

**THE BREASTFEEDING EXPERIENCES
OF OLDER FIRST-TIME MOTHERS:
A CONSTRUCTIVIST GROUNDED THEORY STUDY.**

By

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Abstract

Background: In Canada over the past three decades first-time mothers ≥ 35 years have been, and continue to be, the fastest growing demographic of new mothers. The quality of a mother's breastfeeding experience has the potential to affect breastfeeding duration and other mothering behaviours that promote healthy maternal-infant attachment, optimal infant growth and development, and maternal mental health. Previous studies on breastfeeding have not examined the breastfeeding experiences of older first-time mothers. Older mothers are a group that is potentially unique due to their experience of coming to motherhood in the context of the growing phenomenon of delayed childbearing in the 21st century. Older women often come to motherhood with both well-established life and professional experiences, and as such may have different needs from those of their younger or multiparous counterparts.

Research Question: What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?

Design: A constructivist grounded theory study

Findings: The theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* provides an explanation of both the factors affecting the decisions the mothers made related to breastfeeding, and how these factors affected the decisions they ultimately made. The mothers worked through the processes of learning breastfeeding, redefining self, and defining motherhood. This occurred under the belief that breastfeeding is pivotal to motherhood. Over the first six months postpartum, the influence of the belief in breastfeeding defining mothering waned as the mothers became increasingly active agents in decision making around infant feeding and their overall mothering practices.

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Glossary of Terms

Attachment Parenting: A parenting philosophy that advocated for proximity-based parenting and emphasises mother-child bonding through mothering practices including breastfeeding, baby-wearing, and co-sleeping (Sears & Sears, 2001)

Breastfeeding: Feeding of any human milk to an infant (can include donor milk).

Breastfeeding Duration: Length of time an infant is breastfed (any breastfeeding- for the purpose of this study breastfeeding duration is not limited to exclusive breastfeeding).

Breastfeeding Ideology: Normative beliefs and values related to breastfeeding in Western culture, western media, social media, and breastfeeding/health promotion.

Breastfeeding Initiation: Any mother “who breastfed or tried to breastfeed” for any period of time (Statistics Canada, 2013) and/or evidence that the infant received any human milk via breastfeeding, expressed breast milk, or donor milk (Breastfeeding Committee for Canada [BCC], 2012).

Early Motherhood: Refers to the period from birth to six months postpartum.

Exclusive Breastfeeding: Exclusive breastfeeding refers to exclusive feeding of human milk to infants, without the addition of water, breast milk substitutes, other liquids and/ or solid foods, with the exception of oral rehydration solution and vitamins, minerals and/or medicines (BCC, 2012).

Infant Feeding: Infant feeding includes any breastfeeding, mixed feeding (breast milk and formula) and/or exclusive formula feeding.

Lactivism: “Strong advocacy for breastfeeding (sometimes used with a negative connotation, suggesting an uncompromising approach)” (Oxford Dictionary, 2019). Early 21st century term merging lactation and activism.

Older First-Time Mother: Any woman who at the time of her first live birth was aged 35 or older.

Practice Level Nursing Theory (also known as Situation Specific Theory): “Theories that focus on specific nursing phenomena that reflect clinical practice and that are limited to specific populations or to a particular field of practice. These theories are socially and historically contexted: they are developed to incorporate, not transcend time, or social or political structures” (Meleis, 2012, pg. 34).

Breastfeeding Committee for Canada (2012). *Breastfeeding Definitions and Data Collection Periods*. Retrieved from http://breastfeedingcanada.ca/documents/BCC_BFI_Breastfeeding_Definitions_and_Data_Collection_English.pdf

Meleis, A. (2012). *Theoretical Nursing: Development and Process, 5th Ed.* Philadelphia, PA: Wolter Kluwer Health/Lippincott Williams & Wilkins.

Oxford English Dictionary (2019). Definition: Lactivism. Retrieved from <http://en.oxforddictionary.com/definition/lactivism>

Sears, W. & Sears, M. (2001). *The attachment parenting book: A common sense guide to understanding and nurturing your baby*. New York: Little, Brown and Company.

