their babies gave quite defensive reasons for doing so.

Of the responses given to the question "Why do you want to breastfeed your baby?", over half, given as the primary reason, involved the presumed psychological benefits which would be gained. The remaining reasons of the women were equally divided among the nutritional and immunological benefits and the convenience over bottle feeding.

Whether speaking of the psychological benefits, nutritional and immunological benefits, or the convenience of breastfeeding, the women still spoke in terms of what a good mother would do. An example of this is given by a 21 year old primigravida:

> I think that mothers that don't nurse their babies aren't giving them the best care that they could. I want to do everything I can for my baby so all I've heard about nursing sounds good.

Positive/Negative Response Norms

While all of the norms of the role of pregnancy were learned and assimilated by the women through interaction with others, the following two norms were classified together because the behaviours associated with the norms were initiated by others. The positive and negative response norms were:

1) to receive special treatment and privileges from others; and

2) to receive adverse reactions and to be stigmatized by others.

All of the women had expected some form of special treatment due to their pregnancies. However, those who reported a reaction against their pregnancies were shocked and surprised.

All of the women reported that they had received special treatment from others which was due solely to their pregnancies. On the whole, the women enjoyed this treatment as one women said:

> I feel special and people being nice to me confirms it, I am special!

While some felt that over-solicitous behaviour on the part of others was unnecessary, they usually justified it on the basis that the individuals concerned were being caring about their health. However, one woman stated that such treatment angered her and that she has responded to it with sharp retorts. She felt that it equated her with a child-like status.

The women reported that this behaviour included both commissions and omissions. They had received extra treats or had been allowed to neglect duties.

The negative reactions of others was something that none of the women had expected. While all of the women

had not experienced such behaviour, some who had not been subjected to it themselves told stories of friends. This behaviour was sometimes merely peculiar, such as related by the following 27 year old primigravida:

> It was really odd. We've been attending a dance class since before I was pregnant and at different stages in the evening, people are supposed to dance with different partners. After my pregnancy became obvious, the only men who would dance with me were men who either had pregnant wives or had recently had children. This wasn't just the young, single men who wouldn't dance with me, older men, too, and I'm sure they've seen a pregnant woman before. I can't figure out why, maybe they think I'm too fragile, might break, or maybe contagious in some way. I don't know, makes me feel like a wallflower at a high school dance.

One woman that felt quite strongly about this aspect of the role of pregnancy related the following incident:

> I guess it's something that women's liberation has done women a disadvantage. The men who are nice to pregnant women are those with wives who want to become pregnant or already are. They're concerned and smile and ask you how you are. A lot of other men, I find, sort of say "So what, lady, you're pregnant, you're a feminist, your pregnancy shouldn't bother you. Why should I give you any special treatment?" I've found that attitude frequently. One day, a young man didn't hold the door open for me after him and I was really tired and it was a heavy door, a real struggle for me to open. He just looked at me, saw that I was pregnant, I mean I was out to here, and I could see him thinking --Take care of yourself, lady. He just let the door shut in my face and he <u>knew</u> I was pregnant. He seemed to do it because I was pregnant.

Other women spoke of having negative responses based upon interactions between their pregnancies and family size, age, marital status, and occupation.

One woman told of having adverse reactions to the news that this was not her first baby:

> Well, the first question from strangers is always "Is this your first baby?". When I say no, this is my fourth, they recoil in horror. It's none of their business.

One of the younger women in the group, 20 years old, spoke of people reacting to her youth and her pregnancy:

> I know I look younger than I am, I mean I'm not that young to have a baby but some people act like I'm thirteen or something. You can tell when they're avoiding looking at your stomach as if it's something I should be ashamed of.

A woman who had her first baby as a single parent and has since married noted the differences between the two pregnancies based upon her marriage:

> People, especially old women, look at your left hand for the ring. Before, they'd look, not see it, and look away. They wouldn't talk to me. Now, they see the ring and it's all smiles and "how are you, dear?". I think there's a big difference with a wedding ring when you're pregnant.

One of the university student respondents told of her experience on receiving the results of her pregnancy test from the student health clinic:

> In a way, I guess it was funny. Probably a positive test is usually bad news in there but they shouldn't assume it is. We were really happy, it was sooner than we had planned but not that much. I went in there all excited and the woman met me with such a face and immediately starts to talk about having an abortion. She didn't even wait to see if I thought it was good or bad news. I was kind of upset. She didn't have to act as if all pregnancies were bad news.

An important distinction appears between the positive and the negative response norms. When people were reacting positively to the pregnancies, their actions and words were directed specifically and explicitly to the pregnancies. However, the negative response norms were not so explicit. The women assumed that the actions were directed to them because of their pregnancies but there was no indication from the individuals concerned that this was so. The women were assuming motivations which may or may not have been the motivations of the individuals.

Conclusion

In summary, this chapter delineated the social role of pregnancy through an explication of the medical, prenatal, birthing, postnatal, and positive/negative response

norms which comprise the role. The majority of the norms can be considered ranking norms as they frequently involved the judgement as to conduct which would constitute a "good pregnant woman". Many of the women were falling short of their standards of desirable conduct as they would advocate a norm but not practise it.

Several points of interest have risen from this discussion of the norms of the role due to changes over time in the normative expectations for pregnant women.

Within the medical norms, no woman included a proscription on having sex at any stage in the pregnancy. This was not raised from the women nor did any woman state that anyone had suggested this to her when questioned directly on the topic. Some women mentioned that they had ceased having intercourse during the third trimesters of their pregnancies but that this was not due to being told that they should discontinue because it was harmful to the baby. The women who had stopped stated that it was because sex was now uncomfortable or that they were not interested.

Within the prenatal, birthing and postnatal norms appeared the obligation for the women to read about pregnancy, birth, and child care. Women who were not in their first pregnancies mentioned this as a difference from their previous pregnancies. However, without further research as to the degree of compliance from the women, it is difficult to

ascertain if the norms involve the reading of the books or simply buying and collecting the material.

A significant new trend over the practices of the post World War II period is the number of the women who intend to breastfeed their babies, 41 of the 43 respondents stated their intentions to breastfeed rather than bottle feed their babies. Several interesting points arise from these intentions. While the nutritional and immunological benefits were mentioned, the major reason for breastfeeding was the presumed psychological benefit, that of bonding the mother and the infant. This raises a problem for those women who stressed the sharing of the experience with their husbands. A benefit of bottle feeding is that the father can participate in the feeding of the baby. Some of the women had anticipated this problem and intended to express their milk to enable their husbands to share in the feeding of the baby. However, this could hardly be seen as a convenient method of feeding the baby and convenience was mentioned as an advantage of breastfeeding over bottle feeding. The dilemma of convenience versus/infant bonding was not dealt with by the women. Another contradiction in the intention to breastfeed is that many of the women also intend to return to the labour force fairly shortly after the birth. Since continually expressing milk is inconvenient and time-consuming and very few employers make provisions for nursing

mothers, it would appear that an early return to the labour force is inconsistent with an intention to breastfeed. None of the women mentioned their plans for dealing with this inconsistency.

Two interesting points develop from the new emphasis of the women for the sharing of the experience with their husbands. This meant the sharing of the pregnancy, the sharing of the birth, and the sharing of the baby care.

The first point is that of the duty and obligation of the fathers to be in attendance at the birth. Some of the women reacted in a defensive manner when asked why their husbands were going to be in the delivery room as if it was an assumption that shouldn't be questioned. All except for two fathers were intending to be in attendance at the birth. Included in those attending was a scheduled Caesarean-section for which the parents had received permission from the doctor for the father to be present.

The only fathers present during the interviews were those most strongly emphasizing the sharing of the experience. They were not asked their opinion of viewing the birth but it is suspected that these men would have concurred with their wives. However, some wives reported that it was more their idea than their husbands that the men should be in the delivery room. A research possibility which could be followed is to question the degree of acquiescence of these men to be included in the birthing process.

The other point which arises from the women's emphasis on the sharing of the experience with their husbands is the contradiction between the intention of sharing the child care with the lack of discussion as to the actual mechanisms for this sharing. Implicit in this lack of discussion is that the child care will be the wives' responsibility solely and there is no need to discuss the care. While all of the women felt that their husbands would be involved in the care of the child, the lack of discussion would seem to indicate that this care would probably be at only the most token level. The contradiction between the intentions and discussion of plans for the care was not raised by the women. An alternate explanation could be that the women were leaving this discussion until after the birth.

Another development from this data is the women's mention of plans for the birth. In the fairly recent past, as evidenced by multigravidae comparing their previous experiences with the present pregnancy, women put themselves and their deliveries into the hands of their doctors and followed orders. Discussions as to the type of medical intervention allowed would have been superfluous as the control of the delivery rested firmly with the doctor. In addition, the women would not have had the knowledge to set demands and conditions for the birth. It is only with the advent of prenatal classes and consumer-oriented guides to birth

that women have had the knowledge to draw up birth plans. However, although women now have the knowledge for such plans, the control of the process is only superficially theirs and it is possible that during the delivery, those physicians who reluctantly relinquished control will supercede the women's plans and regain control of the birth.

The setting of plans of demands and conditions for the birth will likely bring the women into confrontation with some medical management personnel. During the course of the interviewing, it became apparent that this had occurred and the women had dealt with it by "doctor shopping". The extent of doctor shopping in this group is not possible to determine as respondents were not specifically asked if they had done so until the interviewing was already in progress.

