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STARTING LATE

**Problems and coping strategies of
women who delay parenting until after
the age of 40 years.**

A thesis presented in partial fulfilment of the
requirements for the degree of Master of Arts in Nursing
at Massey University

Nel Vincent

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ABSTRACT

The purpose of this study was to explore the meaning of motherhood for women over 40 years of age at the birth of their first child. The research answers two questions, “What parenting related problems and coping strategies are identified by mothers who delay parenting until after the age of 40 years?”, and “How can nurses and midwives provide effective support for older mothers?” The descriptive exploratory method used in this research proved to be very effective in enabling the mothers to relate their experiences as they perceived them. Data was gathered from semi-structured interviews and the process of thematic analysis was used to identify the major themes.

The research highlighted the resourcefulness and the positive attitudes of the participants, who were able to draw on an abundance of resources from their previous roles as career women. Most of these women had expected to become mothers in their early to mid thirties if not before, but for some of them conception was a problem and for others the timing for motherhood was not right. The major stressors identified by the participants related to fertility issues and genetic screening. At these times they would have valued increased support from health professionals. One persistent theme was the concern “What if something happens”, either to the child or themselves. There was a need to know everything related to their own and their childrens’ experiences prior to making a decision. The teenage years were seen as a major problem, with most participants expressing their concern about the high incidence of mental health problems related to this group.

Implications for nurses and midwives are explored throughout the study, with a discussion of the health and social services that the participants found to be helpful.

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GLOSSARY

Aetiology: The medical study of the causation of disease.

Alpha-fetoprotein: The maternal alpha-feto-protein test is designed to screen open neural tube defects such as spina bifida and anencephaly.

Anencephaly: A congenital absence of all or part of the brain.

Amniocentesis: The insertion of a hollow needle into the uterus of a pregnant woman to withdraw a sample of the amniotic fluid to test for foetal abnormalities.

Chorionic villi: Tissue formed into projections which are part of placental tissue.

Chorionic villi sampling: A method of diagnosing abnormalities in a foetus by removing a tiny sample of chorionic tissues from the edge of the placenta for laboratory analysis.

Clomiphene stimulation test: An oral treatment of clomiphene which is used to stimulate ovulation in apparently infertile women.

Donor gametes: Reproductive sperm or ova, each with 23 chromosomes from another person.

Eclampsia: Toxaemia of pregnancy, in which convulsions occur.

Gamete IntraFallopian Transfer of oocytes (GIFT): An infertility treatment involving direct transfer of eggs and sperm into the woman's fallopian tubes, where conception may occur.

In vitro fertilisation (IVF): Fertilisation of an ovum by mixing with sperm in a culture medium, after which the fertilised egg is implanted in the uterus to continue normal development.

La Leche League: A support group which provides information and encouragement to all mothers who want to breast feed their babies.

Leslie Centre: A counselling and therapy facility for families of children having behavioural, social or emotional difficulties.

Multipara: A woman who has completed two or more pregnancies.

Parent Centre: A nationwide volunteer organisation run by parents, for parents and children. Concerned with preparing and supporting parents in their role.

Primipara: A woman who has carried one pregnancy to a viable stage.

Primigravida: A woman who is pregnant for the first time.

Primary health care: Essential health services based on practical and socially acceptable methods and technology made universally accessible to individuals and families in the community.

Syndactyly: a congenital abnormality in which the digits are fused, similar to birds and mammals.

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PREFACE

When considering the present trend for women to postpone childbirth I often reflect upon the difficulties that my Aunt faced. In 1948 she gave birth to her first child at the age of 49 years old. Family and friends were reluctant to accept this new social condition with many considering her to be too old to become a mother. Furthermore, the physical demands of motherhood were compounded by mid-life changes and the inability to see her son without wearing her glasses. Strangers often mistook my Aunt for a grandmother.

These problems were compounded when my uncle died, leaving her alone to care for a three year old child. Fortunately she was a stoic woman and in her words, "I just got on with life and coped the best I could". Nevertheless, she related well to her son and his peers during the teenage years at a time in her life when she was well into her sixties. Both mother and son had an excellent sense of humour and enjoyed each other's company.

Her experiences prompted my personal interest in the meaning of first time motherhood for older women. How do they cope? What are their life experiences? Is there still a stigma attached to older mothers? As a nurse, midwife and an educator I was also keen to identify the need of women in this age group for professional support from nurses and midwives. Although extremely rewarding, motherhood places a considerable burden on older women who may also have to deal with menopause and the care of elderly parents.

AIMS OF THE STUDY

- To explore the meaning of first time motherhood for older mothers.
- To identify the coping strategies that these mothers used.
- To identify the health and social services that these mothers would find helpful.
- To inform nurses and midwives of what motherhood means to older first time mothers.

Research questions

- What parenting-related problems and coping strategies are identified by mothers who delay parenting until after the age of forty years?
- How can nurses and midwives provide effective support for older first time mothers?

Rationale

Knowledge of problems and coping strategies is likely to assist women who are already older parents or who may be contemplating delayed parenting. Nurses and midwives are ideally placed to offer positive encouragement and informed advice to these women. As primary health care workers they are actively involved in health promotion which benefits women and their families. These women will need to know the answers to questions such as:

- What are the psychological and social implications of being an older mother?
- What are the biological risks of having children later in life?
- How do older mothers cope with children when they are over the age of 40 years?

STRUCTURE OF THE THESIS

The thesis is presented in eight chapters:

Chapter 1 introduces the trend towards delayed parenting both in New Zealand and overseas, reviews the ramifications of this development on women's fertility and discusses the primary health concept where this relates to older women.

Chapter 2 identifies local and international literature relevant to the discussion of delayed parenting.

Chapter 3 compares the positivist and interpretive paradigms and introduces the exploratory descriptive design used in this thesis.

Chapter 4 provides an introduction and overview of the data analysis.

Chapters 5 to 7 present the findings and the interpretation of each of the sub-themes as they relate to the meaning of motherhood. Implications of the findings are considered in relation to nursing and midwifery practice.

Chapter 8 includes a general overview of the research, discusses limitations on implementation of the findings and offers recommendations for parents, nurses, midwives, other health professionals and for further research.

CHAPTER ONE

INTRODUCTION

Abraham threw himself down on his face; he laughed and said to himself 'Can a son be born to a man who is a hundred years old? Can Sarah bear a son when she is ninety?

(New English Bible, 1970, Genesis 17)

Apart from Old Testament Sarah, 57 year old Ruth Kistler is the oldest woman on record to naturally conceive and give birth to a live child, although Ellen Ellis was 15 years older when she delivered a stillborn baby at the age of 72 years (Berryman, Thorpe & Windridge, 1995). In more recent times the birth of a daughter with the assistance of *in vitro* fertilisation (IVF) to 62 year old Italian Rosanna Della Corte made headlines around the globe (Berryman et al., 1995). The eligibility of older women for IVF was questioned, with many calling for procedural guidelines to protect the interests of the unborn child. Consequently most infertility treatment in New Zealand is presently only available to women under the age of 50 years (Fisher, 1993).

Parenting Trends Since the 1960s

In 1962 at the height of the post-war 'baby boom' the birth rate peaked at 4.2 births per woman in New Zealand. Since then the birth rate has changed considerably. Couples are now likely to marry at a later age, with a high proportion choosing to delay parenthood once married (Jackson & Pool, 1994). These changes in the birth rate trace a strong trend towards delayed parenting in Australia, Europe and North America.

Between 1962 and 1994 the median age of first time mothers in New Zealand has increased at more than two and a half times the rate for all mothers during this time. The 5.7 year increase in the median age of first time mothers over this period is most

noticeable among nuptial births. In 1994 married mothers giving birth for the first time had a median age of 29.9 years, compared to 24.3 years for ex-nuptial mothers.

The proportion of nuptial births to first time mothers aged between 35 and 39 years old has increased from 3.0% in 1962 to 8.8% in 1995. There was a smaller increase for first time mothers over the age of 40 years where the birth rate rose from 0.9% in 1962 to 1.3% by 1995. It is significant that the rate of births to married women over the age of forty years quadrupled between 1985 and 1995.

Pool (1995) warns that official New Zealand statistics are unlikely to reflect recent increases in first time births to de facto partners. Statistics New Zealand only publishes data for nuptial first births, rendering the dissemination of accurate information on the general incidence of first births extremely difficult. Nevertheless the following statistics offer some insight into the trend towards delayed parenting.

The baby boomers: Fertility and the New Zealand family

Baby boomers venerated the nuclear family as a post-war ideal. The return home of armed forces personnel after World War II caused massive unemployment among women who had constituted a large proportion of the workforce during the war years. A dramatic increase in birth rates resulted, as the media (and in particular British and American films) began promoting a vision of a happily married couple in their early to mid twenties with two 'well adjusted' children. Roughly five years after the birth of the second child a third (and last) 'idyllic' child would be born. The family lived in a comfortable three bedroom home on a quarter acre section in the suburbs. Father worked a 40 hour week while mother was a staunch Plunket supporter or a member of the kindergarten committee.

High divorce rates for those baby boomers who married young have soured this dream. A high rate of marital breakdowns can in part be traced to post-war years when fashionable ideals, picture book weddings and a blissful family life did not always equate with reality. However, these statistics are clouded by the decision of many parents to delay dissolution until after their children had left home. Children of married mothers accounted for 80% of all live births in 1976, falling dramatically to 62 percent by 1991 (Pool, 1995).

The children of baby boomers seem less likely to subscribe to the nuclear family ideal. Experience of family dysfunction during their childhood and teenage years may have left many second and third generation adults reluctant to repeat the mistakes of their parents, choosing instead to delay parenting or not to parent at all. This family dysfunction is not just a New Zealand phenomenon. It appears throughout the developed world and is especially strong in Britain, the United States, Australia and New Zealand.

Several potential causes of the nuclear family's dysfunction are apparent. For thousands of years patriarchal culture has held men responsible for women and their children. In recent years increasing numbers of women are breaking free from this cultural trap, demanding their independence while enforcing maintenance contributions against their husbands. In New Zealand women appear to have exchanged husbands for benefits. However, the Domestic Purpose Benefit should not be solely blamed for the breakdown of marriage. The contraceptive pill was a symptom of relaxed social standards which sanctioned an increase in extramarital sexual relationships. The change initiated by improved contraception and the Domestic Purpose Benefit contributed to a dramatic decline in the birth rate, which fell to below replacement levels in 1983 (Statistics NZ, 1996). Today almost all developed Western countries have sub-replacement populations. Perhaps the children of 'baby boomers' have become disillusioned by their parents' lifestyles and decided that they are going to enjoy life outside the confines of the nuclear family. This does not imply that parenting trends of the last 50 years have initiated a dysfunctional society, but rather that societal changes now accommodate diversity.

A decline in the proportion of households which include parents of young children is more likely to be due to a series of demographic 'squeezes' than the decline of the family as a social institution. The general upward movement of the age structure to middle and older ages has resulted in a shift to non-parenting family structures for various life cycle stages, not at all suggestive of dysfunction. Between 1976 and 1991 there was a slight decrease, 7%, in the number of two-parent families, but a massive increase, 51 percent, in non-parenting households (Pool, 1995).

Western society appears to be splitting into two groups. A minority, typically less well-off, seem to have inherited the capacity enjoyed by the majority of baby boomers

to conceive with consummate ease at a very young age. Yet even women in this lower socio-economic groups are now more aware of the benefits of family planning and consequently the birth rate for women under 20 years of age is decreasing. Although teenage birth rates are lower in New Zealand than in the United States, they remain higher than in most Western countries. In contrast, the majority of women today are reproducing at older ages.

Patterns of fertility adopted by baby boom parental cohorts (those born between 1925 and 1954) clearly deviate from those trends demonstrated by both previous and more recent generations of twentieth century parents (Statistics NZ, 1997). In 1931 the total birth rate in New Zealand was 2.6 live births per woman. Thirty years later in 1961 this had increased to 4.3 live births per woman, but by 1991 the rate of 2.2 live births per woman had reverted to pre-war levels. These figures demonstrate the startling impact of the baby boom years, although the influence of the contraceptive pill in the 1960s may be at least partly responsible for a decline in the birth rate after that period.

The New Zealand birth rate fell to 1.9 live births per woman in 1983. Since then the rate has climbed slowly to reach a level of 2.4 births per woman by 1995 (Statistics NZ, 1996). Even this higher rate is barely sufficient for our population to replace itself without increased immigration. It is too early to assess whether the change reflects a structural adjustment which accommodates the decision of increasing numbers of women to delay parenting.

Maori

In 1962 the Maori birth rate peaked at 6.2 births per Maori woman, higher than at any other time since the 1890s and a rate of 2.1 births higher than for non-Maori women. By 1990 that distinction could no longer be drawn. The 1970s saw the Maori birth rate fall more rapidly than the birth rate of any country in the developed world, although the United States, Australia and the Mediterranean experienced a similar if less spectacular decline. For Maori, a 65% decrease in birth rate by 1990 meant that the gap between the Maori and non-Maori birth rate narrowed to 0.02 births, (although widening slightly to 0.4 births by 1995). Statistics New Zealand has traditionally identified as Maori persons those with half or more Maori blood.

However, since 1992 this categorisation has been widened to include all people who specified that they belong to the New Zealand Maori ethnic grouping (Statistics NZ, 1996). Future comparative statistics will thus be distorted.

Age-specific demographics do not show the same convergence in patterns of fertility. Although data collected by Jackson and Pool (1994) indicate that Maori are increasingly likely to delay first births, the median age of first time Maori mothers is five years lower than for European mothers. This age is steadily rising, however, and a general upward swing for Maori first births in most of the age related cohorts is expected, paralleling general population trends.

Teenagers

Both Maori and non-Maori adolescent birth rates declined dramatically from 1962 to 1995, with a fall of 63.9% for Maori mirroring the decrease in birth rates among New Zealand women generally. This fall cannot be attributed to any substantial increase in the rate of induced abortion (Statistics NZ, 1994). It may be that lower birth rates among teenagers are due to increased knowledge of contraceptive techniques.

Delaying marriage

Teenage marriages have become relatively uncommon. In 1995 only one in 33 marriages involved teenage women, compared with one in three marriages in 1971. Marriage is increasingly occurring at an older age. The median ages in 1995 of a bride and groom married for the first time were 26.9 years and 28.9 years respectively. This compares with a median age of marriage of 22.2 years for women and 24.8 years for men in 1976 (Statistics NZ, 1996). New Zealand women are now marrying on average four years later than they did in the 1970s. The trend towards delayed parenting may in fact be partly responsible for these later marriages, as increasing number of people are choosing to remain single or to live in de facto relationships (Statistics NZ, 1996).

Changes in reproductive behaviour have contributed to an overall decline in the proportion of households with young children (Pool, 1995). It would appear that efficient contraception, sterilisation and the womens' liberation movement may have

strengthened knowledge of and attitudes toward family planning. Furthermore, the postponement of marriage has been partly offset by the increasing acceptability of de facto relationships. Such relationships may be either a prelude to, or a substitute for, formal marriages.

Delaying birth

The decision by increasing numbers of parents to delay the birth of their first child has generated what Jackson and Pool (1994) term 'demographic momentum'. Although this shift was first manifested in the decision of younger women to delay parenting, it should not be seen as characteristic of a dysfunctional family relationship. The massive 51.5% increase in non-parenting households over the fifteen years before 1991 is likely to be only a temporary disruption to demographic patterns, resulting from the shift to later childbearing. Jackson & Pool (1994) found that despite a decline in the birth rate of teenagers and of the 20 to 24 year old cohort, there was very little difference in the overall birth rate for New Zealand mothers over the 1976-1991 period. This has been attributed to delayed child bearing among the 30 – 34 year old cohort. Note however that older mothers are unlikely to lift the birth rate above replacement levels. Statistics New Zealand (1996) data indicates that older women are likely to have fewer children.

It appears that increasing numbers of married women and de facto couples are actively planning their families. However, women appear less reliant on the support of a partner for life when raising a child. Indications are that more and more women are choosing to live in a de facto relationship or as a solo parent (Jackson and Pool, 1994). There has also been a dramatic change in family composition over the last decade, with the decreasing divorce rate, remarriage, and many children being brought up in reconstituted households where one of the biological parents is missing while another adult has usurped the natural parent role. These patterns challenge the perceived wisdom of past generations which placed the married couple at the heart of any stable, secure nuclear family.

Pool (1995) describes how delayed parenting has caused a dramatic increase in the number of non-parenting households over the last 20 years. In New Zealand there is no longer any certainty whether members of a given demographic have dependent

children living at home. For example, the 15-29 year old household age cohort is likely to consist of non-related persons who may be in the process of a relationship but are not at the parenting stage. The 30-54 year old age group is identified by Poole (1995) as the greatest contributor to the increase in non-parenting households. This cohort includes many couples aged in their thirties who have chosen to delay parenting, as well as 'empty nesters' who had their children at a young age. Taking into account an expected increase in the number of couples who choose to delay parenting, there is unlikely to be any reduction in the number of non-parenting households in the immediate future.

The dynamics of the recent decline in birth rates are complex. Increased use of contraceptives, increased participation of women in the labour force, rising divorce rates and general economic conditions have probably all directly or indirectly contributed. Patterns of marriage and family formation have changed radically, with a shift to later marriage and delayed childbearing.

Childlessness

Today the decision whether or not to have a child is given much greater consideration than ever before. Although previous generations of women laboured under a social expectation that they would marry and bear children, feminist debate since the 1960s has defended the right of women to choose. Anderson (1995) cites British Government projections which predict that 20% of British women born between 1960 and 1990 will choose never to have children.

Information on voluntary childlessness in New Zealand is much more limited. Jackson and Pool (1994) record that at the 1991 census, nearly half of all households were non-parenting. Note however that some of this change is due to the increasing life expectancy of the aging European New Zealand population (Statistics NZ, 1996). As the median age increases, the proportion of couple only ('empty nest') and single person (widowed) households also increase. In contrast, 72.1 percent of all Maori households were parenting households, reflecting a structurally 'younger' Maori population (Jackson & Pool, 1994). However these findings are complicated by the whanau (extended family) relationships common to many Maori households, which can make it difficult to achieve an accurate census on where children are living. For

instance children may be born to younger Maori and 'adopted' by older mothers within the whanau, to be returned to the mother when they are older.

Biological Time Clock

Why are more and more women choosing to delay parenting? Sheehy (1996) believes that more effective methods of contraception now enable women to control their fertility much more successfully than in the past. Women who delay parenting are more likely to be successful in their professional, financial, and personal lives (Harker & Thorpe, 1992; Randall, 1993; Reece, 1993). But many women at mid-life experience a crisis of unfulfilment, as if something is missing. A woman's fertility deadline is a reality that few can ignore. The majority of women interviewed by Soloway and Smith (1987) indicated that the biological clock was a major factor influencing the move to discuss starting a family. This powerful motivation for women to become mothers may arise for different women at different stages in their lives. Although for many young women children is not a priority, by the time that these women reach their forties motherhood can become an obsession (Sheehy, 1996). The longer parenting is postponed, the stronger this urge may become.

I am not saying every woman must have a baby to fulfil herself as a woman, but I say from experience as well as the experience of women down through the ages, we are the people who give birth to babies, and that there is a powerful need to use that ability. It is a powerful value in women's [sic] identity.

(Friedlan, 1982, in Schlessinger & Danaher, 1984, p.4)

Fackelmann (1993) describes a growing demand in the United States among women aged in their fifties for IVF. As the tendency develops for New Zealand women to postpone childbirth IVF may well become a sought after treatment in this country. Experts claim that there are no apparent age limits on a successful IVF procedure (Fackelmann, 1993). Daniels and Weingarten (1980) found that chronological aging was not a predictor of physical age. In fact, 'feeling old' is more closely related to a person's life experiences and how they coped with them. A 25 year old person may

have the traits of a 50 year old while a 60 year old may be 'young at heart' and enjoy interacting with young children.

Effects of Infertility

Unfortunately some women delay parenting until it becomes biologically too late to conceive naturally. Desperation has forced many of these would-be mothers to go to extreme lengths to conceive. Women are now able to conceive in their late forties and fifties through such technological advances as *in vitro* fertilisation and donor gametes. Although these techniques are expensive there are many couples in the middle and upper socio-economic groups who are financially able to afford such treatment (Sandelowski, 1994).

In the United States some young women are facing pressure from post-menopausal would-be mothers to donate their ova (Sheehy, 1996). Perhaps in the future there may be facilities available for women in their twenties to store their ova for implantation in later life. The foetus resulting from these ova will not only inherit the mother's genetic makeup but should also have a significantly decreased incidence of genetic abnormalities.

Couples need to access expert opinions about the risks of IVF treatment. An advanced form of IVF involving the injection of a single sperm into an egg (intracytoplasm sperm injection) was once considered to be as safe as natural contraception. This understanding has since been challenged by Australian researchers who claim that the risk of major birth defects is doubled when mothers conceive through this technique (Day & Anderson, 1997). Although the experts will continue to disagree, any couples considering IVF treatment must ensure that all research has been thoroughly tested, and that they themselves receive appropriate counselling.

Infertility attaches as a stigma which leaves women and men feeling incomplete and inadequate. Couples who experience temporary infertility and then conceive following treatment may later describe themselves as a normal fertile couple. They are even more likely to explain the infertile period as a time when their lives were extremely stressful, creating pressure which reduced their fertility and prevented

conception. Sandelowski (1994) found that infertility often caused emotional scars which remained even after the birth of a child. Couples who were unable to conceive viewed this failure as a “permanent physical or emotional condition” (Sandelowski, 1994, p.750).

The uncertainty of infertility contributes to extreme stress, often developing into a chronic or prolonged crisis state (Whiteford & Gonzalez, 1995). Technological advances may contribute to the intense distress of couples, who sometimes seem to make a career of the pursuit of pregnancy (Sandelowski, 1994, p.749). The participants in Whiteford & Gonzalez’s (1995) research lament society’s failure to accept women without children.

The women feel as though they have broken some accepted if unspoken cultural rule and they pay for it by being classified as ‘other’. Infertile sisters refer to each other as normals, while placing themselves in the other category.

Whiteford & Gonzalez (1995, p.29)

The contraceptive pill has allowed women to control their fertility by planning conception. Although this has been empowering for many women, sadly these plans cannot accommodate any mistake in judging the biological time clock. Nor can such advances compensate for increases in infertility when the need for a child becomes so great that stress and anxiety levels inhibit conception.

Because menopause occurs at different ages the only real predictor of fertility is to identify the ‘ovarian reserve’ of individual women by using the clomiphene stimulation test. There is a 50% decrease in the fertility of women after the age of 40 years and two to three times the incidence of spontaneous abortion as compared to younger women (Tomer, 1993). Women who contemplate delaying parenting may be well advised to carefully identify their fertility status.

The medicalisation of infertility treatment and the stigma of childlessness should not outweigh the value to women of control over their (present) fertility. However, the mandate granted by the sexual revolution to delay parenting has serious implications

for an aging population which continues to reproduce at sub-replacement levels. Many Western countries are now facing a similar crisis of fertility.

Women considering whether to delay parenting or to remain childless will require up to date information on becoming a parent after the age of 40 years. At present such a decision is likely to be handicapped by the paucity of research available in New Zealand or overseas which draws on the experiences of older primigravidae. The studies which have been completed indicate that older mothers quickly develop excellent resources and skills to support them during their parenting years. Although the participants in this study all described their experiences of motherhood in positive terms, most considered in retrospect that the age of 35 years would have been an ideal time to give birth to their first child. This opinion largely flowed from concern about the risk of infertility. Although nine of the participants in this research conceived naturally, two depended on fertility technologies for assistance.

It is hoped that the information from this study and others like it which focus on first time parenting among this cohort may equip women with the knowledge to overcome the fears of often mythical consequences arising from delayed parenting. The trend to delay parenting shows no sign of abating. Contributing factors include the increasing cost of tertiary education and the decision of growing numbers of women to pursue a professional career. It therefore becomes important for women who decide that motherhood is not an immediate priority to know that parenting after the age of 35 years of age still has a lot to offer. Delayed parenting should be recognised as a viable, or even preferable alternative.

Primary Health Care

Patterns of delayed parenting have significant implications for nurses and midwives working in the primary health care area. Primary health care is essential care made universally available to individuals and families in the community. Self care and self management are encouraged by primary care providers such as midwives, Plunket nurses, practice nurses, mental health nurses, and school nurses.

Each practitioner has a discrete health care responsibility, which includes collaborative relationships with medical colleagues, social workers and teachers. The

practice nurse is frequently at the centre of a client's primary health care network, channelling information to other care providers. This person is likely to be the first point of contact for the older mother in her quest for information on maternal and child health care services. Information such as this will direct the mother's search for the lead maternity carer whom she can trust to provide quality pregnancy care and deliver her precious baby. The practitioner must be sensitive to the concerns of older women about the risks of genetic screening, and take account of the anxiety felt by these women, who are acutely aware that this may be their only opportunity of having a child. Because of their age all the women in this research were advised by their general practitioners to seek specialist obstetric care. Most of the participants in this research delivered before independent midwifery was established or when it was still in its infancy, and at a time when the stereotype of the problematic 'elderly' primigravida was still in vogue.