Statistics Canada (2013). Breastfeeding trends in Canada. Retrieved from www.statcan.gc.ca/pub/2-624-x/201300/article/11879-eng.htm

CHAPTER ONE

Organization of Thesis and Introduction

Organization of Thesis

This thesis is organized in a manuscript-based style. The introduction in Chapter One provides background to the clinical issue, situates the researcher, and introduces the research problem and research question. Chapter Two has a full explanation of the methods utilized in this study, including the constructivist grounded theory methodology, the sensitizing concepts, research design, data collection, data analysis, and considerations of rigour. Chapter Three presents the study findings, which include the codes and demographic data from the interviews. Chapter Four *The Breastfeeding Experiences of Older First-time Mothers: A Constructivist Grounded Theory Study* is the manuscript about the study and introduces the theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother*. Chapter Five contains the manuscript of the literature review on the phenomenon of delayed childbearing in Canada entitled *An Exploration of the Current State of the Literature on the Growing Phenomenon of Delayed Childbearing in Canada and Other Developed Countries: A Narrative Literature Review*. In keeping with constructivist grounded theory methodology, the comprehensive literature review was conducted following the completion of the data collection and analysis. The literature review presented in Chapter Five was used mainly to inform and provide context for the discussion of the results. The manuscript entitled *Supporting Older First-time Mothers with Breastfeeding and Becoming a Mother: Insights for Clinical Practice* which explores the clinical implications and recommendations based in the findings of this study is found in Chapter Six. The final chapter, Chapter Seven, contains the summary of the

integration of results, study limitations, recommendations for future research, and the conclusion of the dissertation.

Introduction

Since the 1990s there has been a growing trend in developed countries towards women delaying childbearing, with increasing numbers of new mothers being over the age of 35 at the time of first live birth (Best Start [BS], 2015; Canadian Institute for Health Information [CIHI], 2011; Mills, Smith & Lavender, 2012). In 2018, one in five live births (23% of total births) in Canada was to a mother over the age of 35 (Statistics Canada (SC), 2018A), with first births to women over 35 accounting for 11% of all Canadian births (Society of Obstetricians and Gynecologists of Canada [SOGC], 2012). This number represents an increase of 47% over the number of live births to women over the age of 35 in 1998 (BS, 2015; CIHI, 2011). In the province of Ontario alone, births to women over 35 years of age in 2014-2016 accounted for a quarter of all births (23.1% of all hospital births) in Ontario, with 15.1% of those births being to first-time mothers 35 years of age or over (Better Outcomes Registry & Network [BORN] Ontario, 2019). The phenomenon of women delaying childbearing into their mid-30s to early 40s is driven by a multitude of complex and interrelated social, economic, and cultural forces (BS, 2015; Lemoine & Ravitsky, 2015). These factors include, but are not limited to, higher levels of educational attainment, changes in the role of marriage and romantic relationships, and career opportunities (BS, 2015; Southby, Cooke & Lavender, 2019).

Older mothers are a group of first-time mothers with a unique set of experiences related to delayed childbearing, who experience an increased incidence of pregnancy and birth related complications that could negatively affect early breastfeeding (Brown & Jordan, 2012). Due to higher rates of maternal and infant morbidities that are correlated with poor breastfeeding

outcomes, mothers over the age of 35 are especially at risk for early breastfeeding cessation (BS, 2015; Brown & Jordan, 2012; CIHI, 2011; Fisher et al., 2013). Despite representing approximately 11% of new mothers in Canada (SC, 2018B), the expectations, experiences, and factors influencing the decision making process about the breastfeeding practices and beliefs of older first-time mothers are poorly understood and not represented in the literature (Cooke et al., 2012).

Clinical Significance. The breastfeeding experiences of older first-time mothers, have the potential to both negatively and positively affect breastfeeding duration. Breastfeeding experiences can also affect mothering behaviours that influence maternal-infant attachment, infant growth and development, infant mental health, maternal role transition, and maternal mental health (Chalmers, & Royle, 2009). Older first-time mothers may experience breastfeeding and breastfeeding support differently than their younger or multiparous counterparts due to their different life experiences prior to childbearing and parenting. Research about the expectations, experiences, and factors influencing decision-making processes about the breastfeeding practices of older women is largely absent from the literature. It is important to understand the experiences and needs of this growing group of mothers in order to provide both appropriate breastfeeding support and appropriate supports for their role-transition to early motherhood.