CHAPTER SIX

TYPOLOGY OF THE PREGNANCY ROLE

While all of the norms were adhered to or mentioned by at least eighty percent of the women, differences among the women in their attitudes to their pregnancies became apparent. Two women advocating the same health norm would do so for very different reasons which indicated fundamental differences in the way they thought about their pregnancies. Using Barton's (1955) method for the substruction and reduction of property-space, three ideal types for the pregnancy role were developed.

Barton specifies that, just as geographical location can be indicated by its degrees of latitude and longitude, "Other properties besides location in physical space can likewise be indicated by coordinates" (Barton, 1955:40). The location of an individual in a property-space refers to her scores on a dimension being considered. Although it is possible for the categories of the dimension to be quantitative, usually they will be qualitative. Barton applies substruction and reduction to the problem of clarification of typologies. Although these devices were not developed for use in the construction of typologies, it is possible to do so. Reduction refers to the combination of categories to

obtain a more parsimonious group of dimensions. Substruction is defined as the procedure for locating the property-space coordinates for a typology.

The reduction of the categories to dimensions consisted of determining which questions on the schedule logically grouped together. A set of 15 dimensions was tentatively assumed to exist. These dimensions were intuitively thought to differentiate among the feelings of the women towards the enactment of the social role of pregnancy. Again, using intuition, tables were constructed with pairs of dimensions which were thought to be related in an attempt to determine the ways in which women may relate to being pregnant. The respondents were then scored on the dimensions and located by their coordinates in the property-space. At the point when the scores on the dimensions could be placed without overlap or forcing, into a cell of the table, it was felt that the data had been reduced and the substructions of the typology had emerged. Through the reduction, the original 15 dimensions were reduced to 9 dimensions formed from 26 items. These 9 dimensions with their 26 items are displayed in Table III.

The objectives of this chapter are to describe:

1) ideal types and the typology;
2) the dimensions of the typology with a table illustrating the women's responses by Type; and
3) a composite for each Type.

Ideal Types

Weber first advanced the concept of ideal type in 1904. It was considered to be an "...analytical accentuation of certain elements of reality" (Thompson and Tunstall, 1971:63). It was formulated as "...hypothetically concrete individuals ... constructed out of their relevant components by the researcher for the purpose of instituting precise comparisons" (Martindale, 1960:381). While the components will exist in reality, the type in toto may not necessarily. Neither is the ideal type considered to be a preferred version as there is no evaluative connotation attached to the term. The ideal type is solely a hypothetical construct to be used for the comparison of an institution.

The Typology

The typology developed for the comparison of women's enactment of their pregnancies consists of three Types: the Romanticist, the Conformist, and the Realist. Drawing from the data, the dimensions of the Types emerged. Nine dimensions which are formed from 26 items distinguished among the women on their attitudes towards their pregnancies. By scoring the women on the 26 items of the dimensions, it was possible to classify the women among the three different Types. Of the 43 women in the study, 16 were classified as

Romanticist, 14 as Conformist, and 13 as Realist.

The basic distinguishing characteristic among the three types is the definition that the women used for pregnancy and being pregnant:

1) The Romanticist defines being pregnant as a special and unique experience. She regards the pregnancy as a spiritual event and intensely enjoys being pregnant and revels in the attention that the pregnancy has brought;
2) The Conformist defines being pregnant as scripted. It is part of being female and the essence of being a woman. Being pregnant is assumed as a part of life and is neither questioned nor celebrated;
3) The Realist regards the pregnancy ambivalently, there are some special aspects and some ordinary. She sees the experience and the future as bringing some good and some bad changes. She does enjoy being pregnant but feels that the end, the baby, not the means, the pregnancy, is important.

Table III, which follows, lists the nine dimensions and the 26 items which form the types with illustrative responses of the women by Type.

TABLE III: Illustrative Responses of the Women by Type

	ROMANTICIST	CONFORMIST	REALIST
1. Attitude to Motherhood			
a. Motivation for motherhood	always wanted to be a mother, loves children, spiritual experience	it's time, baby(ies) = family	not sure, combination of reasons
b. Is motherhood important for women?	no, it is for me	yes, even if some say it's not	yes, but not for all women
c. Is there a maternal instinct?	no, a parenting instinct	yes	I don't know, I hope so
d. Definition of femininity	biological	social	androgynous
2. Pregnancy/Childbirth Information			
a. Amount	high, actively and enthusiastically sought	low, not sure if it's necessary since it's a natural process	medium, felt that should
b. Sources	experiential, listen to your body; books; females	experts; females	books
c. Search	specific, systematic	minimal	general
d. Type	inclusive	basic	haphazard

	ROMANTICIST	CONFORMIST	REALIST
3. Husband Involvement a. Pregnancy and birth	high-innovative; encouraged - with husband agreement	low-conventional; discouraged	medium-bridge; encouraged - without husband agreement
b. Baby	high-innovative; encouraged - with husband agreement	low-conventional discouraged	medium-bridge; encouraged - without husband agreement
4. Body Image a. Reaction to figure	enjoy	endure	indifferent
b. Maternity clothes	make-do, baggy clothes	early, obvious, new (preferably)	make-do, minimal
5. Pregnancy Impact	enthusiastic	intolerant	tolerant
6. Health Attitudes a. Attitude towards experts	sceptical	doctors and nurses know best	follows advice but questions
b. Reasons for adhering to medical norms	healthy baby	easiest for mother, e.g. to get one's figure back	should

	ROMANTICIST	CONFORMIST	REALIST
7. Childbirth Attitudes a. attitude to birth	spiritual experience, looking forward; innovative	uninformed, apprehensive, not looking forward; conventional	pragmatic, ends not means important; bridge
b. Birth plans	detailed	not considered	basic
c. Attitude to medical intervention	against	not considered, intervention defines	if doctor feels necessary
8. Baby Information a. Amount	high	low	medium
b. Sources	experiential, as parents we'll know	experts; females	books
c. Search	specific, systematic	minimal	general
d. Type	inclusive	basic	haphazard

	ROMANTICIST	CONFORMIST	REALIST
9. Future a. Image of future	rosy fantasy	not considered, assumed part of life	pragmatic
b. Discussion of future	detailed, emphasis on values	none	practical, emphasis on behaviour
c. Baby affect life	enthusiastic	tolerant	not sure
d. Anticipation of motherhood	enthusiastic, innovative	tolerant, conventional	not sure, pragmatic

Previous research has not used the subjective experiences of the women as an important variable in determining how women will react to their pregnancies, rather, mainly demographic variables have been used to distinguish among women on their attitudes to the pregnancies. Graham says that the traditional variables used (marital status, parity, social class, intentionality, etc.) have neglected the commonality of the pregnancy experience "...given the common physiological context in which reproduction takes place" (Graham, 1977b:83).

Table IV displays the results of Goodman and Kruskel Tau's calculated for cross-tabulated tables of Type by previously used variable. In no table did the Tau exceed .11.

TABLE IV: G-K Tau's for Type by Specified Variables

Type by:	Age	.09
	Education	.03
	Marital Status	.02
	Length of Relationship	.04
	Parity	.04
	Gravidity	.06
	Planning of Pregnancy	.10
	Desirability of Pregnancy	.07
	Length of Pregnancy	.09
	Location of Birth	.11
	Residence	.06
	Emotional Symptoms	.02
	Physical Symptoms	.03

The first nine variables cross-tabulated with type are the same as those presented in Table I. The categories for each variable are the same for both tables. The variable "Location of Birth" is categorized into home or hospital based upon the woman's stated intentions. "Residence" is a combination of whether the residence is owned or rented and whether it is a single family or multiple family dwelling. This variable is a rough indication of the family's social status. "Emotional Symptoms" is categorized into high, medium, and low based upon the woman's responses to the 12 items of the Medical History Questionnaire. "Physical Symptoms" is categorized into high, medium, and low based upon the woman's responses to questions on the incidence of different physical problems associated with pregnancy. These questions were contained within the interview schedule and originated from Oakley's schedules.

The cross-tabulation of "Desirability of Pregnancy" by Type is the only table in which the categories of the independent variable are such that zero cells in the table are a problem. Given the current availability and accessibility of contraception and abortion, unwanted pregnancies are not as common as previously. Only two of the 43 women in this group stated that they did not want their pregnancies. Of the remaining 41, 29 wanted their pregnancies now and 12 wanted them "sooner or later".

Given that no G-K Tau in the table exceeded .11, it would appear that the basic way in which a woman defines being pregnant is a more unifying variable than whether she's married or living with the father, whether she's university educated or not, whether this is her first or third child, or any of the other variables considered.

Composites

The following composites offer an amalgamated picture of the women which comprise each Type. Since they are drawn from the responses for each Type, they do not provide a description of an actual respondent. The picture given is taken from the data of many women for each Type. Each composite is, therefore, a summary of the women for each Type.

Romanticist

Charmaine and Bob have been married for two years. This is their first baby and while Charmaine states that the pregnancy was not planned, she is most emphatic that the baby is wanted. She says that it was an accidental pregnancy in that they were not using any form of contraception but were also not intending that she become pregnant. Charmaine felt intuitively that she was pregnant from the moment of conception.

The main defining characteristic of the Romanticist woman is their definition of being pregnant as being special and unique. Charmaine holds this view most definitely and frequently used the word "special" to describe her feelings about aspects of her pregnancy.