New Zealand women have the option of four lead maternity carers:

- Independent midwives
- General practitioners
- Obstetricians
- Crown Health Enterprise (CHE)

In becoming a lead maternity carer the independent midwife enters into a partnership with women, providing the knowledge that the expectant mother will need to make informed choices on all aspects of her care. Independent midwives have direct access to obstetricians should they need to confer regarding aspects of concern relating to a woman in their care. This collaboration may also extend to a discussion of coping strategies with mental health nurses for the genetic screening process. Midwives collaborate with hospital obstetric services if complications arise and women may need to transfer to the CHE for secondary care.

During the postnatal period independent midwives transfer the care of the client to Plunket nurses or other community based nurses. The Plunket nurses described in this research were exceptionally good examples of primary health care providers, acting as a valuable source of support and information on child care. This help guided the participants through an extremely vulnerable time following discharge from hospital, providing the women with the knowledge and skills to enable them to move forward.

Participants were able to reinforce learned coping skills by drawing on experiences from their previous 'world' as professional women.

Primary health care providers encourage mothers to take responsibility for their own health and the health of their families. Midwives and nurses as the promoters of primary health care encourage life-long learning. Such learning needs to commence in the homes and schools. Both school nurses and public health nurses have an ongoing responsibility to provide skills and knowledge in the promotion of health through their teaching in schools and other community venues. Encouraging women to take responsibility for their own health and the health of their child(ren) shifts dependence from nurses and midwives whilst empowering women with the knowledge and responsibility to act independently. This is a goal that midwives and nurses continually strive towards.

This chapter has traced parenting trends in New Zealand and compared these developments with the experiences of women in other countries. Reasons for the demographic shift to older parenting have been identified, and are complemented by an insight into the implications of delayed childbearing for fertility levels and the future ability to conceive. The chapter concludes with a discussion of the roles of nurses and midwives as providers of primary health care to older primigravidae.

The next chapter provides an overview of the literature relating to delayed parenting, both in New Zealand and overseas.

CHAPTER TWO

LITERATURE REVIEW

An overview of the trends and statistics relating to delayed parenting was presented in the previous chapter. The literature review seeks to identify the reasons for these trends and investigates how they have affected parenting, both in New Zealand and internationally.

Overseas Literature

This literature review follows demographic trends in three cohort age groups: over 30 years, over 35 years, and over 40 years of age. Most of the overseas literature to date concerning women who have delayed parenting has been limited to retrospective, longitudinal or descriptive quantitative studies. Women have been interviewed for a specific purpose, whether this be to identify reasons for delaying childbirth, the nature of the mother and baby relationship, or family support.

First time mothers over 30 years of age

Four main studies were identified as pertaining to women over 30 years of age.

Gottesman (1992) recruited 50 first time mothers from a private obstetric practice and a health maintenance organisation in New York. In comparing progress towards maternal adaptation in pregnancy, a marked difference was found between the younger and older women. The criteria for the study were that all the participants were experiencing a normal pregnancy, were English speaking women, over 20 years of age, married, living with their husbands, and had completed high school. The 41 women included in Gottesman's final sample were classified in three groups: early child bearers (10 women aged 20-24 years), middle child bearers (13 women aged 25-29 years), and late child bearers (18 women aged 30 years and over). The groups were compared on the six variables shown in Table 1 (Gottesman, 1992). The test used was the log linear analysis, an extension of the chi-square analysis.

Table 1: Percentage of women in the early, middle and late childbearing groups receiving low and high ratings on the interview variables

Variable	Groups	Low %	High %	Probability
<i>Motivation for motherhood</i>	Early	80	20	< 0.001
	Middle	15	85	
	Late	13	87	
<i>Preparation for motherhood</i>	Early	50	50	NS
	Middle	15	55	
	Late	33	67	
<i>Quality of marital relationship</i>	Early	40	60	NS
	Middle	23	77	
	Late	11	89	
<i>Maternal – foetal relationship</i>	Early	80	20	< 0.02
	Middle	31	69	
	Late	28	72	
<i>Maternal role conceptualisation</i>	Early	50	20	< 0.001
	Middle	31	69	
	Late	11	89	
<i>Attitude towards the pregnancy</i>	Early	50	50	NS
	Middle	31	69	
	Late	17	83	

NS = not significant

Gottesman (1992, p.104)

Motivation for motherhood

More women in the early childbearing group reported unwanted pregnancies and many of these mothers did not accept their baby until close to term. In contrast, women in the middle and late age groups had nearly all planned for their pregnancy, and there was a sense of readiness and expectation.

Preparation for motherhood

Younger childbearing mothers had read very little about pregnancy or foetal development and relied mainly on the experiences of their mothers and other relatives.

The middle and older groups gained a considerable amount of information through their reading about nutrition, early pregnancy, miscarriage, labour and delivery. Both of these latter groups were also more likely to learn about childbearing and parenting experiences from their friends.

Quality of the marital relationship

Although no-one in the younger group noticed any change in their partners' attitude to their pregnancies, a small percentage in the middle and in the older groups noticed definite changes in their partners' responses:

"In the beginning when I first found out, it was exciting for him. But he went through a period when I was two or three months that maybe this wasn't what he wanted. So I talked to two or three other people, and it seems to be a common reaction. . . . Now for the past two months, he's just been super."

(Gottesman, 1992, p.105)

Maternal - foetal relationship

The response patterns were different for the three groups. The younger group described their feelings about their baby as:

". . . scared and apprehensive . . . I'll never be alone again, there will always be someone else to think about, to worry about . . ."

(Gottesman 1992, p. 106)

Both the middle and older groups found that they had "rich interactive relationships" (p.106). Some played music for their babies, and the older the woman, the greater the likelihood that she would talk to her baby and communicate by touch.

Maternal role conceptualisation

The most reluctant mothers were found in the younger group of women. Although the older women were quick to visualise themselves as mothers, many of the younger women were not as excited or happy about the whole concept. The women in the

middle group were often ambivalent, sharing the feelings of both the older and the younger group.

Attitude towards pregnancy

The younger group described quite a variety of problems with their symptoms and changes in appearance associated with pregnancy. Although they were generally positive about their pregnancies they were less enthusiastic about the mothering role. The middle group were less bothered by physical symptoms, identifying more with the older women who generally had little or no problems with their physical symptoms of pregnancy or changes in appearance.

Since the middle age group in this study mostly favoured the stance of the older women, an eight to ten year gap between cohort groups may have produced more distinct results. It would be difficult to apply the findings of this study to other women with the same socio-economic background. Nor does the study address cultural differences. Educational differences could also be a problem as most first time mothers aged 25 years and older would probably have had some tertiary education. However, with an understanding of these limitations this study nevertheless presents a generally informative view of older and younger pregnant mothers and their attitudes to parenting.

In a comparative study of mothers' perception of parenting Ragozin, Basham, Crnic, Greenberg and Robinson (1982) found that maternal age was a significant influence on attitudinal and behavioural components of the parenting role. The researchers set out to examine the proposition that maternal age influences maternal role performance and overall parenting satisfaction. One hundred and five mothers were sampled, aged from 16 to 38 years. Fifty two of the infants were pre-term and 53 were term infants. The term infants were matched to the pre-term infants on the basis of race and maternal education. The mean age of pre-term mothers was 25.3 years, compared to a mean age of 23.9 years for the term mothers. The combined sample was 80% Caucasian, with 86% of the infants coming from two parent families. On average the mothers sampled had spent 12.6 years in formal education.

The mother's adjustment to parenting, her social support system, her life satisfaction and the family's demographic background were assessed one month after birth. This

assessment took place at the mother's home during a one and a half hour structured interview. The mother's feelings about her baby and parenting role were measured on a five point 'Satisfaction With Parenting Scale' which graded satisfaction in caregiving chores, competency as a mother, irritation with the baby, regrets about the pregnancy, and overall feelings about having the baby. The scale also reported the mother's satisfaction with the availability of professional and non-professional advice, and with whom she could discuss her negative feelings about her baby. The research does not clarify how this scale was devised or whether it had been trialled previously, which has implications for the reliability and validity of the research.

The results showed that maternal age significantly influenced the attitudinal and behavioural component of the parenting role. Younger mothers reported fewer caregiving responsibilities, more time away from the baby and less satisfaction with parenting. Older mothers showed increased maternal behaviour and caregiving responsibilities with less social time away from the baby in both the term and the pre-term samples. Indeed older mothers of pre-term babies expressed more pleasure in parenting than mothers of term babies. Interestingly, maternal age is a positive factor only when applied to the first time older mother and not to the multiparous mother. Older primiparous women who have had more experiences in non-parenting roles appear more committed to the parenting role (Ragozin et al., 1982).

Maternal behaviour was also observed when the infants were four months of age during an unstructured observational video-taped session. Mother and baby were left in a small room equipped with a chair and a book for the mother, and a table with an infant seat and toys for the baby. A microphone and a one way mirror was used to monitor the behaviour of both. Comparison of data gathered from pre-term and term mothers showed only one statistically significant difference: pre-term mothers spent more time away from their babies ($p < 0.01$). Although Ragozin et al. (1982) attribute this disparity to cultural difference, in fact 80% of the participants were Caucasian and the mothers were all matched according to race and age. Furthermore, the researchers fail to adequately explain the effect of a pre-term birth on the mother. The study does not reveal how long the babies were separated from their mothers, how soon the mothers were able to care for them, or how long the babies were in hospital. All of these factors could have affected the interaction of the mothers and their babies.

Increased age was also a positive factor in Mercer's (1986) longitudinal study. In this assessment of mothers variables of age and/or maternal attitudes were better predictors of later mothering behaviour than those of stress and social support. Postnatal mothers were assessed at 1, 4, 8 and 12 months. Two hundred and forty two mothers from the San Francisco Bay region completed the study. They were divided into three age groups:

- 15-19 year old group comprising 40 mothers, 65% of whom were non-white, 35% were married, and 45% had not completed high school.
- 20-29 year old group comprising 114 mothers, 32% of whom were non-white, 79% were married, 39% had degree status or higher and one did not complete high school.
- 30-42 year old group comprising 88 mothers, 20% of whom were non-white, 80% were married, 64% had degree status or higher and one did not complete high school.

According to Reaves (1992) there are no restrictions to the number of predictor variables a researcher may use, although the complexity and length of the study increases with the addition of each predictor variable. At the one year follow up Mercer (1986) used eight predictor variables to assess differences in maternal role attainment. They were:

- race
- educational levels
- marital state
- self concept
- maternal attitude reciprocity
- negative life experiences
- infant related stress
- maternal attitude control

Table 2 shows group differences. Table 3 shows the maternal role attainment index.

Table 2: Group differences in maternal role attainment variables

Age	15-19		20-29		30-42		
Variable	Mean	Sd.	Mean	sd	Mean	sd	F (df)
Feelings about baby	35.1	2.1	35.0	2.7	35.0	2.5	0.04 (2,240)
Gratification in role	56.1	7.0	58.0	6.1	55.1	7.0	4.78 (2,241)**
Maternal role behavior	32.8	5.6	36.6	5.1	37.8	3.7	15.45 (2,240)***
Ways to handle child behavior	8.6	2.1	7.6	1.9	6.6	2.2	14.77 (2,241)***
Infant growth	0.05	1.1	0.12	1.2	-0.20	1.3	1.50 (2,197)
Maternal role attainment index	0.05	1.1	0.09	1.3	0.14	1.2	4.30 (2,196)*

* $p < 0.05$

Mercer (1986, p.19)

** $p < 0.01$ *** $p < 0.001$ **Table 3: Predictors of maternal role attainment index at one year**

Predictor variable	Percentage of unique variance	Percentage of accumulative variance	F (2,157)	P
Forced:	8.6	8.6		
Race			12.08	.0007
Educational level			0.06	0.8142
Married			0.33	0.5581
Self concept	16.9	25.5	34.73	0.0001
Maternal attitude reciprocity	7.4	32.9	16.66	0.0001
Negative life experiences	1.7	34.6	3.95	0.0487
Infant related stress	1.8	36.4	4.21	0.0420
Maternal attitude control	1.5	37.9	3.72	0.0555

Mercer (1986, p.21)

The results clearly show increased age to be an asset in maternal role behaviour and in managing child behaviour, mirroring the conclusions of the earlier study by Ragozin

et al. (1982). The older the mother the more likely she was to direct irritable child behaviour to more socially acceptable pursuits. Although teenage mothers gained more overall satisfaction as parents than older mothers, they were less able to cope with continually irritating child behaviour and instead became more stressed themselves. Teenagers scored less on all predictor variables except for infant related stress, which was understandably similar for all ages (Mercer, 1986). The tendency for Caucasian women to score higher could be due to an instrumental bias, or because these women receive less positive feedback in their development of self concept (Mercer, 1986).

It is likely that teenagers demonstrate less positive behaviours than older mothers because they have fewer learned resources to call upon. Older mothers with a higher educational level and successful careers had a greater self concept. Mercer (1986) emphasised that there was no difference in the womens' feelings for their infants or in the infants' growth and development. The older groups were just more adept in the maternal role than the teenagers.

According to Meisenhelder and Merservey (1987) older women appear to have more advanced parenting skills because of their material and educational resources. The majority of first time mothers over the age of thirty responded very positively to parenting in correlation studies conducted by these researchers, who used Miller's Maternal Attitude Questionnaire to assess the desirable and undesirable aspects of parenting. Married women over 29 years of age in their first parenting year were recruited from community agencies, which included doctors surgeries and women's associations. Of the 68 women who participated, 25% had experienced difficulty in conceiving for more than one year while a further 18% had a history of miscarriages. Thirty three percent experienced an abnormal labour. All participants were married, Caucasians from a middle to upper socio-economic class.

As in the previous studies, Meisenhelder and Merservey's research (1987) characterises older primiparae as well educated career women. Fifty percent of the sample had postgraduate degrees and all but two of the women had received some college education. These figures were reflected in the overall educational mean of 16.9 years. The women sampled were predominantly employed in professional occupations. At the time of the research 24 women were working full time, 20

women worked part time, 24 women were currently unemployed, (of whom 17 intended to return to work), one was undecided, and six had no plans to return to work.

Parenting was delayed because 12 of the participants were recently married; 23 needed more time to develop their careers; 27 needed more time to develop their marriages; 22 needed to establish their careers; 8 required more time to assess if they wanted children and 7 experienced infertility problems or miscarriages. Most women gave two or more reasons for delaying parenting.

One third of the women in the sample experienced abnormal labours or deliveries, with a high incidence of Caesarian births and labours lasting for more than 24 hours.

Child care was managed in a variety of ways. In 42 families the woman was the primary caregiver; 12 couples split the child care between both parents; 2 fathers were the primary caregivers; 21 couples used family and friends to assist with the care of the child; nannies were used in 17 of the family units; 3 families used professional day care organisations while 27 mothers did not use any form of child care at all. All women in paid employment used some form of regular child care arrangement for their child.

These professional, well educated women had the freedom to choose when to have a baby according to their own professional, personal and financial needs. Instead of the mothers structuring a career around the needs of their children, the children were required to fit in with the mothers' needs. Apart from the risk of future infertility problems they did not feel pressured into having a child to suit societal expectations. When the maternal satisfaction scores of this group were compared to another group comprising of varied ages and educational levels, the older primiparae showed a slightly higher mean satisfaction score. These women had a more realistic view of the rewards of parenting and were more accepting of the undesirable aspects. Although employed women appear to have more intellectual stimulation, more demands on their time and energy and more help with child care, their overall satisfaction as parents was no more or no less than that of full time mothers at home. Meisenhelder and Merservey (1987) suggested that this was because the women had freely chosen to remain in full time employment and were obviously happy with this decision.

First time mother over 35 years of age

In this section of the literature review five main studies were found: a large statistical review by Baird, Sadovnick and Yee (1991) and four small descriptive quantitative studies. Most of these studies mirror the findings from previously reported research of the 30 to 35 year age group.

Baird et al. (1991) undertook a review of the Health Surveillance Register of British Columbia which included a centralised prenatal diagnosis programme, a large number of births, a division of vital statistics on maternal ages for all births in the province, and an assessment of the causes which may have contributed to birth defects. The review was implemented because of the increasing number of women delaying parenting who questioned whether birth defects other than chromosomal anomalies were related to maternal age.

In order to assess the accuracy of the data-based aetiology codes a pilot study was carried out on 1000 randomly selected cases. It was found that if there were three or more birth defects listed the data input cards for that person would need to be reviewed, since an array of birth defects sometimes indicated a known cause syndrome. The chosen study period was from 1966 to 1981. The group was limited to live births from British Columbia. In total 26,952 cases were reviewed either in the pilot or main research studies. Fortunately for the researchers all pregnant women had routine ultrasound, chromosome analysis and alpha-fetoprotein measurements which enabled the identification of some foetuses with birth defects of unknown aetiology and termination of those pregnancies.

Other than in the identification of chromosomal disorders, studies on maternal age and the incidence of birth defects have been inconclusive. Previous studies have found a weak association between maternal age and cleft palates, syndactyly and reduction of deformities, but only on first births. Maternal age-specific studies of incidence rates for spina bifida and anencephaly showed no association with maternal age in the Baird et al. (1991) review.

There was a positive correlation between maternal age and increased risk of malformations of the sense organs in 1,238 cases of birth defects included in the British Columbia sample. Babies of women over the age of 25 years faced a greater

risk of suffering cardiac disorders, while babies of mothers aged 35 or older were more likely to develop malformations of the digestive system. Maternal age was also linked to infantile autism and dyslexia.

Baird et al. (1991) state that “26,000 infants with birth defects of unknown aetiology occurring in over 500,000 consecutive live births do not suggest an association with advanced maternal age” (p.529). These findings must be reassuring for women who delay childbirth, provided that they do not have conditions which are known to increase risks such as diabetes, Rhesus incompatibility, or alcoholism.

Barnes (1991) in her review of literature available in the United States found that older women were keen to develop their understanding of pregnancy, labour and childbirth, as well as actively seeking advice on postnatal and early childhood care. Many sought preconceptual counselling from experienced midwives to enable them to make informed decisions as to whether to have a child, the availability of tests, probable risks, lifestyle changes, and the availability of social support services such as child care.

Harker and Thorpe (1992, p.27) found that the negative connotations suggested by the expressions “elderly primigravida”, “older mother”, and “late childbearing”, only served to perpetuate the myth that older mothers experience more problems during pregnancy, labour and childbirth. These women undergo more ultrasound scans than younger women, and the researchers agreed with the findings of Berryman, Thorpe and Windridge (1995) when observing that increased screening was likely to exacerbate psychological problems. Participants interviewed by Harker and Thorpe (1992) reported that even some of their family and friends consider first time older motherhood to be inappropriate.

This review has found that when pre-existing conditions such as hypertension, diabetes and obesity are excluded there are no increased risks to older women or their children from delayed parenting. Baird et al. (1991) and Roberts (1994) support the findings of Harker and Thorpe (1992), who observed no increased rate of abnormalities in the children of older mothers other than those relating to chromosomal anomalies. On the contrary, the babies of these women face a lower risk of infant mortality and Sudden Infant Death Syndrome, while overall neonatal

outcomes are improved. Although many of these women were still working full time they did not appear to be any more tired than the 20 year olds. This could well be attributed to the high self esteem and personal fulfilment which these women bring with them into motherhood. Having made a number of role transitions during their working life they enter motherhood from a totally different background than younger mothers.

Social support is important for all pregnant women. Older mothers often experience more problems than younger mothers when developing new networks to replace established friends and support agencies which are no longer appropriate. A restricted longitudinal study by Reece (1993) assessed the relationship between social support and the early maternal experiences in primiparae 35 years of age and older. Data were collected during the last trimester of pregnancy and one month postnatal.

The 93 participants were all over 35 years of age and expecting their first child. Seventy eight percent of the women had attended college and 59.3% had attended graduate school. Fertility was not a problem for these women; over 75% of the participants conceived within one year of trying to become pregnant while 14 women from this group described their pregnancy as unplanned.

Five different instruments were used to collect the data: the Norbeck Social Support Questionnaire; a self reporting questionnaire; the Parenting Support Questionnaire; the Parenting Network Scale and the 'What Being a Parent of a Baby is Like' instrument which had been revised for the study. Overall the support from previous networks shifted to existing networks of mothers with new babies, especially in the first month postnatal. Family support seemed particularly important for a positive outcome. The greatest support came from partners in the antenatal and postnatal periods. This support increased during the early transition stage to parenting. However, the partners seemed unable to assist the new mothers with postnatal stress.

Roberts (1994) found that 5.7% of first births in Australia in 1980 were to women over the age of 35 years. By 1990 this ratio had increased to 10%. These women did not have an increased risk of premature birth, low perinatal weight, perinatal death, low Apgar scores, neonatal resuscitation, threatened premature labour or postnatal haemorrhage. However, the research did show that older women were more prone to

increased operative delivery, induction of labour, episiotomies and epidural anaesthesia. Harker and Thorpe (1992) suggested that these interventions were as a result of medical management of older women, although this notion was not considered by Roberts (1994).

First time mothers over 30 years old to middle 40 years old, and older

The literature found in this age group was comprised of three large reviews by Price 1977; Fabe and Wikler (1979) and Daniels and Weingarten (1982), which are all over 16 years old. Most of the literature in this section is not exclusive to parents over the age of forty but addresses a wider spread, focusing primarily on women between 37 and 45 years of age.

During the period from 1975 to 1978 there was a 37% increase in the rate of first births in the United States to women between the ages of 30 and 34 years; a 22% increase for women aged 35 to 39 years, and a 4.8% increase among women aged 40 to 44 years (Daniels and Weingarten, 1982). Price (1977) interviewed 24 couples who each had their first child in their thirties or forties. The study was prompted by the surging birth rate for women aged 25 to 34 years. The research found that with the genetic and obstetric advances of the 1970s the chances of having a healthy baby were excellent for older women.

Price (1977) suggested that age, when related to emotional maturity and personal growth, has a positive effect on marital happiness. Couples who married at around thirty years of age made rapid and effective emotional adjustments, while 20 year olds experienced difficulties in finding marital satisfaction. Men who married at 20 years of age or younger were three times more likely to divorce than men who married after the age of 30 years. Most partners of first time mothers over the age of 40 years tended on average to be three years younger. This may be because mothers have been free to follow their chosen lifestyle, and consequently appeared to be more dynamic and youthful compared to other women. Older parents who had travelled or established careers were also much more aware of their "strengths and limitations" (Price, 1977, p. 25).

Many of the women who delayed parenting intentionally until their thirties were found to be exceptional achievers in their professions. Although these women derived tremendous joy from motherhood, they did not see themselves as just mothers. Price (1977) found that the women sampled had been educated to a tertiary level. They worked “. . . in a lucrative or interesting job, with well developed interests and activities, a wide variety of friends and did not equate having children with a woman’s role” (p.18). Postponement of parenting until after the age of 30 years was considered an advantage, especially with the escalating costs of child rearing. Price (1977) estimated the cost of a child from conception to college graduation for a middle to upper class family at approximately US\$200,000 in 1977. This figure is conservative and does not include the potential loss of earnings for the professional woman with a post-graduate degree who stays at home to care for her children until her youngest child has completed high school. This alone could add at least another US\$100,000.

Fabe and Wikler (1979) in their research titled Up against the clock interviewed 95 mothers, including ten women whose in-depth stories appear in their book. The research arose out of a personal need to seek information about this topic, as both of the researchers were over 30 years of age and unsure whether parenting would allow them both to continue with their careers.

Previously there was a belief that children’s characters are influenced by their mothers, making it important for the mother to be at home with her child. This view was challenged by some of the participants in Fabe and Wikler’s research (1979) who believed that because children’s personalities are shaped at birth it was unimportant who cared for the child as long as their needs were met. This was supported by Berger (1984) who argues that personality is shaped by hereditary factors and environmental influences.

By the time couples reach 35 to 40 years of age, they have often established professional careers, are more likely to feel secure in their work, and are no longer under the pressures they were in their twenties and early thirties. Younger mothers who take time out to have their children are under the dual pressure to commit to their children and to their careers. Conversely, the longer a woman has been employed the “. . . more likely the employer is to have a vested interest in retaining her position” (Price, 1977, p.31). The longer a woman stays home with her children the more

difficult it is to re-enter the work force, especially if she spent less than ten years in employment prior to having children. Increasing numbers of keen graduates with degrees or higher qualifications present fierce competition for these women. How well older mothers will fare depends on their age, skills and the length of time they have been at home.