This study utilized Charmaz's (2014) constructivist grounded theory (CGT) methodology to explore older first-time mothers' breastfeeding experiences, the associated transition to motherhood, and the factors influencing their decision-making processes related to feeding their infants over the first six months postpartum. The purpose of this study was to explore the multiple factors that affect older first-time mothers' expectations, experiences, and decision-

making about breastfeeding. The aim of this study was to generate a theory grounded from the data, exploring the factors influencing the decisions the older first-time mothers were making related to breastfeeding.

The theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* was developed from the study findings. This substantive theory is being proposed to act as a theoretical basis to inform future evidence-based nursing practices related to breastfeeding support, health promotion, and targeted interventions for this population.

Research Question. What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?

Sub-Questions.

- 1/ What are the prenatal expectations about breastfeeding of first-time mothers ≥ 35 years of age?
- 2/ What are the factors influencing the choices first-time mothers ≥ 35 years of age make about feeding their infants in the first six months postpartum?
- 3/ What are the facilitators and barriers affecting the decisions first-time mothers ≥ 35 years of age make about breastfeeding their infants in the first six months postpartum?
- 4/ Given the decisions that are made about breastfeeding, what do first-time mothers ≥ 35 years of age identify as their achievements and regrets about their experience breastfeeding their infants in the first six months postpartum?

Summary of the Literature

The summary of the literature on breastfeeding was conducted to inform the research proposal and initial stages of study design. A comprehensive literature review on the

phenomenon of older first-time motherhood was completed following data analysis and is presented in Chapter Five. The review presented below provides a summary of the literature from the years 2004-2018 from the CINAHL, PUBMED, and EMBASE databases on the topics of breastfeeding, breastfeeding supports, and practices. Due to the large volume of literature published in the last fourteen years related to breastfeeding, the articles included in this literature review were limited to those on the mother's experiences of breastfeeding, and the factors influencing their breastfeeding practices. Only publications in English from North America, Europe, Australia, and New Zealand were included, with the understanding that that the breastfeeding and health promotion culture is similar in these regions. Articles related to mothers of infants requiring neonatal intensive care, premature infants, and/or medically complex infants were excluded from this review. The focus of this review is on breastfeeding in general, as this review was conducted primarily to inform the research proposal. For the complete narrative literature review on the phenomenon of delayed childbearing and first-time motherhood for women 35 years of age and over in Canada, see Chapter Five for the manuscript of the article entitled *An Exploration of the Current State of the Literature on the Growing Phenomenon of Delayed Childbearing in Developed Countries: A Narrative Literature Review*.

An online search was also conducted for Canadian federal and provincial government statistics on rates of pregnancy, live births, breastfeeding initiation, duration, and exclusivity rates, and for international and national reports on breastfeeding promotion, specifically the World Health Organization's (WHO) Baby Friendly Initiative. A hand search of relevant articles and publications related to women's experiences of breastfeeding was conducted from the reference lists of the peer reviewed articles included in the literature review.

The interconnectedness of mothers and their breastfeeding practices to their larger social, cultural, political, and historical contexts was found to be the overarching theme in the literature on breastfeeding. The review is organized according to sub-themes found in the literature: 1) maternal internal and external resources, 2) expectations versus realities, 3) breastfeeding and becoming a mother, and 4) breastfeeding and professional supports.

Maternal Internal and External Resources. Hospital practices that encourage early breastfeeding, such as the adoption of practices based on the WHO's and the United Nations Children's Fund's (UNICEF) Baby Friendly Initiative are positively correlated with the high percentage of new mothers who initiate breastfeeding in North America (Burns, Fenwick, Sheehan & Schmeid., 2013; Semenic, Loiselle & Gottlieb, 2008). However, these practices and policies are not translating into comparable rates for breastfeeding duration. Breastfeeding duration has been found to be a complex multifactorial interplay of maternal internal and external resources including role modeling, peer, family, and professional supports, as well as the mother's emotional resources (Bomer-Norton, 2013; de Jager, Skouteris, Broadbent, Amir & Mellor, 2014; Dennis, 2006).