Charmaine stated often throughout the interview her great love for children. She felt that this desire to have children has been present for as long as she can remember. She views having children and being a mother as a spiritual experience. However, she doesn't feel that this is a universal attitude among women. Motherhood is extremely important to her but not necessarily for all women. She feels that due to the suppression of culture what is commonly called the maternal instinct is really a parenting instinct and that the male's desire to be a parent has been smothered by the artificial layers of the male role. When asked to define femininity, she replies in terms of a biological femininity. She's happy and contented with being female and smugly satisfied with being able to have a baby.

Although she states that she usually doesn't read very much, during the course of her pregnancy, she has become an omnivorous and insatiable collector and reader on pregnancy and childbirth. Charmaine believes that the primary source of information on pregnancy should be the pregnant woman's own body, that is the woman "should listen to her

body". By this she means that her feelings should guide her actions. In conjunction with this, she refers to many books to confirm her beliefs. To obtain these books, she has raided both public and friends' libraries, as well as seeking out books from stores. Her search has been systematic as she looks for specific titles on topics in which she is interested. These books ranged from standard treatments of pregnancy and childbirth to books devoted to a single aspect of pregnancy, e.g., a book on exercise for pregnant women. Her reading also included some of the more esoteric treatments of pregnancy such as the benefits of singing and talking to one's pregnant belly. Her information is inclusive with all aspects of the pregnancy and childbirth process being covered.

Charmaine and Bob are very closely involved with the pregnancy referring to it as "our" pregnancy and "when we became pregnant". Bob has altered his diet along with Charmaine. They are both drinking the quantities of milk recommended for pregnant women and both are conscious of their daily nutritional intake. Both the parents' focus has become the pregnancy and the baby. Bob does not regard himself as a helper in this event, but as an active partner.

Charmaine felt that questions which could be interpreted as meaning that Bob would not be involved with the pregnancy and the birth were slightly insulting. She stated that neither she nor Bob ever questioned the notion that he

would participate in the birth. Both have been attending the doctor and prenatal classes together and are highly resistent to any idea that his activity is unusual.

Charmaine has said that Bob is looking forward to being a father as much as she is anticipating motherhood and has been active in aspects of preparation for the baby. She feels that Bob will not avoid any part of baby care, even the more unpleasant duties.

Charmaine is thrilled with her pregnant shape and feels that some of the jokes against pregnant women's figures are based on envy. She has a collection of photographs taken by Bob both clothed and unclothed of her figure at different stages in the pregnancy. According to Charmaine, Bob finds her blossoming shape sensuous. Charmaine has made no attempt to hide her shape with maternity clothes. She is wearing loose dresses, from her normal wardrobe, which provide more comfort but do not disguise the pregnancy.

Charmaine is most enthusiastic about the impact of the pregnancy on her life. However, she is quite contradictory about this impact. Different from the other two women, she states that she has made no changes due to the pregnancy but when questioned in depth appears to have made the most changes. When this contradiction is pointed out to her, she argues that since she made these changes most willingly, they are not, therefore, interfering in her life.

Given that from her own statements it seems that she has become a professional pregnant woman for the duration of her pregnancy with all her attention and focus upon the pregnancy, she has definitely altered her life from before she became pregnant. However, she is still satisfied with this change.

Of the three women, Charmaine is the most sceptical of the advice of medical experts, preferring to follow her own advice. She visits her doctor with lists of questions and resists any information which is not congruent with her own ideas. She ritualistically abides by the medical norms with the objective being a healthy baby, on this she is insistent.

Charmaine is looking forward to the birth of the baby as being a spiritual experience. She sees the birth, with her husband's participation, as a means of drawing the three of them more closely together. Charmaine has expectations of the birth as being a somewhat holy experience and describes it in terms of drug "trips" of the sixties. Given the opportunity, she would like to incorporate some of the ideas that she has obtained from her books: dim lights, soft music, and a complete absence of medical technology. However, as a not entirely satisfactory alternative, she is hoping that the birthing room of the hospital will be available.

She has written detailed plans for the birth,

listing by name the drugs that are to be avoided. Her doctor has acquiesced with her plans but Charmaine feels that there was a noticeable lack of enthusiasm. The only concern that she has about the birth is that when the time comes her doctor will not follow her plans. Bob has decided that as well as providing emotional support for Charmaine during the birth, his duties will consist of deterring medical personnel from going against their wishes.

The main theme of the birth plans consists of their attitude against medical intervention. Using the correct terminology, their plans list their demands for the process of the birth. Charmaine and Bob are the most stridently against medical intervention and associate their ideas with being good parents. If complications or a loss of their control necessitate medical intervention, Charmaine will most keenly feel the disappointment and is likely to regard it as her failure to perform as a woman and to be a good mother.

While Charmaine has the highest amount of information about babies and their care, she did not obtain as much of this information from books as she did about pregnancy. Most of her ideas have been developed in consultation with Bob and her friends. She has sought books on specific topics such as breastfeeding but has avoided the more standard books on child care, such as Spock. She feels that as

parents she and Bob will intuitively know how to care for the baby. Again, her search for information was specific and inclusive.

Charmaine's image of the future with her baby is a rosy fantasy. Pictures, in soft focus, of herself nursing the baby in a rocking chair before a fire predominate. The more unpleasant parts of looking after a baby have been ignored. When questions about the possibility of sleepless nights with a colicky, crying infant are brought up, she states that this is due to poor mothering. She refuses to see any of this as being in her picture of the future.

Her discussions with Bob regarding the baby have been detailed with a great emphasis upon the values they wish to instill in their child. No attention has been paid to the actual mechanisms that they will use to accomplish this task.

Again a contradiction appears in Charmain's discussion of her feelings regarding the effect that the baby will have on her life. From her conversation she will be making great changes; she has no intention of returning to work until she has completed her family and all children are in school, she doesn't believe that good mothers would leave their children with babysitters ever, and intends to devote at least another ten years to full-time childraising. It would seem that from being a professional pregnant woman, Charmaine is going to become a professional mother with no

interests outside of her home and her children. However, she again says that she will be making no changes in her life when the baby arrives.

Charmaine's attitude to her pregnancy and baby can be encapsulated by her belief that her pregnancy is special and unique. Her romantic vision of the future in which there will be no problems that other women experience with their babies due to her good mothering extends from her experiences with her pregnancy. Rather than acknowledging that her lack of morning sickness was due to luck of body chemistry, she congratulates herself on caring for herself properly. Given that even the most perfect baby can have a bad day, it would appear that Charmaine is setting herself up for the possibility of failure and disappointment in the same context as her ideas about birth.

Conformist

Maria and Robert have been married now for five years. This is their second baby and was planned. There will be only one year difference between the ages of the two babies. When questioned as to why she had decided to have this baby, Maria was unable to immediately give an answer. She seemed taken aback at the question, as if the answer would be obvious. When questioned further, it would appear that she had decided upon this pregnancy for the same reasons

as the first. It was the time in their lives when it was appropriate to have babies. She did not want her first child to be an only child and was thus providing her with a brother or sister. Maria feels that she and Robert could not have a family without children being present but she had given the idea as to why she wanted either children or family no thought.

Maria was most emphatic that motherhood was important to women even to the point of insisting that women who state otherwise are mistaken and will eventually come around to her way of thinking. She feels sorry for women who remain childless as she worries that when they finally realize that all women really do want to be mothers it might be too late for them. She firmly states that there is a maternal instinct and illustrates this statement with her comment that mothers intuitively know what every cry their baby makes means. Maria defines femininity in terms of social and cultural ideas on women, whether one wears dresses and make-up, and not upon the physical fact of being a female.

Maria's information on pregnancy and childbirth is very limited when compared to the other two women. She has neither actively sought information like Charmaine nor does she feel that she should like Rachel. Rather, there is a feeling that, since this is a natural process that millions of women have accomplished, there is no necessity for

an abundance of material. Maria's main sources of information have been her doctor and female friends. She is the most likely of the three to sit with experienced mothers and listen to their stories on their pregnancies and births. The books that she has read are only the most basic ones which are provided in prenatal classes.

Robert is involved in Maria's pregnancy solely as an onlooker. He does not wish any further involvement and neither does Maria encourage this. There is very much a feeling that pregnancy is the business of women only.

There is also no intention that Robert will be involved with the care of the baby. Maria feels that since she will be staying home to look after their children, this will be her job and hers alone. She says that while he may occasionally help her with her duties, she will discourage any further participation.

Maria is very dissatisfied with the changes in her figure due to the pregnancy and feels that this is something which must be endured in order for her to have her baby. Robert is also displeased with the weight which she has gained and makes remarks which Maria regards as "cracks" about her fatness. Although she is hurt by these remarks, she says that she can understand why he would be making them as she feels that she is very unattractive at the moment. Maria wore very obvious maternity clothes quite early in her pregnancy as she wanted to make certain that people saw

her as pregnant rather than fat. Given her feelings of being unattractive, the clothes which she wore were new with no thought given to the fact that she might not be able to use them again. Her main goal was to attempt to look and feel attractive. Although she had maternity clothes from her previous pregnancy still available, she said she was only wearing them around the house as she no longer felt that they were pretty.