Professional women are likely to enjoy more autonomy and flexibility of work time than other working women. Most of these mothers returned to some form of paid employment for personal reasons, financial reasons and career maintenance but were particularly careful in the child care they chose. The responsibilities of part time casual workers were never as demanding as those experienced by women working in a professional capacity. Some participants were happy to trade some of their career status to spend more time with their children. Others were reluctant to relinquish their responsibilities. Unfortunately the women could not predict these feelings prior to the birth of the baby. Some thought that they would be content to leave behind their competitive work environment, but by the time their child was three months old they could not wait to resume their careers.

Price (1977) also found that older parents were more easy going than younger parents, with the ability to draw on a greater range of resources which assisted them in coping with irritating child behaviours. More older mothers returned to work and kept up interests which relieved the pressure that they were under as constant caregivers and made their time with the children more enjoyable. Older couples were generally more financially secure, and were often able to afford child care, household help, holidays abroad and baby sitters. These luxuries are not usually available for younger parents. Many older parents only have one child who does not need to compete with other siblings for affection. The child can act naturally at all times because there is no competition for parental attention.

Fabe and Wikler (1979) identified attitudes towards work, demands of the job, beliefs about the availability of child care and the experience of motherhood as four key factors in determining the ease or difficulty of combining careers and parenting. Flexibility proved to be the most important influence in minimising conflict. The fourth factor, the experience of motherhood, impacts on the other three factors as a mother may reduce her work demands to spend more time with her child. Fabe and

Wikler (1979) found that overall stress and conflict levels were determined by the way the four factors interacted.

Forty years of age is not too late for parenthood, but the experience is significantly different than for first time parents between 20 and 30 years of age. In a comparative study of the timing of parenthood, Daniels and Weingarten (1982) interviewed 36 couples who had their first child at about 20 years of age, 36 couples who had their first child at about 30 years of age, and 14 couples who had their first child at about 40 years of age. Mothers in the latter group all had an amniocentesis during their pregnancy. All were interviewed at least one year after the birth. This group was well educated, with seven women and nine men holding advanced degrees. Many of the women were employed as professionals. Twelve of the women interviewed were employed full time before the birth of their child, while the other two women worked part time. After the birth of their children 11 of the 14 women returned to work within six months. The researchers found that this was a significantly higher incidence than for younger women. Family incomes ranged from US\$15,000 to US\$75,000. Most of the couples owned their own homes and were both employed full time. Although 36% of the couples were in mixed marriages their lifestyles reflected the culture of Caucasian Americans.

Daniels and Weingarten (1982) identified the availability of screening for chromosomal abnormalities and the larger numbers of women enjoying professional careers as factors contributing to the delay of first time parenting. Motherhood has become more of a choice than an expectation, and as we are now living longer a "never too late mentality" is not uncommon (Daniels and Weingarten, 1982, p.165). The pregnancies of four of the women interviewed were unplanned. One was due to a miscalculation of her menstrual cycle and the other three considered themselves to be infertile, not having used contraceptives for many years. The remaining nine pregnancies were planned.

There is no traditional wisdom for women who are seeking information about delaying parenthood until after the age of 40 years, as very little is known about the phenomenon of having a first child at that time. Perhaps this is why Daniels and Weingarten (1982) describe motherhood as an experiment, "to do it your own way" (p.166).

The children

Most of the research relating to older parents has concentrated on mothers. This section looks at the experiences of their children. Research by Yarrow (1991) focused on children born to parents aged 35 years and older. In their study relating to mothers over the age of 35 years Berryman et al. (1995) have included a considerable section which discusses the effect of delayed parenting on the children.

Yarrow's (1991) own experiences as a child of parents in their late thirties caused him to write his initial article on this topic in The New York Times. He decided to study delayed parenting and placed notices in three different publications seeking participants for his research. This sparked an immense amount of interest in the United States and Canada. The subsequent publication is written from a children's perspective of parents over the age of 35 years old. It does not distinguish latecomers who may have siblings 20 to 25 years older than themselves from delayed children of first time parents. A total of 800 people responded to the advertisements, 75 of whom were interviewed. The remainder were sent a four page questionnaire with multi choice and open-ended questions. Over 80% returned the questionnaires and at least 50% of respondents sent additional pages of their experiences. Respondents came from varied geographical and socio-economic backgrounds. Twenty six percent had no brothers or sisters, and a further 62% were last-born children. The participants ranged in age from 11 years to over 90 years old. The mothers' mean age was 38.5 years, with 40% of these women aged over 40 years old.

The many contradictory responses contained in Yarrow's (1991) research are at least partly explainable on the basis that the survey addresses an age range of over 80 years, and parenting styles have changed greatly in that time. Hence, while some of the findings showed that delayed children are more likely to be dependent, compulsive and susceptible to alcoholism, others showed these children to be more loved and protected, intelligent, high achievers, conscientious, intense, and jealous, with a greater self esteem than their peers. Yarrow (1991) found that it has become more fashionable to have children later in life and that although the stigma of older parents appears to be disappearing there is no doubt that this has caused problems for some children in the past.

Berryman et al. (1995) found that the mother's age made no difference to the child. Much more important were the feelings that the child shared with the mother. Fifty percent of the participants agreed with the statement "I feel that I had a unique and special relationship with my child" (p.231). These mothers were more patient and relaxed about discipline than 20 year old mothers, who were quicker to punish and ridicule the child. Children of younger parents sometimes wished that their parents had been older, observing that older parents are less likely to compete with their children. Of course, there are examples all over the world of grandmothers and foster mothers well over 50 years of age raising children as successfully, if not more successfully, than younger women.

Children of older parents considered themselves to be more advantaged than disadvantaged financially. Although some children found their parents distant, serious, and formal, it needs to be remembered that most of these children were born at least a generation ago (Yarrow, 1991).

Statements from only and first born children

"My parents were professional people who adored me . . ."
(p.11)

"My childhood was idyllic . . ." (p.73)

"They had planned and waited for me. I was not a last born accident." (p.71)

"My mother never worked after my birth . . ." (p.74)

"They did not get upset over minor problems . . ." (p.95)

"I was doted on and obviously adored . . ." (p.62)

"They never lost their temper . . ." (p.105)

". . . felt very comfortable and quite loved." (p.82)

(Yarrow, 1991)

Statements from latecomers

"My parents were relics of an earlier era . . ." (p.87)

"My mother was never "Mom" she was always 'Mother' . . ."
(p.89)

"There was no horsing around, she was always dignified . . ."
(p.89)

“When you grow up with older parents you think older automatically . . .” (p.90)

“I was brought up like someone in the 1930s rather than the 1940s or 1950s . . .” (p.91)

“ . . . old fashioned values, a strict disciplinarian.” (p.99)

(Yarrow, 1991)

The children of older mothers scored higher in intelligence tests even when the researcher controlled variables such as social class and education (Ragozin et al., 1982). These findings were echoed by Yarrow (1991) who agreed that children of older mothers were overall high achievers. A number of the children in this study were members of Mensa. This may be due to the stimulating experiences that their parents exposed them to. They enjoyed exciting holidays and mixed with their parents’ friends and social circles. Twenty percent of the children had first born friends or older siblings to bridge the communication gap.

A substantial number of first born or only children of older parents also delayed parenting as they had seen the benefits of this for themselves. Some women who delayed parenting continued a family trend, with one mother discovering that her parents, grandparents and great grandparents had all been over the age of 35 years when their first child was born. There were also first born children who had children of their own in their twenties because of negative feelings about their own parents. Some later considered this decision to be a mistake. One such woman compared her own parenting practice to that of her parents and conceded that her parents had done a much better job (Yarrow, 1991).

Having children when you are young was seen as positive by quite a number of participants. Yarrow (1991) does not always distinguish between latecomers and older delayed children but when he does so a substantial difference in attitude emerges. Latecomers are generally more resentful towards their ‘old’ parents, although this was not the case for delayed children. Latecomers generally regard themselves as an accident, whereas delayed first births usually cannot help but feel wanted. This issue is complicated by Yarrow’s failure to identify how old these

'children' were when they replied to the survey, as many of these children come from a different era when parenting was much more rigid.

Single parenting

Most of the research of older mothers has focused on mothers and their partners. Fabe and Wikler (1979) include the experiences of older single mothers in their study.

Married women often felt pressured into motherhood by society and peers. Fabe and Wikler (1979) describe how although towards the end of the 1970s single older motherhood by choice was not very common, single mothers when interviewed often expressed a strong desire to have a child of their own for psychological, social and ideological reasons. They either did not have the opportunity or did not choose to share this experience with a partner.

Single mothers expressed disillusionment with the matrimonial institution. They felt that strong career ambitions, an inability to fit into the traditional mother role, and radical or lesbian tendencies were incompatible with marriage. These women were very confident that they could care for a child psychologically, socially and financially. All the participants had carefully considered the aspects of single parenting and as time moved on they felt that they could not wait any longer for the 'right man' to share a parental relationship. One of the concerns at the time of the research highlighted the negative cultural stereotype of single mothers, but nearly 20 years later these no longer appear relevant (Fabe and Wikler, 1979).

For children born to a single woman the concern is always that the mother may be forced to bear the burden of an absent partner. Fabe and Wikler (1979) do not consider the child's dependency to be a concern for women who remain actively involved in their careers. Most of these women also have a wide network of friends and acquaintances to support them in their role as mothers and assist with child care. The women interviewed by the researchers were all from large urban centres and stigma was not a problem, although this could be different for a single mother living in a small provincial town.

Turner and Helms (1987) did not see any psychological or social problems in single mothers bringing up children without a male parent. Children who are brought up

without a male parent develop their gender identity through their extended family, media, literature and play with other children (Turner & Helms, 1987).

Like married women, the ease or difficulty experienced by the single mother in combining parenting with a career depends on job demands, work attitudes, childcare availability, and the experience of motherhood (Fabe and Wikler, 1979). Single mothers may need to be even more flexible than those mothers with partners, seeking support from family and friends or working with other parents in a network. Fabe and Wikler (1979) suggest that communal households where others are paid for their assistance in child care have been positive for single mothers. Such opportunities and the growing social acceptance of the legitimacy of the single mother means that many children will receive more support from a mature single parent who has made a major change to her lifestyle in order to care for her child than the child would otherwise receive if raised in a traumatic parental relationship. The study also shows that the older single mother with a career who has planned her support services carefully may find parenting less stressful than a professional married mother who also has to consider her partner.

New Zealand Literature

First time mothers from 30 to 39 years of age

Although New Zealand studies relating to first time older parenting have been limited, the results have been similar to those identified in overseas research. For example, the Society for Research on Women (1991) carried out a longitudinal study of mothers aged between 30 and 39 years old. The women were initially surveyed in 1981 at the time of their first birth, and a second interview was conducted in 1986. Reasons for delaying parenting were similar to overseas studies in that although women experienced some pressure to conform to the parenting role their decisions were not dominated by external influences. The main reasons for delaying parenting both in New Zealand and overseas seems to be related to personal goals and financial reasons.

Most of the participants made no conscious decision to postpone parenting. They made the decision to further careers, travel or buy a house, and only became parents when they felt the time was right. Only a few of the women had decided at an earlier age to delay parenting until after the age of 30 years.

The women stated that the birth of the child had contributed positively to their relationship with their partners. The majority had experienced a change in interests, friends and recreational activities. New friendships had been formed through the children and through neighbourhood contacts. Out of the 37 women initially interviewed in 1981, 16 women were in some form of paid employment at the time of the follow up, while 9 had been employed for some time since the interview and were not working at the time of the follow up. Twelve women had not returned to work at the time of the second interview in 1986. Only two of the women were in full time employment at the time of the second interview in 1986, although most women had initially intended to pursue their careers. Often a decision not to work, or to work only minimal hours was made because many women found fitting in with the children, home and work very stressful and extremely tiring. Quality child care was difficult to access as there were long waiting lists. A few women who had tried nannies claimed that finding a suitable person was very stressful and that some nannies were inclined to 'take over'. It would appear that at the time of this research New Zealand was still well behind many other Western countries in providing quality child care services.

Of the 37 women interviewed 26 did not intend to have any more children, most regarding 40 years of age as the limit of their physical and psychological childbearing capacity. The father was supportive, although many women considered that there was only so much that he could contribute. Most of the couples said that the children had enriched their relationship, although one admitted to being somewhat envious that her partner was able to get on with his life and that this was not possible for her. Twelve mentioned that they were no longer able to spend as much time with their partners.

The experience of having children after 30 years of age had been positive for most of the participants and, although for some this had not been a deliberate decision they did not feel trapped. Being financially secure was seen as very important, and many were pleased they had taken the time to achieve a number of goals prior to having children.

Overall the women acknowledged that the stability and maturity of age had combined to create the right time for motherhood for them.

Although the research by the Society of Research for Women (1991) has been informative it only pertains to first time mothers between the ages of 30 and 39 years. Statistics New Zealand (1996) has shown a steady increase in the number of women who delay parenting until the age of 40 years. Thus the aim of this thesis is to inform women about the phenomenon of first time motherhood after the age of 40 years.

In the next chapter the exploratory descriptive method underpinning the research in this thesis will be discussed.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter examines the philosophical viewpoints of the positivist/interpretive research debate. The focus later proceeds to a discussion of the exploratory descriptive design which is the method used in this research, followed by a description of the data collection methods and analysis. The chapter concludes with an overview of the ethical considerations pertinent to this study.

Positivist versus interpretive paradigms

The debate over the application of positivist and interpretive paradigms has been heated (Cushing, 1994; Greenwood, 1994; King, 1994; Nolan & Behi, 1995). Ongoing discussion, especially on the part of positivist scientists, has revolved around the subjectivity of the interpretive approach against the objectivity of positivist research in relation to what constitutes credible evidence (Thorne, 1991). Both the positivist and interpretive paradigms have furthered nursing knowledge through research.

A paradigm is a set of propositions which explain how the world is perceived. It breaks down the complexity of the real world by informing researchers “what is important, legitimate and reasonable” (Patten, 1990, p.37). Paradigms include assumptions, the important issues to be addressed or problems to be solved and the research techniques to be used (Neuman, 1994). The interpretive approach focuses on the meaning of observable human behaviour in its natural setting where the process of qualitative data analysis and data collection occurs simultaneously (Patten, 1990). The positivist paradigm places emphasis on measurement and quantification and is concerned with testing hypotheses which generate verifiable numerical or quantifiable data (Lincoln & Guba, 1985). Positivist philosophy assumes that there is only one reality or truth that exists independently of the human mind, a duality between the known and the unknown where everything can be explained by cause and effect, and

events are orderly and consistent. This is diametrically opposed to the multiple reality perspective of the interpretive qualitative approach, where knowledge of a phenomenon can only be sought through subjective experiences such as observing, describing and understanding (Streubert & Carpenter, 1995).

While debate about the two paradigms has often exaggerated distinctive attributes, the main difference between the two approaches lies in their divergent theoretical perspectives and particular world views (Carr, 1994). The positivist view maintains that the purpose of research is to discover more about the world so that events can be controlled and predicted. The philosophy and principles of the present day positivist paradigm evolved from the Cartesian philosophy of mind-body dualism. This was at a time in history when scholars' thinking changed from speculation about theological issues to "systematically describing, explaining and attempting to control natural phenomenon" (Polgar & Thomas, 1995, p.5).

The positivist paradigm is the oldest and most widely used approach (Lincoln & Guba, 1985). It defines reality "as everything that can be perceived through the senses; reality is 'out there' independent of human consciousness, it is and relies mainly on quantification to explain scientific theories known as "laws" (Sarantakos, (1993, p.34). These laws, known as 'the laws of nature' or causal laws are recognised as universally valid (Allen, Benner & Diekelman, 1986). Scientific research derived from these laws increases knowledge about the world. Quantitative methodology underpins a number of differing data collection methods including surveys, experiments and correlation studies. In order to obtain knowledge and to ascertain cause and effect the researcher controls and manipulates behaviours or events. During this process the researcher is assumed to remain neutral, detached, objective and rigorous in the application of rationality and systematic observations in a way which excludes personal prejudice (Nolan & Behi, 1995). A positivist, quantitative approach views the person as a rational individual who has no free will and is a composite of many quantifiable parts (Parse, 1995). Positivist research moves from the general to the specific by a deductive approach in which a hypothesis is tested.

The interpretive paradigm can be traced back to the nineteenth century, when Max Weber first expressed the belief that sociologists should be studying social action (Neuman, 1994). His idea of *verstehen* (empathic understanding) reflects a concern

for looking at how people feel on the inside, including how they viewed their lives and their personal motivations. This was the beginning of the interpretive social science, which differs markedly from the positivist view. The social researchers use methods which seek to understand the ways that other people see the world; to discover the embedded meaning (Patten, 1990). Reality is not constant. It changes with the environment, a person's background, his or her culture and gender. Interpretive researchers are committed to observing people in their own environment and attempt to interpret why "people act the way they do" and "what their motives are" (Neuman, 1994).

Interpretive qualitative research includes a number of different methodologies such as grounded theory, ethnography and phenomenology. Interpretive researchers seek to explain the entirety of a phenomenon. They are concerned with the holistic, dynamic and individual aspects of human experiences (Carr, 1994). Although each of the differing methodologies has its own focus there are some commonalities. Interpretive research takes place in the context of the situation and provides the researcher with a unique insight into a phenomenon which may not be gained in any other way. The researcher, through active involvement in the participant's reality, seeks to understand the meaning of the phenomenon by encouraging the participants to relate their experiences (Patten, 1990). This differs markedly from a positivist approach where the researcher is objective, detached and seeks to identify facts which explain, predict and control events (LoBiondo-Wood & Haber, 1994).

The choice of methodology to use, whether quantitative or qualitative depends on the question to be asked. Qualitative research addresses questions such as 'What is . . . ?' or 'How does . . . ?' (Morse & Field, 1995, p.14). But when the question is 'How much?' or 'How many?' the researcher should be looking to use a quantitative approach in which there is complete objectivity and data can be verified through further research under similar conditions.

Interpretive Research

Interpretive research designs appear to be used when very little is known about the topic and the researcher seeks to obtain the information from the 'expert'. One of the assumptions of the interpretive approach is that it is inductive. Theories or hypotheses arise from the data but these are relevant only for that period in time (Morse & Field, 1995). Phenomena may change over time, as illustrated in the literature review with the trend towards older first time parenting. There are few preconceived ideas in explorative or phenomenological studies, where little is known of the phenomenon. Knowledge can only be obtained from those persons who have lived the experience (Morse & Field, 1995). This is why the exploratory descriptive design was used for this study. The interpretive researcher is especially interested in the emphasis that participants place on events related to the phenomenon, which is why this approach is frequently conducted in the natural setting of the phenomena or in an environment selected by the participant (Carr, 1994). Participants must feel comfortable about accepting the researcher into the study as stressful relationships can distort data. Another reason for choosing to conduct research in the participant's environment may be to provide the researcher with a more holistic picture of the phenomena, exposing reality in its natural setting (Morse & Field, 1995).

Interpretive research does not rely on external controls or manipulation. It assumes that knowledge of the participant or the phenomenon emerges from inductive analysis of the data obtained through direct contact with the participants (Patten, 1990). Threats to external validity are reduced in interpretive research as the phenomena are studied in their natural setting where there are fewer controlling factors. However, the findings are unique to the participants and not generalisable to other settings. Nor does the interpretive method eliminate researcher bias, subjectivity, or environmental influences such as the intrusive presence of a tape recorder.

An assumption underpinning interpretive research is the belief that multiple realities exist, holding particular meanings for each participant. Individuals are involved in social interactions and as a result of these interactions each person views the world in different ways (Streubert & Carpenter, 1995). The researcher is committed to interpreting the world through the eyes of the participants using the most appropriate

method to suit the research question. There is a total commitment to understanding the person's world and recognising them as valued co-partners, which contributes to the enrichment of the data (Streubert & Carpenter, 1995). Researchers need to develop a close trusting relationship with the participants fairly quickly so that they will feel able to share their experiences.

Data are generally collected from interviews and observations while the researcher listens intently so that the reality of the participant's view is accurately portrayed. Because of the emphasis on the individual's reality qualitative research requires a minimum of structure, although there is a maximum of researcher involvement in attempting to understand the participants' experiences (Parse, 1996).

Data generated through stories or descriptions are analysed by searching for commonalities or themes. Through this process new theories emerge. Theories generated through qualitative methods are rich in description and assist nurses in their practice (Morse & Field, 1995). Although a qualitative researcher's focus is directed to generating theory, sometimes he or she may begin by testing known knowledge. Some researchers set aside or bracket any previous knowledge of the phenomenon until the research is completed, when it may be acknowledged and compared (Morse, & Field, 1995). For example, Husserlian phenomenology emphasises that in order for the research to have true meaning it must understand the true nature of the phenomenon. This understanding can only be obtained by bracketing the researcher's preconceived ideas and experience (Walters, 1994). To achieve this researchers must remain neutral in their thinking and block out any previous expectations of the phenomenon in order for the description to be a true account of the experiences of the participants (Streubert & Carpenter, 1995).

There are many researchers who do not accept that it is possible to bracket one's own experience and knowledge. Hermeneutical researchers interpret the text as they perceive it, through meaningful questioning (Ray, 1994). Researchers who adopt the hermeneutical approach believe that some experience of the phenomenon is necessary in order to interpret the data correctly. The hermeneutic view is based on the belief that the researcher approaches the interpretation of the phenomenon from a certain perspective or situational content and that it is not possible to bracket out one's past experiences. Patten (1990) expands this philosophy even further, believing that in

order to understand the findings of a hermeneutic study it is necessary to have knowledge of both the researcher and the participants.

During the data analysis certain data may be highlighted to identify discrepancies when compared to the rest of the data. The process of collecting data through unstructured interviews can be quite extensive and expensive in time and cost, which often limits the numbers of participants. Carr (1994) suggests that this could be a weakness of the study as the voluminous data may overwhelm the researcher who may be unable to limit or confine it. It is therefore important to ensure that the sampling is purposeful. The participants are selected for a clearly defined purpose which in this study relates to the experience of first time parenting over the age of forty years. Purposive sampling enables the researcher to study the phenomenon in detail. The size of the sample does not compromise the validity of the data as "the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size" (Peters & Waterman, 1982, in Patten, 1990, p. 185). It is important for the validity of the research that sampling procedures are fully described. The researcher must not only declare the strengths and weaknesses of the sample but also whether this affected the findings of the study in any way (Patten, 1990). Where there is a variance of data this will be marked in the study highlighting any major discrepancies. Data are closely examined for common themes, and grouping or clustering of data which is similar (Streubert & Carpenter, 1995). Qualitative data are presented in a literary style. It is vital that what is written portrays the perspectives of the participants as they see themselves and not as they are viewed by the researcher.

Exploratory Description

The choice of the research method depends largely on how much is known about the phenomenon (Morse & Field, 1995). An extensive search of the literature revealed very little information about "the experience of parenting by mothers over the age of 40 years". It was therefore impossible to identify a hypothesis from previous research. Morse and Field (1995) suggest that when the previous research pertaining to the topic is very limited either an exploratory descriptive qualitative methodology,

or the phenomenological method, would be appropriate as both of these are particularly suited to describing a phenomenon from the participant's perspective.

There appears to be some confusion in the literature over whether exploratory research is seen as qualitative or quantitative. LoBiondo-Wood and Haber (1994) viewed exploratory descriptive studies as quantitative survey designs which may be used to obtain accurate information about particular phenomena. Structured questionnaires, interviews or unstructured interviews may be used to collect the data. Only one variable is used to relate to another. There is no attempt to predetermine causation as in experimental research design. Polit and Hungler (1993, p.142) explained the descriptive method as "to observe, describe, and explore aspects of a situation" which could be used as either a quantitative or qualitative design.

By comparison Parse (1996) has discussed how the descriptive exploratory design (which will be used in this study), is derived from the social sciences and differs from some qualitative approaches such as grounded theory and phenomenology as it is not involved in the essences of things. She argued that descriptive exploratory studies are generically phenomenological but do not utilise the phenomenological method. The purpose of descriptive exploratory research is, according to Parse (1996), to investigate a phenomenon in depth to identify patterns and themes. The questions which guide data gathering are generated by the researcher and arise from the conceptual framework of the study, which is different from phenomenology where the context and content are driven by the participant. Polkinghorne (1983, 1988 in Parse, 1996, p.12) has described two different narratives: descriptive narrative, which is "a story told by individuals or groups about an experience, event, object, idea or lived experience" and explanatory narrative, "a linguistic account of why an event occurred". This research used the descriptive narrative. Although the outcomes of the two methods are different the process of data collection and analysis is quite similar.

