

INTRODUCTION

The transition to motherhood is a major developmental life event. Becoming a mother involves moving from a known, current reality to an unknown, new reality. (Mercer 2004:229).

The main objective of this study is to better understand the experiences that first-time mothers who gave birth to a living child have in the different stages of the childbearing process. This study explored the expectations these women had of how their pregnancy, the birth and their new life as a parent would be. More specifically, the intention was to explore if perceptions and social expectations shape how women perceive the process of becoming a first-time mother and how those compare to the reality of giving birth and the time afterwards.

Different cultural norms and social expectations shape how people construct their lives and opinions (Bailey 2007). Accordingly, there are a variety of books on childbearing and many different opinions and social norms on every aspect of the process of pregnancy, birth and parenting. A woman who gets pregnant in the industrialized world today has to figure out what advice she wants to take, what she considers to be the right choice for her and what resources she will use.

On the following pages, I will speak of women's experiences and expectations. However, it is important to note that I am referring to the stated expectations and reported experiences of the participants for the purpose of this study.

The first aim of this study was to explore the reported thoughts and the emotions of women immediately after they find out that they are pregnant, and how these feelings and thoughts change over the span of the pregnancy. Once these women decide how they wanted their pregnancy and especially the birth experience to proceed, what specific information do they seek? How do these women prepare for the birth? What are their expectations, and specifically how do those expectations compare to reality in terms of what actually happens during and after pregnancy?

This study also examined experiences with the postpartum period, which is still associated with idealized images and performance expectations that are not coherent with a mother's experienced reality (Beck and Watson Driscoll 2006:59). Often media portrayal of the baby blues and postpartum depression trivializes the issue. Another problem that occurs is the sensationalizing of extreme cases of postpartum psychosis involving infanticide, for instance, the highly publicized case of Andrea Yates, who killed her children while reportedly suffering from postpartum psychosis. While it was a terrible event, the extensive coverage of this tragedy and others similar to it reinforces the stereotypes and the stigma attached to postpartum emotional disorders. Studies show that 35 percent of all mothers in the United States report being depressed six months after giving birth (Beck and Watson Driscoll 2006:65), and that approximately 50 percent of all cases go unreported because of the social stigma attached to mental and especially postpartum emotional disorders (Goldbort 2002). While biological and genetic predisposition is believed to be a factor in developing

these disorders, social and cultural factors also play a significant role, but are often not emphasized.

The primary research question for this study was:

What social factors influence the expectations and experiences first-time mothers report having before, during and after birth and how?

To address this question this study had two specific aims:

1. To describe the experiences first-time mothers have before, during and after birth.
2. To explore the expectations first-time mothers say they have and what social factors shape them and how these factors compare to their reality of becoming and being a parent.

The study's findings' potential significance is to understand further the difficulties women have to deal with before, during and after giving birth. Additionally, the findings can also help to develop more focused and specific support systems and educational measures for women who are becoming mothers for the first time.

LITERATURE REVIEW

Previous literature has identified several important themes, including (1) the medicalization of childbirth and the negative influence this can have on women's experience of birth, (2) postpartum mental health and the social and psychological factors that heighten the risk of postpartum emotional difficulties, (3) the role assignment and relationship transitions, especially the socio-cultural factors that influence the experience of first-time mothers, such as social support and role allocation within families, and (4) the myths and realities of motherhood, focusing on the level of preparation for the challenges after giving birth.

The Medicalization of Childbirth

While most births in industrialized countries happen in a hospital setting, the percentage is the highest in the United States. According to Block's introduction to her book *Pushed – The Painful Truth About Childbirth and Modern Maternity Care*, "99% of women give birth in a hospital" (2007:xiv). Comparatively, 20 to 30 percent of all births in the Netherlands are homebirths with almost no medical intervention (Block 2007). In 2002, 26.1 percent of all births in America were C-sections, according to the National Center for Health Statistics (NCHS 2003), which is an increase from 2001 of seven percent. Birth is becoming increasingly medicalized and standardized in terms of being less what is socially considered "natural" and more focused on the medical side of birth rather than the emotional and psychological experience (Davis-Floyd 1994). Block (2007) describes how, while hospitalization is the norm for laboring women

in the U.S. and medical standards are among the best, maternal and infant mortality rates are substantially higher than in European countries. The CIA World Factbook (2007) lists the American infant mortality rate as 6.37 deaths per 1000 births, while in the Netherlands it is 4.88 deaths per 1000 live births and in Germany 4.08 deaths per 1000 live births, to give a few examples. Unfortunately, the race of the mother has a strong influence on pregnancy outcome in the United States, according to the National Center for Health Statistics (2007). In 2003, the maternal mortality rate for white women was 8.7 per 100,000 births, while 30.5 black women died per 100,000 births. The overall maternal mortality rate for the United States in that year was 12.1 per 100,000 births, but black women were 3.5 times more likely to die than white women (2007).

Fox and Warts (1999:327-328) claim, in their literature review, that the view on childbirth as a dangerous event adopted by most medical professionals frames a physiological process as a medical procedure. They also say that this takes away the positive aspects, the “empowering” experience of giving birth, from the women and alienates and distances them from the whole process. In the United States, pregnant women are subjected to technological interventions, like electronic fetal monitoring, induction of labor, and high rates of surgeries (Barfield 1996; NCHS 2003). Electronic fetal monitoring is standard procedure in hospital births today (Block 2007:35), but the positive effects have yet to be proven. The World Health Organization recommends regular monitoring with a fetoscope or an ultrasound device, but that practice would require a 1:1 nurse patient ratio, which does not exist in today’s hospitals (Block 2007:35). Women

are unable to move around to ease pain or to relax, if they are literally strapped to the bed by the monitors. Additionally, the chance of needing an emergency C-section increases if labor is artificially induced, according to Block (2007:10). The common drug used to induce labor is Pitocin, a synthetic form of the natural hormone oxytocin that simulates labor by contracting the uterus (Block 2007:2). It is administered through an IV-drip, which, in combination with fetal monitoring, further immobilizes the woman:

There is a tendency to look upon labor intervention, such as induction, in isolation, when it should be regarded more of a package deal. With Pitocin comes amniotomy, internal fetal monitoring, immobilization, epidural, and urine catheter; oftentimes a blood sample will be taken from the fetus's scalp to confirm a heart tracing, and an intrauterine pressure catheter will be inserted to measure the contractions' strength within the womb. (Block 2007:139)

While all of the above mentioned interventions are also frequently implemented when Pitocin is not administered, the medical induction of labor increases the chance of being subjected to these practices. The medicalization of childbirth has a tremendous impact on the development of a new identity for women during the transition to motherhood (Davis-Floyd 1994; Fox and Warts 1999). If the women say they feel "disempowered" and experience pregnancy and birth as a passive process, they further run the risk of developing a sense of dependency, which then often reinforces feelings of failure and inadequacy (Fox and Warts 1999). These are also common feelings described by women who suffer from postpartum depression (Beck and Watson Driscoll 2006).

Postpartum Mental Health

The transition into motherhood has been researched from various perspectives. The medical field is mostly concerned with postpartum mental difficulties and what constitutes the biggest risk factors. Many medical and psychological studies have been conducted on postpartum depression and similar disorders, but they have been mostly descriptive and focused on the cases that have been reported to a health care professional. They focus on intervention and treatment of the symptoms and the cause of the disease. Even though most mention stigma and poor education as factors in the underreporting of this illness, they do not explore these phenomena extensively.

The high prevalence of postpartum emotional disorders is still a subject of scientific research and there are different theories about the root of the problem. Even though the main cause of postpartum emotional disorders is unknown, some theorists believe that postpartum depression is triggered by the sudden hormonal shift in the brain after birth (Jones 1990; O'Hara et al. 1990; Simchak 2005). In addition to that, a common finding is that women who experienced symptoms of depression prior to or during the pregnancy are at greater risk to develop postpartum depression (Beck and Watson Driscoll 2006). Social support for a new mother is also sometimes considered a factor in her mental well-being (Beck and Watson Driscoll 2006; Goldbort 2002; Sanford 2002; Simchak 2005). Other cultures, for example, China, have strong support systems for new mothers. They “do the month”, which means that for 30 days after birth new mothers follow certain rules and get a lot of rest and attention (Pillsbury 1978, in

Beck and Watson Driscoll 2006:67). In these environments, the family can support them after giving birth and can make sure that they received enough rest to heal (Beck and Watson Driscoll 2006). Such structures are less common in Western culture and Pillsbury (1978, in Beck and Watson Driscoll 2006:67) claims that these rites of passages are not completed in Western society. This lack of strong support might make it more difficult for women to adjust to motherhood and can trigger maternity blues (Fox and Warts 1999). However, previous research has shown that postpartum depression also occurs in cultures that have supporting rituals for new mothers, and that the prevalence of postpartum depression is fairly consistent worldwide (Beck and Watson Driscoll 2006). Cox (1983, in Beck and Watson Driscoll 2006:67) conducted a study on semi-rural African women who were diagnosed with postpartum depression, which showed that this illness is not only confined to Western societies.

Leathers and Kelley (2000) conducted a study on unintended pregnancies and how these can affect both parents' mental stability. They found that the risk for postpartum depression is especially high for women who intended to become pregnant, while the fathers did not share the intent to have a child. They also found that even among married and well-insured couples about 32 percent of all pregnancies are unintended. These studies all focus on depression and similar difficulties but do not deal with expectations women might have about their life as mothers.

Underreporting of Postpartum Mental Disorders. A recent cross-cultural comparison of postpartum depression revealed that 6 months after birth in the

United States 35 percent of all mothers were considered to suffer from postpartum depression, in Canada 54 percent were still depressed and in Sweden only 13 percent were depressed (Beck and Watson Driscoll 2006:65). Today postpartum depression is a disorder that can be cured through therapy and/or medication, but approximately 50 percent of all cases go unreported due to the social stigma attached to mental and especially postpartum depression (Goldbort 2002). Even the most modest of these percentages shows the importance of further exploration into why women who suffer from this disorder choose to stay silent and how significant it is to develop and employ strategies to motivate women to seek professional help. Postpartum depression is a severe mental disorder. Symptoms can include an inability to bond with or care for the baby. Depressed women might also feel a general lack of pleasure in life, accompanied by a loss of interest in activities they used to enjoy. Women, who suffer from postpartum depression, are also very likely to feel weak, incompetent and flawed (Sanford 2002). These symptoms usually will not disappear on their own, but need professional treatment to enable the women to function again. Medical attention is especially important, because of the damaging effects this illness can have on the development of the dependent children (Beck and Watson Driscoll 2006:90).

Social stigma might be the main factor in the underreporting, but most likely is not the only influencing aspect in the decision to not consult a professional. While social stigma relates to the majority of mothers with postpartum depression, a large number still chooses to go into treatment. As a

second factor, I propose self-stigma. If cultural stereotypes and norms are internalized to the degree where these norms become a person's own values, a failure to meet these expectations might result in denial and shame, namely self-stigmatization (Barney et al. 2006). If this is the case, the likelihood of seeking treatment is probably diminished.

In the review of the literature, several themes emerged regarding the connection between the willingness to report mental illness and stigma. Self-stigma and perceived social stigma were found to be the two main reasons for a person not to report a mental illness (Barney et al. 2006; Kelly and Jorm 2007). Regarding postpartum depression, Beck and Watson Driscoll (2006) described that "it has been our observations that often women suffer in silence for weeks, sometimes months before they seek help" (Pg. 6). As a reason for this silent suffering they report self-blame, "which leads to shame and lowered self-esteem, not only as a mother but also as a woman" (Pg. 6). A problem with this statement is the difficulty of disentangling self-stigma from self-reports of general feelings of unworthiness that women might give.

Stigma of Mental Illness. Most literature focuses on mental illness or depression in general when talking about stigma. While I was unable to find any literature that specifically deals with postpartum depression and its connection to stigma, previous studies and articles can be helpful in describing the phenomenon I am interested in.

Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others. The stigma of mental illness, although more often related to context than to a person's appearance,

remains a powerful negative attribute in all social relations. (Byrnes 2000:65)

Byrnes (2000) describes how prejudiced society still is when it comes to mental illness. He states that several studies found that mental illness is a cause of embarrassment for society and how that leads to secrecy and silence. He also describes a specific form of stigma referred to as *courtesy stigma*, which relates to the immediate social environment of a stigmatized person (for example the family, but also to people who are otherwise associated with a stigmatized person). This can lead to *scapegoating* and can isolate a stigmatized person even more. Another important aspect that Byrnes (2000) explains is the myths surrounding mental illness. Mentally ill people are often seen as being pathetic or dangerous, which again is a form of stigmatization and not necessarily grounded in reality. In addition to that, Kelly and Jorm (2007) describe how some studies discovered the social belief that mentally ill people could “just snap out of it”, if they only wanted to. This belief leads to the findings of Rodin et al. (1989) who observed that people are more likely to be prejudiced and behave in a discriminatory manner toward a person who, in their mindset, has a social flaw that this person has control over and could choose not to have.

Lee and Craft (2002) conducted a study on why people with stigmatized illnesses conceal their disease and on why they sometimes choose to reveal their status to others with no apparent reason to do so. They found that people who suffer from a stigmatized condition face a dilemma: while revealing themselves to others might result in rejection, isolation and social punishment, keeping the secret is an obstacle to true intimacy in their relationships. Even

though their study was on the physical condition of genital herpes, their findings also fit with the behavior of mentally ill persons. This explains the idea of perceived stigma. The mentally ill person evaluates the level of stigmatization that they might have to encounter once they reveal their status to society. They hold the belief that revealing their illness might lead to more or less negative sanctions from society. They fear being viewed negatively or treated in a negative manner by professionals or others (Barney et al. 2006). Kelly and Jorm (2007) detailed in their article that participants of a study on stigma and mental health reported they were too embarrassed to report their symptoms to a health care professional and at the same time were afraid of resentment from those professionals (Kelly and Jorm 2007). In conclusion, suffering from a stigmatized condition often leads to a delay in seeking medical attention (Berger, Wagner, and Baker 2005).

Role Assignment and Relationship Transitions within Families

In recent decades, feminist discourse changed the view society has of childrearing responsibilities; however, Lupton (Australia, 2000) cites a number of studies from the 1980s and 1990s in the introduction to her paper, which found that women and men still consider the mother to be the most important part in a child's life, whereas the father predominately still carries the role of the breadwinner. More recently, there has been a noticeable shift in these conceptions. Women now expect more cooperation from their partners, but many still construct the demands they have regarding co-parenting in terms like "helping me out" and "being supported by" their significant others (Rashley 2005;

Singley and Hynes 2005). This conception is still connected to the idea that the father has to provide first and then take care of the child, and that the mother has to be selfless and have undivided attention for their children (Choi et al. 2005; Lupton 2000; Mullin 2005; Wharton 2005). This belief is commonly known as the “motherhood mandate”. Important to note here is the fact that these popular views usually presume a traditional heterosexual nuclear family.

As Gardner (1994) notes in her analysis of popular advice during pregnancy, more specifically the magazine *American Baby*, pregnant women are advised to “clean up” and “get organized” before the birth. This is not expected from their potential (male) partners, who are assumed to have other important things to take care of, presumably working to provide for their growing family. This is important to note, considering it suggests that society’s traditional role allocation expectations start even before the child is born. Furthermore, Wharton (2005:107) notes that after birth the woman’s social ties are affected and decrease to a higher degree than men’s due to childrearing. An additional reason might be the frequent, at least temporary, exit from the workforce of new mothers, which was explored by Singley and Hynes (2005). They found that the decision of workforce participation of the parents depended on how gendered the couple’s parenting role ideologies are. Compared to couples with egalitarian views of parenting, in couples with traditional parenting ideologies, the women were more likely to stay at home, either for an extended leave or for an unlimited amount of time after giving birth, regardless of who earned more money, (Singley and Hynes 2005). Financial and practical aspects are, however, often the

reasoning behind a couple's choice about who stays at home. "[W]omen's access to time off from work for physical recuperation and men's lack of access to paid parental leave acted together to reinforce the primacy of women's initial caregiving role" (Pg. 389), as Singley and Hynes (2005) found in their exploration of the subject.