Maria is very intolerant of the impact that this pregnancy has made upon her life. With one baby already and another one on the way, she has felt very restricted in her activities. No longer feeling that she is an attractive woman has also made her intolerant of being pregnant.

Maria does not question any of the information that she receives from her doctor. Her limited reading on the subject of pregnancy has not provided her with a basis to question as she is unaware of some of the controversies which exist in the literature on the care of pregnant women. Her attitude is basically that her doctor knows what is best for her, when she hears, through friends, of differences in medical care, these opinions are immediately discounted. The medical norms which she follows, such as exercising and maintaining a good diet, are for her benefit as she intends to get her figure back as soon as possible.

Although this is her second baby, she is much more uninformed about the birth than the other two women. She

is unaware of the correct terminology for procedures which she underwent during the birth of her first child and is apprehensive about this birth. When asked if she is looking forward to the birth, she says she is only looking forward to it being over. Robert is very reluctantly going to attend the birth. He feels that since he was present at the first birth, there is no need for his presence a second time. His attitude being that since he had already seen a birth, why would he want to see another? There is no suggestion of him being a partner in the event or of providing Maria with emotional support during the birth.

Maria and Robert have not made any plans for the birth of their baby. Since Maria feels that the doctor will know what is best for her, the idea of presenting the doctor with plans was not considered.

While Maria uses the term natural childbirth when referring to this birth and the birth of her first baby, it seems to mean only that she will not be totally unconscious for the birth as several forms of medical intervention were used in the first birth with her agreement and seem to form part of her definition of the birthing process. The idea of medical intervention being unnecessary is foreign to her as it forms such an integral part of her definition.

Maria's information on baby care is again much lower than the other two women's even considering that she

is already giving care to a baby. She is unaware of the various theories available on the correct way to raise children and seems to use a "whatever works" method of child-rearing. When encountering a problem, she refers to either her doctor or to an older woman for advice. She makes no other search for information and what she has obtained is only the most minimal.

She has given no thought to what her life will be like with two small children and is unable to conjure up an image of that future. The assumption is that having children is just a part of life seems to stop her imagination from dwelling on this. Maria and Robert have not discussed their future with two children and have no intention to do so. The practical details of raising two children are solely Maria's responsibility and there is little reason for including Robert in such a discussion.

Maria realizes that two babies will greatly affect her life and she is tolerant of the changes which she will have to make, again assuming, that it's just part of life. Her anticipation of becoming a mother for the second time is very different from Charmaine. She sees it as neither a cause for joy nor for concern.

Maria sees her life with her pregnancies and her babies as conforming to some immutable standards which have guided her in her decisions but do not allow questioning. In fact, the idea of questioning will not occur.

Realist

Rachel and Mark have lived together for five years and have now been married for six months. Their decision to get married was partially based upon the pregnancy. However, Rachel said that the pregnancy only advanced the wedding as they intended to become married anyway. The pregnancy was very planned with Rachel taking her temperature daily to ensure the optimal time for conception. She and Mark had been concerned that conception might prove difficult since Rachel had been taking oral contraceptives for many years but their fears were groundless and she actually became pregnant before they had hoped she would.

The main defining characteristic of the Realist is the ambivalence towards the pregnancy and the baby. Although Rachel planned the pregnancy and definitely wants the baby, she has many doubts as to whether this is the course that she and Mark should be taking.

She is equally unsure as to why she decided to have a baby. She suggested that it is probably a combination of reasons and hopes that she hasn't made this decision for what she would consider to be an invalid reason. She said that she never felt that one of her goals in life was to have children but she was happy that she had made the choice even if she was still having misgivings.

While stating that motherhood was important for

her, she hesitated to ascribe this belief to all women. In reference to the question of whether a maternal instinct exists, she hesitated again. Finally, she says that she doesn't know but certainly hopes so because she's going to need it fairly soon. Her definition of femininity included neither the biological nor the social and she found the question slightly repugnant preferring to think of herself in human terms. She wanted to describe herself in terms of what she considered to be good attributes for humans, whether male or female, an androgynous definition.

Rachel did not have as much information about pregnancy and childbirth as Charmaine but felt vaguely that she should be more diligent in her search for material differing from Maria who did not consider there to be a need to search for material. Her main source of information was books and she was much less likely than Charmaine to seek information from friends. The idea of obtaining information from one's own body did not enter her mind. Her search for books was very general with no system for covering all aspects of the pregnancy and the birth. Her information was thus quite haphazard with some topics covered in more than one book and other completely missed.

Mark's involvement with the birth is halfway between the total enthusiasm and partnership of Charmaine and Bob and the more conventional arrangement of Maria and Robert.

He made an effort to read some of the books that Rachel provided but preferred to have condensed summaries told to him by her. He did not seek out any material himself.

Rachel feels that Mark should be more involved with the pregnancy and encourages him to do so but without his agreement. He has agreed to be present at the birth but is somewhat reluctant to be there. He feels that he will be more a spectator than a participant in the event.

Similarly, Rachel does not feel that he will participate in the baby care as much as she would like. While she does feel that he will undertake all of the duties of child care, even the unpleasant ones, she feels that he will do so more as a help to her than a primary caregiver to the child.

Rachel is indifferent to the changes that the pregnancy has wrought in her figure. She does not regard it as something with which one should be proud but neither does it upset her. On the whole, her new shape is just a change which arrives with the pregnancy and will leave with it also. Her maternity clothes are mainly baggy clothes from her own wardrobe with a few additions to fill in some gaps. The clothing which she has chosen neither hides nor emphasizes her figure but seems mainly a means by which to be comfortably covered.

She is tolerant of the changes which have occurred

in her life due to her pregnancy and sees them almost as indifferently as the changes in her figure. She has made fewer changes than Charmaine and has not refocussed her life upon the pregnancy.

Rachel follows the advice of her doctor but does not accept it unquestioningly. She arrives at her doctor's office with a list of questions based upon her reading but is satisfied with the answers that she receives. She adheres to the medical norms but does not do so with the insistence upon a healthy baby which is Charmaine's goal. She has a vague idea that one should do so but is unable to state exactly why.

Rachel is very pragmatic about the birth of the baby and sees the end result not the means as being most important. She is not viewing the birth as an experience which she is excitedly looking forward to but more as something which must be done in order for her to obtain her baby. Given the option of magically obtaining her baby without the pregnancy and the birth, she said she would definitely take the baby without all of the rest.

Mark plans to be at the birth but is not as interested as Rachel would like him to be. They have made some plans for the birth but not nearly as detailed as Charmaine and Bob. Their plans include Mark's attendance, a hope that the birthing room would be available and a desire to have a natural birth. It is not the same list of demands to be

complied with by the medical personnel that Charmaine and Bob have developed. Rachel hopes that medical intervention will not be necessary but has accepted the idea that if the doctor feels that such intervention is called for she and Mark will be in agreement. She has not defined a completely natural birth with the idea of being a good mother and will not feel the same degree of failure and disappointment as Charmaine should intervention occur.

Again, her knowledge of baby care is more limited than Charmaine's and she is again relying more upon books as her source of information. She does not feel that she will have an intuitive grasp of what her baby will require of her, thus, her statement that she hopes that a maternal instinct will exist and will make its appearance when she needs it. She has not made a specific search for material on child care but has picked up books on a haphazard collection of topics. She has made no reliance on the advice of other females.

Rachel's image of the future is very pragmatic and somewhat ambivalent. She does not see the soft focus picture of the future that appears for Charmaine but rather sees a series of vignettes in which sometimes the baby is the sweet, well-behaved child but will often keep her awake for half the night crying. She is worried about her ability to deal with the nights of sleeplessness and the noise of

the crying which she regards as an inevitable consequence of having a baby. She is hoping that these incidences will be outweighed by the pleasure of having a baby.

Rachel and Mark have had detailed discussions of the methods they wish to use to raise their child. They have not discussed values at all but have decided upon disciplinary methods they will use to obtain the types of behaviours they desire.

Rachel is very unsure as to how she will feel about the impact that the baby will have upon their lives. Since she has decided not to return to the labour force at least for a year after the baby is born, she has wondered if this absence will make her feel resentful of the child. She is concerned that she will feel isolated at home and will miss the companionship of her colleagues on the job. At present, she is not friendly with any other women who stay at home and is wondering where she will make such friends. She is equally concerned as to how Mark will react to the restrictions placed upon their lives by the baby. Without her income, their entertainment budget will be limited and, with the baby, their mobility will be restricted. While she says that this will not be a problem, she worries as to how he will feel when it actually happens.

Rachel's feelings towards her pregnancy and her baby are best characterized by ambivalence. She had planned

for and definitely wants this baby but is unsure as to how well she will be able to cope with all of the aspects of baby care. She would like Mark to be more involved with the pregnancy and, in the future, the baby and will encourage him to do so but does not feel that this is likely to occur.

Conclusion

The three Types developed here distinguish among women on the basis of their definitions of being pregnant with the Romanticist defining being pregnant as special, the Conformist as scripted, and the Realist as ambivalent.

The Romanticist and the Conformist can be seen as opposites. The Romanticist views her pregnancy as being unique and special with magical qualities. She and her husband talk to the unborn baby, an action which the Conformist would not think of doing and, if suggested, would regard as ridiculous. The Romanticist defines the birth as a shared, natural experience a quality with which she has also endowed the pregnancy. She is vehemently opposed to medical intervention in the birth while the Conformist's very definition of the birth includes not only the probability of intervention but the necessity. Opposed to the Romanticist viewpoint, the Conformist sees herself and her pregnancy as ordinary and mundane. Her husband will also attend the birth but as a reluctant spectator not an active partner.