Parse (1996, p.10) refers to phenomenology as "an approach which implies that the researcher studies the phenomenon as it is lived in a natural setting using processes that lead to narrative descriptions". She describes as grounded in phenomenology such methods as descriptive exploratory, grounded theory and hermeneutics, and labels phenomenology "the study of the phenomenon as it is, lived in a natural setting

using processes that lead to narrative description" (p.10-11). Omery (1983, in Streubert & Carpenter, 1995) described the phenomenological method as an approach which "is inductive and descriptive in design" (p.30). It is the description or story of the person's lived experiences and the perceptions of these experiences which gives meaning to the phenomenon. Van Manen (1990, in Plager, 1994) has offered some practical principles and guide lines for interpretive research:

1. Turning to a phenomenon, which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualise it;
3. reflecting the essential themes, which characterise the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole.

(van Manen, 1990 in Plager, 1994, p.78)

These guidelines are well suited to this exploratory descriptive study which seeks to obtain information about the experience of older motherhood, a concept about which little is known.

In the exploratory descriptive design the researcher seeks to accurately describe the characteristics and experiences of people and their life styles (Patten, 1990; Kellehaer, 1993). Seaman (1987) believes that anthropological, historical and ethnosience studies which seek to understand the culture of people in their natural settings, are all suited to the method of exploratory studies. This method has the advantage of accumulating extensive data with a richness of detail which has not previously been available and is therefore often the foundation for further studies (Seaman, 1987). The overall focus is on the 'what', 'who' and 'how', while the findings present a detailed picture of the phenomenon (Neuman, 1994). In descriptive exploratory design the researcher collects a wide range of information which has not been

available previously, as in this study of first time mothers over the age of 40 years old, where the trend has only begun to develop over recent years. Throughout the process of data analysis the researcher is analysing and comparing the data, identifying themes and patterns until an authentic view of the phenomenon is achieved (Seaman, 1987). The descriptions must be thorough and detailed as the foundation of the theory will be developed from the descriptions.

The method used in this thesis, has similarities to descriptive phenomenology. However, the exploratory descriptive design was selected because the aims of the research were not confined to the understanding of the 'lived experience' of first time mothers over the age of 40 years. In addition to exploring the meaning of motherhood over the age of 40 years the research sought to identify coping strategies used by older mothers and the helpfulness of health and social services. Thus the interview process did not solely seek narrative description of the phenomenon as lived. Questions designed to elicit information about coping strategies related to aspects of motherhood, the use and helpfulness of health professionals and social services were also introduced.

The Participants

In their work on qualitative research methods for health professionals Morse & Field (1995) discussed the appropriateness and adequacy of sampling. In qualitative research the number of participants are kept to a minimum as otherwise the time and cost involved can become excessive. For this study 11 women who were 40 years old at the time of their first child's birth were invited to participate in the study. All of these children were aged five years or older at the time of the study.

Because of the interpretive nature of the research a maximum of ten participants was initially agreed upon to meet the requirements of the thesis for Massey University. A problem in recruiting participants was initially envisaged because of the difficulty of informing women in the target group about the research. Accordingly two of the participants were accepted into the study even though their children were only three and a half and four and a half years of age. In retrospect this was unnecessary as a total of 17 women who met the criteria volunteered to participate in the research. One

of these women was recruited in case any of the participants withdrew, but the others were not accepted because the sample maximum had already been achieved and there were time limitations imposed. Except for the two children whose mothers were recruited initially, the children of the remaining participants in the sample were all over five years of age.

The participants all spoke fluent English and had lived the experience that the researcher was investigating. They volunteered to participate in the research following a newspaper article outlining the purpose of the study. The article stated that any woman who met the criteria and was interested in becoming a participant could contact the researcher by phone. All the participants volunteered either as a result of reading the newspaper article or were informed about the article by their social networks. Following the initial contact interested participants were sent an information sheet outlining the nature and purpose of the study, the method of data collection, how their anonymity would be protected, and their role in the research process (Appendix 1). The participants were self selecting and knew that they were able to withdraw from the study at any time.

The development of a trusting relationship between the participants and the researcher was crucial for this study. If the relationship is not based on trust participants may withhold crucial information, a result of feeling unsafe in the relationship.

Participants were asked to sign a consent form prior to the commencement of the study (Appendix 2).

Data Collection

Data were gathered from semi-structured audio taped interviews, and from the observations and impressions of the interviewer which were documented in a journal. The participants chose the venue for the interviews. All except two were in the participants' own homes. The other two interviews took place in the researcher's home at the participants' request. Prior to the commencement of each interview the researcher ensured that the participant was as comfortable as possible and asked whether she had any questions. Demographic data were confined to the age of the woman at the birth of her first child, her ethnicity and whether she was in a permanent

relationship. It was anticipated that other relevant data would emerge during the interview. An overall statement was made by the interviewer directing the focus of the interview to include the reason(s) for delaying parenting, experiences in becoming a mother, and how motherhood had affected her lifestyle.

Morse & Field (1995) state that it is important to allow time for the participant to ask the researcher questions which may have been concerning her and which had not been addressed in the information sheet. This should ideally be done before the interview as the participant may have a concern which (if not addressed) could adversely influence the interview.

Prior to the commencement of the interview the researcher asked individual participants whether they had any questions. Minor questions were asked relating to how loud they would have to speak and whether the researcher would prompt them if they became 'tongue tied'. They were reassured that they could speak normally and that they would be prompted if they experienced problems in 'telling their stories'. Some of the participants did require some prompting but when the researchers requested the women to talk about another aspect of their stories they continued to relate their experiences.

At the conclusion of the interview the participant was asked if she had any further questions related to the process of the research, as suggested by Morse & Field (1995). All the participants stated that they felt comfortable with the interview and had no further questions, although they were happy to answer any further queries that the researcher might have.

The interview process allows the researcher to prompt the participant when this seems appropriate, thereby increasing the richness of the data (Patton, 1990). During the interviews the researcher occasionally brought the participants 'back on track' when they lost their momentum. This was usually more in the form of an acknowledgement or encouragement. Structured interviews are inclined to become stilted as the researchers may only ask questions pertaining to their own interest, potentially creating a bias in the data. The purpose of these interviews was for the women to talk freely about their experiences as older first time mothers. Morse & Field (1995) state that an unstructured interview is commonly used when there is very little known about

the topic as in this study. The researcher had some prepared questions to fall back on in case the participant was unsure as to what was required of her or if she forgot what she was saying, but they were not required.

Patten (1990) has discussed how data triangulation increases the validity of the research. If only one method of data collection is used the study could be vulnerable to misinterpretation or bias, especially if the participant was anxious or the research question was slanted. This opinion is supported by Kimichi, Polivka & Stevenson (1991) who found that the interpretative process was enhanced by using differing data sources such as observation, open ended questions in interviews and cross checking of transcripts by the participants. It is in the data analysis that different methods of data collection lend credence to the credibility of the study. Streubert and Carpenter (1995) also supported the value of multiple data collection and found that handwritten notes of descriptive observational data generated by intense listening, assessing the social situation and the reactions of the participant, combined with verbally transcribed accounts helped to achieve the most comprehensive and accurate descriptions.

Patten (1990) warned that although analysis triangulation will seldom concur, it is important to understand why this does not happen. It frequently means that the researcher, using different data collection methods, has perceived differing understandings of the phenomenon and in order to increase the validity of the research the reasons for this must be examined and explained. For instance observational data may differ from interview data. This may not mean that either method is invalid, but rather that each method has collected different information. If journal notes are initially separated from transcribed data and later compared to assess differences or similarities during the identification of themes and patterns of observations, the reliability of the findings is increased (Kimchi et al., 1991). In this study the data was collected by the researcher who used an audio recorder and kept a journal relating to the observed behaviour of the participants. The participants were sent a copy of their transcript as well as the thematic analysis pertaining to it. They were requested to make changes or corrections in the transcript and the thematic analysis if on reflection they considered that this was not really how they perceived their experiences. Some

of the participants made minor alterations to their transcripts but this did not alter the interpretation.

Triangulation of data analysis gives the research more validity. Indeed, Patten (1990) has discussed the importance of providing the participants with the analysis and asking for written comments on the credibility of the report. Potential bias was also reduced by involving the researcher's supervisor, who in this study was actively engaged in the process of the analysis.

Data Analysis

The data analysis followed the principles and processes used in qualitative research. Analysis begins simultaneously with the collection of the data. Miles & Huberman (1984) view data collection as an interactive model, a continuous cyclical process of data collection, data reduction, data display, coding, and conclusion drawing or verification. The aim of the cycle is to identify patterns and themes which form the structural meanings of the data. The process of questioning and verifying is a crucial aspect of data analysis, during which listening is critically important in order for the researcher to discuss and interpret meanings (Streubert & Carpenter, 1995). During data analysis patterns were observed. From these patterns information was clustered under identifiable themes. Thematic analysis revealed a central theme (child centredness) which permeated throughout three cluster sets. These cluster sets influenced the central theme and became the sub-themes. The analysis was verified with the participants which heightened the trustworthiness of the analysis.

Ethical Considerations

Because this research involved participants from a very unique group of women, extra precautions were taken to protect their anonymity. As this was an easily identifiable group, participants were requested to choose pseudonyms for the purpose of the research. There were no problems with this and no-one chose the same name.

The research proposal was submitted to the Massey University Human Ethics Committee and a large regional Health Ethics Committee. Written informed consent

was obtained from the participants prior to the commencement of the interviews (Appendix 2). They were informed about the necessity to tape the interviews and that at the conclusion of the research the tapes would be erased. The information sheet (Appendix 1) was discussed with the participants. They were asked to sign a form consenting to their participation in the research. These forms were stored securely, separate from the data collected.

Reliability, Validity and Reactivity

The measures identified by Lincoln & Guba (1985) as credibility, transferability, dependability and confirmability were used to establish the reliability and validity of the research.

Credibility was achieved by returning the transcripts and the thematic analysis to the participants to ensure that the written account was a true interpretation of their experience as older mothers. Was this the way the women perceived themselves to be? Verification of the research will only truly be achieved when other older first time mothers accept the report as valid.

Transferability occurs when another researcher undertakes a similar study in a very similar context to the initial study and achieves very similar results.

Dependability was validated by the research supervisor who worked closely with the researcher and discussed process and progress at regular stages of the study. The supervisor read the transcripts, which ensured that the contextual nature of the women's stories was preserved. This has been likened to an "audit trail" (Lincoln & Guba, 1985) where all the entries in the ledger are checked off. The auditor (or supervisor) was able to verify the research process to ensure that all the entries and interpretations fell within acceptable professional, legal and ethical limits. The supervisor was well acquainted with the method which ensured that the process was sound.

Confirmability will be established when credibility, transferability and dependability are achieved (Lincoln & Guba, 1985).

Paterson (1994) warns qualitative researchers to guard against research vulnerability when confronted by incredible information in the interpretation of the data. The response of the researcher and the research participants to each other during the research process is described by Paterson (1994, p.301) as “reactivity”. Such reactivity or vulnerability is similar to the Hawthorne effect which occurs when participants react differently than they normally would because they know that they are being observed (Neuman, 1994). Researchers must be aware of their influence on the data collection. Paterson (1994) argues that to understand this they need to reflect on their past experiences and behaviours and attitudes. If researchers are able to identify how they react to the participants’ experiences it will enable them to acknowledge this in the data interpretation.

Paterson (1994, p.303-307) identified the sources of reactivity as five central themes:

- **Emotional valence** relates to the level of trust established in the data collection which may determine to what extent the participant is willing to share the data.
- The **distribution of power** may be experienced as an issue either by the researcher or participants.
- The **goal of the interaction** may be unclear to the participants which confuses the purpose of the research.
- The **importance of the interaction** needs to be respected especially when the researcher is bored or tired by the mundane responses of the participants and seeks to focus on the exotic or extreme data.
- The **effect of normative or cultural criteria** relates to our personal values of behaviour which may differ for the researcher or participant and consequently be misinterpreted. Trust between the researcher and the participant is essential in qualitative research.

Paterson (1994) suggested several ways in which the researcher might identify reactivity, including bracketing, journaling, memo writing, peer review, and member checks. However she also acknowledged that this is time consuming, and suggested

that the five themes of the reactivity analysis framework might be more user friendly to the researcher.

This chapter has presented a comparison of the positivist and interpretive paradigms and discussed the descriptive exploratory method used in this research. The ethical issues, interview process and selection of the participants have also been considered.

In the next chapter an introduction to the research findings and their interpretation will be given. The findings have been divided according to the major emergent themes and have been assigned individual chapters (ie. Chapters Five, Six, and Seven).

CHAPTER FOUR

INTRODUCTION AND OVERVIEW OF RESEARCH FINDINGS

New Zealanders have been slow to acknowledge the growing number of women who choose to delay parenting. The importance of this phenomenon is reflected in the 30 to 34 year old age group, which is now the second most popular cohort for mothers who are having their first baby.

Why another study on delayed parenting?

The only local work which is of relevance to the current study is a publication by the Society for Research on Women (SROW) (1991), undertaken in Wellington. It is now 16 years since the SROW began their longitudinal study, which focused on the experiences of first time mothers between 30 and 39 years of age during the first five years of motherhood. In the SROW research 87% of the participants were between 30 and 34 years of age at the birth of their first child, while the remaining 13% of women were aged between 35 and 39 years. Eleven percent of the total number of first births for married women in 1982 (when the study commenced) were to women in the 30 to 34 year age group (Statistics NZ, 1996).

In the current research all the participants were over the age of 40 years at the birth of their first child. Their children ranged in age from 3½ to 20 years old. In 1995 the percentage of married women who gave birth to their first child in the 40 to 44 year old cohort was 1.4% of the total number of births to married women.

A trend towards delayed parenting in the 30 to 34 year age group was already apparent when the Society for Research on Women (1991) initiated its research in 1982. Yet in 1997 a pattern of first time parenting after the age of 40 years is still in its infancy. Statistics New Zealand figures are based on nuptial births, and in 1982 de facto relationships were not as popular as they had become by 1995 (Statistics NZ, 1995). The incidence of first time older motherhood after the age of 40 years could

therefore be considerably higher than these statistics indicate. For these reasons the current study is important, not only for women who are contemplating delaying parenting, but also for midwives and nurses who will be caring for this group of older women and their families. With the exception of the SROW (1991) study, the research in the area of older mothers has been dominated by overseas studies.

Demographic Data of the Participants

Eleven women who became first time mothers after the age of forty years volunteered to participate in the research. Ten of the eleven participants were married or in a stable relationship with their child's father. One of the participants was a solo parent who was not in contact with the father of her child. The women's ages at the commencement of the study ranged from 44 years to 60 years. The women had 14 children between them, ranging from 3½ to 20 years of age. Three of the mothers gave birth to their second child before their first child's third birthday. There was a predominance of sons in the group (10 sons compared to 4 daughters). The mothers were all European New Zealanders from middle to upper socio-economic backgrounds. All the women were highly articulate and appeared keen to share their experiences so that other women could make a more informed choice about delaying parenting. After an initial hesitancy which appeared to be related to the tape recorder the participants spoke freely. As the information was not generally overly sensitive there was no evidence that any relevant information was withheld.

Interpretation of the data

The guidelines proposed by van Manen (1990, in Plager, 1994) for interpretive research proved to be very useful during the interpretation of the findings.

1. Turning to a phenomenon which seriously interests us and commits us to the world.

The phenomenon of older motherhood was of particular interest to the researcher, both professionally and for personal reasons as stated in the preface.

2. Investigating experience as we live it rather than as we conceptualise it.

The experience was lived by the participants and the researcher was privileged to share their stories.

3. Reflecting the essential themes which characterise the phenomenon.

Reflection was a continuing process which was aided by the researcher becoming immersed in the data by re-reading the verbatim transcripts of the data followed by continuing reflection. Initially everything in the data and the researcher's observations were relevant, but through reflection the trends and similarities were grouped together. After consideration the central theme of child-centred and the sub-themes were identified in this way.

4. Describing the phenomenon through the art of writing and rewriting.

Writing was hard work and involved a sequence of steps. Organisation of the material was a high priority, requiring an outline to provide early structure (although this changed considerably during the writing and rewriting process). Ensuring that all the ideas followed a sequence proved to be vital in producing a legible report. Writing and re-writing involved a re-examination of the literature and findings. Keeping an open mind and adjusting to the changes was important. Proof reading by a second person was found to be invaluable.

5. Maintaining a strong oriented pedagogical relation to the phenomenon.

The researcher maintained the veracity of the experience as it was lived by the participant who narrated it to her. The researcher became absorbed in the research and so

maintained a strong focus throughout the duration of the project.

6. Balancing the research context by considering parts and whole.

It was important to become immersed in all the aspects of the data. Maintaining an overview of the whole thesis assisted in the identification of the central theme and sub-themes.

(van Manen, 1990, in Plager, 1994, p.78)

Reactivity

Reactivity was not apparent during the data collection, but should be acknowledged as a possible limiting factor of the research findings. The five central themes of reactivity described by Paterson (1994, p.309) and discussed in the methodology chapter may now be applied to the data collection.

- **Emotional valence** relates to the level of trust established in the data collection which may determine to what extent the participant is willing to share the data.

The participants did not appear to withhold any information intentionally. This was evident in their fluency during the interviews. The participants showed no apparent hesitancy when relating their experiences.

- **Distribution of power** may become an issue either for the researcher or participants.

Although it was difficult to eliminate all preconceived ideas and my observations may be biased, I believe that power was not an issue. The participants and the researcher were professional in their interaction and appeared comfortable with each other. This was further substantiated by the friendly encouraging notes received when the participants returned their transcripts.

- The **goal of the interaction** may be unclear to the participants, which confuses the purpose of the research.

The overall purpose was quite clear; it was an integral part of the data collection.

- The **importance of the interaction** needs to be respected, especially when the researcher is bored or tired by the mundane responses of the participants and seeks to focus on the exotic or extreme data.

This was not an issue in the data collection as all the participants were seen as individuals and each had her unique story to relate, while the researcher was keenly interested in the topic.

- **Effect of normative or cultural criteria** relates to our personal values of behaviour which may differ for the researcher or participant and consequently be misinterpreted. Trust between the researcher and the participant is essential in qualitative research.

Although this study did not focus on cultural norms as it was attempting to establish these, this theme did not appear to be a problem. The participants believed that they were assisting other women by relating their experiences which were valued. Trust was evidenced by the enthusiasm of participants to assist with the research.

The researcher used a process of critical reflection in the identification of the themes. No reactive effects were identified in the collection of the data.

Paterson (1994) also warns of the possibility that the relationship between participant and researcher may become too close. This is acknowledged to be a complicating factor, but it is submitted that the research has not been compromised by proximity. The relationship between researcher and participants was friendly and non-threatening. At no time did the researcher become a confidante of any of the participants. Although the researcher recognises that no interpretative research is value free, every attempt was made to maintain an objective, professional approach throughout the research.

Themes

The overall experiences of the participants were very similar. Most of the women had waited several years to have a child. The mothers were totally child focused and the child was considered in all their activities both before and after the birth. The central theme of 'child centered' was an integral part of the mother and child relationship.

The researcher identified three major influences on the child centred theme which became the sub themes (See Figure 1, p.62):

- awareness of passing time;
- the need to know;
- what if something happens?

The central theme of child centredness appeared to motivate the mothers in every activity they undertook. While the participants did not make this child centred focus explicit in their interviews they verified that the theme pervaded the subthemes. Each of the sub-themes has categories relating to them. The findings and interpretation do not follow a chronological order from pregnancy through to teenagers but are presented under the sub-themes and categories that are appropriate for them. The findings and interpretation relating to each of the sub-themes will be discussed in separate chapters.

In the three chapters which follow:

- an overview of the participants' experiences of older motherhood in the 1990s is provided;
- the findings in relation to the literature are discussed;
- the implications of the findings for nursing and midwifery practice are considered.

Chapters Five to Seven are titled:

- **AWARENESS OF PASSING TIME**
- **THE NEED TO KNOW**
- **WHAT IF SOMETHING HAPPENS?**

The implications for nursing and midwifery practice are presented under the appropriate category, as are the health and social services that the participants found helpful or would like to see improved.

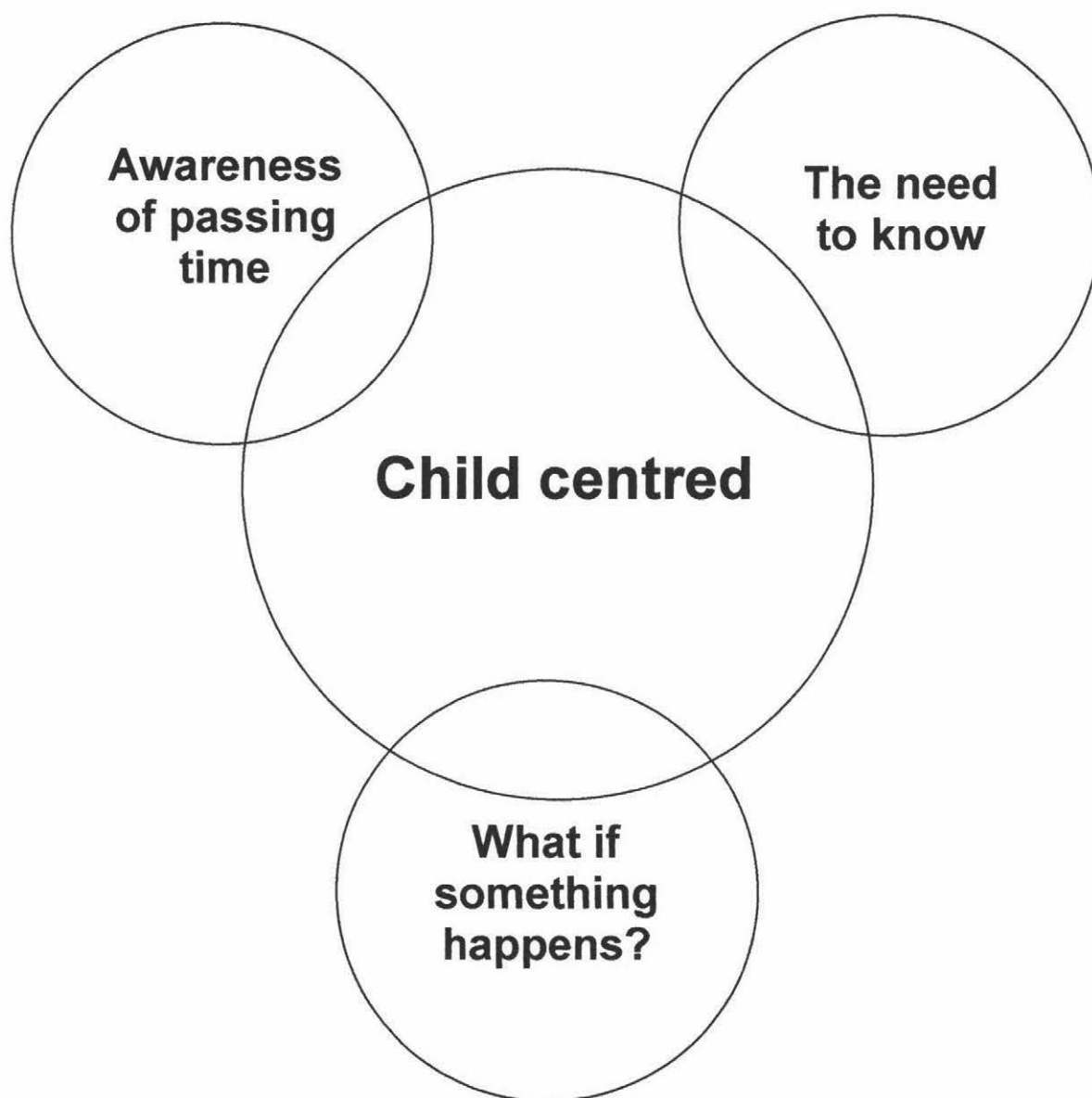


Figure 1: Interconnected themes

CHAPTER FIVE

AWARENESS OF PASSING TIME

The 'awareness of passing time' relates to the passing years of motherhood. In the years prior to becoming parents the participants were free to enjoy life as they pleased. Although some women opted to travel and others chose to further their careers, the overall goal was to become financially secure. In this chapter the mothers reflect on their lives and discuss the advice that they would offer to other women who are contemplating delaying motherhood.

The participants claim that it was not their intention to delay parenting until their forties. Time moved on and their biological clocks caught up with them, leading to a difficult period when many of the women were initially unable to conceive. After some delay most of them conceived naturally. Several of the women went on to try for child number two, and three of the mothers later gave birth to a second child. The happiest time was during the preschool years when they cherished their 'precious' gift. They had lived their lives to the full and now they could enjoy this 'wonder'.

Included in the concerns of older mothers is the adjustment that these capable women had to make in their first energy-depleting year of parenting. Although they had experienced long working hours, a busy social life and shift work nothing had prepared them for this exhaustion. Their age in comparison to the parents of their children's peers was a concern for some mothers while most of them saw the teenage years as a challenge.