Kalmuss, Davidson and Cushman (1992) conducted a study on violated parenting expectations and found that, a year after giving birth, a majority of their respondents had expected their relationship with spouses and friends to be better than they actually perceived it to be and that they had anticipated more parenting assistance from their partner than they felt they received. Additionally, the participants expected to feel more confident in their competency as mothers than they actually felt during the first year postpartum. This dissatisfaction with the social and marital support and competency was positively correlated with what Kalmuss et al. (1992) call *inflated expectations*. This means that the higher the expectations were regarding parenting, co-parenting and social support, the stronger the disappointment was, regardless of the amount of spousal or social support the mothers actually received. The changing dynamic of a couple's relationship after the arrival of the first child was studied by Ahlborg, Dahlöf and Hallberg (Sweden, 2005), with a focus on intimacy and sexuality. They found that even though the experience of having a child together can create a special bond between new parents, several stressors, like exhaustion, often burden the intimate and sexual relationship in the first six months. Byrd et al. (1998) conducted a large-scale study on sexuality during pregnancy and in the

postpartum period and found that couples on average resume intercourse seven weeks after the birth, similar to findings by DeJudicibus and McCabe (Australia, 2005) who reported that the majority of women in their study reported being sexually active again at 12 weeks postpartum. Women who breastfeed report being significantly less sexually satisfied and not as sexually active, than women who do not breastfeed (Byrd et al. 1998). Additionally, Byrd et al. (1998) found few differences between women who had delivered vaginally and women who had given birth via Caesarians, except that the latter started to be sexually active again somewhat sooner. In their conclusion, they call for physicians to routinely educate patients about probable changes in their sex life, to minimize potential disappointment and to help facilitate an easier transition into their new circumstances, which Olsson et al. (Sweden, 2005) also propose. In their qualitative focus group study, Olsson et al. (2005) identified several factors that influence women's sexual desire and needs postpartum: body image insecurities, new stressors in their family lives, a difference in the level of sexual desire with their partners, and a need for confirmation that they are physically ready.

The Myths and Realities of Motherhood

McVeigh (1997) researched more specifically how first-time mothers experience motherhood and found that they felt unprepared. The women in McVeigh's (1997) study talked about "the unrelenting nature of infant care, fatigue, the feeling of being unprepared, lack of personal time, and the role support played in easing the stress and strain during the early weeks of motherhood" (Pg. 345). The women had the feeling that nobody told them about

the harsh reality of taking care of a newborn. This is a phenomenon that McVeigh (1997) called a *Conspiracy of Silence*.

In a British qualitative study (Choi et al. 2005) on the myths and the reality of motherhood, many of the women studied had idealized ideas about what motherhood is going to be like and then, faced with reality, went through stages of disappointments and feelings of failure. Being unprepared for the practical issues as well as for the changes that affected their lives was shocking to them. The sleep deprivation and time-consuming labor was not what they had expected motherhood to be like, which is supportive of McVeigh (1997). Shame and the fear of others finding out that they had trouble dealing with the difficulties were mentioned by the studied women. This is also a theme in cases of postpartum depression (Beck and Watson Driscoll 2006). Role strain was also a notable source of feeling incompetent, according to Mercer (2004), who cited the findings of her older study from 1986. Mercer (2004) calls for a replacement of the term “maternal role attainment” with the term “becoming a mother” in the academic discourse. She argues that the latter describes “the initial transformation and continuing growths” (Pg. 231) into the new, potentially overwhelming identity more accurately than “maternal role attainment”. In Sweden, Heinig (2006) found that childcare classes have shown a positive effect on how women perceive their abilities to cope with the new life as a mother. The women who attended these classes enjoyed nursing and spending time with their children more in the long-term, compared to women who did not attend any educational classes.

Surprisingly few studies have been done on the expectations and experiences of first-time mothers who are not part of a sensitive group, like teenagers or women with major depression. Additionally, many studies have focused on the career and work path of new mothers. While those studies are of great importance, the experiences women have during the transition to motherhood still need to be studied more, and the discrepancies between their expectations and reality have to be discovered to support future educational measures. The findings from this study can assist in this endeavor.

METHOD

My motivation for this study came from several directions. I had written a paper on postpartum depression in a previous semester, which made me more alert to what I felt were misconceptions and misrepresented images of motherhood in the media. There seems to be a growing awareness regarding postpartum difficulties today, partly due to celebrities who took on the issue, for example, actress Brooke Shields in her book on her personal experiences with postpartum depression *Down Came the Rain* (2005). Nevertheless, becoming a mother is still an idealized event and the negative sides remain taboo. This study can contribute to a societal change and help society recognize the difficulties many women go through in this transition.

Some of my friends became parents in recent years and through conversations I discovered that women who get pregnant have a specific set of expectations of how their life is going to be after having the child. This realization was the main impetus for me to explore how these expectations compared to what I saw as the reality of the transformation from being an independent person to being a mother and responsible for another human being. I also plan on being a mother myself in the future, which made this topic of study intriguing to me on a personal level.

Pilot Study

I conducted a small qualitative study on expectations and experiences of first-time mothers as part of a Qualitative Research Methods class at the

graduate level in 2006. This study was aimed at discovering the experiences and expectations of six first-time mothers, how they dealt with their changed situation and how they managed, strategized and negotiated their new roles in life. For the pilot study I interviewed six women, four of them face-to-face and two via e-mail; five of them had given birth within the last 18 months before the day of the interview and one was about three weeks before her due date. The advantage of interviewing women who had gone through the experience of pregnancy and birth recently was that their accounts were still vivid and not tainted by too much time having passed. The interviews were all transcribed, and then I used line-by-line and focused coding and analyzed them. For the purpose of using the data for the current study, I coded the interviews again, making it a point not to be too influenced by the pilot analysis. All of the pilot interviews were included in this study, and I cannot claim with absolute certainty that I have not been influenced in my previous codes. Peer debriefing and reflexivity were used to stay close to the data, but it is not ideal to mix pilot and current data, due to the potentially biasing effects this can have on the entire process.

Guiding Methodological Perspective

The study will be based on an interpretive paradigm for several reasons. The intention is to discover the experiences the studied women had and the meanings and definitions they assigned to those experiences. The individuals' perspectives on their own experiences are the central focus of this study. To understand these perspectives the researcher has to understand what meanings are assigned to certain processes. What types of social interaction do informants

say influenced those meanings? How are they being interpreted and because of that what might have changed over the course of time (Esterberg 2002:15)?

Bailey (2007) answers that “adherents of an interpretive paradigm believe that what researchers learn from the participants depends, in part, on their own status characteristics, values, and behaviors” (Pg. 54). Because I interpret those meanings and actions described by the participants according to my own set of meanings, the chosen paradigm is interpretive (Rubin and Rubin 2005; Williams 2000). My main concern was to stay close to the data and to not interpret the information from an exclusive perspective. The reflexivity and awareness of my role in the research process, as well as the coding in the later stages, were invaluable components in preserving my informants’ meanings.

Researcher Role and Reflexivity

One of the most important aspects in qualitative research is the role researchers take and how the data is approached by them. The researcher has to take into account how her presence could have contributed to the collected data (Bailey 2007:119). Additionally, the researcher has to be sensitive to how her assumptions influence the data collection and the analysis to increase the quality of the research (Murphy and Dingwall 2003:195). The researcher cannot be considered a “tabula rasa.” It is important to recognize and be aware of the role the researcher takes and the impact he or she has on the data and the entire process. Constant reflexivity is significant to the quality of the research (Clarke 2005). As Clarke (2005) noted, race, socioeconomic status, gender, and political

ideology impact the research process. In the following paragraphs I will describe the efforts I made to improve the quality of my research.

In this study I took an outsider role, which has advantages as well as disadvantages. While the participants might have felt that I had not experienced what they went through first hand, considering that I have never been pregnant, and because of that I might not be as understanding, they had the opportunity to feel and act as experts and educate me about their personal experiences. In all of the interviews my inexperience appeared to be an advantage, because it seemed to have an empowering component for the participants to educate me about personal experiences, in this case the process of becoming a mother. The participants might have felt that they were providing important perspectives to the study that otherwise I would not have been able to obtain. As a way of communicating interest and curiosity, I made it a point to ask follow-up questions and also for explanations when I did not understand a medical term or procedure. This often led to more detailed narratives and solicited in-depth answers that without those questions might not have been given. My student status seemed helpful as well, because it appeared to be less intimidating than a higher academic rank. Only one of the participants' ethnicity or race differed from mine (Caucasian), which limits the diversity of the study. Unfortunately I was not able to obtain a more racially diverse sample. Another advantage could have been that I am a German student, studying abroad, which allowed for the participants to be more specific about the American experience with the health care system and childbirth. In the pilot study, as well as in the current study this proved to give

an interesting perspective to the interviews. One of the participants was a German, who has been living in the United States for four years now and is married to an American, and another one was a Brazilian citizen married to an American.

An important aspect during the analysis was that I actively tried not to impose my own meanings on the data. Constant reflection on the process and my own opinions and behavior showed to be important. I kept a research diary, which consisted of notes on how I felt after the interviews and of me reflecting on the knowledge I obtained during the literature research. Additionally, I used an interview guide to allow for all angles to be covered and to make sure that I did not skip any important questions. I also used peer debriefing methods by talking about and reflecting on the research process and difficulties with fellow students, of course only to the extent that confidentiality was not being violated (Bailey 2007:188; Murphy and Dingwall 2003). Several meetings with the chair of my committee, Professor Carol B. Gardner, were also very helpful in this regard. As an international student I am aware of cultural differences between America and Germany and actively reflected on social stereotypes I might hold, I did not allow myself to be judgmental or prejudiced (positively as well as negatively) toward the American experience. To further prevent this from happening I worked closely with Professor Gardner, my thesis chair, who examined my interview guide and two of the transcripts (after all identifying markers were removed) and with whom I discussed difficulties and problems. This proved to be especially helpful regarding the issue of obtaining a large enough sample. Due to many

unresponsive contacts and growing time constraints it looked as if I would have to cut my sample size by two, but eventually I was able to find the last two participants.

My role as an interviewer was to actively listen and allow for the participants to share their stories without unnecessary interruptions. They were assured of absolute confidentiality, which helped to allow for candid answers and I also made sure that the participants felt that I was interested in their stories. I tape-recorded the interviews and jotted down notes after the interview while my memory was still fresh. I transcribed the interviews immediately after they were finished and then used line-by-line coding and grounded theory to help me to prevent me from imposing my personal views on the data.

Study Procedures

The sample size for this study was planned to be 10 women in addition to the 6 interviews from the pilot study. As mentioned above, unfortunately it turned out to be difficult to obtain the planned sample size, which first was cut to 8 women. Eventually, I found 2 more women who wanted to tell their stories, so the original sample size was reached. I conducted semi-structured in-depth interviews (Esterberg 2002:87), 6 of them over a time span of six weeks in 2006 for the pilot study, an additional 8 interviews over approximately four months in 2007, and two more in January 2008. The face-to-face interviews took place in a private room on the IUPUI campus or a location convenient to the participants, for example, the participant's home. All the interviews were audio-taped, later

transcribed by myself and the tapes were destroyed to assure confidentiality. The interviews took from 45 to 90 minutes. The questions were designed to gather a rich set of data, and for the main questions an interview guide was used. The probes, follow-up questions, and the emphasis on certain topics varied depending on the answers of the participants (Rubin and Rubin 2005).

The three e-mail interviews were structured the same way as the face-to-face interviews. The process and purpose of the study was explained to the women via e-mail. The main questions were sent via e-mail, and the incentive in the form of a \$10.00 Target gift card was sent via mail the same day I received the answers. The main difference to the face-to-face interviews was that a set of follow-up questions, based on the responses of the participants, was sent to them following the main questions. The interviews were copied into word documents, including no identifying markers, and the original e-mails were deleted to ensure confidentiality.

Sample and Recruitment Strategies

The current study was designed to find 10 women whose experiences with pregnancy, birth and the process of becoming a parent are still vivid, so the sample was limited to mothers who gave birth within the last 18 months before the day of the interview. This framework allowed me to study women who still had a good and vivid memory of their experiences. Volunteer sampling was used to provide a certain degree of willingness to share experiences for the purpose of this study. The participants had to be at least 18 years of age to be eligible for

this study, and the final sample had an age range between 20 to 36 years of age. While race, ethnicity, socio-economic and marital status were not criteria for this study, they were recorded. All of the women self-identified as Caucasian, aside from one who is a Brazilian immigrant. One participant is a German immigrant and married to an American. This led to a limited racial and ethnic diversity. The socio-economic statuses of the women were of a broad range, and all of them had at least some college experience.

I used different strategies to recruit participants, purposive and snowball-sampling. I posted flyers (see Study Flyer in Appendices) on the IUPUI campus (for example, the business building, Cavanaugh Hall and the nursing building). I also tried to recruit participants with posted flyers at the Jordan YMCA, which appeared to be a good source for participants due to the family-friendly environment. In addition to that I used snowball sampling by handing out the same flyers to friends and classmates and asking them to refer eligible participants. These sampling methods proved to be very effective for the pilot study. The sample size of six women was reached within approximately three weeks. To my surprise it was substantially harder to find reliable participants for the current study. Initially, I was contacted by 20 women, but most of them were unresponsive to my follow-up e-mails. Four women showed interest in participating in e-mail interviews, but failed to reply to the questions, even after several attempts to reengage them. I did, however, complete 10 interviews, seven in person and three via e-mail, and gathered very interesting accounts of the transition to motherhood.

Research Instruments

As described above, flyers were used to advertise the study. The flyers stated the purpose of this study, the eligibility criteria and the contact information. The IRB number was also included and an incentive in form of a \$10.00 Target gift card was offered. An e-mail address was included for respondents to receive more detailed information and to make appointments for the interviews. The Flyer for the current study differed slightly from the one used in the pilot study, a few exclamation points were removed, the sentence offering the incentive was changed to not bold and the study name changed from Expectations and Experiences of First-Time Mothers Before, During and After Pregnancy Research Study to Expectations and Experiences of First-Time Mothers Research Study (see Appendices to compare).

To guarantee efficient time management, the interview process started as soon as the first person was recruited. Due to the complications in the recruitment process, it took about two months longer than initially planned to gather a satisfying set of data. The seven face-to-face interviews took place in private settings (a room at IUPUI, a café, my home, or the participant's home), as mentioned earlier, with only the participant and me as the interviewer in the room (in some cases the child was there as well). For the one interview that took place in a café, I made sure that nobody was in close proximity to overhear the conversation. The interviews were audio-taped to help assure my undivided attention to the participant, as well as to assure the accuracy of the data. Before the interview and the recording started, I explained the risks and benefits of

participating and answered questions regarding the study and confidentiality. The purpose of the study was clearly stated, and the interview process was explained. I informed the participants of their right to stop the interview at any time and their right to refuse to answer any of the questions. I further explained the confidentiality agreement and the taping procedure. Once all preliminary questions were answered and the participant agreed to proceed, the tape-recording was started and I began the interview by asking background questions regarding their age, the age of their child, their educational background, and their marital or partner status. After these were answered, we proceeded with the main questions I had prepared in the interview guide (see Appendices). The questions were designed to motivate long and detailed answers that gave me rich and deep data as described by Rubin and Rubin (2005) or what Geertz (1973) referred to as a “thick description.” A few follow-up questions and probes were also prepared and several arose spontaneously, depending on the answers given, and were used as needed. Some of the questions that I had tested in the pilot study were slightly changed to elicit more detailed answers (compare Pilot Interview Guide and Final Study Interview Guide in Appendices).

In the main interview I asked about the interviewees’ thoughts and feelings when they first learned that they were pregnant, how their pregnancy went in general, and more specifically how they categorize their experiences during the entire process. These questions were designed to meet my first aim. Then I asked them to compare what they had heard from different sources, for example, solicited or unsolicited advice by friends and family, to what actually happened in

their case. This was followed by a question regarding their own expectations and which notable changes they did or did not anticipate. One question was focused on physical, emotional, mental, and social changes before and after birth. The last questions were concerned with what the women might want to be different if they get pregnant again, and what they wish they would have known the first time around. This line of questioning was designed to gain data for my second aim. I closed the interview by asking what advice they would give a friend who is pregnant. Once the interview was over the participants had the chance to add anything they felt was missing or needed to be said.

Following the interview I transcribed the data in a private setting, with only myself listening to the tapes. The tapes were destroyed right after the transcription was finished. The interviews conducted via e-mail were printed out with no identifying markers and deleted from my account. The last step in the process was the coding and analysis of the data.

Analysis

The analysis of the collected data was approached with grounded theory methods based on Charmaz's guide (2006). After the transcription was finished, the data was first ordered using line-by-line coding, which is a form of coding that is used to look at the data systematically and as closely as possible. Every line in every interview was given a name using gerunds to keep the data in active terms. By using this method different themes became visible and the significance of certain points became obvious, for example, through repetitions or avoidances

or because the points seemed to have special meaning (Bailey 2007; Glaser and Holton 2004). This method is also very useful for comparing data, even though this study is not designed to make generalizing statements. After the initial coding was done, I approached the data with focused coding, by using the most frequent and significant line-by-line codes and by turning them into broader themes to make the data more manageable and to discover the informant's meaning.