The Realist shares attributes with both these women. She says that she is enjoying her pregnancy, not to the same extent as the Romanticist, but is the only one who would like to have the baby without the pregnancy. The Conformist finds the pregnancy distasteful and intolerable but would not have the baby without the pregnancy.

The contradictions mentioned at the conclusion of the previous chapter present a problem mainly for the Romanticist. The Realist views the entire process of pregnancy, birth, and motherhood as inherently contradictory. Still, with this view, she has not made arrangements to deal with these contradictions but is aware of their existence. The Conformist's straight forward assumptions regarding her pregnancy and baby do not allow her to consider the possible contradictions. However, they are unlikely to be problematic for her. It would appear that she is merely paying lip service to the idea of sharing the pregnancy, birth, and child care. She does not expect that her husband will be involved with the care so discussions are definitely superfluous.

The Romanticist has made the strongest committment to the notion of a shared pregnancy, birth, and child care arrangements. For a man, sharing a pregnancy and participating in a birth require little output of energy or time. The lack of discussion of the mechanisms for sharing the responsibilities would seem to auger a less than enthusiastic committment to the idea.

CHAPTER SEVEN

CONCLUSION AND IMPLICATIONS

Social pregnancy and physiological pregnancy are separate conditions, which usually, through the correct interpretation of signs and symptoms, occur together. Pregnant women learn the role of pregnancy with its attendant norms as their identities evolve from that of being only physiologically pregnant to also socially pregnant. The initial symptoms of pregnancy were seen as being signs of pregnancy rather than an alternate explanation. Through socialization, the women knew that medical confirmation was necessary for validation of their roles. After validation, the women move towards feeling "really" pregnant; "showing" and foetal movement are indications of being "really" pregnant. After this occurs, the women are more comfortable in the public engagement and display of the norms of the role. Thus, their identities as pregnant women were socially constructed through the meaningful symbols of their society.

Role was defined as "a cluster of social norms" and norms as "standards of conduct which should or should not be followed". From the consensus of the respondents, a collection of norms which define the social role of pregnancy was identified. This collection was divided into five

categories: medical, prenatal, birthing, postnatal, and positive/negative response norms. The medical and prenatal norms were those standards of behaviour which the women were aware of or engaged in during their pregnancies. The birthing and postnatal norms were intentions and preparations for the future. The positive/negative response norms involved the reactions of others to the pregnancy. The positive were explicitly and specifically directed to the pregnancy by others while the negative involved assumptions of the motivations of others by the women.

While all of the norms were adhered to or mentioned by at least eighty percent of the women, differences among the women in their attitudes to their pregnancies were apparent. The typology developed for the comparisons of women's enactment of the pregnancy role consisted of three Types: the Romanticist, the Conformist, and the Realist. The basic distinguishing characteristic among the three Types is that of the definition of being pregnant: the Romanticist defined being pregnant as special; the Conformist defined being pregnant as scripted; and the Realist defined being pregnant ambivalently, with some special and some ordinary aspects.

Variables which have been used in previous research on pregnancy were cross-tabulated with Type. In no cross-tabulation did a Goodman and Kruskel Tau exceed .11. It

would thus appear that the way in which a woman defines being pregnant is a more unifying variable than the more traditional demographics.

Limitations of the Research

This research contains limitations in both the areas of the design and the methodology. If this research were to be pursued, changes should be made in both these areas.

Two technical changes would be made in the research methodology. First, a much better quality tape recorder would be used; one which would not be subject to as much malfunctioning as occurred and one which had better volume recording control. Seven tapes were discarded due to the malfunctioning of the recorder and many tapes were difficult to hear due to the women moving about as they spoke. A small recorder carried as a back-up, in case of mechanical failure of the main recorder, would also avoid problems.

Second, the method of data processing would be changed. Rather than partial transcriptions of the tapes, following Miller's (1973) example, also based on semi-structured interviews, complete transcriptions would be typed on Ditto Masters. Ten copies of each page would then be reproduced. File folders with topic labels would be used to contain the pages. When a respondent mentioned a particular

topic, it would be circled in red and placed in the appropriate file folder, e.g., all comments on the planning of the pregnancy would be contained in one file folder. This would greatly facilitate the analysis as women would frequently juxtapose widely variant topics in conversation. Each topic could then be viewed easily.

While the following problem was solved during the course of the interviewing, it deserves note here. This is a problem of interviewing technique. It was brought to light emphatically during the interview with the most highly-educated respondent in the group. It became apparent that assumptions had been made about this respondent based upon her profession and that these assumptions were false. Fortunately, this interview occurred early in the data collection and, with awareness of the necessity to avoid having stereotypical ideas about the respondents, efforts were made to ask the questions in the most objective manner possible.

Three changes would be made in the design of the research. First, the women would be interviewed at two stages in their pregnancies; at the end of the first trimester and during the last month of the pregnancy. The data received from the women on their observations and thoughts in retrospective may not be as accurate as desired. Subsequent events may colour attitudes or, as some of the women indicated, the respondents may forget exactly what had occurred five to six months previously.

Second, a larger group of women would be interviewed. The developed typology which seems valid for the group interviewed should be tested against a larger group of women which includes more variation in some of the more traditional variables. It could thus be checked to determine if the typology holds for women of different racial backgrounds, ethnicity, religious beliefs, and socio-economic statuses. As well, all of the women in this group were in stable relationships with the fathers of their babies. Women who are going to be single parents may or may not regard their pregnancies in the same way as the women in this group. The group was also low on pregnant women in the younger age groups.

Third, the design should be altered to include short interviews with the fathers, separate from the mothers, at the same stage in the pregnancies. It is a very strong norm for the women in this group that the fathers participate and share in the pregnancy. It is suspected that some women, reluctant to admit to their husbands' disinterest in the pregnancies, exaggerated the males' interest in the "event".

In addition, while we have the opinions of the husbands as reported by their wives, there is no means other than interviewing the husbands to check on the veracity of these reports. The women would also have been reluctant to

report on disagreements with their husbands over their views on the reproductive process.

Pregnancy and childbirth were ignored in previous work in the social sciences due to the presence of an androcentric bias. However, present pregnancy and childbirth research, by ignoring men, displays a gynocentric bias which, in the interest of valid and reliable data, should be removed.

However, all of these suggestions - interviewing twice during the pregnancies, interviewing more women, interviewing the fathers, using a better quality tape recorder, and having complete transcriptions of the data - would have greatly increased the cost of the research. While I am extremely grateful to the Sara Spencer Awards Committee for providing me with the funds to complete this research, the above additions would have made the research prohibitively expensive.

Implications for Further Research

Although this study has indicated the means by which the women acquired the pregnancy role, the norms of that role, and a typology for adherence to the social role of pregnancy for a group of pregnant women from the Greater Victoria area, it has not closed debate on an area of research. Rather, the implications of this study have revealed numerous unanswered questions which require further investigation.

Medical Management's Perception of the Role

An implication of this research extends from the fact that certain groups of people interact extensively with pregnant women. Medical management personnel are frequently involved with and are influential to pregnant women. From prenatal checks, hospital visits, and prenatal classes to the birth and postnatal checks by both physicians and public health nurses, these individuals have considerable interaction with the women before, during, and after the birth. Whilst maintaining such contacts, the women still reacted emphatically against the medicalization of pregnancy, birth, and early motherhood. The degree of congruence between the opinions held by medical management personnel and those held by the women would have an effect upon the satisfaction that women experience with their care during the antenatal process. If such opinions are widely divergent, the quality and quantity of the care will matter little in the evaluation of the care by pregnant women. Rather, the degree to which medical personnel acquiesce to women's demands and the extent of shared beliefs on the reproductive process will determine the pregnant women's judgement of their caregivers.

The Sexual vs. Nurturant Functions of Breasts

All of the 43 women except for two stated that

they intended to breastfeed their babies. Many of these same women were exercising and watching their diets with the belief that this would enable them to return to their pre-pregnancy figures rapidly after the birth. Simultaneously, some of the women mentioned that neither themselves nor their husbands were attracted to their pregnant figures. However, none of the women reported that either themselves or their husbands felt a conflict between the nurturant function of breasts for nursing their babies and the solely sexual image of breasts as presented in the popular media.

This conflict can be divided into two aspects: that of the effect which breastfeeding has on breasts and that of the contrast between breasts for nurturing and for sexuality.

The solely sexual image of breasts as presented in the popular media portrays the breasts of young non-mothers. Breastfeeding will affect the elasticity of the skin and cause stretch marks, neither of which are part of the ideal image of breasts as pictured in pseudo-erotic magazines. Although anxious to return to their pre-pregnant shapes, the women did not mention the discrepancy between this desire and their intentions to breastfeed. While the primiparous women would possibly be unaware of the effect of nursing upon breasts, the multiparous women, some of whom breastfed their previous babies, would surely be aware of this.

It is interesting that an increase in breastfeeding is occurring simultaneously with the exploitation of women's sexuality for advertising, "jiggle" TV shows, and men's magazines. As more women breastfeed their babies, the likelihood of maintaining the images of the media will decrease, a potential source of problems.