This chapter explores the mothers' awareness of passing time in relation to four categories (see Figure 2, p.64):

- Reasons for delaying parenting
- The biological time clock
- Happy being home
- Concerns of older mothers.

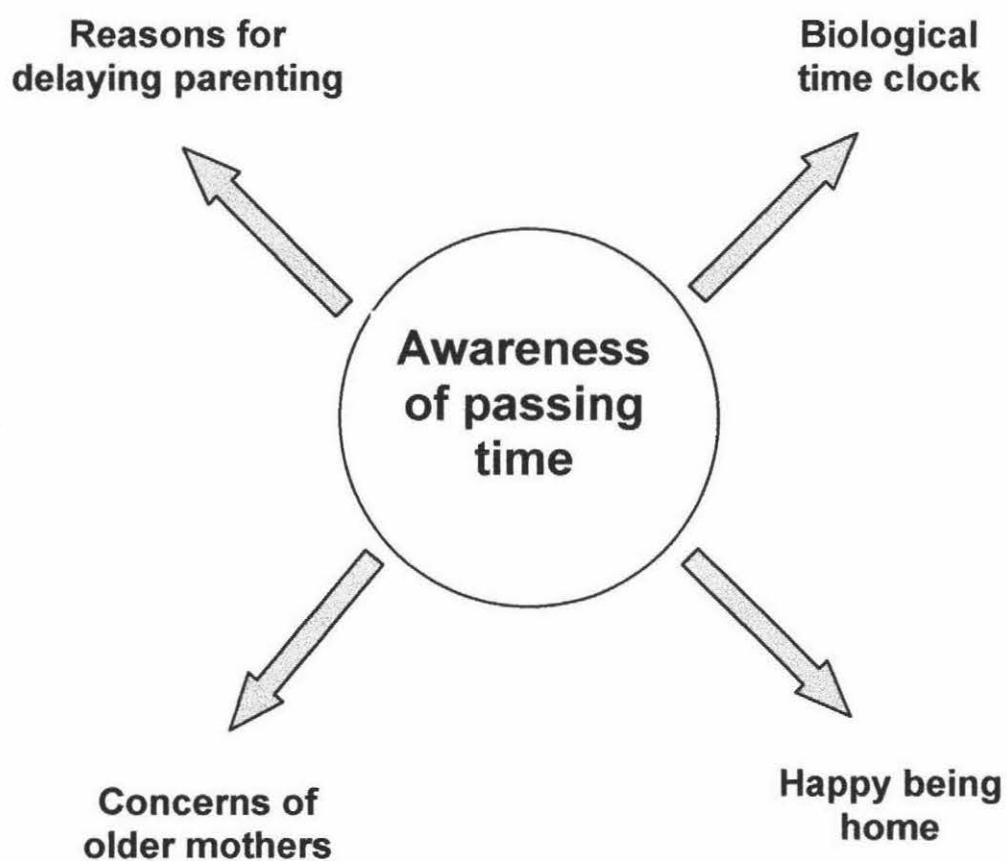


Figure 2: Categories of 'Awareness of passing time'

Reasons for Delaying Parenting

Exploring motivations

The participants were all professional career women at the time of conception. Most considered parenting a low priority when aged in their late teens or early twenties, with the exception of one participant who was unable to find a 'suitable' partner. The other women generally agreed that although the choice of partner was important, this was not the primary reason for their decision to delay parenting. Most were waiting for the right time to settle down and raise a family. Three of the mothers who entered into a permanent relationship in their twenties decided that their priorities were to become financially established and to develop their careers or travel. Parenting was postponed until they were more financially and emotionally prepared:

We made a conscious decision not to have a family initially, and I went on the normal pill and we decided that we were going to be a working couple for a while to get our pennies together.

I decided to wait to have children. I had other things to do.

The decision to delay parenting was generally motivated by at least one of four needs: a need for time to enjoy life, to travel, to pursue career ambitions or to achieve financial goals. Seven out of eleven women who stated that they needed more time to enjoy life had recently completed some form of education such as teaching or nursing. A number of the mothers developed or changed careers, while others travelled extensively with partners, friends, or by themselves:

We sort of went through Australia and Africa and then to London and back through Africa. We did a bit of industrial nursing and private nursing, so that was a wonderful lifestyle.

Berryman, Thorpe and Windridge (1995) detail interviews with women who gave birth to their first child on or after their 35th birthday. These mothers considered that reliable contraception, improved reproduction technology, the biological clock and a feeling of readiness were the main influences on their decision to delay parenting. A study by the Society for Research on Women (1991) describes an increasing

incidence of delayed parenting in this country since the early 1980s. Researchers report reasons for delayed parenting which bear striking parallels with the motivations described by participants in the current research, although they are less closely related to the desires of the American women interviewed by Berryman, Thorpe and Windridge (1995). Parenting was delayed because of career aspirations, travel and because the participants did not feel ready for parenting at that stage.

Delayed parenting has been fashionable in the United States and Western European countries since the early 1970s. Although the trend began in middle and upper socio-economic groups it now boasts a more mainstream appeal (Price, 1977; Daniel & Weingarten, 1982; Morris, 1987; O'Reilly-Green & Cohen, 1993). Harker & Thorpe (1992) predict a continued increase in the number of women choosing to delay parenting as women become increasingly concerned about the financial cost of child rearing and the effect that motherhood could have on their careers.

Advice for older parents

Each participant's reasons for delaying parenting were unique. Remarkably, not one participant remembers planning as a 20 year old to delay parenting until after the age of 40 years. When these women were 20 years old the majority of New Zealand women were still giving birth to their first child before the age of 24 years (Statistics NZ, 1996). With the benefit of hindsight, most participants admitted that a more appropriate age to become a mother would have been when still aged in their early to mid thirties. This timing was based on the biological clock because "if you leave it too late you might miss out" Although nine of the women had conceived naturally, they recognised that after the age of 40 years of age the biological clock was likely to impose limits on the opportunity to conceive. However, all participants agreed that the decision to delay was based on criteria unique to each individual, and that no 'best time' was generalisable.

I wouldn't delay until 40 because there is the danger that you may not be able to have children. I would say start planning early to mid thirties, it's nice to be financially secure. It helps that you can pay for somebody to come in.

All of the participants had enjoyed the opportunity to do their own thing prior to becoming parents:

To me you haven't lived. You've really got to do what you want to do when you're young, and get it out of your system, and then start having a family. So I think that later in life you handle it a lot better and you get more pleasure out of it.

If you want a career, you want to travel, it would be wrong to enter into motherhood because that won't disappear, you'll probably want those things even more when you have a screaming child. I don't think that age comes into it, it's being in the right frame of mind.

One woman who frequently travels to visit family in the United States found a much greater acceptance and awareness of the needs of older parents in that country.

Overall people in New Zealand do not believe that it's a wonderful situation to be a mother over 40, this child is lucky. I now have a mindset at over 40 that my child is very important to me and I'm prepared to make sacrifices to ensure that he has a good start in life.

This mother believes that a trend to delay parenting until after the age of 40 years is still in its infancy in this country. Increasing interest in fertility-assisting technologies means that New Zealanders are likely to develop a heightened awareness of this pattern over the next ten to fifteen years..

Implications for practice (stimulated by the data)

Midwives must gather as much information as they can to be able to advise women about delayed parenting, particularly with regard to the possible risks faced by older women during their pregnancy, labour and delivery and the availability of support services for the parenting years.

The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post partum period.

(NZ College of Midwives, 1993, p.9)

As growing numbers of New Zealand women choose to delay parenting, 30-34 years of age is already the second most popular age group for first time motherhood. Midwives and nurses are increasingly likely to encounter older women in the 35-40 year old age bracket who are pregnant with their first child. Like the participants, many women in their early forties are enthusiastically seeking information on parenting. These women are especially likely to ask how long pregnancy can safely be delayed. They will draw from professional and personal experience to demand the best possible care for their babies.

Biological time clock

Some of the participants decided to delay parenting because they feared the disruption of their lifestyles. Nearly half of the mothers were in their early to middle thirties when they first decided that the time was right to have a child. A 34 year old mother who had been married for nine years stated that:

It was a time in our lives when I felt that if we were going to have a family it was time to do so.

But nature did not always cooperate and several mothers experienced problems conceiving. Five of the eleven participants sought infertility treatment. Extensive waiting lists in New Zealand forced some of these women to travel overseas for treatment. One woman who had tried for two years to conceive was warned that she had just a ten percent chance of conceiving naturally. She chose not to wait for a GIFT (Gamete IntraFallopian Transfer of oocytes) programme to become available in New Zealand, instead rushing to an Australian clinic which was able to treat her immediately.

So we rushed off there and went through all the GIFT programmes and whatever. Nothing happened, that was very disappointing. We went to Fertility Associates after that and we ended up with two GIFT attempts in one year. I did get pregnant the second time but lost it at six weeks. I was quite relieved because I felt absolutely disgusting. In no way would I want to go through it all again. We tried to resign ourselves to the fact that there wouldn't be any children. I don't think you ever really give up 100%, and then about eight years after we started, I was 39 and we had a lovely holiday and I got pregnant!

Infertility deals a huge blow to self esteem, not least because of the feeling of invasion arising from the intimate nature of most treatments (Marshak, 1993). As one participant stated:

You have to remove yourself from the treatment . . . the whole process is horrible yet you have to stay optimistic and relaxed in order for the treatment to work.

Another participant was extensively treated for infertility with a course of drugs which led the gynaecologist to conclude that there was no reason why she could not conceive naturally. Later tests by a general practitioner on the woman's husband revealed the actual cause of the infertility to be a very low sperm count:

. . . so we were told to keep on boxing and sort of not to worry about it.

It was ten years after initially seeking treatment before this woman conceived. Most of the mothers were in their mid-thirties when they experienced infertility problems, and although most received varying forms of IVF treatment only two couples conceived as a direct result. The remaining couples found the treatment so traumatic and disempowering that they exited the programme. These women eventually conceived naturally after the age of 40, when they had given up all hope of having a child.

Davis and Dearman (1991) advise couples who feel disempowered or suffer low self esteem to take time out from the fertility treatment or to limit the time they pursue further cycles. Psychological trauma associated with the treatment is itself likely to have a negative effect on fertility. This is likely to have occurred with at least one couple studied who had been involved in infertility treatment for seven years without conceiving. Eventually they resigned themselves to childlessness.

So we said goodbye and thank you very much for all you've done and decided to pursue our lives without children. In my 41st year I amazingly fell pregnant completely out of the blue, and then conceived again a year later and lost that baby and conceived again a year later and we had . . . who is now two and a half.

The couples felt very alone and found it difficult to discuss their feelings with friends or relatives. Although participants who came to believe that they could not conceive

made a conscious decision to get on with their lives they often experienced feelings of loss and helplessness.

I know that I got fairly low at times. I think that it was always there at the back of my mind. I didn't think that I could ever come to terms with this.

Five of the mothers decided to try for a second child, although only three succeeded. One mother who first conceived at the age of 41 years made continued efforts to conceive again, until she reached the age of 46 years.

Implications for practice (stimulated by the data)

Marshak (1993) discusses the benefits of individualised care by a nurse or midwife. Such practitioners can market their patient management skills, their considerable knowledge and understanding of infertility and various treatment regimes, their extensive research background and their skills as a supportive counsellor. They may work with an obstetrician to co-ordinate client care and relieve some of the burden of basic fertility care. The nurse or midwife is well equipped to extend existing research, benefitting women and enhancing the reputation of their clinic. This expert nurse or midwife will be aware that most women prefer knowledgeable professional care given by someone of their own gender who has the ability to intervene therapeutically in an appropriate empathetic manner (Marshak, 1993).

Women undergoing infertility treatment need the expertise of a health professional who has a concern for the individual woman's quality of life, an understanding of the patient perspective, and the skills for communicating relevant information to meet the client's needs. Skilled independent midwives with appropriate knowledge and counselling skills would be ideally placed to provide support for women who are receiving infertility treatment.

The Midwives Handbook for Practice states that a midwife's work:

... should also involve preconceptual and antenatal education and preparation for parenthood, and extends to certain areas of women's health, family planning and child care.

(NZ College of Midwives 1993, p.9)

This direction can be extended by implication to require that midwives assist women who are experiencing infertility problems. The same health professional would then be ideally placed to offer continuing support and maternity care for these women following conception. This care would be of tremendous benefit for older mothers who experience great stress during infertility treatment.

Happy Being Home

The 'precious years'

Free from financial pressure, most of the participants were happy to stay at home as primary caregivers. Only two mothers took up work outside the home, but even this was only part time employment. The others were very aware of passing time and wanted to be with their children during the "precious years". Interestingly, an earlier New Zealand study of women in their thirties (Society for Research on Women, 1991) describes a feeling of resentment. The participants in that study were often unhappy because their lives had changed while their partners' lives continued as before. This disparity between the findings could be attributed to the ten year difference in target ages for the two groups. Furthermore, many of the participants in the 1991 study may not have satisfied all their personal goals (such as travel or career expectations) prior to having children. All of the participants in the present study made the decision to have children after satisfying their other motivations, which may be why those mothers who chose to remain at home during the preschool years harboured no resentment.

I really did enjoy it. I think she was such a wonder, because I thought, wow, here I am 40 plus, and it was just something I had started to think I wouldn't experience, so those years were very precious. Well they still are but especially the baby ones.

One of the mothers who had been informed that she would never be able to conceive because of a medical condition was absolutely stunned when she found that she was five months pregnant with her daughter.

She's my gift. It's sort of a miracle, so I've treated her like that.

Almost all of the mothers interviewed by Daniels and Weingarten (1982) claimed that motherhood had changed them in some way, describing the experience as a “. . . deepening, opening out, loosening up” (p.221). This theme of being happy at home during the Preschool years came out strongly in most of the interviews. One of the mothers who attempted to work outside the home found that such work was fraught with problems. The available child care was not suited to her needs and the remuneration after paying for care was not worth all the effort. This mother decided that her child needed a full time parent and that she was the person best able to act as primary caregiver. Studies in the United States show that mothers over the age of 40 years increasingly choose to continue in paid employment, including a considerable number of mothers who work from home (Daniels & Weingarten, 1982). Berryman et al. (1995) found that just ten percent of first time mothers preferred to stay at home during the preschool years. Easily accessible day care services and the increased flexibility of working hours have allowed many mothers to maintain their careers.

At the time that these women had their babies professional child care was still relatively scarce in New Zealand. Many of the participants were less than impressed by the shortage of care givers. Those that were fortunate enough to find quality care for their children owed a large part of their success to word of mouth.

So my husband took a ten percent salary cut and he would take . . . to . . . and look after him. After that we found out about the Nanny service so I got someone to come in from there.

Another participant needed to keep up to date with her career skills and was fortunate in having very supportive parents who cared for their grandchild while their daughter worked full time.

I do that for five days a week. I went back when . . . was eleven months old because I would probably go back later [and] I needed to keep up to date.

Return to work

Some of the mothers were able to continue employment whilst maintaining the responsibilities of primary caregiver. Two mothers who were interviewed worked part time from home and would never consider leaving their child to return to the

workplace. The participants who stayed home full time never regretted putting their careers on hold. They were completely absorbed with their child(ren).

So I was at home with them, which I loved. I never pined to be out working, it was like a whole new life and a whole new career.

One mother had waited for twenty years to have a child.

I was quite happy being at home, because I had waited for so long to have a baby. I was just making the most of it.

The working mothers were not generally forced to work for financial reasons, but chose to do so in the interests of maintaining careers or social contacts.

Well I continued to work when our first son was born. By that stage I was a travel consultant but I had actually started working from home. I had a little office with an answerphone and a computer of sorts, and I was several years into working for myself. So it wasn't a change when he was born. But I managed to keep going with him quite happily. He was a great little baby, he slept during the day, he slept at night, he was obliging in most senses. With the imminent arrival of the second child, I decided to give up work altogether.

Another woman who had always enjoyed an active professional career started a new business venture from her home after the birth of her first child.

I've never really stood still. When I was bringing him up, I loved my garden and flowers. And I did a floral art course and did a bit of floristry from that stage. So its funny how it all sort of fits in and now it's the culmination, coming through to houses and, you know interior design and things like that.

This participant has now completed a course in . . . and maintains a successful agency. Another participant decided that she needed to maintain her business skills, returning to work part time while her mother cared for her daughter.

I'd work 7:00 a.m. 'til 1:00 p.m.. I went back to work when . . . was about eleven months old because I felt that I would probably go back later on, and I needed to keep up to date with my skills and that sort of thing. I started off just doing odd things to help out if someone was away, and

then I started back permanently, job sharing with another girl, that works quite well.

In comparison, although most of the women surveyed by Fabe and Wikler (1979) accepted the fact that spending more time with their children might mean a loss in status as a part-time employee, others who had been very deeply involved in their careers found this much more difficult, and their internal conflict was intense.

Ten of the eleven participants have now returned to paid employment. All of the children are either at school or at kindergarten. This extra income has allowed these mothers to indulge their children with luxuries which some would not otherwise have been able to provide. Arguably, the boost to self esteem which employment provides is of infinitely greater value than staying home on their own.

Implications for practice (stimulated by the data)

Child care services were not as freely available five years ago as they are today. It is crucial for all mothers to be aware of who they can turn to should they need professional child care. This is especially important for women who delay parenting, as these mothers are often unable to turn to their parents for help or relief. Hollaway (1994) has compiled a practical guide to the early years of parenting, providing the resources to enable older mothers to overcome some challenges. However, the midwife or practice nurse is likely to be in the best position to offer informed advice on local childcare services.

Concerns of Older Mothers

Energy

The participants felt that they had less energy than ten years prior to motherhood when they believe that they would have coped better with the loss of sleep and the constant demands of a small baby. The first year of parenting was the most physically exhausting for these parents. They did not begrudge the time they gave to their child but felt a little 'zombie-like' trying to cope.

The worst thing being when you get to 40 you really like to sleep, and with a newborn baby you don't get very much of it.

One mother who had experienced a traumatic forceps delivery and was coping with an extremely colicky baby received very little support from her partner who had been used to being the centre of attention. Reece (1993) similarly observed that partners seemed unable to assist the new mothers with postnatal stress. This could be due to the fact that the fathers are attempting to cope with their own major life transition to fatherhood.

I also had a husband that had a very big ego, and although he was very understanding, he wasn't getting any attention. That for me was a major problem, because I really felt that I wanted to concentrate on my child. I didn't have the time or energy for anything else; my interest in sex was absolutely zilch.

New parents, young and old, are often exhausted during the first year after the birth of the child. Price (1977) discusses how a young child can be both physically and psychologically demanding. It is acknowledged that as people age they have a diminished capacity to cope with stress, but the level of physical and emotional tolerance varies for each person. There is an enormous variation in each individual's level of stamina. Many older people in their fifties and sixties are much more vigorous than twenty year olds. Price (1977) believes that attitude is a more proximate influence on energy than age. Older people may have more emotional 'staying power' while younger people have more physical energy. Older parents may have to call on other resources to overcome the energy problem.

The first six to twelve months was the most exhausting time for the participants. These mothers had been in complete control of their lives and managed high pressure careers, but experienced great difficulty coping with a new born baby. Several mothers worried that they were unable to provide the quality of care that their children deserved. They were unaware that most mothers go through a period of helplessness, of not knowing what is normal or abnormal in the behaviour of a baby. Some were fortunate to have the child's grandparents to help out, but for most participants this support was unavailable and although their partners offered assistance when they could, many of them were also working long hours. Stress, tiredness and a lack of

energy were also experienced by participants in the Society for Research on Women (1991) study, who were aged in their early thirties at the birth of their first child. It would appear that this exhaustion may be related more to motherhood than to the mother's age.

Partners were often unable to understand why these capable women could not cope with a baby. The mothers' inability to manage their babies became very personal. They felt that they were failing because of their age and became increasingly tired, which affected their lactation and increased their inability to cope. One mother with a colicky baby despaired:

I think that I would have preferred somebody with me full time showing me every little detail of what to do. I had this child who screamed all the time, woke up in the middle of the night. He had [colic] for four months. He lost a lot of weight, and then I was overfeeding him.

Although most of the participants blamed age for their overwhelming fatigue, Turner & Helms (1987) suggest that motherhood is exhausting at any age, especially when the mother sets herself very high standards. One participant agreed:

I don't think it matters whether you are an older mum, whether you're emotionally stable, whether you wanted this child. This whole new mother thing is very much a unique experience.

I think probably what got me through the first, the most exhausting six months to a year was the fact that I had desperately wanted a baby. I felt that I had done a lot of things in my life, I'd done most things I wanted to do, I'd travelled and enjoyed my work, and this was the next best step that I had been waiting to take for quite some time, and so I managed to survive all the exhaustion.

Despite the perception that energy levels decrease with age, often older women have increased levels of emotional tolerance (Price, 1977). Levels of energy appear to fluctuate according to how a person views themselves. If they see themselves as old they will have less energy. A doctor who is herself an older parent believes that all healthy people should have the stamina to cope with children (Price, 1977). However it should be noted that a health professional has a better grasp on the range of behaviours manifest in a perfectly healthy normal child and is less likely to harbour

the anxieties of a mother who does not have this knowledge. Berryman et al. (1995) found no difference between the energy levels of mothers who gave birth after the age of thirty five years and younger mothers. The two groups were compared sixteen weeks after childbirth. It would seem that parenting can be exhausting at any age.

The participants maintained an enthusiastic involvement in their child(ren)'s activities. Although they are coping well with cricket, tennis, dancing, netball, soccer, and fishing at present, many harbour concerns about whether they will have the energy to keep up with their children in the future.

I just hope that we can stay fit and healthy enough. They say that children keep you young.

Mothers not in paid employment found that they were able to give their children a lot more time. The psychological advantages of older motherhood, including financial resources, maturity, stability and a clear conception of their own strengths also help to offset the stresses which have been attributed to delayed parenting (Mansfield, 1988).

There's so much negative business about, you know, older mothers and about the biological clock ticking by and they're sort of saying people are getting desperate. I think until you reach menopause why not have children?

You're only as old as you feel

Several of the participants would have enjoyed the opportunity to interact with other older mothers prior to having their children and even now would find a support group helpful to discuss common issues. Most of the mothers considered that projecting a positive image of themselves as 'vital mothers' was important to counter a widespread negative image of older motherhood. If they see themselves as old, others are more likely to see them the same way. The mothers who were interviewed are vibrant and outgoing, enjoying their respective lifestyles. Many of their friends are younger than them, although some of these friends are unlikely to recognise the age gap.

I remember when one of my friends found out how old I was and I just about died. She actually thought that I was about ten years younger than I was.

Age did not appear to be a problem with other parents or their child(ren)'s peers. Most of the parents of the child(ren)'s friends had already raised three or four children

and were only about five years younger than the participants. At preschool there was no problem relating to younger or older mothers as it was difficult to tell whether it was the mother's first or fifth child. Other children discussed their parents' ages at school but most of the children in this study appeared not to know how old their parents were. It is interesting that although the mothers claimed not to see age as an issue they were reluctant to inform their children of their true age. Children of older parents interviewed by Morris (1987) were aged between 20 and 54 years old. Although some of these children considered that their parents had been an embarrassment, others felt that they had not only benefited financially but also by the attention their parents bestowed on them. The determinate factor for a child's love and acceptance of older parents appears to be the quality of time spent with them (Morris, 1987).

Yarrow (1991) reports that some children of older parents harbour resentment, while others see a wonderful resource. Both groups of children occupied the centre of their parents' attention, and were surrounded by all the love and material wealth any child could want. However, many of these children considered their parents too staid, and complained that they had less fun than their peers enjoyed with their younger parents.

Aging is very much an individual concept. Older mothers who are concerned about their age may feel disadvantaged when sharing common interests with younger mothers. Many of the participants claimed that they did not let their age worry them.

I don't care whether you are fifteen or whether I'm 40 you know we're both mothers and we come across the same problems, we've both got to deal with them together. Age has never worried me. I don't feel my age, I don't feel that I'm old.

Price (1977) observed that older parents found it difficult to relate to younger parents. There appeared to be a communication gap between mothers in their twenties and those in their late thirties or early forties. Although older mothers attempted to make friends with the parents of their children's peers, they shared few interests and found these younger parents difficult to relate to. Children interviewed by Berryman, Thorpe and Windridge (1995) claimed that their mothers were sometimes mistaken for their grandmothers. Most were amused by this, but for a minority it caused the

same embarrassment that children suffer whose parents are obese or who suffer from a disability.

The participants describe their children as a wonderful bonus. They planned and lived their lives the way they wished, without many of the stresses of younger parents. They were actively involved in all their child(ren)'s interests, mixing easily with parents sometimes fifteen years younger than themselves.