A new mother's confidence in her body's ability to nourish her infant, or her breastfeeding self-efficacy, is critical to her ability to breastfeed (Andrews & Harvey, 2011; Bomer-Norton; 2013; Craig & Dietsch, 2010; de Jager et al., 2014; Dennis, 2006; Meedy, Fahy & Kable, 2010). As such, nursing practices that undermine a new mother's sense of confidence have the potential to negatively affect breastfeeding outcomes (Avishai, 2007; Craig & Dietsch, 2010; Semenic et al., 2008).

While the majority of new mothers in Canada initiate breastfeeding, duration has been found to be highly dependent on the individual mother's level of commitment and her

expectations related to breastfeeding and knowledge of normal newborn behaviour and feeding patterns (de Jager et al., 2014; Dennis, 2006). The normalization of breastfeeding through identification with other mothers has been found to increase mothers' feelings of control, confidence, and realistic expectations related to breastfeeding (Andrews & Harvey, 2011; Bevan & Brown, 2013; Nelson, 2006).

Expectations versus Realities. A recurrent theme in the literature was women's lack of knowledge regarding early breastfeeding and subsequently women reporting experiencing a disconnect between their expectations and the realities of breastfeeding (Hinsliff-Smith, Spencer & Walsh, 2014; Ludlow et al, 2012; Marshall, Godfrey & Renfrew, 2007; Semetic et al., 2008; Shakespeare, Blake & Garcia, 2004). This divide between the expectations and the realities of early breastfeeding has been found to be partially due to a lack of knowledge regarding normal newborn behaviour, and to worries related to fears of not knowing how to breastfeed *right*, thus beginning the breastfeeding relationship with anxiety (Craig & Dietsch, 2010; Dykes, 2005; Hinsliff-Smith et al., 2014; Ludlow et al, 2012; Marshall et al., 2007). Women are learning the technical skills of breastfeeding in hospital, yet are largely unprepared for the intense emotional and physical involvement of early breastfeeding (Marshall et al., 2007; Nelson, 2006; Shaw, 2004).

Breastfeeding and Becoming a Mother. In the current literature on early motherhood there is a recurrent link between the western cultural ideal of the risk-adverse, or *good mother* and breastfeeding (Avishai, 2007; Charbrol et al., 2004; Crossley, 2009). Despite the fact that the majority of mothers do not breastfeed for the recommended 6 months to 2 years, the dominant cultural ideal of motherhood is the mother who breastfeeds (Charbrol et al., 2004; Crossley, 2009; Dykes & Flacking, 2010; Ludlow et al., 2012). How she is meeting social and

cultural expectations has been found to have an effect on how confident a woman will be in her mothering abilities (Brouwner, Drummond & Willis, 2012; Knaak, 2010; Lee, 2008; Leeming, Williams, Lyttle & Johnson, 2013). Breastfeeding is an integral component of emerging maternal identity and has the potential to positively or negatively affect maternal feelings of competence and mental health (Andrew & Harvey, 2011; Brouwner et al., 2012; Marshall et al., 2007; Spencer, 2008; Ward, 2004).

Women's experience of guilt related to infant feeding and mothering are an underlying theme in the literature on breastfeeding promotion, duration, and cessation (Crossley, 2009; Hinsliff-Smith et al., 2014; Ludlow et al., 2012; Ward, 2004; Wirihana & Barnard, 2012). How a mother feeds her infant is so important to a woman's identity as a new mother that women who do not meet either their own expectations, or what they view as societal expectations related to breastfeeding, construct narratives to explain or justify their infant feeding practices (Ludlow et al., 2012; Wirihana & Barnard, 2012). Although the prevailing view is that guilt is a negative by-product of breastfeeding promotion, recent studies have examined how the expression of guilt is an important component of constructing a positive maternal identity for mothers who cease breastfeeding and switch to infant formula (Ludlow et al., 2012; Williams, Donaghue & Kurz, 2012). If they felt guilty and expressed these feelings of guilt to others, they could preserve their status as good mothers who had to sacrifice (in this case, breastfeeding) for the sake of their infant's well-being (Ludlow et al., 2012; Williams, Kurz, Summers & Crabb, 2012).