The third step in this process was the writing of memos, using significant pieces of the data as well as the frequent themes. These memos consist of an evocative title, a definition of the topic and what it means in the context of the interview, and fitting quotes from the interviews. These memos were then used to write the findings section of this paper. The memo writing is not a closed process; it is an ongoing sense-making approach to the data, parallel to the coding (Charmaz 2006; Dick 2005). During this process, I also started to review the existing literature on the subject of pregnancy, childbirth and parenting in the United States and the industrialized world to get a more comprehensive knowledge of prior research and to compare findings.

As mentioned above, this study does not claim to generalize the findings to a greater population, but it can be used to develop concepts and theories, and because of that can be helpful to further studies. Some of the themes in the findings might be common to mothers with similar backgrounds and experiences (Payne and Williams 2005), and some could be representative of mothers or even parents in general.

Validity

In order to achieve a high level of validity and quality in the data, which is of particular concern in qualitative research, several methods were incorporated in the process. I emphasized confidentiality, which might have put the participants at ease to share more intimate details and to engage in more comprehensive descriptions of their experiences. In addition, the interview guide was tested in the pilot study and proved to obtain a rich set of data by motivating the participants to give long and detailed accounts of their experiences. Due to the fact that I was the only interviewer and transcriber, I had control over the quality of the process. Working closely with my Thesis Advisor, Professor Gardner, helped to keep the main focus on the quality of the study. Constant reflexivity of the researcher provided an additional critical process to ensure that the interpretation of the data is representative of the participants' accounts and not the personal perspective of the researcher.

Limitations

The main limitation of this study was recruitment issues, which were expected to be unlikely, but arose. Fortunately, the sample size was reached, but for a long period of time it seemed that I would have to cut the sample size by two. It would have been beneficial to have a more diverse sample. For future studies it would be interesting to further explore racial, ethnic, and socio-economic differences in the experiences and expectations of first-time mothers, but for this study this is not a main concern. My main interest was to explore this

topic in a general way and eventually to conduct a study that is more diverse. A limitation of qualitative research is that it cannot be generalized to a larger population. The purpose of this study was to explore in-depth experiences and to assist future research by developing concepts and theories, and no attempts to generalize were made. As described earlier, the questions were designed to elicit long and detailed answers, and the participants were responsive and engaged in the interview. Using the data from the pilot study also might have limited the study to a certain extent, because of its potentially biasing effects on the researcher. The pilot data had already been analyzed before, and while I made efforts to code it without bias, I cannot be absolutely certain that the familiarity of the data did not influence my analysis. It is also not desirable to mix face-to-face and e-mail interviews in a study due to the difference in the response and overall data, but in this case it was the most suitable option to reach the sample size and much care was taken to assure validity and quality of the final data.

Human Subjects Concern

After the study was designed, the Institutional Review Board (IRB) of IUPUI approved the study proposal (see Appendices), and I was able to move forward and start advertising the study. Due to the initial recruiting problems an addendum to the IRB approval was proposed and granted to include e-mail interviews in the study (see Appendices). There were minimal risks for the participants to being involved in this study. The women were informed of the few risks. Some of the participating women became emotional while revealing personal experiences about their pregnancy, the birth, and being a parent. An

additional risk that was explained to the interviewees is that Indiana State Law requires the researcher to break confidentiality when she learns of specific information such as any of the following: learning of child sexual or physical abuse, learning of harm the participant plans to do toward herself or another human being, or having this information subpoenaed by legal authorities if illegal activities are spoken about during an interview study. Fortunately, none of these issues arose. An informational brochure from the Indiana Perinatal Network was provided, in case the participants felt they needed professional help. The pamphlet includes literature on the postpartum period, as well as the number to a hotline that provides women with contact information for mental health professionals and help networks (see Appendices).

All personal information was kept confidential. As a researcher I cannot guarantee absolute confidentiality of course. The participants' personal information may be disclosed if required by law, as mentioned above. Their identity is held in confidence now and will be in the future in reports in which the study may be published. The only person to hear the tape recorded interviews was the researcher. I transcribed each of the recordings in private to protect confidentiality, and the participants' real names do not appear on those transcripts or following reports. Specific descriptions that might reveal their identity were changed to ensure anonymity. The audiotapes once transcribed were destroyed, and the other material was kept in a locked file cabinet in a locked office. As for the e-mail interviews, all of the original e-mails were deleted and the identity of the participants was modified to be unrecognizable in the

printed documents. These were also kept in a locked cabinet. The names appearing in this thesis were randomly chosen to protect the participants' identity.

The benefit of taking part in this study for the participants might have been a feeling of satisfaction when contributing to this research due to sharing personal experiences and opinions with an individual who was interested in what they had to say. In addition, the knowledge that the information the participants provide may help with future research in this area of study could have been a source of satisfaction for them.

The participants were free to choose voluntarily whether they would like to participate or not participate without any coercion or consequences. The participants were also informed that they could end the interview at any time or pass on any question they did not wish to answer.

FINDINGS

Nine themes became obvious in the analysis, which were then arranged into comprehensive clusters: *Getting Ready*, *Giving Birth*, *Exhausted and Changed Bodies*, and *Emotional Realities*. The experiences of the women are told with direct quotation, as well as paraphrasing, and prior literature is used to highlight and further explain specific aspects.

Getting Ready

Three themes described the process of being pregnant and what it took for the women to get ready for the delivery, as well as motherhood. Almost all of the women in this study had not planned to get pregnant. *Coping with Unintended Pregnancy* covers the women's descriptions of their initial feelings and of what helped them to overcome their fears. Once they made the choice to go forward with their pregnancy, the women reportedly put a lot of effort into trying to improve pregnancy outcome by focusing on health behaviors, like nutrition and sports. *Being Healthy* describes the accounts of their efforts in depth. The last theme in this cluster deals with the less controllable aspects of the women's pregnancies as they depicted them, *Negative Influences*.

Coping with Unintended Pregnancy. First of all, it is important to note that the labels "unintended" or "unplanned" as definitions for pregnancy intentions do not have clear boundaries. While contraceptives like the pill or condoms are not 100 percent safe, they are highly effective. So the question arises as to how it happens that, according to Finer and Henshaw (2006), in 2001, 49 percent of all

pregnancies were unintended. One explanation for this might be ambivalence towards pregnancy, which has been studied predominantly regarding teenage pregnancy. As Stevens-Simon, Sheeder and Harter (2005) note, many teenagers, asked about their pregnancy report that it was not planned, but that they had known about and would have had access to birth control. This is an important discrepancy to consider when talking about unplanned and unintended pregnancies. A certain amount of ambivalence and naiveté towards pregnancy seems to be a determining factor in the (non-)decision making process to use contraceptives among teenagers (Stevens-Simon et al. 2005). As Kendall et al. (2005) describe in their study of pregnant lower-income women in New Orleans, scarce financial resources make a planned pregnancy less likely and that “[i]n these circumstances women’s report of the intendedness of a pregnancy often seems more like a rationalization after discovering a pregnancy than the outcome of a deliberate and voiced choice” (Pg. 308). This was not a focus in my study, and only two of the women provided me with information about their use of contraception, but it is important to bear in mind that ambivalence towards pregnancy and according non-use or irregular use of contraception can result in “unintended” and “unplanned” conception. A more suited term to describe this kind of pregnancy might be “mistimed”.

However, unexpected pregnancy leaves women with a limited set of choices: abortion, adoption or keeping the child. Approximately half, 48 percent, of all unintended pregnancies in the United States are aborted (Finer and Henshaw 2006). Beck (2001) identified unplanned pregnancy as a predictor for

postpartum depression and claimed that “[e]ven if the surprise pregnancy was a welcome one, women still had to cope with the ramifications of this unplanned event that would affect the rest of their lives” (Pg. 282). Most of the women in this study said they were not planning to become pregnant. Accordingly, they reported having to cope with anxieties and fears that came with the life changing positive pregnancy test. Several themes emerged in this regard.

Kathy was only 19 when she found out that she was pregnant. She was still in college and had been dating her boyfriend for about 4 months. According to her statements, for her, the most daunting prospect was telling her parents. She said, her mother stayed very calm, but her father got very angry and actually stopped talking to her during her pregnancy. Being so young, she reported having been worried about the pain when giving birth, and was also how she was insecure about her capabilities of being a mother. Jessica, a 30-year old media specialist, described being confronted with a positive pregnancy test as a frightening experience. “When I first learned that I was pregnant, I was very scared, didn’t think that I could do it, or that I wanted to do it.” She recounted being worried about telling the father about the pregnancy. Coincidentally, she said, they had just discussed marriage and decided to wait a few years longer. Not knowing at the time she was pregnant, they had also decided they were not sure that they wanted to bring a child into this world. They stayed together and eventually got married, but she said that she was irritated by the feelings she had when she found out that she was pregnant:

Now that I look back at it, I’m kind of frustrated with myself, because I felt so vulnerable and weak at that moment, and usually,

up until then I'd always been independent, I didn't need anyone, but I was so afraid of going through it alone or whatever.

Marion, a service worker in her 30s, also described being very afraid:

When I learned I was very, very scared, because it was not expected and I was not particularly stable financially at all. So I wasn't sure exactly how I was gonna do it, it wasn't an option to put him up for adoption or end the pregnancy at all, but I was very scared.

Susan, a single mother in her 20s, expressed similar fears:

At first I was scared. I knew I was gonna be a single mom, it was overwhelming, just all the emotions. And then later on as the hormones start hitting you and tears start welling up, you cry at the drop of a hat.

She went on to describe how she was afraid for most of her pregnancy, especially due to her lack of experience with children:

For the most part I was scared. I don't really have any, I have one sibling, so I didn't know how to be around kids and I tended to make them cry, not by trying, but just I'd walk up and smile at them and they'd start crying, so I was pretty much scared the entire time I was pregnant, cause I was just unsure.

Another single woman, Julia, a 20-year-old mother of a 4-month-old daughter, described she was excited, but still scared of the changes being pregnant entailed:

Oh man, I was, I don't know, I was kind of excited, but really scared, I don't know, it wasn't really what I had planned at all, I never wanted kids or anything, so...When I first found out I was scared, like really, really scared, it's a whole lot to take in, especially when you are not in any kind of relationship.

She said she tried not to focus on her fears, but stated that "it seemed like the longer I was pregnant, the more scared of becoming a mom I was, than I was when I first found out." A 28-year-old academic, Natalie, reported being overwhelmed by finding out that she was pregnant:

Well, the pregnancy was not planned and so when I first learned that I was pregnant I was shocked and worried and I think there was part of me that thought, Oh no! Like what have I done, what's gonna happen now? And so I was, I was worried, I was concerned, I was concerned about my own capabilities, and so I was concerned.

Sandra, a 25-year-old nursing student, described how becoming pregnant earlier than planned was a shock to her:

I was completely freaked out when I first learned I was pregnant, because I became pregnant about three years before we had planned to start a family. We were planning on waiting until I graduated nursing school, so that we would be more financially ready. So, I was very upset at first at the thought of having to take a leave of absence from school to have a baby, when I calculated my due date and realized I would have the baby in the middle of the fall semester. I didn't want to have to give up the friendships I had made and start all over again with a new group of people when I got back into school.

While Sandra was married, Mary, a 36-year-old student, had just started dating her boyfriend and was attending graduate school. She described her situation as follows:

We went out and like 2 weeks later I'm like pregnant, so...I got pregnant on the day I started graduate school, so I'm kind of up the creek – I'm unemployed, I'm a full time student, I just started dating this guy and I really didn't know exactly what I was gonna do, but I really felt like I was ready to be a mother, for whatever reason.

Miriam, a 31-year-old German mother married to an American, also talked about being scared at first, especially because she was not sure how her husband would be able to cope with the situation. Supportive of Beck (2001), these statements show that even though the pregnancy turned out to be eventually welcomed, the expecting mothers went through times of doubt and fear and had to find ways to cope with this life-changing process. The reported levels of fear and anxiety about the prospect of being a mother varied among the

participants, but eventually they all reconciled with the change in plans. While still being scared, they talked about how they got to the point of being excited.

Some described the financial aspect as especially worrisome, explaining how they were insecure about how to provide and wondering if they would be able to financially handle becoming parents. Jessica, 30, described how she was afraid and worried after finding out that she was pregnant:

I was just scared and I didn't think that I could do it and I didn't know how we would gonna work it out financially and because we weren't married at that point either and I just didn't know what it was going to do to us.

Financial anxiety was also noted by Kalmuss et al. (1992), but they found that at a year postpartum the majority of the women in their study were actually content with their financial status, compared to what they had expected. Mary, a full-time student, explained:

It doesn't make any logical sense, 'cause I always kind of envisioned myself as being more of a provider than that, you know. But I figured I had lived enough to think that I could work whatever I needed to work out. And so after I got to that point in my thinking, I was pretty good about, you know, the whole situation, I was really happy, I was kind of excited.

Finances were not a focus during my interviews, but all of the women at some point during the interviews mentioned they had found ways to cope with these fears and tried to be as prepared as possible.

For some of the women, support from their partners was an important factor in reconciling with their pregnancy, which became obvious in the narratives. Twenty-five-year-old Sandra described how her husband's reaction helped her to be more relaxed:

But my husband, when I walked out of the bathroom with the positive test, sort of shrugged and said, "I'm almost thirty. I'm ready to be a dad." His nonchalance about it helped me to calm down, and get used to the idea.

Jessica, 30, described how she was afraid her boyfriend at the time would leave her, and how it calmed her down that he stayed and was trying to be supportive, even though she said that she came to terms with the situation faster than he did. She said that it took her growing "bigger" for him to really realize what was going on and she described how that was a frustrating process for her. According to Natalie, it was the enthusiasm of her boyfriend that helped her feel more secure and relaxed, considering that she said she had never planned to become a mother and was not sure how to feel about the pregnancy. The importance of being in a positive relationship became particularly obvious in Mary's stories. She talked about how, some years ago, she had chosen to have an abortion because she felt she was in a dysfunctional marriage:

I chose to have an abortion at that point, because my husband was basically a child anyway, so seriously, I could just totally see me, you know, being a single mother with him being a total jerk anyway.

As an important factor in stress reduction and the eventual choice of keeping the baby, a supportive relationship and feeling secure was mentioned several times.

Being Healthy. An interesting, but not surprising, facet of pregnancy mentioned by the women was an emphasis on being healthy. It ranged from watching food intake, being active, doing sports, to worries about alcohol or caffeine consumption. The only woman that was pregnant at the time of the interview, Carrie, said that she had given up coffee, which was hard for her, and she actually started having half a cup a day during the last weeks of her

pregnancy. She also described how she grew frustrated with mainstream pregnancy literature that she felt was too “prescriptive” regarding nutrition. “They tell you to eat, you know, ten servings of spinach a day, which of course no one can ever do. It’s ridiculous.” Jessica, who has an 18-month-old son, also described changing her habits. She quit smoking and refrained from drinking both alcohol and coffee. In addition, she said, she drank a lot of milk, started exercising more and made sure she got enough sleep. Jessica also emphasized that she did not take any medication, with the single exception of a Tylenol, while she was pregnant. She said of her pregnancy that “that was the healthiest I’ve ever felt.” Mary described how doing yoga was a great tool for her to stay relaxed and focused on positive things. For her, too, physical activity was an important aspect during her pregnancy. She said,

Overall I was very active, and I was very healthy, doing things that a lot of people don’t do when they’re not pregnant, like swimming. I would swim, like even, I was like in my eighth month of pregnancy I used swim like twenty laps.

Natalie described how her main concern, when she found out that she was pregnant, was the consumption of alcohol and cigarettes. She explained that she had been drinking and smoking in the first weeks of her pregnancy, before she did the pregnancy test. She said, she later talked to her midwife about her fears, and the midwife reassured her that she would be okay. Natalie also described how she did prenatal yoga, participated in a parents-to-be water aerobics class, and took prenatal vitamins. Sandra made it a point to be active as well. She said,

I kept working out, lifting weights or walking on the treadmill or walking around town every day. I bought *Fit Pregnancy* magazine, and I would use the workouts from that to try to stay in shape.

Sandra and Stephanie, a 30-year-old mother, both described how constant calorie intake helped them with their morning sickness. Caroline, a 25-year-old nurse, described how she made changes in her diet, including staying away from consuming deli products such as cheese and meat, because of the possibility of listeriosis and from fish, because of the mercury content. She also stayed away from herbal teas.

All the women in this study relied on different sources for their health during pregnancy, but all of them made choices as to what they deemed to be good for them, and, more importantly, beneficial for their unborn child. These findings are supportive of what Gardner (1994) noted in her analysis of pregnancy literature. She found that exceptional emphasis and responsibility is placed on pregnant women concerning what they ingest in regard to pregnancy outcome.