Having children later does mean our energies can go into them, perhaps a lot more easily than if you're working long hours and being worn out at the end of the day . . . and you think oh, and now I've got to deal with the children. I suppose the fact that you're established helps, therefore being older was party to that.

Having kids has been a wonderful bonus, it wasn't really something we talked about in our thirties.

For some mothers age was totally irrelevant and has never been an issue in their lives. They feel that they will be easily able to cope in the future, especially when they compare themselves to their own mothers who did not have the benefit of modern houses and labour saving devices. They also explained that as they had no financial worries, did not work long hours to pay the mortgage, and had considerable life experience, they were able to cope more easily. Many of these mothers feel fortunate to have already packed so much into life.

Teenagers

The 'generation gap' was a concern for participants, several of whom commented that they had not kept up with the trends. Staying in touch with adolescent trends was considered by several parents to be essential for effective communication with their children. Participants stressed that parents and teenagers must understand each other, even if they could not always agree. Many predicted that the teenage years would be a time when relationships with their children would present the greatest problems. However, one participant whose children were aged 17 and 20 years old had not encountered any major conflict. Both children had a circle of steady friends with whom they had grown up. This mother didn't believe that being older made any

difference, maintaining that her judgement when coping with her teenagers was just as sound as any other parent.

I'm sure a lot of the problems we have today with teenagers . . . I'm sure it's because Mum isn't there.

Some of the mothers who have not yet lived through this mother's experiences find the teenage years a daunting prospect. One of the mothers who had experienced behavioural problems with her child throughout his childhood was considering boarding school:

[I] have to think why, why am I looking at sending this child to school, and basically it's because I'm terrified of his adolescence.

Another one of the mothers asked:

Will we be able to keep up with him. . . ?

She later answered her own question by relating how her mother who was in her late thirties at the time of her adolescence could not keep up with her and was totally unaware of the activities she was involved in.

Others perceive the teenage years to be no different for older parents than younger parents.

The pressures teenagers bring, in that they get involved with so much outside the family, whatever age they are, you've got to keep abreast of the modern world and what the kids are up to and what they have to face, the hurdles they've got to cope with. I suppose the thing is to go through these with them.

I just think if you just know how to handle togetherness . . I can't see that there should be any problems, but you know we'll face them. I'm going to do a parenting course with . . . just to make sure we're still on the right track.

Some of the fears of participants relating to teenagers were reflected in research by Daniels & Weingarten (1982), who found that caring for teenagers required emotional dexterity “. . . because the balance of protecting and letting go shifts.” (p.284). Parents stated that they required an extraordinary amount of perception in order to understand the confusing messages that teenagers sent and the wisdom of Methusalah

to deal with the catastrophes. The maintenance of open communication channels is vital during these turbulent years.

It is interesting that the mothers of daughters were much more concerned about a 'battle of wills' than those with sons. The latter were more likely to worry about the risks taken by teenagers. One mother with two sons stated jokingly:

When our kids are teenagers and they're coming home late we won't worry about it because we'll be so deaf we won't be able to hear them!

The majority of participants believe that good schooling is fundamental to securing a less troubled adolescence. The value of good schooling was recognised by both older parents and their children, who felt that this had advantaged them (Yarrow, 1991). One mother who was not looking forward to the teenage years moved her child out of the public school system;

One of the main reasons for taking him out of the state system of schooling was because I am fearful of peer pressure. I know it exists in all schools but I am fearful of what I see as slack standards of discipline in the state schools . . . the school he's in now I see as more traditionalist and placing emphasis on values and that sort of thing. If he goes to school with like minded families, although it's probably not a real life situation, that's not how the world is, but there tends to be less temptation so less problems.

These mothers want to be actively involved with their children by looking after their interests without smothering them. "Just being there to listen, sharing their problems and keeping the communication lines open" was considered a sound way of preventing problems.

Implications for practice (stimulated by the data)

The teenage years should be a happy and carefree time before the young person becomes immersed in the complexities of adulthood. Yet the New Zealand rate of teenage suicide is one of the highest in the Western world. Suicide is often provoked by a major change in a teenager's life, causing depression, fuelled by a sense of worthlessness, apprehension and hopelessness (Bennett, 1995). The parents of the

children in this study recognise the problems that they and their children face in the teenage years and are likely to investigate this concern thoroughly.

The services of mental health nurses need to be engaged to deal with such problems. These professionals have the skills to identify and address the problems of depressed teenagers. In practice, however, mental health is too often used as a last resort, encouraging comparisons with the 'ambulance at the bottom of the cliff'. Mental health nurses should be more actively involved in developing programmes to aid recognition of signs of depression and to treat mental health problems before they become critical.

All nurses, especially practice nurses and school nurses should be aware that parents are becoming increasingly aware of the incidence of mental health problems among New Zealand teenagers, and will be seeking guidelines as to how they can assist their children to avoid or to cope with these. The practice nurse is often in the best position to assess the urgency of the problem confronting the parent and the child. Nurses must be able to advise parents of the warning signs and to direct concerned parents to appropriate support and counselling agencies.

The participants were 'child centred' well before their babies were born when their investigations related to information on parenting and child development. They were voracious readers, attended courses and formed new friendships so that they could learn from other parents and share experiences. The participants went to extraordinary lengths to investigate suitable day care and preschool centres which would benefit their child intellectually and socially, as well as ensuring that the child was content and happy. Secondary schools were subject to equal if not greater scrutiny, especially as some were perceived to have a more beneficial effect on adolescent behaviour. Parents were prepared to spend large sums of money in order to achieve the optimum learning environment for their child(ren). As there are still concerns about the problems that the children may encounter during adolescence, parents continue to actively seek information which may be helpful to them during this time.

The participants saw the generation gap in relation to teenagers as a challenge. They were aware of the increasing incidence of drug abuse and teenage suicide, and had

developed a keen understanding of the value of sound schooling during adolescence. Keeping up with the trends and maintaining open channels of communication were seen as key factors in coping during these years.

CHAPTER SIX

THE NEED TO KNOW

Motherhood was a new experience for the participants, who appeared to have developed a compulsion 'to know' everything about the phenomenon of motherhood. The collection of information was akin to a research project, which they carried out in a methodical manner. LoBiondo-Wood & Haber's (1994, p.39) description of how "new knowledge is sought through a systematically planned investigation" accurately reflects the way that these women accessed resources. To improve their understanding of motherhood they sought a wide range of information on topics such as growth and development to broaden their understanding and to prevent problems by making the best choices for their children. The women felt that this knowledge was essential in order for them to understand how to cope in their new role as mothers. These mature women had previously held positions of responsibility and were keen to apply their maturity and considerable skills to parenting. There were three categories in this sub-theme:

- Pregnancy, labour and birth
- Child care
- School

(see Figure 3, p.85).

**Pregnancy,
labour and birth**

Child care

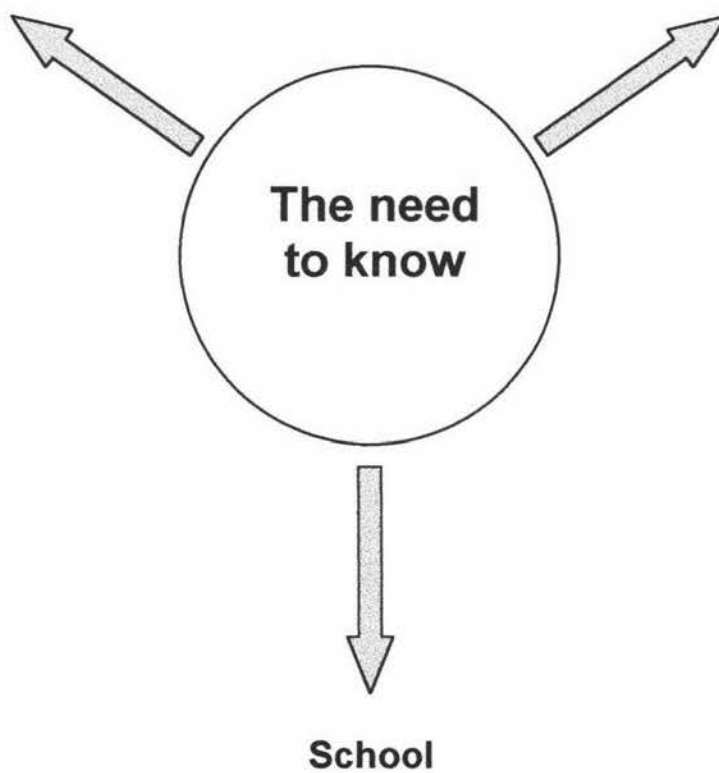


Figure 3: Categories of 'The need to know'

Pregnancy, Labour and Birth

Investigation

Research into delayed parenting has generally focused on older professional women with high educational levels and well established careers. These characteristics are now recognised as very favourable to pregnancy outcomes as such women usually seek antenatal care considerably earlier than most. Even without this additional information older women are often more emotionally, psychologically and intellectually prepared for the changes which occur during pregnancy, labour and childbirth (Daniels & Weingarten, 1982; Yarrow, 1991; Harker & Thorpe, 1992).

The participants in this study read widely, not only when they saw an article of interest but actively researching the relevant topics.

I read a lot, I had baby books about nutrition and all that sort of thing that I'd read up and work out what to do.

I had done a lot of reading. I think being an older mum you do tend to get out all the books that you think are relevant and swot hard before, after and during.

These knowledge seekers initially explored the phenomenon of motherhood, before a more thorough investigation into whether it was realistic to become first time mothers after the age of forty years. They sought to understand the problems relating to conception, pregnancy, labour and childbirth including the screening process for amniocentesis and chorionic villi sampling. Several participants particularly valued the information made available by Parent Centre. Winslow (1987) corroborates these findings in her research on older mothers. For these women, costs incurred in the fact-finding were of no great importance.

I wanted to know everything about pregnancy and things like that, and I went to classes, the usual things that mothers do.

An 'at risk' group?

The participants believed that, as older primigravidae, they and their babies were more at risk of complications during pregnancy, labour and childbirth than younger

women. This belief was reinforced by the information that they read and comments made by GPs who advised them to seek specialist care.

I read avidly because I was very much aware that it could be stillborn. I was aware that I was this elderly primigravida. I had been told or heard that, then I read that this was not necessarily true.

The whole time I was pregnant I read everything that I could possibly read. And sometimes I think a little bit of knowledge is dangerous.

The description of older women as elderly primigravidae creates a self-fulfilling prophecy which places women at greater risk of obstetric intervention (Mansfield & McCool, 1989; Harker and Thorpe, 1992). This attitude may well increase anxiety and enhance the potential for psychological problems by categorising older women as members of an at risk group. As Berryman, Thorpe and Windridge (1995) observe, these women generally undergo more ultrasound scans than younger women, increasing anxiety and the risk of psychological problems. These findings are supported by Baird, Sadnonick, and Yee (1991). Interestingly, the midwives in Harker and Thorpe's (1992) study did not agree with the 'high risk classification' and generally found that first time mothers over the age of 35 years made the same progress in labour as 20 year old primigravidae. Mansfield and McCool (1989) interviewed several obstetricians who felt that the enthusiasm of older women for information about pregnancy and childbirth was likely to lessen the chance of being labelled as an at risk patient.

With this baby being very very wanted I was very paranoid . . . about a sip of wine, I'd forgotten I'd actually had it! Oh God I had a glass of wine, Foetal Alcohol Syndrome!

Despite women being seen to be less at risk now than they were formerly, all participants except one were referred by their GPs to obstetricians for maternity care.

I went to the doctor, and he referred me to a specialist. My philosophy was that okay, I'm obviously having to go to a specialist because of my age.

Acceptance by these specialists of a lower level of risk could be attributed to the fact that the participants were healthy and led active lives. On the other hand, it may

reflect a growing understanding of the needs of elderly primigravidae. The realisation that older women are now less prone to problems which previously labelled them as 'at risk' may protect women in the future from unnecessary interventions.

Although it was difficult for the women to ascertain whether they were treated differently from younger primigravidae, each felt very comfortable with the support and advice that they received from their obstetrician. Participants were especially keen to retain obstetric supervision because their first child was so precious to them.

I went to . . . who I related well to, and I felt that I could really trust him. And I didn't have any preconceived ideas or anything.

I saw specialist care mainly as a safety net. You never know when something could go wrong, especially at my age. Therefore I thought it best to seek expert care.

Helplessness

The 'need to know' became very important in the early postnatal period when some of the participants really struggled with breast feeding and mothering skills.

I really wanted to give him the best and became very frustrated when I didn't get the hang of it. In the end he was losing out and I put him on the bottle. I found out about La Leche later; if only I'd known about this group earlier.

The participants believed that breast feeding was nutritionally important for the baby and that it would aid the bonding process. Some of the mothers adapted naturally to breast feeding, while others found it much more difficult. Advice was very confusing, with conflicting messages from differing members of hospital staff in the immediate postnatal period.

One nurse would tell you to feed him as long as the baby wanted to and then the next one would come along and say "Is he still up? He needs to be put down". I never knew where I was.

I also got looks from people as if to say I think this woman is loopy, or not coping with breast feeding, or whatever. The only person I found really helpful was a Niuean woman who was there during the night. I don't know if

she was a Nurse Aid or a cleaner. She helped me every night while I was in hospital and seemed to have the uncanny knack of knowing when the baby was waking up. She was very calm and smiled a lot.

The first year was quite difficult because I was very tired. I did breast feed until she was fourteen months.

The length of the postnatal hospital stay varied from eight to twelve days. This is considerably longer than today's average length of stay, with current hospital practice usually requiring discharge no more than two to three days after delivery. Many of the participants' babies were born several years ago, when the length of the postnatal stay was routinely longer. Participants also delayed their departure until they believed they had the knowledge and confidence to cope with their baby. Some mothers had no family support, and all were aware that support from community services would be strictly rationed. The mothers were quite assertive in stating their needs and demonstrated their protectiveness of their child by insisting that they were not ready for discharge. One mother who gave birth to her first child at the age of 41 years explained:

With the first one a long stay in . . . was fantastic for me because I got everything sorted out, and every day they'd say are you going home today? And you'd say no, I'm going to do the nappy, or changing the nappies today. How to bath him, how to change him, and how to feed him; it was all a new experience.

Although each mother had made every effort to equip herself with knowledge, nothing had prepared them for the helplessness that they felt when arriving home with their babies. A mother's joy when holding her baby is tremendously different to the responsibility which confronts her when she returns home with the child. Babies appear to sense their mother's insecurity, becoming more unsettled and thereby increasing a mother's anxiety. Jones (1996) records the helplessness of two older mothers when caring for their babies on discharge from the hospital:

"I remember thinking 24 hours after he was born, 'What have I done?'" One older mother remembers putting her baby down in the carry cot in the centre of the room and then sitting down and crying: "What was I to do with him?' I would have to wake up two or three times a night every night from

now on. I could never go anywhere without him, or if I did, I would have to rush back again soon and I would worry about him all the time anyway. Nothing was ever going to be the same again.”

(Jones, 1996, p.179)

The participants and their partners continued to attend training exercises of relevance to their parenting situation. One mother stated that she attended a number of courses in a search for information to assist her to deal with her child's behavioural problems:

I've been to parenting courses and management of angry children courses and stuff, which are good in that you meet a lot of people. You don't necessarily find all the answers but you do meet people who are going through the same things and realise that you are not alone in this.

Many participants found Parent Centre particularly helpful. Staff were very supportive and were able to draw on the latest information when giving advice. Such forums not only provided a valuable source of information, but a chance to meet new friends and gain support over a shared experience.

Parent Centre was great, it was really good. And quite a few of the people who were in that coffee group, we still all see each other...they also ran really good courses such as Baby and You and Toddler and You and Positive Parenting. It was all new information, but it was also good to get out and mix with some other people, sort of to hear their stories and what they're experiencing, and it makes you realise that the things your kids were doing were quite normal.

Many of the friendships formed when attending groups such as Parent Centre continue to provide support for participants.

Implications for practice (stimulated by the data)

Historically the children of first time mothers over the age of 40 years have been delivered in hospitals, but research has now shown that home birth deliveries carry no increased risk for this age group (Mansfield & McCool, 1989). Midwives may need to market their skills and inform parents of the benefits of a relaxed home environment and ongoing follow up care in the home following the delivery.

Informed mothers are likely to welcome the partnership alternative offered by independent midwives.

Midwifery takes place in partnership with women. Continuity of midwifery care enhances and protects the normal process of childbirth.

(New Zealand College of Midwives, 1993, p.7).

Child Care

The term child care is used by the participants in relation to child minding and play groups. Participants were careful to select the 'right' environment for the child's early years as they considered that this could have a significant formative effect on the child's development.

Child minding

The distinction between child minding and child care is seldom acknowledged and, when recognised, is difficult to qualify. Several participants used the terms interchangeably. When pressed, they claimed that child minding connotes full time, individual care from birth, while child care may be for just a few hours each day. Preschool facilities which direct activities for groups of children were cited as an example of this concept of child care.

During their pregnancy these mothers undertook extensive research into day care and child minding facilities. All were cautious about who they trusted with the care of their precious child. Many participants had no close relatives and most of their friends and former colleagues worked during the day when the mothers most needed the support of child care. Child minders were generally used only when these mothers desperately needed time out for themselves, or when social engagements demanded their attendance. Where possible the child's father would care for his child, although unfortunately most of the participants' partners worked long hours. Jones (1996) describes the difficulty in finding suitable day care, concluding that nannies provided the only reliable care option. Although the high financial cost is likely to preclude many mothers from taking advantage of the service provided by nannies, alternative

care services are very limited and the participants experienced some difficulty finding someone who was reliable and caring. One mother left her child with a minder for three hours a week while she attended a course:

I took him to this woman's place from when he was about five months old. Once I picked him up a bit later than usual I found him crying on his own and decided that no way would I go back there. I found him, he'd been sobbing his little heart out and they'd put a strap over his cot. They had him lying on his tummy, they'd given him some Bonjela because they thought he was teething, but I think that he just wanted to be picked up and cuddled. Then I got a woman who took him to her place and he came back three times in a row smelling heavily of cigarettes.

Most of the participants in the study by the Society for Research on Women (1991) encountered what they considered to be substandard care, and commented that the stress involved in identifying suitable care was not worth it. Most of the child care centres were difficult to access due to long waiting lists.

Finding suitable child minding services often develops into an ongoing concern for working mothers. Mothers can experience considerable stress in identifying quality child care (Jones, 1996). One participant lamented that despite a thorough investigation of child care alternatives she could not be satisfied that any of them would provide the high standard of care that her child needed. This mother could find no published information relating to these services and was forced to rely on word of mouth and advertisements in local newspapers. Another mother experiencing similar problems later took advantage of the service provided by nannies. Although she was delighted by the dramatic improvement in the quality of her son's care, this participant feels that the service should have been promoted more widely so that all parents are aware of it. Another participant shared a nanny with a friend:

One of the women, the wife of my husband's friend had a son. We got together and hired a nanny who came in once a week and looked after both of the little boys. She was just absolutely marvellous, just a wonderful girl.

Berryman et al. (1995) discuss how full time child minding is only positive for a child if the care is of a high standard. Unfortunately, many of the participants in this research had difficulty finding quality full time child care, partly because the service

provided by nannies was not widely recognised at the time. However, mothers who later used this service found it excellent. Those who were unaware of its existence claimed that they would have used the service if they had known that such help was available. One woman who was unable to depend on family members for help was extremely relieved when she developed bronchitis that such a capable person was able to take over the care of her child.

So I had a nanny coming for another week or two until I got back onto my feet, but yes the lack of family members as you get older, it's probably one of the disadvantages.

Several of the participants especially appreciated the 'time out' granted by Plunket's Karitane support service. These Karitane nurses worked in the community to develop parenting skills for families and caregivers. One mother who had experienced a very traumatic delivery found this service particularly helpful, although she worried that sometimes the quality of care left her feeling inadequate.

You could just go there for a day, just for a rest and to give yourself a breather, give them the baby and just lie there and go to sleep, or go for a walk or whatever you wanted to do. He slept when *they* wanted him to sleep, fed when *they* wanted him to feed. How come he doesn't do that for me?

The mothers in this study were either full time mothers or went to work part time while a relative, (usually the child's grandmother) looked after the child. The grandmothers helping with these children were all aged over 70 years, with one almost 80 years of age.

Preschool

All of the mothers used child care at some stage during the preschool years. Prospective child care facilities were thoroughly investigated, with some parents going to incredible lengths to find the most stimulating experience for their child. One child was taken to three different child minding facilities and five child care centres prior to starting school.

I did experiment, because he was going to be an only child, I wanted to experience as many things as possible and so I

joined . . . when he was about eighteen months old . . . there was a lovely preschool centre and he was about two and a half at this stage and he went along for two terms for two to three hours a week. They didn't really encourage you to stay with them, I wish they had've really, and then that closed. And so I enrolled him in . . . he didn't like that at all, he wasn't allowed to go out and play when he liked . . . it was awful, I mean the stress factor . . . and it was becoming a bit of a battle to get him to go, so we left. And then when he was four he left . . . as his name had come up at the local kindy, which he loved.

Although this mother's testing of the suitability of child care centres was perhaps a little extreme, all of the mothers were very concerned to ensure that their child attended quality day care and preschool facilities. It was important not only that the child enjoy the experience, but also that he or she receive sufficient stimulation. Barnado's was rated highly by one participant, who believed that the ratio of just four children to one caregiver created an environment which provided excellent stimulation for her child. Although mother and daughter had become very close, time apart from each other proved mutually beneficial.

If I'd known about Barnado's beforehand I probably would have put her in long before I did. I wouldn't have got so clingy with her, I could have started the break a little earlier.

The demand on public kindergarten enrolments frequently makes it difficult for a child to secure a place until they are at least four years of age. Public kindergartens did not always meet the standard of mental stimulation some mothers felt their children needed. This was one of the reasons that some participants used private kindergartens or preschool. Some of the mothers actively stimulated their child intellectually and sought preschools which would develop their child's mental ability further. However, the advanced intellectual development of several of these children meant that they sometimes found it difficult to relate to children of their own age.

As an only child he has always enjoyed the company of older children and adults. The preschool situation worked well while there were older children there. Once when he became the oldest child in the group he no longer thrived because there was a lack of stimulation.

Yarrow (1991) found that only children generally surpass all others in their school achievements. Only children, and children of older parents, are carefully directed by their parents into preschools which reflect appropriate socio-economic and intellectual qualities.

If later-born children are more intellectually stimulated and expected to know more about the world and how things work, it may make them particularly savvy about life at a young age. It may also make them more precocious than their peers.

Yarrow (1991, p.74)

The mother of one of the children went to great lengths to find the right preschool centre and finally enrolled the child at a private preschool three days a week for eight hours a day. The preschool accepts intelligent four year olds exclusively, providing a carefully tailored programme which includes:

... a computer, manual dexterity skills, using the scissors, using the pencil correctly. They have quite a science programme as well. It is only small; there are only about 9 children in the class.

Implications for Practice (stimulated by the data)

In A Working Mother's Handbook, Holloway (1994) offers some excellent practical advice for all mothers, including a guide to available support services. The Treasures Baby Book (1997) also contains a detailed list of support agencies and is free to all club members. All primary health care workers, especially midwives and Plunket nurses, need to ensure that mothers are aware of these books. Nurses and midwives practising in the community may consider compiling guides to local services for the women in their area.

Schooling

Mothers who had carefully investigated day care and preschool facilities also gave considerable thought to schooling options. Some moved their families into a

particular school zone so that their child(ren) could attend a primary school more suited to their needs.

I didn't want him to go to the local school; I hadn't heard very nice things about the head mistress. I wanted to get him into this other school, so I got back into relief teaching knowing full well that there was a teacher shortage and that teachers who taught there permanently, their children could be accepted in the school. After I'd been there about a term I suggested to the head that he put me on a contract as a relief teacher, on condition that . . . could go to that school.

However this was not always possible and most of the children attended their local primary school. With the majority of children aged seven years or younger at the time of this study, most participants were yet to commit themselves to a particular secondary school. This was considered to be an extremely important decision. They researched the schools as they had previously researched other decisions affecting their child(ren). The participants found making a choice difficult when faced with the very real possibility that the focus of the school could change after the child had been enrolled. The children of two participants attended reputable private schools for their intermediate and secondary years. This was the result of a careful selection which the parents felt would stand them in good stead for the future. Two other couples, still engaged in the decision making process, described this as one of the most important issues in preparing children for adulthood. Schools were not only ranked on academic status, but also on the suitability of social contacts that the children would be likely to make.

Education is foremost. In the initial stages they'll go through the local school as the local school is providing what it should be providing. We're going to be a little more specific about secondary schools, so we'll do the rounds of what's available when it comes to secondary school. I think that sort of sets them up for whatever's ahead of them.

One of the mothers took her son out of a public school and enrolled him in a private school because she believed that there was a stronger emphasis on values and the children would be kept constructively occupied from an early age.