The second aspect of the conflict between the sexual and nurturant functions of breasts is with the sexual relationships of couples. Inundated with images of breasts as having a solely sexual function may cause fathers to feel a repugnance for the figures of women who are breastfeeding their babies and cause the mothers to feel that as mothers, they are not sexual beings. This could cause a considerable disharmony in the relationship and be a source of dissatisfaction.

The reasons for the women not mentioning the distinction between breasts for nurturing a baby and breasts for sexuality can only be speculated upon. However, three possibilities are available. First, the primiparous women may be unaware of the effect of breastfeeding upon their breasts and would, therefore, not have considered the impact that this may have on their marital relationships. That the multiparous women would be aware of this and still not mention it could be explained by the fact that they have already dealt with this problem with their previous babies

and no longer consider it an issue. Second, the women may have hesitated through embarrassment to mention it. Given the type of information that was received during the interviews, this seems unlikely. However, sexuality is not a topic without some vestige of taboo. Third, for this particular group of women, the idea of a dichotomy existing between the functions of breasts would seem false. Since some of the women mentioned their husbands' lack of interest in their pregnant bodies and their husbands' emphasis upon slim non-mother female figures as being an ideal and their hope that their wives would return to this shape soon, it seems unlikely that this third reason would hold for all of the women in the group. It would appear likely that a combination of the above three reasons could provide an explanation for the women not discussing this dichotomy.

The Stability and Usefulness of the Typology

Since the women in this group were interviewed at only one stage in the reproductive process, it was not possible to ascertain if the typology is stable over time. However, it is possible to speculate that perhaps women would change Types, especially when reality impinges upon their visions of the future.

Since the Realists incorporate within their definition the possibility of some bad occurring with the good,

child care, with its benefits and disadvantages, will not hold surprises. It had already been foreseen that this will occur and when such ambivalent events are reality, the Realist will be prepared.

However, the Conformist defines pregnancy as scripted; she has married, decided upon a child, become pregnant, and will become a mother because it is "in the script". A Conformist will be seriously distressed when events occur which are not in the script, for example, a handicapped child. At this point, she will be forced to think of problems and plans for which no solution had been provided for in the script. It is possible that at this time, the Conformist could become a Realist with the realization that some good and some bad events have occurred. Another possibility could be the construction of an alternate script to be followed under the new circumstances.

The Romanticist sees the entire antenatal process as a rosy fantasy. Since not all children are bright, beautiful, and good-natured, and neither are all relationships loving, sharing, and equal; it is possible that reality will seriously distort the view that the Romanticist sees of the future. Two solutions are possible for this problem: first, the Romanticist could become a Realist and incorporate the ambivalent aspects of childrearing into the definition or, second, the image could be revisualized, with the supporting evidence being emphasized and contradictory events

being suppressed.

The potential usefulness of the typology would be based upon its predictive power in practical applications. The present study looked at normal pregnancies, those pregnancies which could be considered abnormal were not included. However, similar research on pregnancies of adolescents and those women destined to be single mothers could prove to be interesting. Since the Romanticists seemed to hold a view of pregnancy and babies which was based on fantasy, the Type to which a single mother adhered would seem to have an effect upon the decision to terminate a pregnancy, keep the baby, or place the baby for adoption. The usefulness of the typology could be seen in such circumstances if a correlation existed between such decisions and Types.

The Discrepancy Between Aspirations and Reality

An anomaly existed with the defining of some of the norms. The majority of the norms would be considered to be ranking norms, means to evaluate differentially individuals on the basis of attaining certain standards. The women would not just define a norm in terms of "pregnant women should..." or "mothers-to-be should..." but as "good pregnant women should..." or "good mothers should..." with a strong judgement of the individual taking the action. Their definitions of themselves were thus interwoven with

their ability to enact the norms. For the Realists, who are the most pragmatic, and for the Conformists, who for some of the norms defined pregnancy and childbirth in terms of medical expertise and medical intervention, this would appear not to be a problem. However, for the Romanticists with their visionary view of pregnancy, birth, and mothering, the discrepancy between their aspired ideals for their own behaviour with a judgement of themselves based upon enactment of that behaviour and the reality of behaviour governed by circumstances out of their control would seem to predict future problems.

This discrepancy between the ideal contained in the norms of the role and the reality of a situation out of the control of the women is particularly evident and potentially problematic in two areas: the birth and wife/husband sharing. Stemming from this discrepancy and a consequence of unmet standards is a third area, that of the possibility of societal sanctions against deviant behaviour.

The Birth:

In regard to the labour and delivery, the women's intentions included using psychoprophylaxsis instead of analgesics and anaesthetics, planning the birth to exclude medical intervention, and having the father in attendance. Although differring on the definition, the women were intending to have "natural" births.

However, the reality of the situation is that analgesics and anaesthetics are encouraged; Caesarean births, monitoring techniques, and episiotomies do occur; and, in some situations, e.g., emergency Caesareans, fathers are excluded. It is not relevant that these occurrences may be stipulated by the necessity to avoid harm to either the mother or to the baby and, therefore, could not be caused or avoided by the mother's actions. To women who are setting standards based upon what good mothers do or do not do, the very fact that these events have occurred indicates neglect.

An example of this took place during the pregnancies concerned the aetiology of morning sickness, many of the women felt that morning sickness was directly attributable to neglect on the woman's part, which is rarely the case. However, the women stated that incorrect diets, lack of exercise, and lack of will-power and self-discipline would lead to morning sickness. These types of statements were made by both the women who had experienced morning sickness and those who had not; those who suffered with morning sickness felt at fault and those without such symptoms felt it was to their credit. Following this reasoning, the explanation for the medical intervention during the delivery would not eradicate the fact that it may occur when intentions were that the birth should be "natural".

Concurrent with the rise in prenatal classes and the subsequent increase in the awareness of "natural" births

as an objective has come an expansion in the degree of medical intervention in births (communication from the Research Division, Hospital Programs, British Columbia Ministry of Health). These conflicting trends will lead to an increase in the number of women that experience a discrepancy between their ideals and reality. Oakley states that "...the holding and unlearning of unrealistic expectations is especially inimical to self-esteem, and is potentially an influence on the chances of maladaption and depression following birth" (Oakley, 1980:281). It would thus follow that an increase in postnatal depression would be more likely for women who hold the least realistic picture of the perinatal process.

Wife/Husband Sharing:

The women professed to a strongly-held belief that the fathers of their babies should share in the pregnancy, birth, and child care. As the fathers themselves were not interviewed, only reported attitudes and behaviours from the women were available; the degree of congruency between the father and the mother remains to be investigated. Discordant opinions would indubitably lead to stress on the relationship with the possibility of marital dissatisfaction and marital disharmony.

All of the Romanticists reported that their husbands agreed with their concept of shared pregnancy,

birth, and child care. Women who were Realists indicated that they wished that their husbands were more involved with the pregnancy and hoped that they would be more active in the birth and child care than present behaviour would predict. The Conformists seemed satisfied with their husbands' present involvement and future intentions.

However, one point becomes obvious from this discussion, regardless of the amount of husband involvement or the wife's satisfaction with that involvement. For a male to share in a pregnancy and to attend a birth requires little committment of time or energy; the long term committment to shared child care duties requires a considerably larger expenditure of both time and effort. This could possibly be the point where a divergence in the opinions of the husbands and wives on the importance of sharing appears.

Societal Sanctions:

The discrepancy between the advocation of the norms and the enactment of those norms means that the women were, in many areas, falling short of their stated standards. One can assume that, for this particular group of women and the people with whom they interact, these standards are desirable behaviour. The lack of adherence to such standards would usually be considered to be a form of deviance. The significance and importance of performing the norms would

vary positively with the type and degree of sanctions against deviant behaviour, that is, those norms which a group regards as the most important will have the heaviest sanctions for their non-performance. If the standards which were outlined in the present research are widely held and if variations from these standards are seen as being deviant, it would be expected that sanctions against this deviance will exist in the community with the severity of the sanctions dependent upon the importance placed upon the standards.

The Values Behind the Role

The social role of pregnancy consists of five categories of norms. While some of these norms can be seen to originate from advances in medical research, e.g., the ease with which substances can pass through the placenta and possibly harm the foetus and the benefits gained by the mother through exercise, the origin of others is not so clear and could possibly be based in the value system of the women of this group.

All of the pregnancies in this group except two were reported to be wanted. Not all of these were specifically planned but the women did state that they were wanted sooner or later, if not right at the present. The desirability of the pregnancy was, therefore, more a matter of timing rather than an unwanted pregnancy. The normative requirements

of being pregnant, as determined by these women, directed that the women change, in some cases drastically, their normal lives and routines. To willingly undergo such changes, the motivations to do so must be more magnetic than the desire to remain static. For these women, it could be speculated that their motivations were based upon a value of wanted pregnancies, whether now or sooner or later. Technological advances in reliable contraception and the availability of abortion have allowed women to hold the value of pregnancies being wanted.

It would appear that it is a normative requirement of being pregnant for a woman to attend prenatal classes and to be well-informed about pregnancy, childbirth, and childrearing. This could be seen as an off-shoot of a general concern with medical consumerism which has increased in recent years. This need for information is related to an objective for "natural" births. Reacting against the medicalization of the perinatal process but occurring simultaneously with an increase of this same medicalization, all of the women in this group intended for their childbearing to be "natural". Although all striving for the same goal, the women held different definitions of a "natural" birth, ranging from the intention to have the baby at home with the assistance of a midwife with family, friends, and younger children in attendance and no medical intervention to a

standard hospital birth with only the father attending and medical intervention "if necessary". All of the women placed great importance upon the value of having a "natural" birth.