During pregnancy... what can usually be accomplished without great thought is to be constantly on a woman's mind.... As a woman reads popular, even scientific, sources, she discovers that basically no ingestible is reliably safe, so that even eating – which might be the most humble, even automatic of required actions – is difficult to perform without meticulous consideration.... (Gardner 1994:76)

This appeared to be taken without much complaint by the women in this study. The only time some mild annoyance was apparent was when it came to abstaining from coffee and the prescription of foods in the interview with Carrie. The reason for her being the only one to voice discontent might have been the fact that she was still pregnant and might have been feeling she had to abide by these rules, while all the other women had already given birth.

Bondas and Eriksson (2001) also found the theme of specific health behaviors in their study of 80 Finnish mothers. The women in their study reported that they tried to eat healthy and to be physically active to improve their pregnancy outcome. They also found that the women tried to be harmonious and balanced; something that was also mentioned by the participants in this study. The aspect of physical activity, especially in regard to “staying in shape” and being physically prepared for labor and delivery was researched by Dworkin and Wachs (2004). Analyzing *Shape Fit Magazine*, they found that women are being groomed to work out during pregnancy to be fit and healthy. Pregnancy and especially delivery are being referred to in athletic analogies, for example a runner training for a marathon (Dworkin and Wachs 2004). What is interesting about this new approach is how women are supposed to prepare for a delivery they are often not going to experience, due to the highly medicalized procedure birth has become in the United States (Dworkin and Wachs 2004).

Only one woman in this study reported to have had severe physical difficulties. Emily, a 22-year-old mother, described how she went through several major scares in her pregnancy. As she reported, it started with her doctor telling her that her son might have Down Syndrome. He had extra skin on his neck and holes in his heart, which are typically indications of this disability. Genetic test results showed that he did not have Down Syndrome, but for a few days she was very scared. She went on to describe how she then started to have stomach cramps and back problems. Additionally, she reported that her blood pressure was dangerously high throughout her entire pregnancy. First, she was on

informal bed rest, but was still allowed to be up in a wheelchair. However, for the last month of her pregnancy, she was ordered to stay in bed completely. She had to have her blood pressure taken three times a day and eventually was connected to a machine that was sending her blood pressure levels to a terminal, where emergency response teams could be immediately dispatched, if her levels would get too high. Pregnancy was a very frightening time for her, according to her description of it.

Mental positivity was emphasized several times during the interviews. Mary mentioned about how yoga helped her to be more centered and to let go of stress. She also talked about shutting negativity out of her life. She was very critical of the information she received from her doctor, and said that it did not include positive birth stories. She said,

You don't read about birth stories that [say] "Well, this was fantastic. This was life changing. I enjoyed labor." I mean you hardly ever hear the positive, right?

She stressed the focus on medicalized birth given in her Lamaze class. Reportedly, her plan was to give birth naturally, but she felt that the teacher of her Lamaze class was catering to the majority of the women in the class, who appeared to plan on having epidurals and C-sections. She felt that the women were groomed to be good patients and that the way birth was approached was in a very negative way. The medicalization of childbirth by healthcare professionals seemed very disempowering to her, a feeling supported by Fox and Warts' (1999) study of first-time mothers. She described being especially disappointed with the negative stance on birth taken by her Lamaze teacher:

I mean, if that's the only prenatal care you get, to me it's no wonder that you're hooked to machines. It's like, I'd be terrified, too. I mean, they kind of set you up for failure. They talk about all this gadgets, and all those, stuff that's gonna be, you know, used during your birth, where it's not necessarily the way it needs to be.

Susan also described the birthing class she took as negative. She had the feeling that the teacher was actually trying to scare the women. Carrie, who at the time of the interview was eight months pregnant, felt that she had to look for alternative information. She explained that as follows:

Pregnancy in America can be a very guilt-ridden proposition, because you feel like, you know, we all get to control things and you just feel like, everything you do, every single action you do is like directly affecting this child, so I kind of tried to be a little calm about that.

Miriam said that in the beginning of her pregnancy she read several books and went through the information her doctor and her midwife gave her. In the later stages of her pregnancy, however, she recounted, she chose to stay away from any media related to pregnancy and birth, stating:

I was not afraid to give birth and I did not want to hear any of the horror stories usually making the rounds on TV/Internet. I intentionally did not join a class, since I thought my body can do this naturally and I did not want to mess with my instincts.

This seems especially interesting, considering that these classes are designed to help women, but are apparently viewed as a negative influence on their mental state by some women now.

Negative Influences. When asked about the pregnancy, the women's desire to be surrounded by positivity became obvious. The women felt that they were confronted with negativity in many different forms. For some of the women

it was relatives; for others it was certain books or advice from other sources that they felt were harmful to their state of mind. Carrie explained:

There are certain books out there that I feel have a lot of negative energy in them and just tell you all the negative things about what childbirth is like. So I've actually tried to avoid some of those, you know, they are really prescriptive, they tell you to eat, you know, ten servings of spinach a day, which of course no one can ever do, it's ridiculous. So those kind of things that only make you feel worse. I really just tried to avoid those.

One book, *What To Expect When You're Expecting*, a very popular pregnancy guide in the United States, was mentioned three times as having a negative message and as being especially scary, proscriptive and prescriptive.

Caroline described her experience with the book as follows:

For every month it gives you like developmental milestones you should be expecting, and so I would read, and I would read that he should be picking up his head and like pushing up on his elbows like at, I don't know, 4 months. So I would watch him and I kept waiting for this to happen and it didn't happen, and so then we moved on to five months and like by 5 months he should be pushing up with his hands and he still isn't pushing up on his elbows and so he developed a little more slowly, like his motor skills, but then he caught up by the time he was 9 months, he was right where he should be. So sometimes like reading those very generalized books it causes a lot of anxiety.

While *What To Expect When You're Expecting* was also mentioned in positive terms by other women, it seemed significant that this specific book elicited similar reactions from three different women.

As mentioned above, relatives can play a very supportive and positive role during pregnancy, but it can also be the opposite. Carrie mentioned her mother's advice as very helpful; on the other hand, Natalie felt that her mother was a negative influence during her pregnancy. From the very beginning on, she said,

she felt demoralized and undermined by her mother being very supportive of her boyfriend, but doubting her:

The most negative part about my pregnancy and then the birth is my mom's reaction to, my mom is very worst case scenario about everything and so that's the way she's been throughout my pregnancy and throughout my life, so that's the way she was like throughout my pregnancy, so that was the most negative thing.

Natalie went on to describe how the reported negativity of her mother was a source of frustration to her during the pregnancy:

She would always say things like, the night that I called her to tell her I was pregnant, "I know that James will be a great dad, but I'm not sure if you're gonna be a great mom." And I mean, which what I really needed was not an assessment of what kind of parent I was gonna be, but I needed just some support, you know, about being pregnant. I hadn't even had enough time to think about what kind of mother I was gonna be. So those kind of comments like "I'm sure James is gonna have to do it all, because you're not an early riser."

She stated that she was still very upset about her mother not believing in her capabilities. The constant criticism wore her out and appears to have made her more insecure about how she felt about her pregnancy, which she already doubted:

The night that I found out I was pregnant, I called my mom and my mom said "Oh, Natalie, I don't think you're gonna be able to do this." And so, and I hung up the phone and didn't know which part she meant, like I didn't know like I'm not gonna be able to be a parent, I'm not gonna be able to handle the pregnancy. And so, but her saying that made me think, and that was also a concern, that I wasn't going to be a good parent, that that's what my mom thought, that I wasn't gonna be a good parent, so the concern was first my own freedom and then my second concern was how adequate I was gonna be at parenting.

Mary also felt that her mother was a negative influence, while it was not as extreme as in Natalie's case; still Mary said about her birth:

Like I didn't want my mom to show up until like much later. She didn't listen to me, she showed up anyway, but I was...but she was very positive and it was okay, but she is generally kind of a negative person so I was like "No!". If you're around people, who are negative, you are going to be scared, you know. Whether it'd be your doctor, or your friend, or whoever, your mother, whatever... just stay away from them. And be very proactive and bring in other people, who are positive.

It is important to emphasize the influence negativity can have on the emotional state of the expecting women. While comments and criticism from relatives are hard, if not impossible, to control, positive reinforcement through preparation and counseling could be a supporting aspect pushed by healthcare providers and educators.

Giving Birth

The actual process of giving birth was a major issue that all of the women in this study reportedly put a lot of thought and planning into. They all stated that they had wanted to attempt natural childbirth, with no or as little medication as possible. Mary described her impression of the American medicalized approach to childbirth as "you're like you're a number, one mother after another kind of thing and things will just happen to you and you don't have control of the situation." This statement is in accordance with what Block (2007) describes in her book on the medicalization of childbirth. Block (2007) talks about how most women have little contact with the obstetrician when arriving at the hospital and how nurses report being pushed for a speedy process and delivery. She claims that women are being pressured into labor induction by their doctors and have

little control in deciding what would be ideal for them, which became apparent in two of the interviews.

As Caroline described her experience, her doctor left her practice while she was pregnant, and told her that she was planning to be out of town the day after her due date. The doctors supposed to cover her reportedly said, they would not let Caroline's midwife attend the birth. She described the event as following:

So she decided to induce me on my due date, and I really was opposed to that, just because like I told you I didn't want any medications and she insisted that it would be fine, no problem, this happens all the time, it's no big deal, and I just felt like from a health standpoint, once you have one intervention, it kind of snowballs into needing a bunch of other interventions and I didn't want that. And I really didn't want a C-section and then I didn't want an epidural, that kind of thing. And then from a, just an honesty standpoint, I was worried about what she was telling my insurance company.

Caroline recounted how she weighed her options, both very unappealing to her, and decided to go forward with the induction. After 23 hours of labor, she described how she ended up asking for an epidural. A similar scheduling problem reportedly occurred in Jessica's case:

I also wanted my doctor, because I'm very particular with my physicians or dentist or whatever. Like my doctor is from a big practice, so there were 6-9 physicians and they rotate their schedule, so we knew that it would be any day now. If I wasn't already over, 'cause we weren't quite clear on my due date, when it was. So we went ahead and scheduled for me to be induced.

Doulas and midwives were one way for the women to try gain control of the situation by having someone who had more time to educate them about what to expect, while most doctors only have a small amount of time they can dedicate

to their patients. These professionals have the time and education to help expecting parents to figure out which decisions to make on how they want the birth to go. They can explain to expecting women what options they have and help to make informed decisions. Doulas and midwives can also serve as an agent between the medical staff and the women to make sure that the birth goes as planned.

So I was able to ask her kind of a different perspective than what you're normally presented with. And so I think just by having her present, this other alternative point of view, really helped me open up to different ideas of how I wanted my birth to go. Not that I have power, but at least try.

My doctor really didn't go into it so much with me about the lack of pain blocking hormones [when labor is induced], but my doula; she explained to me that it would be very difficult.

Most of the women in this study were able to give birth vaginally with no major medical complications, but three women went through emergency C-sections. One had a very positive experience with it and was back on her feet quickly after, but for Jessica it was emotionally devastating. She had planned to have an all natural birth and felt that she did not receive adequate information on Caesarians, so when she had to go into surgery she was extremely surprised:

I remember in our childbirth class, the video they showed, it focused more on traditional vaginal delivery and the Caesarian portion of the video is very short and brief. I mean, they made it so that...they made it so brief, so that you watched it and you didn't even think it could happen to you. So I didn't. I just, I assumed I was going in for natural childbirth or worst case scenario have an epidural and deliver vaginally that way, but...like I just didn't even think that I would have a C-section and then I did have to have one.

She got very emotional talking about how she felt cheated out of the experience of birth and how terrible it was for her to be strapped down to the operation table.

That she was not able to hold and nurse her son right after birth, as she had expected, still very much bothers her. Sarah, who has a 5 weeks old daughter, described how a complication in her pregnancy led to an emergency C-section. She was diagnosed with Intrauterine Growth Restriction in the thirty-seventh week of her pregnancy, so her doctor advised her to induce labor:

They were worried about stillbirth and pressed for early induction. I agreed and they induced me. I labored for 30 or so hours but my cervix refused to dilate. I ended up having a cesarean section. The whole thing was quite traumatic, physically and emotionally.

She said that she was so afraid for the health of the baby that she felt she had to do everything her doctor told her to do. The loss of control over the process was a very negative experience for her. She had planned a vaginal delivery and said that she wished she would have talked to her caregiver about her options if complications arose. She said, "I wish I had been more assertive regarding my wishes for the birth."

Julia did not schedule an induction and emphasized in the interview that she wanted a vaginal delivery. She had only gathered information on vaginal birth and did not expect anything else. She eventually was administered Pitocin after being in labor for several hours when her contractions suddenly stopped:

Which, before the Pitocin, it was bad, but it was like bearable, but after the Pitocin it just felt like someone was like hitting a sledgehammer in my back, so I wind up getting an epidural, well, first I got the narcotics, which was a horrible choice, because I always said I wouldn't do that anyway, but then like, it was probably 18 hours into labor, that I got the shot.

She went on to describe how the Demerol she was given made her sleepy between contractions and made it even more exhausting for her. She then asked

for an epidural, because she felt that without it she would not be able to push at all. Not wanting medication was important to her, as she stated in the interview, and that she ended up being administered several drugs left her disappointed in herself, which could be categorized as self-stigmatization:

And I'm just so disappointed. It's just so weird, that even though it was like one day, I'm gonna think about that for the rest of my life, how disappointed I am. And it's just weird, 'cause you think, even though she's like completely healthy and really happy, I just think, Maybe she would be happier, if I didn't have to get the drugs, you know, or maybe something would be different.

Marion was not even told that she was being induced. Her doctor "stripped" her membranes twice, but only told her that this was supposed to stimulate labor. She was not informed of the risks of the procedure or how painful it can be.

[This] is a technique whereby the practitioner inserts a gloved finger into the vagina to jostle the mucus plug and lift the amniotic sac off the cervix. This is a method of induction and carries with it a risk of infection, but many providers report using the technique routinely at the end of a woman's pregnancy. (Block 2007:17)

The first time nothing happened, but after the second time, she said, she went into labor within four hours of the procedure. An additional risk to this is that this procedure can lead to the water breaking before contractions start, which then often leads to the administration of Pitocin (Block 2007:17). Block (2007) claims that she talked to several women whose membranes were "stripped" without them being informed about it or giving consent to the procedure. This seems, to a certain degree, to be true for Marion in this study. She had a very relaxed birth and eventually asked for an epidural, which she describes as a positive experience, but that does not change the fact that she reported not being properly informed. Her water was broken manually by her doctor, which she said

she was not told about until later. Additionally, she said she was told she would be medically induced, if she did not go into labor on her own within a week of her due date.

Natalie also described having had some difficulties during the birth. Her cervix “got stuck” and she stopped dilating. When her midwife tried to move it, it reportedly resulted in excruciating pain so Natalie refused to let the midwife proceed. Two hours later, when she once again let her midwife try to move her cervix, she had a fast birth. As described before, Natalie’s mother had reportedly been a strong but negative influence throughout her pregnancy and continued to make her feel bad even after the birth:

It was a good experience, and I’m glad that I did it that way, but my mother, she did not and does not support that I didn’t have an epidural and so apparently, she was not in the room when I had, she was in the hospital, but she was not in the room when I had him, and, so as soon as she came in she was really pissed off and she was acting, you know, just really upset and I ask my sister ‘what’s going on’ and my sister tells me, well, there was some argument between my mother and my boyfriend’s mother and my mother was being completely irrational. Apparently she was outside of the hospital, and I didn’t know at the time I was birthing him, but I knew it immediately afterwards that my mom was outside the door cussing and screaming, and, you know, really just acting completely irrational.

She still says she feels bad about the way her mother acted while she gave birth to her child. These findings show how the women’s expectations influence how the women feel about the outcome and how comprehensive prenatal instruction might have helped either of these women to be better prepared for potential difficulties. The birth is so highly anticipated and idealized that if anything diverges from the plan, it can turn into an emotional burden and apparently self-

stigmatization in the form of feelings of failure, disappointment, and guilt. As Julia said, it is just one day, but the birthing experience is one of the most important experiences in a mother's life, and that memory will remain with them forever. The emotional impact of child birth on the life of a woman cannot be stressed enough. Comprehensive information about all the possibilities and potential complications appears to not be easily available.

The only woman in this study whose baby was breech was Miriam.

Fortunately, she had a positive experience:

The only scare we had was at 35 weeks, when at a routine check my daughter turned out to be breech (head up in the womb). In the Seattle area there is no provider who will deliver breech babies vaginally (for insurance reasons), a c-section is almost mandatory. My midwife suggested to try an external cephalic version and recommended an OB/GYN who practiced at the same hospital. At the end of 36 weeks I went in for the procedure, which was successful, the doctor turned her head down by applying pressure from the outside. That was pretty amazing!