He's so busy with home work and other things he's just not going to have time to get into mischief. Whereas my husband up until recently tended to think that they go to the local school no matter what it's like and they sink or swim.

With the 'need to know' satisfied, parents were able to evaluate the possibilities and make a decision which they could be happy with. Participants related how life became a little easier once their children were in the school of their choice.

I'm just thrilled that he's got into . . . you know that they have a very high standard, there's a good racial mix similar to society and I think that's important that they deal with those ethnic groups, you know you just don't know what the future holds.

This opinion concurs with the findings of Yarrow's (1991) study which showed that older parents are extremely selective in their choice of schooling. It appears that schooling was carefully selected by the participants in Yarrow's research, not only for the level of education but also for the social contact provided. Again, these findings are backed up by the participants in this research.

Implications for practice (stimulated by the data)

Secondary schools were subject to an equal if not greater scrutiny, especially as some were perceived to have a more beneficial effect on adolescent behaviour. School nurses and public health nurses should be aware that the competitive pressures faced by children of older parents may have a detrimental effect on the health of these students.

The participants were avid readers and researchers, who checked out all conflicting advice. Their lengthy postnatal stay in hospital is a good example of 'needing to know' everything pertaining to infant care. Older women having babies at present may find some difficulty in extending their postnatal stay for such a lengthy period. Child minding and preschool care came under extensive scrutiny, which was important in order to ascertain the best child care. This investigation of schooling alternatives became especially important during the teenage years. A need for improved information services on all these issues would be of great benefit for all mothers and their children.

CHAPTER SEVEN

WHAT IF SOMETHING HAPPENS?

The potential for something unexpected to change the mother and child relationship is a constant source of concern. Many of the participants first felt this anxiety when they unsuccessfully tried to conceive. This sub-theme identifies very closely with the central theme of 'child centred' and is an integral part of all mother and child relationships. Protectiveness, or the effort that mothers make to ensure the child's safety and interests, is a major feature of this sub-theme. Concern over the risk of 'something' happening will be present from the time that mothers are informed of their pregnancy until something happens to end the maternal relationship (usually the mother's death). Participants confirm that the fear that they might die before their children become independent is constantly in the back of their minds and has become a key part of all their decision-making.

This sub-theme is influential throughout the data and is closely aligned to the main theme of 'child centredness'. Four related categories have been identified.

- Pregnancy
- Labour and birth
- Support
- What if something happens to us?

(see Figure 4, p.99).

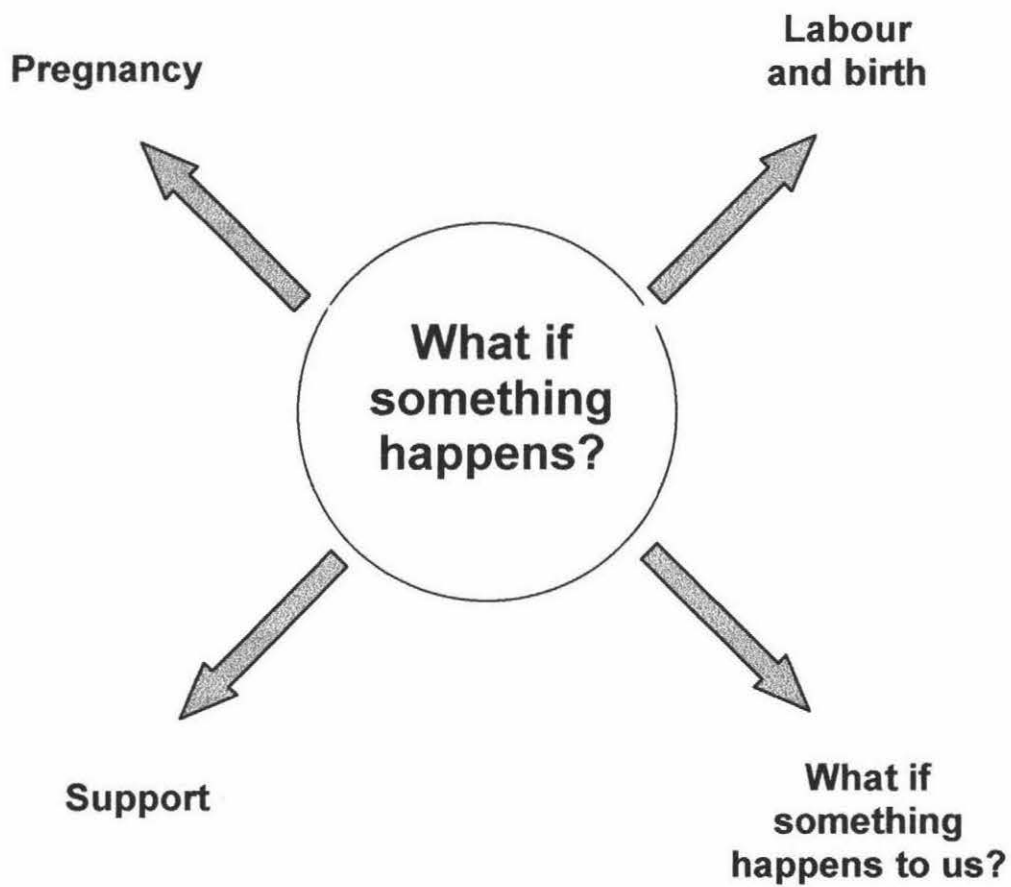


Figure 4: Categories of 'What if something happens?'

Pregnancy

The participants related how feelings of jubilation and hope with the confirmation of their pregnancies were mixed with an uneasy fear that something could go wrong before the birth of their baby.

We celebrated and were overjoyed but there was always that nagging doubt about something that could still happen. With this baby being very, very much wanted, I was very paranoid during the pregnancy. Physically I was well but emotionally I was very keyed up because it was very important, and I thought that this might be a one off, there may not be another chance.

I had tummy cramps, these sort of cramps alarmed me a bit because I thought, god, I'm going to miscarry, so that was when I was referred to a specialist and that was when he put his stethoscope on and you could hear this little train going "ch-ch-ch". I thought gosh, it really is there then, everything was fine, it was just a general settling down.

Winslow (1987) found similar reactions in her study of older women over the age of 35 years. Although they had mixed feelings these participants were very successful in using coping strategies that had proved to be effective previously. Older primigravidae appear to be more emotionally prepared for the birth process and motherhood than younger primigravidae, who often lack the coping strategies that are learned from life experience. This premise is supported by Gottesman (1992) who considers that older women bring a stronger commitment and motivation to the maternal role.

Excepting the risk of complications from pre-existing conditions such as hypertension, diabetes and chromosomal abnormalities, Harker and Thorpe's (1992) survey of previous research (1992) showed that there were no increased risks for an older first time mother over the age of 40 years, or for her child. Only one of the eleven participants did not receive specialist care for her pregnancy and labour. Two of the mothers had experienced earlier miscarriages while five others had encountered infertility problems. For seven of the mothers pregnancy was a "breeze" and they had never felt better. Of the four participants who experienced problems during

pregnancy, two were troubled with morning sickness for most of their pregnancy; a third experienced problems with mild pre-eclampsia, and the fourth mother had a small antenatal haemorrhage.

I didn't have a very good pregnancy. I ate too much and put too much weight on, although as far as my health was concerned, it was very good. I had constant feelings of being sick but I never actually was. I had indigestion the whole time.

There were very positive comments from some participants who felt extremely well all the way through their pregnancy from the time of conception.

I had a fantastic pregnancy. I stayed very fit and worked out in the gym every day, ate very well and got lots of sleep, reduced my stress levels . . . there were times many people didn't even know I was pregnant.

One mother had been pregnant for five months before she became aware that she had conceived. This woman continued in a very active career until she was eight and a half months pregnant, at which point she informed her colleagues at work of her pregnancy.

One of the reasons was because I felt as though they would have old fashioned ideas, like because I was pregnant I shouldn't be working because you're crawling on your hands and knees and doing quite heavy physical work. I thought their attitude would be quite old fashioned.

One of the mothers had three friends who all delivered at about the same time that she did. All were first time mothers over 40 years of age, and all the babies were boys. This mother had no problems during her pregnancy.

It just felt so good from day one.

Price (1977) discusses how the overwhelming majority of women in her research on older first time mothers continued with their routine activities up to the day of their children's births. No allowances needed to be made for these primigravidae. Like the participants in this study they coped extremely well with pregnancy, labour and childbirth and maintained a high level of physical fitness.

The increasing numbers of women who choose to delay parenting have heightened the importance of genetic counselling prior to screening for chromosomal abnormalities. Counselling was recognised as an essential element of the screening process (Burke & Kolker, 1994). Women over the age of 35 years may choose between two major types of genetic screening:

- **Chorionic villi sampling** is available at 9 to 12 weeks gestation. The older the mother the greater her chances of aborting as a result of chorionic villi sampling. At 35 years of age the mother's risk of aborting her baby as a result of the screening is the same as the risk of giving birth to a child with Down's syndrome. After the age of 35 years the incidence of Down's syndrome increases. Neural tube defects are not identified by chorionic villi sampling. However there is a blood test, alpha-fetoprotein, available in the 18th week of pregnancy which will identify neural tube defects such as spina bifida (Bombard & Naef, 1993).
- **Amniocentesis** is generally conducted between 15 and 18 weeks gestation. Although there is a 0.5% risk of foetal loss with this screening procedure, amniocentesis is also able to screen for neural tube defects. Amniocentesis is now also available between 10 and 13 weeks, but this earlier test carries a much higher risk of spontaneous abortion (Bombard & Naef, 1993).

All except two participants were screened for chromosomal abnormalities. This procedure was originally conducted by amniocentesis. However the participants who became pregnant with their second child have chosen this screening procedure. Of the two women who were not screened at all one delivered over twenty years ago when this procedure was not routinely carried out. Another mother was already five months pregnant when her pregnancy was confirmed and therefore well past the appropriate screening period. Participants who were screened declared that the most traumatic part of the process was the wait for results.

I was a bit worried at the age of 41 about the possibility of Downs syndrome, but, a couple of aunts had babies in their forties and my mother was 38 when my brother was born.

I had the [amniocentesis] and then we had to wait about a month or so, which was absolutely terrible, because by the time the result comes you are twenty weeks pregnant.

The women who were given a choice of screening procedures preferred chorionic villi sampling as this method offered a shorter delay before results could be confirmed. Some of the mothers confessed that they would have aborted the foetus if there had been any major abnormality. Concern was expressed that even if as mothers they were able to cope, the child could become a burden if something happened to either parent.

I had an [amniocentesis] to check that everything was all right. I'd advise that, because I wouldn't want to have a child that shouldn't be here, what say if something happened to you, no-one really wants to look after children that are disabled.

Nothing was quite as bad as the waiting time and the agonising over the decision that would have to be made if the screening detected abnormalities. Daniels and Weingarten (1982) report that women undergoing screening had to indicate prior to any testing whether they would seek to abort the foetus if chromosomal abnormalities were detected. All agreed to end the pregnancy should the analysis show a serious defect. As one woman said: "If this was going to be my only chance at it, I want it to be the best kind of human production possible [sic]" (Daniels & Weingarten, 1982, p.189).

None of the participants in this research were referred for genetic counselling, although this opportunity was made available by their doctors. They were not asked to make a binding decision before genetic testing, although the risk of the test itself was carefully explained. Given the risk of spontaneous termination it is unlikely that those couples opposed to abortion on moral grounds would agree to screening.

Participants waiting for the results of screening were given no counselling during this time, leaving many couples isolated and without support. Even after they were informed of the results of the chromosomal test the feeling that something might happen persisted.

In my husband's family one brother had a child with spina bifida and hydrocephalus, and that was diagnosed *in utero*, and it was aborted. One of the older brothers had a child with Down's syndrome so we were very apprehensive. We knew that we could not cope with a child with severe disabilities.

Implications for practice (stimulated by the data)

The Midwives Handbook for Practice (NZ College of Midwives, 1993) declares a midwife responsible for preparing, supporting, and educating women, not only during pregnancy and labour but also in the postnatal period.

The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the postnatal period, to conduct deliveries on her responsibility and to care for the new born infant.

This care includes preventative measures, detecting complications in mother and child, assessing medical assistance when necessary and carrying out emergency measures. She has an important task in health counselling and education not only for women, but also within the family and the community. The work should involve pre-conceptual and antenatal education and preparation for parenthood, and extends to certain areas of women's health, family planning and child care. She may practise in any setting, including the home, hospital and community.

(New Zealand College of Midwives, 1993, p.9)

Carr and Liu (1994) discuss the importance of support for older women both before and after chromosomal screening. Skilled midwives may enable the couples to make a decision on whether to proceed with screening, and their support during the waiting period may relieve stress. Wright (1994) agrees, and further advises midwives of the importance of maintaining current knowledge about screening procedures so that they are able to provide appropriate information and support. It is fundamentally important that all participants in the screening process know and understand the risks involved. Midwives must be non-judgemental in their counselling, allowing families to make choices that are appropriate for them. The most skilled counselling and support will be needed when test results show abnormalities and women must decide without delay whether to abort the baby or to proceed with the pregnancy. To be forced to make such a choice is devastating for any couple, but even more so when the chances of having another child are limited by maternal age.

Pauker and Pauker (1994), themselves older parents who endured the trauma of genetic screening have devised a decision making tree which they now share with other parents. This tool, which incorporates the parents' own needs and feelings about abortion, termination and whether to carry the pregnancy to term comes strongly recommended by the participants in Pauker and Pauker's research. The values of individual couples form the basis of decision making and, as the authors explain, the values of prospective parents continue to be the most important element in decisions about prenatal diagnosis (Pauker & Pauker, 1994, p.1152).

Labour and Birth

For the participants in this study, the return of their genetic screening results meant that they were able to eliminate the fear of Downs syndrome. All were conscious however that many things could still go wrong, especially during labour and the birth of the baby. Many had heard terrible stories about the experiences of other older mothers and although they had been reassured that they were no more at risk than any other first time mother the fear remained.

I made very little preparation for the arrival of this baby. I always had a horror of something going wrong and having this room full of baby clothes and mobiles and stuff and no baby to bring home to it.

I thought this might be a one-off, that there may not be another chance for this baby. If anything happened that was probably going to be it.

The obstetrician said that he was facing the wrong way and he would have to turn him. He was very matter of fact and he said "No, I think I'm going to turn him", and then he said "Oh, this head's a lot bigger than I thought, you're going to have a problem here". So there I was, lying there thinking "My God, what's happening to me". He did manage to pull him out, but oh there was a lot of heaving and pushing. He was born with a fractured clavicle because of the birth, and also because of my obstetrician.

This woman never received an explanation of what had actually occurred. Although an immediate explanation would have been inappropriate given the stress which the mother was under, she should have been informed about what had occurred the next

day. Unfortunately this mother also had a particularly difficult time after the birth, and she was unable to see her baby for 24 hours. However there were also some very positive comments about obstetricians:

I trusted him, I felt that he was a good doctor. So the baby was going to be induced and along we went in the morning. I think I went into labour about midday and he was born about half past three.

The labours and births of the other participants were less traumatic. With the exception of one woman whose first child was delivered by Caesarian section, the other participants had relatively easy births.

I didn't realise that I was going into labour until my waters broke and I thought "Well, it is definitely time", and it was. The only difficulty with labour was that I had become so fit my muscles wouldn't relax.

The pregnancy had some anxious moments. I had some bleeding and did need to rest for a couple of weeks, but after that I came right. Everything was fine and I had an exceptional birth I think for a first time, it was only a five hour labour.

Of the fourteen children born to the participants in this study, six experienced a normal delivery; a further three were induced but their delivery was normal; one mother's baby was delivered by a Caesarian section for a breech presentation; and four deliveries were aided by forceps due to lack of progress. The delivery of one large baby required an internal rotation and was followed by a very traumatic forceps delivery, during which the baby's clavicle fractured. Needless to say this mother was very distraught emotionally and in considerable physical distress for a number of days.

Berryman, Thorpe and Windridge (1995) observed little substantive difference between younger and older first time mothers in their experiences of labour. Interestingly, older primigravidae in a study by Berryman et al. (1995) required less pain relief than initially anticipated. The researchers added that older women also appeared to have greater control during labour than younger women.

The mothers asserted their right to remain in hospital for as long as they needed care and assistance. The constant concern that something might happen to their babies was

manifest in a fierce protectiveness. One mother who has two children explained this feeling:

They said to me “We’ll take him to the nursery”. I said “NO!”. I just wanted them there, I didn’t want them in the nursery where people might be able to steal them.

Another mother who had waited for twenty years to have her child was distraught over the removal of her baby after delivery.

They said that they had to keep her, which I didn’t like. They had to keep her because she was delivered by forceps, I think. I couldn’t see her for 24 hours, I couldn’t hold her for 24 hours, they took her away for 24 hours, I wanted to breast feed her.

The participants found that the immediate postnatal period was a vital time to learn the basic skills of motherhood. Some of the mothers wondered how they would cope at home as they had expected to receive much clearer guidance on parenting skills during their hospital stay. Not everyone considered the staff helpful, with some participants emerging confused by conflicting messages and frustrated by the lack of support.

All the shifts seem to have different ways of doing things. I was really confused as to what to do. In the end one of my visitors helped, and from then on I did my own thing.

The staff all seemed to be dissatisfied, or there was something political going on, I don’t know. They all seemed to be annoyed with each other, the big difficulty I had was with changing shifts and the changes in attitudes and beliefs and I found that motherhood didn’t come to me naturally.

This contrasted markedly with comments from some of the other participants:

The staff at the hospital were very good. I stayed there for ten days. After I came home I had a midwife for four days. She came around every day.

I found the nursing staff and everything very good. I know there’s people that don’t like it but she was only 5.1 pounds, so I stayed there for eight days ‘til she’d put on a bit of weight.

Most of these women remained in hospital for eight to twelve days after the birth of their first baby. All were extremely concerned about the recently introduced early discharge policy, considering that they could not have coped if asked to return home on their second day postnatal.

. . . after all you do not have the knowledge and anything could happen.

Price (1977) relates how the participants in her study also experienced feelings of inadequacy and helplessness. These emotions are likely to be a natural reaction for most mothers, flowing from a lack of support rather than from any age distinction.

Implications for Practice (stimulated by the data)

Traditionally there have been few options for those seeking professional care during pregnancy, childbirth and the postnatal recovery. The participants were automatically referred to specialist care. In recent years increasing numbers of women have come to view independent midwifery care as a viable alternative. If the enthusiasm with which participants have collected information is any indication of normal practice, older primigravidae are likely to carefully weigh their options in the search for caregivers. Midwives are more likely to be sought out as lead maternity carers, as the perceived need for specialist care for older women is reduced in the light of recent evidence that older women do not pose greater obstetric risks.

Support

There are few mothers who have not considered how they would react if something were to happen to themselves, their partner or their child. This concern emerged as an important motivation, leading many participants to develop contingency plans. These preparations included not only the nomination of caregivers and guardians, but also the purchase of second cars and mobile phones so that they could be contacted and react quickly in the event of an emergency. One mother always volunteered to provide transport for school trips and although she was willing to provide other children with transport she did not allow her own children to travel in other parents' cars. This mother was extremely protective of her children as she had waited 20 years for them.

I tried not to be too protective, but if something happened to her I'd never forgive myself.

I was paranoid that something was going to happen if I wasn't there looking after him the whole time. I wouldn't leave him with anyone else.

Participants described a multitude of support mechanisms which varied according to the needs of each mother and child. The couples depended on each other for support throughout the pregnancy, especially during the long wait for results of genetic testing. The mothers particularly needed support during the first year after the baby's birth, as low energy levels and a feeling of vulnerability left mothers feeling emotionally and physically exhausted.

For most of these women the child's father was the first and greatest reservoir of support, especially for couples who experienced infertility and sought medical assistance to conceive. The participants relied heavily on their partners for support during pregnancy and labour. Most had been together in a solid partnership for many years.

A really supportive husband, 100 percent supportive.

My husband's very supportive, and is wonderful with [my son]. He has a fairly stressful job, he works long hours, but he does try to take over at the weekends and spend time with him.

Tiller (1993) in a longitudinal descriptive study of partners' parenting attitudes reports that mothers value the support of their partners above that of all other agents. Fathers may respond to parenting by assisting in more household chores and gradually becoming involved in infant care. Partners may also take responsibility for feeding, changing, bathing, playing, putting the child(ren) to bed and getting up to them at night. Like the fathers in this research, those in Tiller's study found that they became more comfortable with their children as they developed beyond the baby stage. Although competence in child care must be learned, fathers in both studies demonstrated some instinctive care-giving skills.

The delay of parenting meant that there were fewer grandparents around to support the participants and their children. Only one participant could boast the support of all four grandparents, alive and well and living nearby. Many other mothers found that

their aged parents were unable to offer much in the way of support or interaction with their grandchildren. There were always exceptions. One 83 year old grandmother took her grandchild and his parents to Disneyland for a holiday. The delighted mother described a feisty lady who manages the family farm where her grandson spends many happy hours. Another grandmother who was very supportive with a difficult grandchild became very attached to the child.

Mum understood him and he has always got on extremely well with my Mum. They're very close, a great relationship, which has been very fulfilling for the three of us.

Some of the children's grandparents were deceased while others did not always live nearby but when they were around they were very helpful. Grandparents who were able to help often assisted with baby sitting and preparing meals. Although this help was always welcome, participants particularly valued their parents' support immediately after the birth of their child(ren).

My mother was a tremendous support. She was available, there to talk to, she was there to come and push this pushchair or the pram back and forward making the rhythm to get this child to sleep.

Most participants found family and friends to be very supportive. Berryman et al. (1995) described how that it took around eleven months for mothers over 40 years of age to feel physically normal again after the birth of their first child. Breast feeding problems and depletion of energy were largely responsible for this delay, forcing mothers to depend on support from professional care givers. Many older mothers are able to adapt their lifestyles, integrating the child into their lives with the assistance of capable child carers (Daniels and Weingarten, 1982). These mothers are much less reliant on friends and family for support, but depend more heavily on paid child care. Most of the mothers surveyed by Daniels and Weingarten (1982) paid casual house cleaners who relieved them of some of the more mundane tasks.

Many of the participants in this study have made new friends through their childrens' activities. Age does not appear to be a barrier to these relationships. Although new friendships can be time consuming they frequently prove to be very worthwhile, providing common interests which become especially important during the preschool

years. Many participants found that younger mothers were experiencing similar problems to themselves. One mother who was very involved in kindergarten committees described how often younger parents are struggling to deal with the same kinds of problems that worry older mothers.

It was also good to get out and mix with some other people, to hear their stories and what they are experiencing, and it makes you realise that the things your kids were doing were quite normal. Being on those two committees was great fun, there's always something to keep your mind going.

This mother and her husband continue to take an active interest in their children's interests and activities and have found this experience immensely rewarding. Most participants made friends with parents who had children of a similar age. Some kept in touch with friends that they met before becoming mothers, although these relationships rarely maintained the same intensity. Friends that were once very close might only make contact twice a year, as friends drawn from the parents of their children's peers and their children compete for time. In contrast, research by Daniels and Weingarten (1982) found that the peers of participant children often had parents who were ten years younger, generally without the emotional maturity of the participant group. Even though the children provided common interests, mothers interviewed by Berryman et al. (1995) tended to seek out other like-minded professional career women who also happened to be in a parenting role.

Professional support was very important for the participants in this research who particularly valued the help and encouragement given by Plunket. For most mothers Plunket provided their only postnatal professional support. Participants were unanimous in their praise for the common sense advice dispensed by the ever patient Plunket Nurse. Although most of these mothers stayed in hospital for eight to twelve days after the birth, they claim that they could not have coped with breast feeding without the Plunket visits.

I think the best thing was the Plunket Nurse. I think that it would be an absolute tragedy if that service went. My lifeline to start with was the Plunket Nurse.

Plunket was marvellous, I had great admiration for Plunket. I had a change of Plunket Nurse with each baby, but both were good.

Plunket is an exceptional organization and I would encourage anybody who is having children in later years definitely to get plugged into them.

Two desperate mothers who needed time out to sleep or to recover emotionally from the rigours of childcare welcomed the help of the Karitane Support Service provided by Plunket. Private nannies were used by two of the women, although several other women stated that they would have called on nannies to secure some time out if they had known that this service was available. These comments were echoed by participants who were keen to breastfeed but lacked the technique or support. Only two mothers used La Leche (a breastfeeding support group) or were aware that this service existed.

I couldn't get him to latch on to the breast, I had terrible difficulty. I wanted to breast feed. They said, "Oh, you'll get the hang of it", but I just couldn't feed. Nobody seemed to know why. The staff seemed to be dissatisfied, they all seemed annoyed with each other. I just never had any success. It would have been great to have known about the La Leche group .

Those mothers who used La Leche found the help and advice on breast feeding invaluable.