All of the women emphasized the value of sharing the experience of pregnancy, birth, and child care. Again, the women differed on the degree which they expected their husbands to share with them in these experiences but did not differ in the value placed upon sharing with the husband cast as either a passive spectator or an active or reluctant participant. A new trend indicative of this value is the husbands' attendance at deliveries where they are not only expected to be present but their presence is regarded as a duty and an obligation by the women.

These three values, that a pregnancy be voluntary and wanted, that births be "natural", and that the couple share the experiences of the reproductive process, were serendipitous findings of the research in that the values behind the social role of pregnancy were not actively or directly sought but emerged from the data. The universality of such values remains to be explored.

Through the explication of the norms associated with pregnancy, the social role of pregnancy was defined for a group of 43 Greater Victoria women. The movement from being only physiologically pregnant to feeling and acting

socially pregnant was obtained through the social construction of reality. The women interpreted the physical signs and symptoms of pregnancy as being pregnancy and not a competing alternative. Upon the realization of the pregnancies, the women comfortably assumed the role of "pregnant woman" and either enacted, or were aware of, the norms of that role. Although there were no differences among the women regarding their knowledge of the normative requirements of the pregnancy role, differences appeared in the reasons which the women gave for adhering to the norms which reflected basic differences in their attitudes towards pregnancy and being pregnant. A typology was developed which encompassed these differential attitudes which consisted of three Types: the Romanticist, the Conformist, and the Realist.

The implications which arose from this study opened rather than closed debate on the topic. The two most major of these were the discrepancy between the women's idealized aspirations and reality and the values behind the role of pregnancy. The discrepancy between aspirations and reality has the most serious possible repercussions as it would appear that this gap is likely to increase rather than decrease unless major changes are made in the established system of maternity care which, as presently designed, fosters such a discrepancy. Of the three values of the role, the concept of voluntary, wanted pregnancies is the least problematic as it is the most amenable to the control of the

women concerned. The values of a shared experience and "natural" births may be important and highly salient to the women but are governed by forces outside of their control.

FOOTNOTES

1. The two incomplete interviews resulted from the women's misunderstanding of the length of time required for the interviews. Both had made additional appointments on the same day as the interview which necessitated their early departure. In neither case was it possible to reschedule the interview before the birth of the baby.

2. Stedman's Medical Dictionary, 22nd edition, Baltimore: Williams and Wilkins, 1973.

   Parity: The state of a woman as regards the fact of having borne children.

3. Ibid.
   Gravidity: Number of pregnancies.

4. The attempt to interview woman as close as possible to their expected due dates resulted in missing twelve women who delivered early.

5. One woman was accepted for inclusion in the study although she was not in her last trimester. As a Lamaze instructor, she learned of the study and very enthusiastically and persistently volunteered for the interview. Although her expected due date was not for four months, her responses did not differ radically from the other women's.

6. The most frequent question being if the researcher had any children of her own.

APPENDIX A

Interview Schedule

1. Age?
2. Education?
3. Marital status?
4. Length of relationship?
5. Residence?
6. Is this your first baby?
   - If no, how many children do you already have?
7. How many children are you going to have?
   - Why?
8. Have you had any other pregnancies before that ended in a miscarriage or ectopic pregnancy or an abortion?
   - If yes, how many?
     when?
     what did you feel about it?
9. What first made you think you might be pregnant this time?
10. Some women say they know the day when they conceived. Do you have any idea when that was?
    - If yes, how do you know it was then?
11. Did you want this pregnancy?
    - If wanted pregnancy, - had you been trying to get pregnant for some time?
      If yes, how long?

11. Did you want this pregnancy? (Continued)

- If unwanted pregnancy, - did you consider having an abortion?
  - If yes, - did you discuss this with the doctor?
  - what did he/she say?
  - why did you decide against having an abortion?
  - what do you feel about that decision now?

12. What about your husband? Did he want it?
    - How did he feel when he first knew you were pregnant?
    - Was he told first?
    - Did he already suspect?

13. Has being pregnant affected your relationship with your husband, do you think?
    - If no, do you think it will in the next few months?
      - If yes, how?
    - If yes, how - in what ways?

14. Do you and your husband talk about the pregnancy or the baby much?
    - If yes, - does he enjoy talking about it, do you think?
      - do you enjoy talking about it?

15. What sorts of changes have you and your husband made in your lives because of this pregnancy?
    - How do you feel about these changes?
    - How does he?

16. When did you first go to the doctor about your pregnancy?
    - Was that your regular doctor?
    - Why did you decide to go?

17. Did you have a pregnancy test done before that?
    - If yes, when?
      where?
      what was the result?
      what did you feel about that?

18. Did the doctor give you a due date?
    - If no, did you expect one?
    - If yes, what date was given?
      had you worked out a date? How?
    - If not same date, did the difference worry you?
      did you discuss it with your doctor?
    - Do you know how the doctor worked out the date?
    - Did the doctor ask you if you knew the date of conception?

19. Did the doctor give you any general advice about pregnancy?
    - If no, did you expect him/her to?
    - If yes, what did he/she say?
      what did you feel about that?
    - Did he/she tell you what you should or should not do while pregnant?
      - How do you feel about that?

20. Were you given any advice about: diet?
    exercise?
    smoking?
    drinking?
    medication?
    vitamins?
    - Has anyone else given you advice about these?
    - Have you heard about or read about these?
    - Have you modified your habits in regard to these?

21. Did you ask the doctor any questions about anything related to the pregnancy or birth?
    - If no, - did you want to, even though you didn't?
      - why didn't you?
      - what did you want to ask?

21. Did you ask the doctor any questions about anything related to the pregnancy or birth? (Continued)

    - If yes, - what did you ask?
      - what did he/she say?
      - what did you feel about that?

22. How much do you think you knew about pregnancy before you became pregnant?

    - Where did you get your information?

23. When did you first feel "I'm pregnant"?

    - What made you feel that way?

24. When you found out that you were definitely pregnant, how did you feel about it?

25. Was there anything in particular that you thought about?

26. Did you have any particular fears or worries when you first knew you were pregnant?

    - If yes, - what were/are they?
      - have you talked to anyone about that?

        If yes, - who?
        what did they say?
        what did you feel about that?

27. Was there anything in particular you felt you'd like to know more about?

    - Did you talk to anyone about that?

      If yes, - who?
      what did they say?
      what did you feel about that?

28. Apart from your husband, who were the first people you told about your pregnancy?

    For each person mentioned by respondent, ask:

    - (i) - What did he/she say?
      What did you feel about that?
    - (ii) - Did he/she give you any particular advice about pregnancy or childbirth or looking after the baby?

      If yes, - what did he/she say?
      what did you feel about that?

29. Do you have any close friends who are pregnant at the moment or who have recently had babies?

    - If yes, - do you discuss pregnancy or the baby with her/them?
    - is there anything in particular that you talk about?
    - has she/have they given you any particular advice?

      If yes, - what was it?
      what do you feel about that?

30. If you had any particular problem to do with your pregnancy - something you wanted to ask someone about - who would you discuss it with first?

31. How much do you think you know about labour?

32. Do you feel you know exactly what to do when you go into labour/how to tell when you're in labour?

33. How much do you know about what childbirth is like?

    - If little, were you concerned?
    - If a lot, where did you gain this information?

34. Have you ever seen anyone having a baby? (Seen a film of anyone having a baby on television?)

    - If no, - would you like to?

      If no, why not?
      If yes, is there any particular reason why you'd like to?

    - If yes, - what did you feel about it?
    - how much of the birth did you see?
    - had you expected it to be like that?

      If no, what did you expect?

35. Have you read any books/magazines/pamphlets about childbirth?

    - If no, - do you intend to?
    - If yes, - what did you read? (exact titles)
    - why did you read that? (did someone suggest it to you?)
    - did you find it helpful?
    - was there anything you didn't understand in it?

36. Do you and your husband talk about what the actual birth will be like?
    - Does your husband intend to be at the baby's birth?
    - Why?

37. Has your mother ever talked to you about what pregnancy and childbirth are like?
    - If no, - do you wish she had?
    - If yes, - what did she say?
      - what did you feel about that?

38. Have you ever talked to anyone (else) about what having a baby is like?
    - If no, - would you like to?
    - If yes, - who was that?
      - what did she say?
      - what did you feel about that?

39. Has your doctor talked to you about the birth?
    - What sorts of things has he/she said?
    - How did you feel about that?

40. How do you feel about the actual birth?
    - Why is that?

41. What are you looking forward to about it - is there anything you're looking forward to about it?

42. What are you not looking forward to about it - is there anything you're not looking forward to about it?

43. Do you have any particular worries or anxieties?
    - Most people are afraid of something when they think of childbirth - what are you most afraid of?
      - damage to self?
      - pain?
      - loss of control/dignity?
      - damage to baby?
      - possible deformity of baby?

44. Are you planning a "natural" birth?
    - Why?
    - Have you talked to anyone about this? (friends, husband, doctor, relatives)
    - What were their reactions?

45. Have you considered the possibility of medical intervention in the birth?
    - How would you feel about that?
    - How would you feel if you required a C-section?