Block (2007:74) states that 10 to 15 percent of all births in America are breech after 33 weeks gestation. She claims that three percent of fetuses are still breech at term. Even though there are successful techniques, among them external version as in Miriam's case, they are hardly ever attempted in the United States (Block 2007:75), and breech babies, as Miriam describes, end up being born via Caesarean: "Women in North America who want a vaginal breech birth are often denied it outright" (Block 2007:77). There are severe risks for the newborn in a breech birth, but C-sections are not risk-free either. A closer look at a study by Hannah et al. (2000, in Block 2007) published in England, comparing infant mortality and morbidity after vaginal breech birth and C-sections, showed that in

countries with low infant mortality in general there was virtually no difference in outcome. However, neonatal morbidity was still higher if the child was delivered vaginally. The study still evokes controversy, and its design is questioned by many (Block 2007:79). The fact that Miriam received excellent prenatal education and was given information with regard to the procedure of repositioning the infant may have saved her from a negative birth experience.

Megan's case stood out for other reasons. She recounted how she had the feeling that her child was getting too big to have a vaginal birth. She explained how she talked to her doctor about it, but was told that it would be okay:

She actually allowed me to have a vaginal birth with a child too large for my pelvic bone. He got shouldered and luckily only ended up with a case of Erb's Palsy that cleared up in a few weeks. Just as an FYI, that is the most common way that mothers can actually die during child birth in present day. My doctor had even told me she would let me go the full two weeks over my due date if labor did not occur on its own.

Her child weighed 10lbs and 2 ounces at birth, and she was rightfully worried. This case seems very unusual, considering that she probably could have sued her doctor for negligence, bearing in mind that Erb's Palsy is a birth injury. While many of the other women in this study encountered physicians that were eager to schedule an induction or C-section, Megan's life was put in danger, as well as the life of her child.

Emily described how she had a very traumatic birth experience. She went into labor a month early and after 24 hours in the hospital they rushed her into

surgery to conduct an emergency C-section. She was upset with the way she was treated during the procedure:

During the C-section I started getting sick. I was shaking and I could feel [the doctor] pushing on my stomach and I was getting sick. The doctor told my boyfriend that he was going to give me some sleeping medicine because I was getting sick. I was feeling my stomach too much. I could hear him telling my boyfriend that but he didn't tell me that. "I'm still awake; tell me what you're doing." I was scared already and it just felt like a dream. I was half in and half out of it. It's crazy.

Once her son was born she expected to be able to hold him immediately, which was not the case. Her son was diagnosed with a heart murmur and pneumonia. He remained in intensive care for several days following the birth, which was incredibly difficult for her. A less dramatic, but very emotional story was that of Maria. She had a C-section, which went well, but was sad, because her mother could not be with her. She wanted to give birth in Brazil, her home country, but her husband would not have been able to be there. Instead of her mother, her mother-in-law attended the birth, which she was unhappy about. These stories show how many different components factor into how the birth is perceived. It is a very personal and emotionally laden event, and everything that happens during that sensitive time impacts the rest of the women's lives.

Exhausted and Changed Bodies

Two themes were apparent in relation to physicality. The women talked about the exhaustion they felt after birth and how tired and worn out they were, due to the demands of their newborns. In *Physical Strains* the women's experiences with that subject will be discussed. The second part of this cluster,

Physical Changes, deals with the issues women had with body image after pregnancy and birth.

Physical Strains. In the first few weeks after giving birth, the body is still healing and recovering from the stress and the work of being pregnant, the birth itself and the hormonal changes. Additionally, women have to deal with emotional distresses of feeling overwhelmed and exhausted. Mary said she was taken aback by how long it took her to get settled into a routine:

I certainly didn't think that I couldn't function for 6 weeks. I mean literally, I was like, I would make a plan to do all these things, and I would get like one thing done. That one thing could consist of, you know, a few things around the house or going to the store for an hour. I mean that was like an all day adventure.

She also described how frustrated she was for the first few weeks about not being able to manage the simplest tasks, like shopping or writing an e-mail. She talked about how the physical exhaustion surprised her and especially the fact that she was so worn down even after having been very active in her pregnancy. Mary went through natural childbirth and felt very good about her experiences, but she was surprised about how long the healing process took. Caroline had made plans for a maternity leave that would be easy and fun. She described how she wanted to go to the park with her son and how she expected she would be able to know when he would need to eat. She thought running errands would not be a big deal. She was not prepared for the time it actually took to take care of a newborn and the total exhaustion she experienced:

The first few months I thought it would be really easy. Like I had all these things planned that I was gonna do while I was off work. And he took up every minute of my day, and by the time my husband came home at night, I would just give him to him and I would say "I

need to go and take a nap” and I would be in my pajamas and I wouldn’t have showered.

Jessica also described the first weeks as difficult. She put more emphasis on the emotional part of the healing process as well as her physical appearance. She said:

As far as being intimate...it took me longer to get back to that point, because here I just went through childbirth and I wasn’t feeling attractive. I went from being this healthy, glowing, pregnant woman to overweight and not...and tired and trying to get my hormones back in balance, and I would be emotional.

Well, I thought that I...the working...because I work 20 hours a week from home, I thought it would be really easy with the baby, that he would just sit there and do his baby thing and then I could work and it would be so easy. And that was a shock, because he had colic for the first three months or whatever, and so it was difficult to work at night and I was tired all the time, and just trying to work and be at home, and keep the house clean...it was hard.

To her, she said, the first three months were especially hard. All of the women reported having experienced difficulties handling the first few weeks. They all prioritized their experiences differently, but the exhaustion was a main theme in all of the answers. Sandra said that she had experienced heavy blood loss during the birth, so she felt the repercussions in the first weeks of being a mother. She said that she was warned about the possibility of that happening, which made her feel better about it:

What was true in my case was that I was completely wiped out physically after having her, which I had always heard happened. I had an above-average blood loss afterward, and I think it was the anemia that made me so tired and weak. I have seen two friends have babies since, and they both felt pretty normal within a few days. It took me a couple weeks to feel normal again. I think in that way, my postpartum time was harder than some women’s.

Marion overestimated her physical capabilities by going back to work as a server a few weeks after delivery. Financially she had no choice, but her body was not ready for it. She recounted how she walked herself sore and described it to be very painful:

I mean I am still very sore, and it's been three weeks later, from delivery, and you know, I still take Ibuprofen a couple of times a day. And that's been the biggest physical change, is the time it's been taking to heal.

She also described having to struggle finding childcare. The father of her son reportedly was not providing financial support nor did he offer to watch him when she had to work. This shows how important it is to provide mothers, especially single mothers, with adequate financial support and also with paid maternity leave. Not every mother is in the position to save up enough money to take several weeks off from work after giving birth. As Caroline and Stephanie both stated,

Nothing prepares you for how tired you feel, just for these first two or three months, you've never felt exhaustion like you do, when the baby is up every two hours to eat, and it's just, it's incredible.

Some days she just, it's like she's pressing my last nerve and I know she's not doing it on purpose, but I'm just tired, and every once in a while there is days where I'm like I can't believe I got into this, this is everyday for the rest of my life, when's my break? And back and forth on the expectations for the motherhood part, I guess it's better than I expected.

Julia reported similar feelings, specifically about the amount of time spent breastfeeding:

Like no one tells you like a lot of stuff. Like no one tells you that nursing takes like an hour at a time, like every other hour you have to spend an hour nursing.

These statements are in accordance with McVeigh's (1997) and Choi et al.'s (2005) findings. Many women feel overwhelmed and unprepared after having their first child. While none of the women in this study said that "nobody told them" that it would be hard, they still felt exhausted and wished they would have been better organized. They also said that "nobody can prepare you for the intensity of the postpartum period". In the first couple of months, women need all the support they can possibly get, and especially single women with little or no support from the father are struggling financially, physically, and emotionally. Compared to some European countries, it is astounding how little help is provided to new mothers in the United States. For example, there is no legally regulated paid maternity leave such as is available in Germany, where new mothers get 14 weeks off of work for which they receive their full wages (Schwab et al. 2007:75). German parents also have the option for one of them to stay at home for an entire year. The parenting year is not fully paid, but the person staying home is compensated with 67percent of their last salary, with a monthly minimum of Euro 300.00 (approximately \$470.00 as of March 2008) and a maximum of Euro 1,800.00 (approximately \$2,830.00 as of March 2008) (Bundesrat 2006). Unfortunately, there are no comparable options for parents in the United States. Should the new mother be the primary financial support, there are few financial resources available that would provide enough money for a family or single mother to survive for a few weeks, not to mention a couple of months.

Physical Changes. With a few exceptions, the women I talked to stated being unhappy or discontent with their weight gain and did not expect it to be so hard to get back to their pre-pregnancy shape. The way celebrity pregnancies are portrayed by the media makes it seem as if it was easy to lose the baby weight and return to a socially idealized weight in a very short period of time. Considering how much scrutiny women's bodies are under in general, it seems just as hard for women who just gave birth to have a healthy body image. While Marion lost all of her pregnancy weight within the first week, she still said that she now has to get used to her body having a different shape. Stephanie described her experience in very similar terms:

I feel like I was lucky I didn't gain a whole lot of weight while I was pregnant, like 20 somewhat pounds, so as far as getting back to my normal weight it didn't take very long, but things are in different places, got the little pooch now, that just won't seem to go away for anything.

Most of the other women reported having more serious issues with the weight they had gained during their pregnancy. Caroline described her frustration as follows:

I gained a lot of weight, I gained like 50 pounds, and now that my son is ten months old I'm still not back to my pre-pregnancy weight, and so that's frustrating, but I'm working on that.

Kathy also described how she was told that it would be easy to lose the weight once her baby was born:

Physically I gained 53 pounds when I was pregnant. I've always had a weight issue but I really noticed that. And getting it off was hard. My mom told me the whole time I was pregnant, 'It'll be easy, you're young; you'll be able to get it off.' It's so hard to get off. That has changed.

Julia also talked about how she had expected to get back to her usual weight quickly, but that was not the case. She was bothered by the stretchmarks she got as a result of her pregnancy and also said that she had lost a lot of muscle mass. Weight gain was also an issue mentioned by Emily and Sarah, but they both said they became used to it after a while. Megan also stated that she was surprised by how hard it is to lose the weight after the birth of a baby:

I expected my body to change, but I did not think I would have this difficult of a time losing the pregnancy weight. Especially still struggling 8 months later. I gained 70 lbs while pregnant. The baby was 10lbs at birth, but that left me a lot lose. I am still working at this and my goal is actually 10 lbs heavier then before and a whole size larger, because I know that some of it just isn't going anywhere.

While Susan also talked about the physical changes, including weight gain, stretchmarks and the changes in her bone structure, Jessica talked about feeling unattractive due to her weight gain. Maria also said she felt bad about the stretchmarks that appeared and how her body changed during the pregnancy.

One of the women in my study, Sandra, mentioned in the interview that she read *Fit Pregnancy Magazine* while she was pregnant; a publication that was analyzed by Dworkin and Wachs (2004). "After birth, there are clear warnings that "letting the body go" constitutes failed womanhood and motherhood" (Pg. 616). Women are supposed to feel "bad" about their bodies and somewhat guilty if they do not take action to get their body back into pre-pregnancy shape as soon as possible. According to Dworkin and Wachs (2004), *Fit Pregnancy* educates women as to how they can almost constantly work out, no matter what they are doing (for example, doing abdominal or Kegel exercises while feeding

their child). While a certain regiment of exercise is undoubtedly healthy and positive for everybody, including new mothers, the emphasis on the possibility of regaining a pre-pregnancy body appears very misleading and is also unlikely for the average woman to achieve. The social and cultural expectations of women to have a perfect body paired with the “formula” to achieve it, sets women up for failure, which seems especially harmful for new mothers. Dworkin and Wachs’ (2004) findings are supportive of Johnson, Burrows and Williamson (2004), who conducted a study on body image and pregnancy in the United Kingdom. They found that the women in their study used pregnancy as an “excuse” to diverge from the hegemonic female body ideal, but still struggled with their bodies being “big”. Carrie, who was pregnant at the time of the interview, talked about her irritation due to gaining weight. For the first several months she only had a very small belly as she described, but then all of a sudden gained a lot of weight:

I was thinking “This can’t continue, can it?” so even though, I mean, I know, it’s really irrational at some point, some level, you know, this is what your body is doing and it needs to do that, but I started, you know, to look in the mirror and just think “Who the hell is this? This is really not me.” And so I was having some negative, negative feelings about “Oh, maybe I should be doing more exercise, more this, more that, and just stop eating the chocolate.”

Julia also struggled with gaining weight during her pregnancy:

I gained like 50 pounds, all those Oreos I shouldn’t have eaten. So the worst day was when I went to the doctor’s office and I stepped on the scale, you know, and they pushed it all the way down and they pushed it all the way back and moved the big one.

Body dissatisfaction is a common problem for women in Western countries, which does not necessarily go away because one gets pregnant and has a baby. Upton and Han (2003) conducted a study on maternity and its

discontent and found that during pregnancy the women's body and behavior is under intense scrutiny. Unsolicited questions and advice are common and women have to obey to a set standard. After pregnancy this changes to some degree. The woman is again solely responsible for her body, but still is subjected to social scrutiny. Supporting Dworkin and Wachs' (2004) observations, Upton and Han (2003) also found that new mothers are being pushed to get back into shape. Another interesting point, raised by Upton and Han (2003), is that new mothers also go through feelings of "loss" of identity. The speed with which the body changes so drastically appears to have an effect on how women perceive themselves and seems to result in a struggle of regaining the lost self. The women in my study talked about the changes their bodies went through, and significant weight gain in a relatively short period of time left them frustrated. While this is a "normal" physiological process and to a certain degree necessary for the health of the unborn child, women still have to deal with the reality of having a changed body. The discontent with the weight gain makes society's focus on and expectations for women's bodies obvious. The portrayal of women in the media has been found to be damaging to girls growing up and adult women trying to conform to social standards. Over-idealized body images, for example the "curvaceously thin" ideal today, that are impossible to obtain for the majority of women can lead to low self-esteem, eating disorders and depression (Forbes et al. 2007; Forbes et al. 2004). Considering this, it is essential to educate women and society in general about realistic expectations regarding

pregnancy and weight gain. Megan gave a great concluding statement that sums up how some people act toward pregnant women:

I was also repeatedly told how large I was toward the end of my pregnancy and everyone swore I was having twins! This does not help the mental stability of a pregnant woman.

Emotional Realities

The last cluster focuses on the different emotional aspects of becoming a mother. First I will focus on how many of the women described how being pregnant and giving birth gave them a sense of accomplishment and self-esteem, in the chapter *Giving Birth as a Source of Confidence*. The second part of this cluster is the experiences many of the women had with postpartum emotional disorders. Unfortunately this was an issue that was raised in half of the interviews, and is being discussed in *Postpartum Difficulties*. The last part of this cluster, *Relationship Transitions*, talks about the way in which the women's relationships were affected by their new roles.

Giving Birth as a Source of Confidence. A feeling of empowerment after giving birth was described in several of the interviews. The women described how they felt that giving birth and going through labor was a very powerful experience. Having an active role in their health care and the decision making process was very important to them:

I felt really good about that, because I was involved. It was my birth. It wasn't somebody else's birth, imposing their ideas or whatever on me. That's maybe why it was such a powerful experience for me, because I was able to do things for myself.

I feel very empowered, because I went through the pregnancy and a long labor and I feel like now I can do anything, because I did that. It sounds cheesy, but it was pretty intense.

I had heard that how the birth goes can affect your self-esteem for the rest of your life, and I think that's true. I felt so empowered and so grateful during and after her birth. I have a lot more confidence in myself and in my body now. I respect myself more.

The women gained self-esteem and confidence from their experiences, which helped them trust their abilities of dealing with their new role as mothers. Marion described how going through the birth helped her feel confident enough to be more outspoken and decisive. Emily described a similar feeling of strength:

I went from feeling bad about myself when I was pregnant and finally empowered myself after I had him. Stop feeling sorry for myself. Started saying, "You know, I can do this and I'm gonna do it" and it started working out.

It is interesting to hear how women acquire so much strength and confidence in themselves from the experience of pregnancy and birth. This feeling of achievement and pride overshadowed many of the more negative aspects of their experiences.

Postpartum Difficulties. Most of the women I talked to experienced some degree of emotional discomfort after birth. Due to the exhaustion in the weeks following birth and hormonal changes in the brain, many women go through an emotionally difficult time. While some just experience frustration and fatigue, others suffer from more serious postpartum mental disorders.