La Leche was very helpful with breast feeding. There was such conflicting information in the hospital, they were always busy.

Another mother who experienced problems in Australia when breast feeding her first child found La Leche extremely supportive on her return to New Zealand where her second child was born.

I went to La Leche right through my pregnancy. I got to know some of the La Leche parents. I didn't have any problems with the age difference.

Some of the women who had found the Plunket nurses really helpful were disappointed by practice nurses who were loathe to provide any information without the prior approval of a GP.

I didn't really want to see the doctor but I was worried about a reaction to immunisation. Although [the practice nurse] had given it, her knowledge was just not there.

Participants expected more practical support from these nurses, whose knowledge about essential services often failed to satisfy.

All the practice nurse did was some injections and dressings. She could not advise me about my child's problem with sleeping. A friend finally told me to go to the Leslie Centre where they were very supportive [(a family counselling centre)].

Most of these mothers would have liked a list of support agencies and child care services as it took much trial and error to independently investigate all of these resources. Furthermore, neither GPs nor practice nurses were able to refer participants to alternative health agencies. One mother who was looking for alternative health care for her asthmatic child was advised by her GP:

Don't waste your money on all that rubbish, a healthy diet is all he needs.

Implications for Practice (stimulated by the data)

The need for additional resources and information to be made available has already been discussed under the 'need to know' sub-theme. However, ease of access to health services and support agencies has become increasingly important given the uncertainty wrought by cuts to public health agencies. Participants describe the retrenchment of Plunket services as a severe loss for all women. The professional, caring attitude of the Plunket nurse is directed by a code of practice:

The scope of practice of the Plunket nurse is to strengthen the families' ability through care and informed advice during pregnancy, early childhood and parenting. Care is preventive and promotive, with emphasis on facilitating learning, support and child health surveillance. Practice may occur in a mix of family/whanau, or community contexts.

(Royal New Zealand Plunket Society, 1995, p.3)

There are many excellent practice nurses and general practitioners in the community who deliver a high standard of primary health care. It is unfortunate that not all health professionals hold themselves similarly accountable. Recent steps towards accreditation require that practice nurses:

. . . are responsible and accountable as professionals to maintain current nursing knowledge for the delivery of safe quality care within appropriate ethical and legal parameters.

(New Zealand Nurses Organisation, 1997, p.2)

What If Something Happens To Us?

Most of the participants worried about what would happen if they died before their children were of an age when they could be independent. In many instances there were no relatives emotionally close enough to the children to offer ongoing support. Most of the surviving grandparents were already too old to cope with the problems of children, teenagers or even young adults.

If anything happens to us, that's a problem. It's always a possibility being older parents and we've got him down to go to friends who would be excellent with him, so that's in our will.

A participant with two children explained with relief that if anything were to happen to either herself or her partner the children would at least be able to depend on each other for support.

That we can keep healthy so that they've got us for as long as we can, that is why we're really so thrilled we had the second one, they will have a sibling.

The fear that something could happen to either parent has sparked interest among several participants in a support group for older parents with younger children, providing a community of interest among children and parents alike.

I think probably just to be able to talk to someone else who's in the same position, because when you're an older mum, and certainly with an only child, you do have concerns because you count the clock and you think, well, I

might not be around when she's . . . and you'd like to know if other people felt that way and how they think they're going to deal with that, how can they prepare their child. I find that very tricky, because I'm quite protective of her and I try to pull back and not be so, because I know that she's probably going to need to be fairly independent.

So it would be nice to know that there are other people out there of the same age. A support group of older people, if I had a support group of older mothers, but I don't know anybody my age.

Although Daniels and Weingarten (1982) commend mothers over 40 years on the way that they have coped as parents, the authors express concern that the decision to delay parenting may prevent parents watching their children reach adulthood. In fact, all the participants are fit and healthy and there is no reason why these mothers should buck historical life expectancy trends. In all likelihood participants will live to see their child(ren)'s 21st birthday. If their children delay parenting however, the participants may never be grandparents. However, a reversal of these parenting patterns is just as possible, with children of older parents choosing to become parents themselves while still aged in their twenties. As Daniels and Weingarten (1982) observe, many questions related to the phenomenon of delayed parenting remain to be answered.

Implications for practice (stimulated by the data)

Present fertility trends indicate that women are increasingly choosing to delay parenting. These parents will not only be more mature in age but also more demanding in terms of the quality of information and support that they require. If future generations of parents follow the patterns set by participants in this study and described by research from overseas they are likely to have no more than two children and will expect a high standard of professional care.

The main theme, child centredness, dominates concern over the fear of something happening to disrupt the parent-child relationship. This anxiety has been an intrinsic component of the participants' lives from the time of conception. They will always seek to protect their child(ren) from harm. As the years pass the emphasis shifts from 'What if something (physically) happens to the child?' to 'What if something happens to us, the parents?'. The child is still in the centre but with time the parents' own mortality becomes a real concern, especially when there is little family support.

This is the last of three chapters which present the findings and discuss the implications of these for practice. This chapter has endeavoured to show the interconnectedness of the three themes; 'awareness of time passing' 'the need to know', and 'what if something happens?'.

In the concluding chapter the research will be summarised, discussion will be undertaken regarding whether the study aims were accomplished, and implications for future research will be made.

CHAPTER EIGHT

CONCLUSION

In this research the meaning of motherhood for first time mothers over the age of 40 years old has been explored. The 11 women of European descent who participated in the study had children aged from 3½ to 20 years of age. The descriptive exploratory design used in this study enabled the participants to tell their stories as they perceived them. The overall findings, their interpretation and implications for practice are summarised in this chapter. The limitations of the study and implications for further research will also be addressed.

This study identified three aims:

To explore the meaning of motherhood for older mothers.

The researcher sought to understand the relationship between mother and child and the mothers' experiences of parenting. The child was perceived as a 'precious gift', someone who gave them joy and brought a new meaning to their lives. The findings detail the positiveness of the mothers' experiences. Their lives changed dramatically after conception from self-focused to child centred.

To identify how the women coped with motherhood.

The findings show that these mothers set themselves very high standards to ensure that their child(ren)'s interests and needs were addressed at the highest level. This sometimes entailed going to extreme lengths to screen all the facilities in which their children became involved (such as day care, preschool, school and recreational activities). The women experienced very low energy levels during the first year of motherhood and would have welcomed some respite to catch up on some much needed sleep.

To identify the health and social services these mothers would find helpful.

Those services will be discussed later in this chapter.

Although a number of overseas studies and literature have focused on the phenomenon of older first time mothers, only one New Zealand study was identified

which focused on first time mothers over 30 years of age. This longitudinal study was undertaken by the Society for Research on Women (1991). The research initially surveyed participants at the time of their first child's birth in 1981 and conducted a follow-up study of the mothers' experiences five years later. Reasons for delaying parenting were similar to those identified by this research.

Most relevant overseas research was developed in the US in the late 1970s and early 1980s, including Price (1977), Fabe and Wikler (1979), and Daniels and Weingarten (1982). However, an English research study by Berryman, Harker and Thorpe (1995) is more recent. These studies concur with many of the findings discussed in this research, particularly those relating to the reasons for delaying parenting, lack of support services, difficulty in accessing quality child care, lack of family support, and the mothers' anxiety about age and their own mortality. In the interpretation of the findings these older parents appeared especially concerned about the risks of genetic screening and adolescence. Some of these concerns are relevant to all parents, although issues such as fertility, genetic screening and mortality will have more limited application.

Methodology

The exploratory descriptive method was well suited to the research as it enabled the women to narrate their experiences as older first time mothers in detail. The researcher felt privileged to have shared the personal beliefs and experiences of these women. A detailed examination of the participants' transcripts, interview notes and observations directed the identification of themes and categories. Once the transcripts had been analysed they were returned to the participants with the analysis for verification. Minor alterations were made by the participants but they all agreed that the analysis was a true and accurate portrayal of their experiences. The transcripts and interpretations were later read by the researcher's supervisor to ensure that the contextual nature of the women's stories were preserved.

Major findings

The central theme, 'child centred' describes a relationship between mother and child of total commitment, taking priority over all other concerns. Almost everything that the mothers did related to their child(ren)'s welfare, especially in the preschool years. Mothers also planned years ahead to ensure that their children would be protected if 'something happened' to them as parents. The parents were aware that they were older than most parents and that they might not live to see their grandchildren, especially if their children also chose to delay parenting. They planned for every eventuality by encouraging their children to participate in a wide range of activities, so that if something happened they would have support from others.

Awareness of passing time

The mothers were very aware of the passing of time, placing special value on the precious years with their children. Most of the participants were happy to be at home with their child during the preschool years. Women who had waited many years to become a mother considered that this time with their child(ren) was extremely fulfilling. However, several mothers were concerned that they might appear older than other parents with children of a similar age. Others were not bothered by this and stated that they had no regrets, having enjoyed very full lives prior to parenting. These mothers considered that they had more to offer their child(ren) because of their experiences and were now content to be at home during their child(ren)'s formative years.

Some of the women found that pregnancy did not occur within the first year of discontinuing contraception. Others conceived spontaneously shortly after stopping contraception. The only true test of fertility is pregnancy, and although hormone levels may provide some indication they cannot guarantee that pregnancy will occur. Only two women conceived as a direct result of an infertility programme. Four other women in the study who experienced infertility problems eventually decided that they were infertile (after a number of GIFT programmes and tests) and stopped further treatment. These women conceived spontaneously after withdrawing from fertility

treatment. It would appear that emotional and physical stress may itself have a major effect on a couple's fertility.

Most parents expected the teenage years to be a difficult time. This is one reason that they tried to stay closely involved with their children, assisting the establishment of sound communication channels. These older parents were especially aware of the need to keep up with trends, and formed support groups for themselves and their children. Some of them felt that they would welcome skilled advice prior to adolescence on how to cope and prepare themselves for what has traditionally been viewed as a traumatic time for both children and parents.

The need to know

The 'need to know' is an integral part of the phenomenon of older motherhood and is interrelated with the other sub-themes 'Awareness of passing time' and 'What if something happens?' The women educated themselves thoroughly on all aspects of pregnancy and utilised their research skills to obtain extensive information relating to pregnancy, labour and childbirth. They were voracious readers who questioned the information provided when they did not understand or when the information was unclear. The women did not automatically enrol their children in the most convenient school or recreational activities, but checked these out carefully so that they knew who their child(ren) associated with and how they would cope in that environment.

What if something happens?

From the time that the participants initially decided to have a child this question was a critical element in their lives. It was initially related to age ("Am I too old to conceive?"), but once pregnant they became concerned about the potential for something to go wrong with their pregnancy. Although some of the mothers had an anxious time wondering if they could conceive, the most traumatic time for this group was spent waiting for the results of genetic screening. Not only were the women naturally concerned about the outcome, they were also very aware (especially those who had been on infertility programmes) that this could be their last chance to give

birth to their own child. Fortunately for these women the results of screening were positive.

After the women received their results they faced their next problem: "What if something happens during labour and childbirth?" Although most experienced a normal labour and birth one of the participants suffered a traumatic forceps delivery and her child sustained a fractured clavicle as a result. During the children's infancy the mothers bonded with their precious child and "What if something happens?" became an even greater issue as the child assumed its own unique personality. Everything their child(ren) were involved in was checked out carefully. One mother who refused to trust the driving skills of other parents volunteered for all the school outings and any other activity which relied on parent transport so that she could take her children in her own car.

The underlying issue was the parents' own mortality. Nearly all of the mothers saw this as a major concern as there were few immediate family available. Although some children had grandparents with whom they enjoyed a positive relationship, other grandparents lived abroad, were too elderly to cope with children (let alone teenagers), or were deceased. To overcome this problem the participants have become very involved in their children's activities, strengthening relationships with the parents of their children's friends who could take some responsibility if something happened to either parent. Most of the mothers also discussed how they would like to be involved in a support group of older mothers so that they could share concerns and perhaps provide support to deal with some of these issues. The researcher has agreed to place interested participants in touch with each other.

The participants all indicated that they and their parents had achieved what they wanted and were ready to have a child. Psychological readiness for parenting is essential for Erikson's generativity stage which is described as "primarily the concern in establishing and guiding the next generation" (Berger, 1984, p.507). Not everyone is ready for parenting at the same time. Although Erikson's stages do not change when parenting is postponed, the fact that we are living longer means that the last and final stage of integrity and despair is unlikely to be reached until much later in life.

Implications for Practice

(stimulated by the data)

The majority of the participants considered in retrospect that 40 years of age might be too old to have a child. Most agreed that 35 years of age would be a better time. As the second most popular age grouping for first time motherhood in New Zealand is from 30 to 34 years of age, midwives and nurses will increasingly encounter older pregnant women who have chosen to delay parenting. Improved contraception means that pregnancy is now often carefully planned. Most of the participants prioritised education, travel, establishing a career and ensuring that they were financially secure before they considered themselves ready for parenthood. They used their professional and personal experiences to achieve the best possible outcomes for their babies.

As the findings have shown under the sub-theme 'the need to know' the mothers will discuss, analyse and question the information that they receive. If they are unhappy or unclear about explanations they will seek other resources. The participants chose specialist care as they perceived this to be in the best interests of both themselves and their children. It would be interesting to know whether this still occurs. This presents a challenge for midwives, to convince older women that they are competent and able to provide an optimal, individualised outcome for mothers and babies.

Midwives

Regrettably, the participants in this study were traditional in their thinking, believing that childbirth takes place in hospital and that babies were delivered by doctors. They were totally unaware of the individual professional care that midwives deliver. These professionals are skilled in identifying the stressors of pregnancy and planning ways of lessening this impact through health promotion. Midwives are able to reassure women that minor discomforts such as morning sickness and fatigue are complaints commonly experienced by many pregnant women. As the literature relating to labour and childbirth has been fairly negative for older women in the past midwives can allay fears, confirming that if the mother is fit and healthy age will not be a disadvantage. The participants described genetic screening as the most traumatic experience of

parenting. The waiting time for the results isolated them from their friends and families as they found that nobody really knew “how they felt at this time”.

- Midwives could market their skills to attract older primigravidae. Older women may be more traditional in their thinking, believing that childbirth takes place in hospital because it is safer and that the best care is provided by a specialist (Chapter 7).
- Midwives could become more involved in infertility care by supporting women during this distressing time. If or when conception occurs the midwife would be able to provide continuing care as a lead maternity carer (Marshak, 1993).
- When caring for women over the age of 35 years midwives will be involved in genetic counselling. Although some midwives are already involved in counselling women over the age of 35 years, participants comments suggest that obstetricians have been somewhat remiss in this area. Expectant mothers and their partners should receive informed and sensitive counselling during the trauma of the decision making process (Chapter 7; Wright, 1994).
- Midwifery care is acutely challenged in the provision of postnatal care since the reduction of funding in this area. This will impact on their ability to maintain the high standards of care which they have provided up to now (Author’s opinion).

Plunket nurses

Most of the participants in the study found that when they came home with their baby they experienced overwhelming feelings of uncertainty and self doubt: “How do I manage?” Postnatal preparation is particularly important at a time of early discharge policies and cutbacks in state funded Plunket and professional midwifery care. Many of the participants returned home with no family support. It would appear that policy makers consider that parenting and breast feeding are instinctive and that women naturally adapt to motherhood. Unfortunately this was not the experience of the women in this research, several of whom relied heavily on the support of health professionals to assist them in the initiation of infant care.

When health services move from the institutional setting the family benefits from the provision of care in familiar surroundings. However for community care to be effective a considerable amount of resources are needed. That this has not happened is to the detriment of mothers and babies. As the participants had very little support to draw on, the knowledge and support gained from health professionals became essential. For these reasons it is important that antenatal classes are extended to include a considerably greater number of sessions which develop parenting skills and focus on the stressors of the early postnatal period.

- The service that Plunket nurses have offered in the past and will be offering in the future is highly valued by all the participants in this research. The participants described them as their “life-line”, and many considered that they could not have coped if this service had not been available (Chapters 6 & 7).
- The participants who used the Karitane support service found this to be most beneficial in providing them with a few hours of rest, secure in the knowledge that their baby was receiving “professional care”. The participants were distressed to learn that this service was no longer provided (Chapters 6 & 7).

General practitioners, practice nurses, public health nurses and school nurses

General practitioners, practice nurses public health nurses and school nurses are likely to be asked for their advice on various issues relating to child development and health care by mothers in this age group.

- Practice nurses are in the unique position of being able to allay some of the concerns of older mothers. For instance most of these women blamed their age for low energy levels. Practice nurses would be well placed to reassure these women that this is also a common problem for many younger women, especially when there is little support (Chapter 7).
- Although these women may have researched a topic themselves they still seek reassurance from professionals that their information is correct. The women expect high standards of health care and when they seek advice from professionals

they expect to be advised of all the positive and negative effects of any care or treatment so that they are able to make an informed decision (Chapters 6 & 7).

- Increased pressure may be placed on children of older first time parents to cope with all of their parents' expectations. These children have always been very special, and have no competition from other siblings. Although this may have been advantageous at an earlier age they may feel somewhat stifled during their teenage years. These children may also be overly encouraged to engage in academic or recreational pursuits which might not be their choice (Chapter 6; Yarrow, 1991). Both public health nurses and school nurses will be involved in health promotion in schools and as such they have a responsibility for the safety and well being of the children. These professionals need to be aware of the pressures that children of older parents may have to cope with.

Mental health nurses

The importance of mental health counselling cannot be emphasised enough. The stress experienced by these women may well have been lessened by the input of skilled counsellors. Mental health professionals could support parents by developing their coping skills during the teenage years. Most parents are aware that adolescence can be a traumatic experience marked by a high suicide rate. Many parents would find it beneficial to attend workshops relevant to adolescence. Preventative counselling for parents may well avert some of the tragedies of this age group.

- The specialised services offered by mental health nurses can be utilised by midwives when women are undertaking infertility treatment and when parents must make a decision relating to genetic screening. It is not suggested that mental health assume the key support role, rather that midwives themselves seek their advice and counsel (Author's opinion).
- Older parents are likely to be more anxious than most about adolescence. Participants with children aged from eight to eleven years have already commented that they would like to enrol on courses to discover how they can prepare themselves for the teenage years (Chapter 5).

- Primary health care practitioners may find ‘workshops’ of assistance in providing parents with the knowledge and skills needed to cope with teenagers (Author’s opinion).
- Seminars or courses pertaining to the teenage years could be well attended by parents who are concerned about these “difficult years”(Author’s opinion).

All nurses should be aware of the changing trend of parenting and that parents will be increasingly seeking information relating to all the activities in which their children are involved. It is important that as primary health care providers nurses maintain a collaborative relationship so that they can share information which will benefit all families.

Support services

Some of the support services the mothers used were very helpful. La Leche helped several of the mothers master breast feeding. However, the service was not well known, and apart from one mother who had joined the group prior to the birth of her baby the other participants only discovered the service by chance. Parent Centre (an information centre for parents) runs a variety of parenting programs including antenatal and postnatal classes. A Working Mother’s Handbook (Holloway, 1994) is a valuable New Zealand resource not only for working mothers but for all mothers. First time mothers are likely to find this book especially useful.

Limitations of the Study

Apart from one mother whose children were aged between 17 and 21 years, all of the other children were aged 11 years and younger. The majority were between five and eight years of age, which limited the findings to childhood experiences. All the participants were of European descent which may reflect the dominance of this ethnic group in trends to delay parenting, but certainly does not reflect the overall New Zealand population.

As this research is submitted in part fulfilment of a Master of Arts degree it has been limited by a constraint of time. Otherwise it would have been valuable to learn the

fathers' perspective of older parenting as the researcher understands that all the fathers except one were first time parents.

Recommendations for Further Research

- As the incidence of delayed parenting is increasing there will be a demand for further information related to this phenomenon. It would therefore be valuable to undertake a follow up study of the mothers in ten years time when the majority of children will be in their teenage years and most of the mothers will be in their 50s.
- With the retrenchment of health services for postnatal mothers, older mothers with their limited social support could be at an increased risk. Research needs to be carried out on different age groupings to ascertain: how they are coping, whether there has been any change in the incidence of breast feeding and if the incidence of readmitting babies to hospital has increased since funding became more limited. The experience of Plunket nurses related to decreased resources would be beneficial.
- If patterns of delayed parenting in New Zealand follow those observed by researchers in the United States, women from lower socio-economic groups are increasingly likely to delay motherhood. Ten years from now New Zealand European older mothers may be less statistically dominant, as other ethnic groups which traditionally have had a lower age of first time motherhood are increasingly likely to delay parenting. If increasing number of parents delay parenting would that imply that the incidence of truancy from schools will change as parents are more mature and involved with their children?
- All the participants experienced a problem with low energy levels during their first year of parenting. They considered that they would have coped better if they had been younger parents. However, younger mothers also have low energy levels, especially if they do not have any support (Berryman et al., 1995). A comparative study of first time mothers aged between 25 and 29 years and first

time mothers in their forties would be helpful in assessing the validity of this belief.

This research has explored the meaning of motherhood for first time mothers over the age of 40 years at the birth of their first child. It has related the high level of parenting satisfaction these women gained in their parenting role. Both the negative and positive experiences of the participants have been presented. The participants have no regrets about their parenting role but stated that they would have preferred to give birth to their first child when aged in their mid-thirties. As a researcher I have been impressed with the positiveness of the participants in their role as older mothers.

As Friedlan (1982 in Schlessinger, Danaher & Robert, 1984) identifies, there appears to be a basic 'need' for women to have a child. The mothers in this study have shown how strong the need was in their relationship for a child to fill a void in their lives. The child centred concept was the focus of their lives, supported by the sub-themes: 'Awareness of time passing'; 'The need to know' and 'What if something happens?'.

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APPENDIX ONE

THE MEANING OF MOTHERHOOD OVER THE AGE OF 40 YEARS

INFORMATION SHEET

My name is Nel Vincent. I am looking for voluntary participants to assist me in my research study which is part of my Masters Degree through Massey University. I am a Registered Nurse and Midwife, and am currently employed as a nurse lecturer at Manukau Institute of Technology.

The research seeks to identify your experiences as mothers who have their first child after the age of 40 years and whose child is now at least five years old. I would like to interview you so that you could tell me what it is like to be an older mother, how you have coped, what has helped you to cope, or what has helped you as a mother?

The purpose of this research is to discover what support older mothers need to care for their children, so that nurses and midwives may be better informed, to assist and advise other mothers like yourself in their parenting role.

As a participant you :

- *will be invited to participate* in an interview of about one and half hours during which you will be asked to discuss your experiences as a mother: how you coped: the problems you encountered; how you could have been more supported, what or who could have assisted you in your role as a mother.
- *need to understand that* our conversation will be recorded on a tape recorder; the tapes will be transcribed by a confidential transcriber, my supervisor will also see the transcripts of the interviews, I will be observing and taking notes during the interview.
- *will be asked to choose a pseudonym* (false name). I will be the only person who knows your true identity. All material transcribed from the tapes will use pseudonyms and will be kept locked in a drawer in my home unless it is being transcribed or read by my supervisor. At the conclusion of the research, the tapes will be erased and the journal and notes will be destroyed.

- *may be requested* to participate in a follow up interview should this be necessary to clarify any details.
- *need to agree* to the use of the research findings being used for further research seminars or publication.
- *will be asked* to sign a consent form.

If you take part in this study, you have the right to:

- *refuse* to answer any questions.
- *withdraw* from the study at any stage without prejudice.
- *provide* information on the understanding that your identity will remain completely anonymous should you wish it.
- *ask* for the audio tape to be turned off at any time during the interview.
- *receive* a summary of the study's findings after the thesis has been submitted.

If you have any queries or concerns you regarding your rights as a participant you may contact the Health Advocates Trust. Phone 6389638.

The supervisor of this study is:

Dr. Gillian White, PhD. MA (Hons), B. Ed. DipSocSc(Psych) RM MTD,
Senior Lecturer, Department of Nursing & Midwifery
Massey University Albany. Phone 443 9373.

I can be contacted by phone in the evenings and weekends: Phone . . .

If I am unavailable please leave your name and phone number on my answer phone and I will return your call as soon as possible.

APPENDIX 2

CONSENT FORM

Title of project: The meaning of motherhood over the age of 40 years

Principal Investigator: Nel Vincent

Name of participant:

I have been given, and have read a written explanation of what is asked of me, and have had an opportunity to ask questions and to have had them answered. I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions. I understand that my consent to participate does not alter my legal rights.

I understand that I will /may choose a pseudonym and that my participation will be anonymous (*The information will be used only for this research and publications arising from this research project*).

I consent to my interview being audio taped but that I have the right to ask for the audio tape to be turned off at any time during the interview.

I consent to take part as a participant in this research.

Signed: _____ Name: _____ Subject

In my opinion my consent was given freely and with my understanding.

Witness name (Please print)

Signature

Date