46. At the time when you first found out about the pregnancy, how much did you feel you knew about looking after a baby?
    - If knew <u>little/nothing</u>, were you at all concerned about that?
    - If knew <u>a lot/fair amount</u>, where had you learnt it from do you think?

47. Have you ever looked after babies/children at all?
    - If <u>yes</u> - what did you do?
      - what did you feel about this?

48. Have you ever held a newborn baby?
    - What was it like?
    - How did you feel?

49. How confident do you feel that you know how to look after a baby?

50. Have you read any books/magazines/pamphlets about looking after babies?
    - If <u>no</u>, - do you intend to?
    - If <u>yes</u>, - what have you read? (exact titles)
      - why did you read that (did someone suggest that to you?)
      - did you find it helpful?

51. Have you talked to anyone about what looking after a baby is like?
    - If yes, - who?
      - what sorts of things did he/she say?
      - what did you feel about that?

52. If there anything to do with looking after a baby that you're particularly worried about? or think about most?
    - If yes, what is that?

53. Is there any special aspect of looking after a baby that you're particularly looking forward to?
    - If yes, what is it?

54. Have you ever seen anyone breastfeeding a baby?
    - If yes, - who was that?
      - what did you feel about that?

55. Are you going to breastfeed your baby?
    - Why?
    - Where did you learn that?
    - Has your husband/friends/relatives/doctor/prenatal class mentioned that?

56. How are you feeling now physically?
    - Any problems?

57. Do you feel sick at all?
    - If no, - did you feel sick earlier in pregnancy?
    - If yes, - are you actually being sick?
      - are you taking any medication for that?
        If yes, - what are they?
        - who gave them to you?
        If no, - did you mention the sickness to your doctor?
    - Did you expect to feel sick in pregnancy?

58. Do you feel more tired than usual at the moment?
    - If yes, did you expect that?

59. Do you find that you have to urinate more often than usual at the moment?
    - If yes, did you expect that?

60. Have you got any particular physical problems at the moment?

Headaches
Backaches
Any other aches and pains
Swollen ankles/fingers
Vaginal bleeding
Vaginal discharge/infection
Problems with sex
Insomnia
Trouble with urination/kidneys
Varicose veins
Haemorrhoids
Constipation
Indigestion
High blood pressure
Toxaemia

For any symptom mentioned:
- How much does that bother you?
- Have you talked to your doctor about it?
- Did you expect to have that?

61. How much do these things bother you?
- Is there anything that particularly bothers you?
  If yes, what is that?
  why is that?
- On the whole, would you say you have had an easy or hard pregnancy?

62. How do you feel apart from the physical side?
- Mentally/emotionally?

63. a) Have you ever had a nervous breakdown?
b) Have you ever felt you were going to have one?
c) Have you ever been bothered by nervousness, feeling fidgety and tense?
d) Have there ever been times when you couldn't take care of things because you just couldn't get going?
e) Do you ever have trouble getting to sleep or staying asleep?
f) Do your hands ever tremble enough to bother you?
g) Are you ever bothered by nightmares?
h) Are you troubled by hands sweating so that you feel damp and clammy?

63. i) Have you ever fainted or blacked-out?

    j) In the past few years, have you had any headaches?

    k) Have you ever had spells of dizziness?

    l) Have you ever been bothered by your heart beating hard?

64. Do you remember whether as a child you wanted to get married and have children?

    - If no, what did you think you would do?

65. On a scale of 1-10, how feminine would you describe yourself?

    - How would you define feminine?

66. Have you given up work yet?

    - If no, - when do you plan to give it up?
    - why haven't you stopped yet?
    - has your doctor said anything about it to you?

For Those Who Have Stopped Work - Next Six Questions:

67. When did you give up work?

68. Was that when maternity leave became available?

    - If no, why did you give up then?

69. How did you feel about giving up work?

70. Have you felt since that you'd like to be back at work?

    - If yes, is there anything in particular that you miss about it?

71. What did you husband feel about your giving up work?

72. Is this the first time you've been at home all the time since you got married?

    - If yes, do you like it?

      If yes, - what do you like about it?
      - Is there anything you dislike about it?

      If no, why not?

73. Do you plan to work after the baby's born?

- If no, - why is that? (Do you think babies need their mothers?)
  - will you go back to work eventually?

    If no, why not? (reasons)
    If yes, when?
- If yes, - why is that?
  - have you discussed that with anyone? (mother/husband/friends?)

    If yes, what do they say about that?
  - what does your husband feel about your working?
  - what will you do with the baby while you work?

74. What does it feel like being _____ months pregnant?

- Are you enjoying being pregnant?
- If you could have this baby without this pregnancy, would you?

75. Have you noticed anyone treating you differently since your pregnancy became obvious?

- Who?
- How do they treat you?

  friends?
  people you work with?
  strangers?
  parents?
  in-laws?

76. Do you think your husband treats you differently?

- Has he made any demands or special requests of you to modify your behaviour?
- Be more careful?

77. Does anyone treat you as though you can't do the things you normally do - as though you're ill/you've got to be careful?

78. Do you, yourself, think that pregnant women should just behave as they normally do, or should they look after themselves more carefully?

- If more carefully, - how - in what ways?
  - why?

79. Do you think of pregnancy as an illness?
    - what would you call it?

80. Have you found you've been able to behave much as normal, or have you found you've had to change your life quite a bit?
    - If change, - how?
      - why?

81. Has the pregnancy been anything like you expected?
    - If no, how has it been different?
    - If yes, what did you expect?

82. What did it feel like when the baby first started to move about inside you?
    - Some people (doctors) say it feels like a gentle fluttering/like butterflies - what would you say it felt like?
    - How did you feel when you realized you were feeling it move for the first time?

83. How much do you think about the baby at the moment?
    - What do you think about?

84. Do you think about the baby as a separate person or do you think about it as part of you?

85. Do you have a nickname for the baby?
    - If yes, what is it?
      where did it come from?

86. Do you have any ideas about what sort of person the baby will be?
    - Why?

87. Do you want a boy or a girl?
    - If definite preference, - why is that?
      - what does your husband want?

88. Do you think boy and girl babies behave differently?
    - If yes, in what ways?

89. Have you had any thoughts, ideas, hunches about your baby's appearance and behaviour after you bring the baby home from the hospital?

90. What changes do you think the baby will make to your life?

- How do you feel about having to make such changes?
- How do you think your husband will feel?

If 2+ baby, how do you think your older child/children will feel about the baby and the changes which will have to be made?

91. Have you bought anything for the baby yet?

- If yes, - what?
  - did your husband come with you or did you go alone?

92. What preparations have you made for the baby?

(decorated room? bought clothes/diapers, crib/buggy?)

93. Have you enjoyed getting them ready?

- What do you think about when you're getting things ready for the baby?

94. Have you and your husband chosen a name or names for the baby?

(yes, - one for either sex;
- a girl's name only or a boy's name only;
- none)

- If yes, - are you and your husband in agreement with the names?
  - are there any particular reasons why you have chosen these names?
- If no, - have you had any pressure from family/friends to hurry up and choose a name or to choose a particular name?

95. With your baby's due date coming closer and your tummy getting larger, what are your feelings about this increase in size?

- How do you think about yourself?
- Has it made you think any differently about yourself?

96. Have you started wearing maternity clothes yet?
    - If yes, - when did you first wear maternity clothes?
      - why?
      - are they new or second-hand?
      - have you felt that you have been treated differently since you have been wearing maternity clothes?
      - type?
    - If no, - why not?
      (not necessary; wear own baggy clothes; other)

97. Is your husband interested in the pregnancy?
    - Why do you think that?
    - In what ways does he show it?

98. Has he read any books about pregnancy, childbirth, or childcare?
    - If yes, - what?
      - did you suggest it or did he want to?

99. How do you think he feels about becoming a father?

100. How much do you expect him to do after the baby is born?
    - What do you think he will do for the baby?
    - Do you think there is anything that he'll refuse to do?

101. Do you think of yourself as a mother?
    - If yes, in what ways?
    - If no, does the idea of being a mother seem strange to you?

102. Do you think that being a mother is important to women?
    - If yes, how - in what ways?
    - What do you think is most important about being a good mother?

103. Do you think that women have a natural instinct (a maternal instinct) for looking after children?

104. How do you think you would feel if you couldn't have children?

105. Was there ever a time when you wanted a baby but couldn't get pregnant?

- If yes, - when was that?
- how did you feel about it?
- Did you talk to anyone about it? (mother/husband/doctor/friends?)

106. How do you expect to feel when you first look after the baby at home?

107. What do you think life will be like with a young baby? What will it be like being a full time mother?

108. Are you attending prenatal classes?

- Why did you decide to go?
- Did anyone suggest you should go? (friends,doctor, relatives?)
- Are you finding them helpful?
- Do you have any criticisms of the classes? Is there anything that you would like changed?
- Do you talk to the other women? If not, would you like to?
- Does your husband attend with you? Why? Did you suggest it?
- How does he feel about the classes?

109. Looking back on it now, do you think that the books/pamphlets/magazines/classes about pregnancy were helpful?

- If no, what in particular do you think was unhelpful or misleading?
- If yes, in what ways?

110. Why did you want to have a baby?

111. Is there anything that you feel is important about your pregnancy that we haven't talked about?

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