Breastfeeding and Professional Supports. New mothers go to healthcare professionals with exceedingly high expectations of the breastfeeding support they will receive and view nurses as the gatekeepers to the knowledge and validation they feel they need to breastfeed their infants (Andrews & Knaak, 2013; Dykes, 2005; Hinsliff-Smith et al., 2014; Lee, 2008; McBride,

White & Benn, 2009; Regan & Ball, 2013). Therefore, the nurse-client relationship is at the centre of successful breastfeeding support and helping mothers shape positive views of themselves as mothers (College of Nurses of Ontario [CNO], 2006; Furber & Thomson, 2010; Hinsliff-Smith et al., 2014; Oushoon, 2005). Nurses have been found to predominantly adopt a task-oriented approach to providing breastfeeding supports, missing many of the complexities of the breastfeeding dyad's relationship and the effects of nursing interventions (Dykes & Flacking, 2010; Marshall et al., 2007). Mercer (2006) argues nurses need to approach new mothers in all aspects of care, including those related to breastfeeding supports, with an understanding that their clients are negotiating personal, community, and cultural expectations while taking on the new role of mother.

Breastfeeding is often seen by professionals in one of two ways: 1) as a complex physical and emotional relationship between the mother-infant dyad or 2) as a process of production and consumption with the breast milk as the product and the infant as the consumer (Dykes, 2005; McBride-Henry et al., 2009; McCarter-Spaulding, 2008). The practice of breastfeeding is often supported by healthcare professionals only in terms of quantifiable measures such as input, namely how much milk the infant received, or as a set of skills and tasks for the woman to master (Burns et al., 2013; Dykes, 2005; Knaak, 2006; Marshall et al., 2007; McBride-Henry et al., 2009). This mentality translates into mothers viewing breastfeeding as a task and not linking breastfeeding to being important to meeting their infants' emotional needs (Avishai, 2007; Dykes, 2005). Instead of the emphasis being on the emotional support of new mothers, with the goal to increase maternal confidence, nurses in their task-oriented mindset often miss the connection between breastfeeding and meeting the infant's emotional needs. Thus, they miss the opportunity to foster the emotional relationship between the mother and infant while providing

breastfeeding supports (Burns et al., 2013; Dykes, 2005; Marshall et al., 2007). Research on transitioning to motherhood supports the need for nurses to move beyond the technical skills of mothering, including breastfeeding skills, to actively listening and understanding the needs of the mother in the unique context of her physical, emotional, and social reality (Mercer, 2006).

The language nurses use in their interactions with mothers may be undermining women's confidence in their ability to breastfeed their infants (Alex-Whitty et al., 2012; Dykes, 2005; Furber & Thomson, 2010; McBride-Henry et al., 2009; Regan & Ball, 2013). Alex-Witty et al. (2012) describe the language often used by healthcare professionals when talking to patients as "a vocabulary of deficits" (Pg. 113). Examples commonly used during breastfeeding support would include the terms 'insufficient milk supply' and 'failure to latch'. The therapeutic nurse-client relationship is one that involves power, as the nurse has the specialized knowledge, access, authority, and position to advocate for new mothers (CNO, 2006). The nurse-client relationship is at the centre of successful breastfeeding support and helping mothers shape positive views of themselves as mothers (CNO, 2006; Furber & Thomson, 2010; Hinsliff-Smith, et al., 2014; Oushoon, 2005).

How women interpret and assign meaning to the messages used by nurses during breastfeeding support is crucial to how women internalize these messages (Alex & Whitty-Rogers, 2012; Burns et al., 2013). Since women in the postpartum period are especially vulnerable to the nuances of language, these messages have the potential to affect their emerging sense of competence and self-identity as a new mother (Alex & Whitty-Rogers, 2012; Burns et al., 2013; Lee, 2008). When nurses use language that objectifies a woman's breasts or places the focus on production and quantifiable consumption, the mother-infant relationship gets lost, as does a normative view of breastfeeding (Bomer-Norton, 2013).