Mary reported how she primarily felt exhausted because her son was so focused on her and she was not able to take a break from caring for him, or even get a full night's sleep:

His father would come home from work and he'd be so excited, oh, he wants to hold his son, and he was like immediately started crying, like "Who is this guy holding me?" And he would cry and was sort of like back to me, but I really needed that break, but it just wasn't gonna happen quite yet, you know. So that was a little frustrating. Really that was the only time that I really felt down and now I think coupled with being up in the middle of the night all the time, like every two hours.

For Jessica, postpartum was considerably harder. She actually described how she suffered from a form of postpartum depression, which mainly showed itself through extreme anxiety and paranoia:

I think I had a form of postpartum depression, with the anxiety issue. My doctor said that it sounded like a form of it, and to let her know if it got worse. And I didn't go back to her, I should have gone back to her, but I didn't, because I didn't want to be put on medication at the time. But I was very anxious and, to the point where it was kind of controlling my thoughts and I was worried that something would happen to my son and that people were watching us and following us and that they wanted to hurt him. And I would have dreams about it.

She suffered from this for an entire year and reportedly only talked to her husband about it twice. Even at the time of the interview, when her son was 16 months old, she still had nightmares, though she said that those had become substantially fewer. She described hearing a friend mention that postpartum depression would last for a year, so she had set this year as her goal and at her son's first birthday decided that she would be better now and she reported that it worked for her. Another example of emotional distress was the experience of Sandra, who described her first days of being alone with her newborn:

I expected to be a little lonely staying home with her, and that was true to some degree. The first full day that I was home alone with her, I had to make a conscious effort to not be depressed. I walked in the living room with her and sort of thought, what do I do now? I could feel myself spiraling down into feeling sorry for myself. I realized that I needed to distract myself from my feelings to keep

from feeling depressed, so I popped in a video right then. I just sat and rocked her and fed her all day, and when one video ended, I would watch another. I went through all of our videos, and then I watched all of my parents'.

Natalie also reportedly experienced symptoms of postpartum depression, but did not categorize them as that at first. After giving birth, she felt lonely, sad and insecure, but did not think she had postpartum depression, because she was neither suicidal nor thinking about harming her child, which were the symptoms described on an informational sheet she received in the hospital:

I didn't feel as severe as some of the things that were on that list, you know, like I didn't feel like I was gonna hurt myself, but I just felt really sad and I felt lonely, so I wish that someone would have said 'it's okay to feel doubtful right after you have your baby' that that's normal, you know, but everyone's saying "Congratulations" and "Oh my gosh, this is the most incredible thing in the world," and you're just, I was just kind of sitting there kind of like "It is?" You know, "I'm exhausted".

None of these women actually sought out the help of professionals and some even chose not to talk to anyone about their symptoms. It is impossible for me to state as a fact that these women suffered from what would clinically be described as postpartum depression, but they self-diagnosed and the symptoms mentioned seem to fit the diagnosis. Considering that these women never sought out professional help, I have to rely on their own assessment of their circumstances. These findings, if medically accurate, support the statistic mentioned in the literature review by Goldbort (2002), who found that many cases of postpartum depression go unreported.

Kathy reportedly had begun seeing a therapist even before she found out that she was pregnant and had started taking medication, because she had been

suffering from depression. She described how she stopped taking her antidepressants during her pregnancy, but stated that eventually she had to start taking them again, while she was still pregnant. She described how she felt that it was very helpful to have somebody to talk to, especially after she gave birth, because she felt very sad and did not know why:

Right after I had my daughter I had a lot of up and downs which I think is pretty normal but it was nothing. I'm so glad I've been in therapy because that's helped so much, just having someone to talk to. So it was nothing real bad but it was feeling sad sometimes and not knowing why. It was kind of what it was like before I got pregnant multiplied by 10 after I had her. I kinda got it back under control. It's nice to have an unbiased opinion. To hear you're not crazy is a wonderful thing from a person who has seen so many different kinds of people and studied it. It's nice to have that kind of reassuring opinion to know you're not going nuts.

Natalie described how she had felt very insecure from the beginning of her pregnancy, and how she was hoping for more positive reinforcement from her mother. She and her baby were healthy and well after the birth, but her mother was upset:

I was disappointed with the way my mom handled it and because she was upset that I didn't have an epidural, she, you know, she left the hospital upset, and she didn't call me for a week, and, you know, she was just...and even still, this past weekend, she said something, you know, about how, because of my own, what she says, my need to prove something, I put my son at risk, and...so that's really tough, because I now am really proud of the birth and it really was an incredible experience and but still my mom's reaction to it, is really disappointing for me, is really hard for me to handle, that she isn't proud of me, and that she even thinks that I was hurtful in some ways.

Natalie appeared to have taken the negativity of her mother and, to a certain degree, internalized it. She held unrealistically high expectations regarding how she should have been able to handle the birth:

Several weeks after the birth, I was really upset about having cried, I mean, I thought, I didn't expect that I was going to say "I can't do this", I mean, I would watch it on the television, like the videos we watched and I would see women say, you know, "I can't do this, I can't do this", but I didn't think I was gonna do that, so I was really disappointed in myself, for having, you know, cried. At one point I'm like "Can they give me some Tylenol or something?" and you know, I'm looking at my boyfriend and say "I really don't think I can do this, I really don't think I can!" I was disappointed in myself afterwards for that, but now I'm not. I mean, now I know, and that's because people, other mothers have said, you know, "This is part of it" and so now I'm not, but in that way, immediately I was disappointed with myself, I thought I would have done better.

Emily described how she had an emotionally hard time immediately after the birth. As mentioned previously, her son was suffering from a heart murmur and pneumonia. She was understandably worried and because of his condition could not hold her son for days. She was given anti-depressants following the birth and described her experience as follows:

The doctors and nurses were really good at explaining things because I wasn't in the best state of mind. They sent a social worker in and pumped me full of anti-depressants, which helped. I don't know if it helped. I mean it helped because I wasn't spazzing out, but I could feel the emotion, but I couldn't let it out. I almost needed to cry, I knew to be mad, but I couldn't.

In the following weeks, she suffered from what is commonly called the baby blues. Mood swings such as happy one minute, then sad the next. As Emily described it:

I did a little bit you know. Especially the month I moved here. But they jumped my system with so many anti-depressants; it was kinda hard for that. But once that actually got out of my system it hit harder. With us being broke up and everything my Doctor was watching me pretty strongly for postpartum, because I had the baby blues pretty bad, but we got over it and I'm fine. That's how I got over it, the working out. I worked through it and I tried to use that to empower myself.

The sense of empowerment after overcoming a very emotional postpartum period was also mentioned by Caroline, one out of two women in this study who had reportedly a severe case of postpartum emotional disorder. Caroline was induced with Pitocin, as described before. She was unhappy about the birth, but downplayed it several times during the interview:

But now that I have more distance from it, it's really, it's not that big of a deal, and he is very healthy and I have recovered fine and so, I was able to still have a vaginal delivery, I did not have to have a C-section, so I figured that's a blessing, so I don't know. I guess, just slightly disappointed and especially initially I felt so disappointed.

It seemed like a protective mechanism, a way of reconciliation with what happened to her. While she was disappointed with the birth, what she described as being even more devastating to her was that she did not produce enough milk to breastfeed her son. She said, describing her discontent with her situation, "Those little things I thought I would have control over and ended up not being able to control, they were just, they were big disappointments." She developed postpartum Obsessive Compulsive Disorder (OCD). Three percent of the general population suffers from OCD, more than half being women (Beck and Watson Driscoll 2006:159). According to Beck and Watson Driscoll (2006), postpartum OCD is understudied, but the women affected by it need immediate and comprehensive treatment, taking into account that it can potentially interrupt the maternal child attachment and can have harmful effects on the newborn's development. Caroline described how she became increasingly germ phobic:

I went through some postpartum Obsessive Compulsive Disorder, which is more rare than depression, but that was interesting to go through with my family, because I was just so obsessed with hand washing and people making him sick and like, around, he was born in October, and so Thanksgiving was when he was about a month

old, and I, and that's when I was really like in the throws of this obsessive compulsive disorder and I didn't want to go to Thanksgiving, I didn't want anyone coming over and I was telling my husband, like I would have these meltdowns, when it was time to leave the house and I didn't want to leave.

She explained her symptoms and anxiety:

I was just really scared of germs, I was scared of, I was convinced that he was going to get sick and die, like I really, I saw that was the outcome, if we weren't careful. And it was so hard on my husband, because he wanted to help anyway he could, and so I would like want him to help with like changing diapers and giving him his bath, and you know, those things, so I could take a nap, but I would like, before I could hand him over, I would be like did you wash your hands, did you use hot water, did you use soap, and I would just run through all of these questions and it was making him frustrated, and rightfully so, I was just not being rational. And you know, if my mom would try to come and help, I would just say "Now I have to do this and this and this." Because I was just really convinced that, you know, I was catastrophizing a bit, he was going to die, I was just convinced.

After three months, she finally sought help from a therapist. She described how went to individual and group counseling and started taking Paxil. What is so significant about this case is that Caroline is a nurse and talked about how she had taken a seminar on postpartum emotional disorders while she was pregnant. She said that her education made a difference in her decision to seek professional help, because it helped her to realize that she was suffering from OCD, but it still took her three months. She was also doubtful that if she had not had the knowledge of the disorder that she did, she would have been able to tell what was going on:

If I would not have had that experience and would only have had interactions with my doctor, I don't know that I would have been able to identify that I was having a problem. And the only thing my doctor said to me was at my postpartum visit is "If you're having any problems, just let me know and I'll get you some medicine." Like it was wrong to feel that way and we better fix it, if you're

having that problem. That it's just as simple as you're gonna take some pills and you'll be fine, which is so not true. And I feel like if I hadn't had the group therapy and the medication and the individual therapy I never would have gotten past it. For me, I needed all those components to get better

When asked about what held her back from talking to a professional, she described her feelings as follows:

I did, I guess, I wanted to, I didn't want to admit, like I saw that as failing again, and so I just didn't want one more, you know, disappointment. But I realized that I couldn't keep making everyone around me nuts.

These feelings of failure can probably be categorized as a form of self-stigmatization. Considering how important control was to her and how she felt that she lost most of it in the birth and afterwards when it came to breastfeeding, the OCD appears to be a way of trying to regain control of whatever she could. Caroline said that once she started treatment she got better and as part of her job now is stressing awareness of postpartum disorders among her patients. She sensed the silence of others with regard to the topic of postpartum disorders and is now talking to the women in her care about the symptoms of the disease. Additionally, she is investigating the connection between the administration of Pitocin and the inability to breastfeed. After talking to several women with similar stories, Caroline stated that she has a strong suspicion that use of the drug and inability to breastfeed may be related. Most importantly, she says that she is not burdened by feelings of failure anymore:

And I can look back on my OCD, and I don't feel like guilt or shame; it's very matter of fact, I went through it and I overcame it and here's where we are. And I don't know, like you said, not having these two extreme ends of the spectrum, like you're either a perfect mom or a complete failure. You know, there is a very large middle ground.

Another woman in this study had a severe case of postpartum depression. She has a long history with bi-polar disorder and had been in treatment for a long time. During pregnancy, she was advised by her doctor to switch medication and was okay for a while. In her postpartum period, she decided to wean her son to the bottle so that she could get back on her regular medication. Once back on her usual medication she felt better, but reportedly stopped taking it regularly, which led to several manic episodes. Due to her dire financial situation, lack in regular health care, and the challenges of being a single mother, she spiraled out of control. After three months, she was finally screened for postpartum depression, and is now trying to get her life back in order by asking for professional help and staying on her medication. During the interview, she explained how she is ashamed of and embarrassed by her illness and has a hard time disclosing it to the people around her. The fear of being stigmatized is obvious in her case. Instead of seeking help when she was becoming unstable she tried to hide it, which she is working on now.

All of these stories show how important it is to de-stigmatize emotional and mental difficulties. If they are considered taboo and something to be ashamed of, women will keep suffering in silence, which has an impact not just on their lives but also on the lives of the people around them, especially their children. The social stigma related to postpartum difficulties leads to self-stigmatization, which became apparent in the interviews, and keeps women from seeking the help they need. Until the stigma is lifted, appropriate, affordable

health care and education needs to be made available, especially to women who recently gave birth and might be suffering from a mental disorder.

Relationship Transitions. The relationships of couples after having their first child are being challenged, apparently due to the shift in priorities that puts the newborn in the center of attention. Some of the women I talked to went through a change of balance in their relationship. They described how they had expected family life to be idyllic and experienced that it takes great effort to keep the relationship healthy. One of the women said:

Our relationship kinda got put on a strain for a while, my relationship with my husband. Not in a, not in a serious or bad way or whatever, but it was kind of challenging at first to divide our time between baby and then still find time for us.

Jessica described expecting that everything would fall into place, which made the adjustment to the reality much harder:

He would be away some, and I would be, like he would be going to practice and I would be at home with this crying baby with colic and I think I built up some resentment throughout that. And I think I used his band as my scapegoat, but yeah, we worked through that. I wasn't expecting to have that strain for a while. I thought it would be just the perfectly sweet, happy family from the get-go, but we had to work through that part. And for us with moving and being newlyweds, too, and it was a lot to adjust to all at once.

Sandra reported having had similar ideas on how her marriage would be after the birth of her child. Even though she had heard about how stressful the birth of a child is on a relationship, she still felt that for her it would be different:

I also had no way of anticipating the degree to which my marriage would change. I had always heard that the first two years after having a child are very stressful on a relationship, but I somehow thought that we were immune to that, because of our amazing relationship. My husband had always been very affectionate and paid a lot of attention to me, maybe even more so when I was

pregnant. Then, my daughter was born. For the first couple weeks, one hundred percent of his attention went to the baby. I felt like a non-person. That was really hard for me.

These couples eventually renegotiated their relationships and found that in the end their relationships had become much stronger through the experience of becoming parents. Emily also described that, but is still very frustrated with how little help she perceives she is getting from her boyfriend. She is a full-time student and holds a part-time job, which would be very stressful for any mother, but she feels that her boyfriend could be more helpful and she is a little resentful because of that. For Kathy and her boyfriend it has been difficult, because they had only been together for a very short time before she got pregnant, as Kathy described:

It's hard to have your alone time just to spend on each other. And short on money so we can't really go out a lot. It's getting to know each other and our daughter at the same time which isn't how I wanted it to be but at the same time its great. I wouldn't trade her for anything.

It is fair to conclude that becoming parents is such an intense transition that it automatically changes the dynamics in a relationship, which can be positive as well as negative. While the problems vary depending on the different situations the couples are in and what type of a relationship they had before they got pregnant, changes appear to be inevitable. It seems like the birth is a rite of passage that "forces" the women to make decisions either to stay in or end the relationship, and to renegotiate and refocus responsibilities and priorities.

The single women inevitably had different experiences than the women who had partners. Marion chose to leave her boyfriend and move in with a family

member five days after the birth. The boyfriend reportedly had been more destructive than helpful. For example, she said, he did not look for continuous employment, but was satisfied with his pregnant girlfriend being the sole provider of their family. She had already planned to leave him eventually, but then decided to act sooner with support from her family. She said that her ex-boyfriend is still refusing to pay child support and not showing much interest in building a relationship with his child. Susan seemed to be in a similar situation with the father of her son. She explained that she had decided that it would be best if he would not be involved with them:

That was part of the agreement. If he doesn't have to pay child support then he doesn't have to see the child. He's not a very good influence and I made that mistake, and learned after the fact that he is into some things he shouldn't be. But my son turned out ok. No. the father has no contact with him whatsoever, has never seen him, has never anything.

While these are certainly not ideal situations, the women appeared to be satisfied with where they were and felt that they were capable of handling their responsibilities on their own, seeking the help of friends and family. The social lives and relationships of the women went through some changes as well, which was mentioned by many of the women. Some of their friends reportedly had difficulties adjusting to the new circumstances and were not as supportive and understanding as the women had hoped. Others reported to gain a lot of strength from their friends' experiences and support.

DISCUSSION AND CONCLUSION

First of all, what is important to note is that the women described the joy their children brought into their lives and how much love they feel for them. They emphasized how a smile of their child makes them exceptionally happy and makes all of the difficulties worthwhile. All of them, reflecting on their pregnancies and childbirth, also had a positive view on their experiences. While almost all of the pregnancies in my sample were unintended, none of the women regretted their choice to carry their child to term and become mothers. This certainly does not mean that they have never had doubts or felt overwhelmed. I found that some of the women overcame their fears relatively quickly and embraced their pregnancies; others had a harder time reconciling with the prospect of birth and motherhood.

There were several characteristics which played a role according to the women's reports. Age and a sense of maturity certainly made a difference in this process, as did financial security. Social support from the partners and spouses, as well as from family and friends also made a difference in the confidence of the women. It became obvious that the women all needed a source of stability to feel secure. There is an urgent need for more consistent financial support systems in America to help women feel more able to raise a child in this society. Affordable childcare, paid parental leave and financial family benefits would certainly help women in the United States to be less stressed during their pregnancy and afterwards. The pressure of having to get back to work as soon as possible after giving birth can lead to physical as well as emotional problems. Few women are

able to save up enough money to be able stay at home for a few months, or even weeks. This is especially hard for single or lower income mothers. For future research, it could be beneficial to focus on the experiences of women of different socio-economic backgrounds and how financial security and stability influences the transition to motherhood.

Even though most of the women in this study did not plan to have a child, either at the time or ever, they put all their energy into gathering information and support in order to make the best possible decision for their situation. This could be explained by their educational and social backgrounds. The women participating in this study were either college graduates or had some college experience, which probably influenced their approach to this rite of passage. All of the women reported reading books, pamphlets and/or magazines and said that they did receive a lot of solicited as well as unsolicited advice from friends, family and in some cases strangers. Retrospectively, they all felt, however, that what people told them was either exaggerated, minimized or not comparable to what they experienced. Many of the women said that nothing can prepare you for the intensity of the fatigue and exhaustion postpartum. Some of the women also reported that they had expected to bond with their child immediately after birth, if not during the pregnancy, and how that was not necessarily the case for them. This is probably one of the most common myths about becoming a mother. For many women it takes time until they feel like they know their child and truly develop a bond. The lack of this expected immediate connection can lead to disappointment, feelings of failure, and self-criticism; more specifically, these

myths can be a contributing source of self-stigmatization among young mothers. Future research should examine the popular beliefs about the “immediate” mother-child connection after birth and how this myth influences the emotional state of a new mother.

Even though so much time and effort was invested in education, there were still some discrepancies between what the women expected the process to be like and how it actually turned out to be. All of the women described how much literature they acquired and read and many of them had doulas or midwives, but they still could not prepare themselves completely. For many of them, trying to distance themselves from the medicalized procedure and attempts to create a different experience gave them a sense of control, but as shown in some of the cases, the control can be easily lost.

When a medical procedure was necessary in Jessica’s case, she said she felt passive and cheated, which supports Fox and Warts’ (1999) theory that medicalized childbirth alienates the woman from the process. Especially the fact that Jessica did not receive proper education about the possibility of surgical intervention and what exactly it involves turned her C-section into a distressing experience. This example shows that comprehensive education from her healthcare provider could have probably made the experience less traumatizing. As Beck and Watson Driscoll (2006) argued, traumatic birth experiences can be an influencing factor in postpartum depression, which might have been one factor in Jessica’s depressive episodes. The number of women having negative birthing experiences due to medical intervention and/or lack of communication by their

doctors was surprising. While my study is not aimed to be generalized and my sample might be skewed, these findings support Block's (2007) claims that birth has become increasingly standardized and medicalized in the United States. The medical community needs to reassess their view of the birthing experience and take a close look at the intervention-model. The use of Pitocin reported in this study seems to have had a strong influence on how many additional interventions followed and on how the women experienced the birth. It appears that the negative effects, on at least the women in this case, outweigh the benefits of this drug. Considering how prevalent the use of Pitocin is and how standardized the medical approach to birth has become in the United States, this should be further examined from a medical, psychological and also a sociological paradigm. Future studies should also focus on the intervention-model during birth and its consequences, as well as the effects midwives and doulas have on the event.

The immediate family and the support from their partners had a large impact on the well-being of the mothers, during the pregnancy itself, but especially in the postpartum period. Many of the women reported that they received a lot of support and help from their children's fathers. While some of them were afraid of being left by their boyfriends in the beginning, none of them actually were. The single women in this study did report feeling burdened doing it alone, and that it was frightening, but also drew strength from their experiences. Realizing that it might be hard, but possible, to get through the day by day on their own, left them feeling more confident and positive about themselves.

Positive reinforcement from family and friends reportedly played an important role for the women. In Natalie's case, her mother's negativity throughout the entire pregnancy reinforced her insecurities about becoming a parent. That her mother reportedly was not proud of her and even said that she had endangered her son's life, because she did not have an epidural, made it even harder for her. For women who became pregnant unintended, support from their partners, family and friends appeared to be of significant importance. Negative comments and doubts about their abilities voiced by people whose opinions the women value, unnecessarily reinforced fears and insecurities. In future studies, the importance of positivity for the well being of new mothers needs to be emphasized. All of the women seemed somewhat surprised by the strain put on their relationships and how exhausting and time-consuming life is with an infant. By idealizing what their family life would be like, they set themselves up for disappointment and had to renegotiate the dynamics in their relationships. Every aspect of their life had been affected and they had to get used to their new routines. As proposed by Byrd et al. (1998) and Olsson et al. (2005), comprehensive education about the potentially difficult transition to a new form of intimate relationship could be beneficial for couples and minimize the risk of disappointments in the postpartum period. For future research, I propose to examine prenatal couple's counseling and education and its effects on relationship satisfaction postpartum.

Half of the women in this study said they suffered from postpartum emotional difficulties. If clinically accurate, this is an alarming fact. Even though they all reported to have depressive symptoms, only five of the eight sought out

or received help by a professional. The women who did not talk to a doctor, hardly talked to anyone at all about what they were going through. The social stigma still attached to these very common problems needs to be annihilated categorically. It cannot be acceptable to society that so many women suffer in silence, because they either underestimate their problems, due to false information or feel like they are crazy or failing as mothers. Much research has been done on the frequency, the symptoms and the effects this illness has, but society still does not pay nearly enough attention. If even college educated women with access to proper health care are not seeking help, women with lower social status most likely are receiving even less support and attention. What is especially crucial to the well-being of the mothers is proper health care and access to it. Additionally to the social stigma still attached to mental illnesses, the self-stigmatization these mothers go through was especially alarming. The woman in this study who has bipolar disorder does not have health insurance and is, according to her, viewed as uninsurable by the providers she contacted to get insured. She did have Medicaid for a few weeks, but once she started working again, she lost that, too. She receives psychological care from a not-for-profit provider, but it is very irregular. She only gets to see her psychologist once every four weeks, if at all, which clearly is not enough, especially postpartum. Universal health care combined with public education about postpartum emotional problems could be an effective approach to better address this problem. Future research should focus on the effects comprehensive education about postpartum emotional difficulties and access to health care have on the

reporting patterns of women suffering from postpartum depression or similar illnesses.

The women's expectations about how their life is going to be like after birth were somewhat unrealistic. The discontent with weight gain and changes in their appearances is not surprising, bearing in mind how unlikely body ideals are being reinforced by out-of-reach media images of post-pregnancy celebrities, as well as by the unattainable beauty standards in today's society. Notions of attractiveness need to become more realistic and less destructive to women's self-conceptions. The last thing a new mother should have to worry about is how her belly looks and how tight her breasts are.

In conclusion, it became obvious how strongly intertwined the different themes found in this study are. If the pregnancy was intended or not made a strong impact on the women's emotional state throughout the pregnancy, and in some cases postpartum. The efforts to plan for the birth and to have a healthy pregnancy were met with disappointment, if control was lost. The way the birth went appeared to influence the emotional lives of the women substantially and gave them strength on one hand and on the other hand feelings of disappointment and failure when the event diverged significantly from the plan. Having high expectations for their performance during the birth and also regarding the postpartum period left some of the women discontent. This also applied to their changed bodies and "domestic" performance. Many of the women talked about how they struggled with keeping up the house and working on their appearance, which often led to self doubt. Throughout the entire process, social

support from their partners, families and friends showed to be of crucial importance to the well-being of the mothers. If one aspect in this picture diverged from the “ideal” situation, it impacted the entire process. The cultural norms regarding birth and motherhood seemed to be internalized by some of the women to the degree where these norms became their own values, and failure to meet these expectations resulted in self-blame and shame, namely self-stigmatization (Barney et al. 2006).

As mentioned before, the intense scrutiny women are under in American society shapes how women perceive themselves. It appears that diverging from the social norm is considered weakness or failure and is deemed unacceptable. A new mother is expected to automatically and immediately develop a bond with her child. She is not allowed to “let herself go”, to not diet to lose the “extra” weight instantaneously, to have a less than neat house. Struggling with her new identity and the changed relationship with her partner also appears to be not approved of. She either has to go back to work and excel there or has to be the perfect full-time mother who has everything under control. It is impossible to perform to society’s standards, which can lead to the sense of failure and insufficiency that many women suffer from. These fears and worries are reinforced and supported by the childbearing and baby-supplies industry, which relies on and caters to insecure parents, and especially mothers, to spend money to feel better about themselves. Self-stigmatization in regard to performance as a mother is a major problem. If women blame and stigmatize themselves for not being able to live up to society’s unrealistic standards, postpartum depression will

stay underreported, women will keep suffering from negative body images, and will keep feeling insufficient as mothers. This not only hurts the mothers and their children and families, but society as a whole. It appears that pregnancy and motherhood are an additional force of social control over women. Women have to meet certain standards (for example, gain weight during the pregnancy, but not too much, and then lose it immediately after, abstain from alcohol and certain foods, etc.) and if they are not in accordance with what at that moment is socially deemed appropriate, have to accept to be frowned upon. The exaggerated positive social myths about becoming a mother can be explained by the fact that society needs women to be willing to procreate to secure its survival. While this is certainly the case, it is important to evaluate the cost to the individual women, who are socialized to have expectations that cannot be met. We need to readjust our expectations of new mothers and women in general. The extreme contrast between the negativity in the medical environment and the unrealistically positive portrayal of motherhood today has to be diminished.

APPENDICES

1. Study Flyer
2. Interview Guide (Pilot Study)
3. Interview Guide (Current Study)
4. Pamphlet by Indiana Perinatal Network
5. IRB Letter of Approval
6. IRB Exempt Change Letter of Approval

FIRST-TIME MOTHERS NEEDED

EXPECTATIONS AND EXPERIENCES OF FIRST-TIME MOTHERS RESEARCH STUDY

Would you be interested in sharing your experiences of pregnancy, childbirth, and becoming a first time parent?

What expectations did you have and how did they compare to the reality of being a parent?

I AM INTERESTED IN YOUR STORY

I am a female IUPUI graduate student conducting a study for my M.A. thesis. I am interested in exploring expectations first-time mothers have and how they compare to their experiences.

Who can participate?

- ✚ Women who gave birth within the last 18 months
- ✚ Women between the ages 18 to 39
- ✚ Women who are willing to participate in a tape-recorded interview that will last 45min to 1 hour

Every participant's identity will be kept CONFIDENTIAL!!

Every participant will receive a \$10.00 TARGET Gift Card for a completed interview!

For more information, or to become a participant,
please e-mail Andrea at:
anfreund@iupui.edu

IRB APPROVAL # **EX0706-21B**

FIRST-TIME MOTHERS NEEDED

EXPECTATIONS AND EXPERIENCES OF FIRST-TIME MOTHERS BEFORE, DURING, AND AFTER PREGNANCY RESEARCH STUDY

Would you be interested in sharing your experiences of pregnancy, childbirth, and becoming a first time parent?

What expectations did you have and how did they compare to the reality of being a parent?

I AM INTERESTED IN YOUR STORY

I am a female IUPUI graduate student conducting a study for my M.A. thesis. I am interested in exploring expectations first-time mothers have and how they compare to their experiences.

Who can participate?

- ✚ Women who gave birth to a living within the last 18 months
- ✚ Women between the ages 18 to 39
- ✚ Women who are willing to participate in a tape-recorded interview that will last 45min to 1 hour

Every participant's identity will be kept CONFIDENTIAL!!
Every participant will receive a \$10.00 TARGET GIFT CARD for a completed interview!!

For more information, or to become a participant,
please email Andrea at:
anfreund@iupui.edu

IRB APPROVAL #

Qualitative Interview Protocol (Pilot Study)

Title: Expectations and Experiences of First Time Mothers Before, During and After
Pregnancy

Chair: Dr. Carol Brooks Gardner

Student: Andrea Freund

Department of Sociology

CA 303, 425 University Blvd.

Indianapolis, Indiana 46202

Phone: (317) 523-1863

E-mail: anfreund@iupui.edu

Pre-Screening Interview Protocol-Draft

The interview process will begin, when a potential interviewee contacts Andrea Freund about the study, through e-mail, in person or on the phone. Andrea Freund will make an introduction and then conduct a pre-screening to establish whether the person meets the eligibility requirements for this study. If eligible, Andrea Freund will then make an appointment for the interview.

1) Introduction

Hello, thank you for getting back to me. I am looking for women who recently gave birth to their first child and are willing to tell me about their experiences. The requirements for this study are the following:

- Women who gave birth to their first living child within the last 18 months
- Women between ages 18 to 39
- Women who are willing to participate in a tape-recorded interview that will last between 45min. to one hour.

If you meet these criteria and are interested in participating, I would be happy to hear from you. I am a 26 year old Sociology student in the graduate program of Indiana University – Purdue University Indianapolis and I am conducting this study for my M.A. thesis. I will be conducting the interview and I am especially interested in the experiences first time mothers make before, during and after pregnancy. After completing the interview, you will be compensated with \$10.00 Target gift card for your

time and effort and all the information will be treated with confidentiality. The findings from this study will assist further studies regarding childbirth and first time motherhood.

2) Pre-Screening Questions

First I have a few questions to determine whether you are eligible to participate in this study.

Screening Interview Questions	Must answer the following for eligibility
1. Are you female?	1. Yes
2. How old are you?	2. Must be between 18 and 29
3. When was your first child born?	3. Must be within the last 18 months

3) Schedule Interview

Once eligibility is established, either through e-mail or verbally, Andrea Freund will schedule an appointment to the participant's convenience.

Can we schedule an interview? When would be a good time for you? I could either come to your home or I could reserve a room at the university or at another private setting. If you don't mind I would be sending you a reminder e-mail with the chosen location and time one day before the interview. If you have any questions or have to postpone the appointment, please feel free to write or call me.

Interview Protocol

4) Introduction

I would like to thank you for coming / having me today. I also want to thank you for participating in this study. Have you ever been interviewed before or is this a new experience for you? I am conducting this study to better understand the experiences women make when they go through they are becoming a mother for the first time. Any findings of this study could help further studies on experiences first time mothers make.

5) Interviewer / Interviewee Role

It is important to me that you feel comfortable and see this as your interview. I am interested in your personal experiences, feelings and opinions and my main role today will be to listen to what you have to say. Please feel free to share whatever comes to your mind. My job will be to accurately record your experiences and thoughts and to understand what these experiences and thoughts mean to you.

6) Explain Taping Procedure

As I mentioned before I will audiotape this interview to achieve accuracy and to allow me to actively listen to what you have to say and won't be distracted by trying to write everything down. Is that okay for you? If it is not okay, I will write down what you will be saying as accurately as possible.

7) Assure Interviewee of Confidentiality

Please feel free to speak openly. This interview will be treated with respect and will be absolutely confidential. Your name and any other information that might make you identifiable will be not be included in my report. In case you don't want to answer a certain question you may simply say "pass" and we will move on. We can also return to a question later if you like.

8) Time Frame of Interview

The interview will approximately last 45 minutes to one hour. If you want to take a break, feel free to let me know. The restrooms are... and smoking areas are...and the baby-nursing and -changing areas are....

9) Questions

This was all I had to talk about before we start the interview. Do you have any questions about the interview? Okay, let's begin. I will now start the tape recorder. I have a few background questions, main questions and closing questions. In case you have any question at the end of the interview, I will be happy to answer them.

10) Background Questions

- a) How old are you? (Must be between 18 and 29)
- b) How old is your child? (Must not be older than 18 months)
- c) How would you describe your and your child's ethnicity?
- d) What is your martial status? (Probe for single, divorced, or separated)
- e) Are you in a partnership? (Probe for cohabiting)
- f) What is your highest educational background?
- g) What is your occupation at the moment? (Probe for occupation during pregnancy and after giving birth)

11) Main Questions

Thank you; let's now get to the main part of the interview. My goal is to understand how women experience pregnancy and becoming a parent for the first time and how they perceive those experiences in hindsight.

AIM ONE: The following questions will meet aim one, which is to describe the experiences first time mothers have during and after pregnancy.

a) Please tell me about your thoughts and feelings about giving birth and becoming a mother when you learned that you were pregnant.

Prompt: What was it like? What happened next?

Possible follow-up questions include:

- i) How about your thoughts and experiences after you gave birth?

b) Could you tell me about your pregnancy?

Prompt: What was that like?

Possible follow-up questions include:

- i) What kind of information did you receive or seek?

Prompt: Doctors, books, educational movies, family, friends, etc.

c) What were the most positive and negative experiences about your pregnancy and becoming a mother?

Prompt: What made that a positive experience for you?

Prompt: What made that a negative experience for you?

AIM TWO: The following questions will meet aim two, which is to explore expectations first time mothers have and how they compare to reality.

d) When you compare what you had heard and what you expected about giving birth and becoming a mother to your experiences, what would you say was true in your case and what was different?

Prompt: Could you give me any specific examples?

Possible follow-up questions include:

- i) Where did you hear about that?
- ii) What made you expect that?

In case the child has disabilities:

- iii) Did you know before the birth that your child would have a disability?
- iv) What kind professional help was available to you?
- v) How did you receive information about your child's disability?

e) What were you expecting your life to be like after giving birth?

Prompt: What were the most drastic changes you expected to happen and how do they compare to what actually changed?

Prompt: What changes did you not expect and how did they affect you in a positive or negative way?

Possible follow-up questions include:

- i) Can you tell me what made you expect that?
- ii) How did you react to these changes?

f) Many women experience emotional difficulties before and after giving birth, e.g., the baby blues. What, if at all, were your experiences with the baby blues?

Prompt: Could you tell me more about that?

Possible follow-up questions include:

- i) If yes: What kind of help and information did you receive and from whom? How did that help you?
- ii) If no: What kind of information did you receive about the possibility of the baby blues and postpartum depression during your pregnancy?

12) Closing Question

g) In case you would get pregnant again, what part did you most enjoy? And what would you want to be different? What would you wish you would have known the first time?

Prompt: Could you please give me a specific example for that?

Possible follow-up questions include:

- i) What advice would you give a woman, who is pregnant for the first time?

We are now at the end of the interview. Is there anything we didn't cover that you would want to add before we finish recording? Feel free to give me feedback and make suggestions regarding what I might have not asked that is of importance to you.

13) Provide \$10.00 Target Gift Card and Thank the Interviewee

Thank you again for agreeing to participate. Here is the Target gift card to thank you for your time.

Thank you again for talking to me. The information you provided will be very helpful. You may contact me if you have any further questions or comments. I will be happy to send you a copy of the transcript of this interview and if you have any objections or feel that something is misrepresented, please let me know.

Thank you for taking the time out of your busy schedule.

Qualitative Interview Protocol (Current Study)

Title: Expectations and Experiences of First Time Mothers

Before, During and After Pregnancy

Chair: Dr. Carol Brooks Gardner
Student: Andrea Freund
Department of Sociology
CA 303, 425 University Blvd.
Indianapolis, Indiana 46202
Phone: (317) 523-1863
E-mail: anfreund@iupui.edu

Pre-Screening Interview Protocol-Draft

The interview process will begin, when a potential interviewee contacts Andrea Freund about the study, through e-mail, in person or on the phone. Andrea Freund will make an introduction and then conduct a pre-screening to establish whether the person meets the eligibility requirements for this study. If eligible, Andrea Freund will then make an appointment for the interview.

14) Introduction

Hello, thank you for getting back to me. I am looking for women who recently gave birth to their first child and are willing to tell me about their experiences. The requirements for this study are the following:

- Women who gave birth to their first living child within the last 18 months
- Women between ages 18 to 39
- Women who are willing to participate in a tape-recorded interview that will last between 45 min. to one hour.

If you meet these criteria and are interested in participating, I would be happy to hear from you. I am a 26 year old Sociology student in the graduate program of Indiana University – Purdue University Indianapolis and I am conducting this study for my M.A. thesis. I will be conducting the interview and I am especially interested in the experiences first time mothers make before, during and after pregnancy. After completing the interview, you will be compensated with \$10.00 Target gift card for your

time and effort and all the information will be treated with confidentiality. The findings from this study will assist further studies regarding childbirth and first time motherhood.

15) Pre-Screening Questions

First I have a few questions to determine whether you are eligible to participate in this study.

Screening Interview Questions	Must answer the following for eligibility
1. Are you female?	1. Yes
2. How old are you?	2. Must be between 18 and 29
3. When was your first child born?	3. Must be within the last 18 months

16) Schedule Interview

Once eligibility is established, either through e-mail or verbally, Andrea Freund will schedule an appointment to the participant's convenience.

Can we schedule an interview? When would be a good time for you? I could either come to your home or I could reserve a room at the university or at another private setting. If you don't mind I would be sending you a reminder e-mail with the chosen location and time one day before the interview. If you have any questions or have to postpone the appointment, please feel free to write or call me.

Interview Protocol

17) Introduction

I would like to thank you for coming / having me today. I also want to thank you for participating in this study. Have you ever been interviewed before or is this a new experience for you? I am conducting this study to better understand the experiences women make when they go through they are becoming a mother for the first time. Any findings of this study could help further studies on experiences first time mothers make.

18) Interviewer / Interviewee Role

It is important to me that you feel comfortable and see this as your interview. I am interested in your personal experiences, feelings and opinions and my main role today will be to listen to what you have to say. Please feel free to share whatever comes to

your mind. My job will be to accurately record your experiences and thoughts and to understand what these experiences and thoughts mean to you.

19) Explain Taping Procedure

As I mentioned before I will audiotape this interview to achieve accuracy and to allow me to actively listen to what you have to say and won't be distracted by trying to write everything down. Is that okay for you? If it is not okay, I will write down what you will be saying as accurately as possible.

20) Assure Interviewee of Confidentiality

Please feel free to speak openly. This interview will be treated with respect and will be absolutely confidential. Your name and any other information that might make you identifiable will be not be included in my report. In case you don't want to answer a certain question you may simply say "pass" and we will move on. We can also return to a question later if you like.

21) Time Frame of Interview

The interview will approximately last 45 minutes to one hour. If you want to take a break, feel free to let me know. The restrooms are... and smoking areas are...and the baby-nursing and -changing areas are....

22) Questions

This was all I had to talk about before we start the interview. Do you have any questions about the interview? Okay, let's begin. I will now start the tape recorder. I have a few background questions, main questions and closing questions. In case you have any question at the end of the interview, I will be happy to answer them.

23) Background Questions

- h) How old are you? (Must be between 18 and 29)
- i) How old is your child? (Must not be older than 18 months)
- j) How would you describe your and your child's ethnicity?
- k) What is your marital status? (Probe for single, divorced, or separated)
- l) Are you in a partnership? (Probe for cohabiting)
- m) What is your highest educational background?

- n) What is your occupation at the moment? (Probe for occupation during pregnancy and after giving birth)

24) Main Questions

Thank you; let's now get to the main part of the interview. My goal is to understand how women experience pregnancy and becoming a parent for the first time and how they perceive those experiences in hindsight.

AIM ONE: The following questions will meet aim one, which is to describe the experiences first time mothers have during and after pregnancy.

- h) Please tell me about your thoughts and feelings about giving birth and becoming a mother when you learned that you were pregnant.**

Prompt: What was it like? What happened next?

Possible follow-up questions include:

- j) How about your thoughts and experiences after you gave birth?
- i) Could you tell me about your pregnancy?**

Prompt: What was that like?

Possible follow-up questions include:

- ii) What kind of information did you receive or seek?
- Prompt:* Doctors, books, educational movies, family, friends, etc.
- j) What were the most positive and negative experiences about your pregnancy and becoming a mother?**

Prompt: What made that a positive experience for you?

Prompt: What made that a negative experience for you?

AIM TWO: The following questions will meet aim two, which is to explore expectations first time mothers have and how they compare to reality.

- k) Can you describe the experiences you already had with childrearing before you had your own child, for example, younger siblings or babysitting responsibilities?**

Prompt: How did that influence your ideas about being a parent?

- l) When you compare what you had heard and what you expected about giving birth and becoming a mother to your experiences, what would you say was true in your case and what was different?**

Prompt: Could you give me any specific examples?

Possible follow-up questions include:

- vi) Where did you hear about that?
- vii) What made you expect that?

- m) What were you expecting your life to be like after giving birth?**

Prompt: What were the most drastic changes you expected to happen and how do they compare to what actually changed?

Prompt: What changes did you not expect and how did they affect you in a positive or negative way?

Possible follow-up questions include:

- iii) Can you tell me what made you expect that?
- iv) How did you react to these changes?

- n) Many women talk about the changes before and after giving birth. What, if at all, were your experiences with ...?**

- 1) Physical changes?**
- 2) Mental changes?**
- 3) Emotional changes?**
- 4) Social changes?**

Prompt: Could you tell me more about that?

25) Closing Question

- o) In case you would get pregnant again, what part did you most enjoy? And what would you want to be different? What would you wish you would have known the first time?**

Prompt: Could you please give me a specific example for that?

Possible follow-up questions include:

- i) What advice would you give a woman, who is pregnant for the first time?

We are now at the end of the interview. Is there anything we didn't cover that you would want to add before we finish recording? Feel free to give me feedback and make suggestions regarding what I might have not asked that is of importance to you.

26) Provide \$10.00 Target Gift Card and Thank the Interviewee

Thank you again for agreeing to participate. Here is the Target gift card to thank you for your time.

Thank you again for talking to me. The information you provided will be very helpful. You may contact me if you have any further questions or comments. For my paper I will use pseudonyms, when I am talking about you and your child. Would you like to choose those names? These names are supposed to protect your privacy and to ensure confidentiality. Thank you for taking the time out of your busy schedule.

Something's

NOT RIGHT...

The Indiana Perinatal Network (IPN) is an alliance of hundreds of individuals and organizations across Indiana committed to the beliefs that:

- Every mother deserves a healthy and safe pregnancy; and
- Every baby deserves to be born healthy and into a safe and nurturing home.

IPN serves to promote and protect the health and safety of mothers, babies and families through consensus building, education and collaborative partnerships among public and private organizations.



SAD?

NEW MOM?

PREGNANT?

ANXIOUS?



INDIANA
PERINATAL
NETWORK

www.indianaperinatal.org
ph: 317.924.0825

Funded by Title V through the
Indiana State Department of Health
Maternal and Child Health Services



Indiana State
Department of Health

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Rev 0806

**You're not alone.
You can get help...**

Baby Blues

The “baby blues” is very common and can begin soon after birth. More than half of new mothers cry and feel overwhelmed, sad, angry and nervous. Some women have lots of ups and downs—like a roller coaster.

“Baby blues” usually goes away in less than two weeks. Take good care of yourself. Ask for and accept help from others. Let your health care provider know if the blues last more than two weeks.



“I haven’t smiled in a month...”

Depression

Depression is worse than the baby blues and lasts longer. It can be treated with caring support, medication and by talking with a counselor. The depression may begin during pregnancy, soon after pregnancy or anytime in the year after birth. About one in ten new mothers feels depressed for more than a couple of weeks.

Depression can be caused by physical changes related to pregnancy and child birth. Let your health care provider know if you experience any signs of depression. They will help you get the treatment that is best for you.

Be aware of the signs of depression and get help as quickly as possible.

1

Resources

Please check with your local hospital for resources.

HELPFUL WEBSITES

- **Postpartum Support International (PSI):** www.postpartum.net, 800.944.4PPD (773)
- **Indiana Perinatal Network:** www.somethingsnotright.org

RECOMMENDED READING

- *Beyond the Blues: A Guide to Understanding & Treating Prenatal & Postpartum Depression*—S. Bennett and P. Indman, 2003
- *Conquering Postpartum Depression, A Proven Plan for Recovery*, 2003—R. Rosenberg, MD
- *The Mother-to-Mother Postpartum Depression Support Book*—S. Poulin, 2006
- *The Postpartum Husband*—K. Kleiman, 2001
- *Pregnancy Blues: What Every Woman Needs to Know about Depression During Pregnancy*—S. Misri, 2005
- *This Isn't What I Expected: Recognizing & Recovering from Depression & Anxiety After Childbirth*—Kleiman, K. & V. Raskin, 1994
- *Women's Moods...What Every Woman Must Know About Hormones, the Brain & Emotional Health*—Sichel, D. & Driscoll, J.W., 2000



6

How Does My Mood Affect My Baby?

If you are depressed, you:

- May have trouble taking care of your baby's basic needs.
- May have trouble bonding or "falling in love" with your baby.
- May not have the energy to talk, sing or play with your baby.

"Good mothers don't think this way. What's wrong with me?"

Getting Help

Get professional help from a health care provider who knows about treating depression during and after pregnancy.

For help and more information, call the
Indiana Family HelpLine
800.433.0746

A MESSAGE FOR DAD, FAMILY & FRIENDS

- Help mom get time for herself by caring for the baby and other children, and preparing meals.
- Ask for help from family and friends.
- Let mom talk about her feelings.
- Encourage her to get help or get it for her if she is not getting better—don't wait!

5

Remember This

Every mother is different, but every mother needs support. If you or someone you know is experiencing depression during or after pregnancy, help is available.

Mothers expect to adjust easily to the birth of their new baby. But, many mothers aren't ready for the emotions and feelings they may have before and after giving birth.

Depression during and after pregnancy can include a wide range of feelings. It is the number one complication of pregnancy...

SIGNS OF DEPRESSION

- | | |
|--|---|
| <input type="checkbox"/> Crying | <input type="checkbox"/> Feelings of guilt |
| <input type="checkbox"/> Anxiousness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Loss of or change in appetite | <input type="checkbox"/> Thoughts of hurting self or baby |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Rapid mood swings |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Frightening thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Feeling "speeded up" |

2

You Are Not Alone

Depression during and after pregnancy (sometimes called *Postpartum Depression*) can be treated. Let your health care provider know if you experience any of the signs mentioned. They will help you get the treatment that is best for you.

Some women think...

"My baby doesn't love me; I should put him up for adoption..."

"I'm not a good mother."

"I just want to run away!"

"I'm afraid I might hurt my baby or myself."



3

Remember
This
You are not alone.
Depression can be
treated.

Taking Good Care of Yourself Helps You Care for Your Baby

SLEEP

- Try to get a good night's sleep.
- Sleep when the baby sleeps.
- Limit your caffeine after 12 noon.
- If you smoke, stop smoking two to three hours before bedtime.

EAT

- Eat good foods—grains, fruits, vegetables, protein and dairy.
- Eat small amounts at a time, several times a day, if you have a poor appetite.
- Make sure you drink a quart of water/juice a day.

TAKE TIME FOR YOURSELF

- Try to take time every day just for you.
- Ask for and accept help from others. If you can, let someone else take care of the baby for a while—take time away from the baby each day.
- Laugh and see the funny things in life.
- Exercise—even if it's just walking around the block.

GET SUPPORT

- Talk about your thoughts and feelings with someone who cares about you. It's okay to cry.
- You may find support online, in a support group, at church or with family and friends.
- You might keep a journal or diary to help express your feelings.

4

INTERDEPARTMENTAL COMMUNICATION
Research Compliance Administration
Indiana University-Purdue University Indianapolis

DATE: June 13, 2007
TO: Dr. Carol Gardner Brooks
Sociology
CA 303
IUPUI
FROM: Regina Wininger
Research Compliance Administration
UN 618
IUPUI
SUBJECT: IUPUI/Clarian Institutional Review Committee - Exempt Review of
Human Study
Study No.: EX0706-21B
Study Title: "Expectations and Experiences of First-Time Mothers (Qualitative
Interview Study)"

Your application for approval of the study named above has been accepted as meeting the criteria of exempt research as described by Federal Regulations [[45 CFR 46.101\(b\), paragraph 2](#)]. A copy of the acceptance is enclosed for your file. If the research is conducted at or funded by the VA, research may not be initiated until approval is received from the VA Research and Development Committee.

Please contact the Indiana University School of Medicine Office of Compliance Services for information regarding a Data Use Agreement, if applicable.

Although a continuing review is not required for an exempt study, prior approval must be obtained before change(s) to the originally approved study can be initiated. When you have completed your study, please inform our office in writing.

When corresponding with our office regarding this study, please refer to the exact study number and title.

If you should have any questions, please contact our office at 317-274-8289.

Enclosures: Copy of acceptance

INTERDEPARTMENTAL COMMUNICATION
Research Compliance Administration
Indiana University-Purdue University Indianapolis

DATE: November 28, 2007

TO: Dr. Carol Gardner Brooks
Sociology
CA 303E
IUPUI

FROM: Regina Wininger
Research Compliance Administration
UN 618

SUBJECT: IUPUI Institutional Review Board – Proposed Changes to an Exempt Study

Study No.: EX0706-21B

Study Title: “Expectations and Experiences of First-Time Mothers (Qualitative Interview Study)”

Your request to add written interviews via e-mail for this study was received. It was determined that the exempt status of this study will not be altered by this change. Therefore, the change you have proposed is accepted and may be initiated immediately.

If you make any other changes to this study, please contact our office. Also, when you have completed your study, please let us know in writing.

If you have any questions, please contact our office.

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