Summary of the Literature on Older Mothers and Delayed Childbearing

For a complete examination of the literature on the phenomenon of delayed childbearing in the Canadian context and that of other western countries see Chapter Five *An Exploration of the Current State of the Literature on the growing Phenomenon of Delayed Childbearing in Developed Countries: A Narrative Literature Review*. The literature on older mothers and the phenomenon of delayed childbearing in developed countries has primarily had one of two foci. Either the studies are investigating the reasons behind women choosing to have children later in life (BS, 2015; Carolan, 2005; Cooke, Mills & Lavender 2010; Cooke et al., 2012) or are examining the risks to both mothers and infants associated with pregnancy and childbirth at an advanced maternal age (Bayrampour & Heaman, 2010; Carolan, Davey, Biro & Kealy, 2011; CIHI, 2011; SOGC, 2012).

It is important to note that the women represented in the studies examining delayed childbearing were not a heterogeneous group (BS, 2015; Cooke et al., 2012). The reasons behind the shift in developed countries towards delayed childbearing are not completely understood. Socioeconomic and cultural factors, including the desire for economic stability, increasing levels of education, access to reliable contraception, and changing family demographics, have all been found to contribute to women waiting longer to have children, and continuing to have them later in life than earlier generations (BS, 2015; Mills et al., 2012). The women who have children later in life have been found to fall into one of three categories: 1) women who delay their first pregnancy, 2) those who experience subfertility, or 3) women who continue to have children later into their reproductive years (Mills et al., 2012).

The risks associated with pregnancy and childbirth at an advanced maternal age include increased risk of infertility, increased incidence of pregnancy related complications including

preterm birth, increased risks of genetic conditions and congenital anomalies, and increased rates interventions during labour (including higher rates of inductions and caesarean sections) (Bayrampour & Heaman, 2010; Carolan et al., 2011; CIHI, 2011; SOGC, 2012).

There is some debate in the literature surrounding the relationship between maternal age and other contributing factors that lead to poorer maternal and infant health outcomes (Carolan & Nelson, 2007; Cooke et al., 2010; Mills et al., 2012). Recent studies have found that the increased rates of interventions during birth were not fully explained by the types and rates of labour and birth related complications (Bayrampour & Heaman, 2010; Carolan & Nelson, 2007). It has been postulated that healthcare providers view older mothers as an inherently high risk group who therefore require a lower threshold of risk before intervening (Bayrampour & Heaman, 2010; Carolan, 2005; Carolan et al., 2011). Bayrampour and Heaman also found that maternal anxiety related to adverse birth outcomes may be a contributing factor to the higher rates of interventions found in older mothers. This anxiety may stem from being labeled by healthcare providers throughout pregnancy as high risk due to their age and increased prenatal screening related to maternal age (Carolan, 2005; Cooke et al., 2010; SOGC, 2012).

Situating the Researcher

In my clinical nursing practice over the past 12 years, I have encountered countless older mothers who expressed feelings of grief, guilt, anger, resentment, disappointment, anxiety, and depression when discussing their breastfeeding experiences. In my role as a public health nurse with a provincial Healthy Babies, Healthy Children home visiting program, I worked with many older mothers for whom the disconnect between expectations and realities of early motherhood and breastfeeding contributed to adverse maternal mental health outcomes, negatively affected the mother-infant relationship, and was a contributing factor to early

weaning. This research has grown out of those poignant experiences with older mothers and a frustration at the lack of research and resources geared toward this distinct, and in many respects vulnerable, group of new mothers and infants.

I believe the way to truly provide appropriate and ethical care is to approach the client in a holistic manner, as a whole person who exists within a cultural, social, economic, and physiological reality. Each client, although sharing attributes and contexts with others, is unique. In my practice I believe that each interaction with every client has been unique to that time and place. Both the nurse and the client come to the relationship influenced by the broader discourses surrounding their personal and professional existences. As such, I view knowledge creation as transactional and value-laden, co-constructed by the interactions of individuals to each other. It is important to note that breastfeeding is not simply a practice shaped by the cultural norms of the day, but an embodied act between two individuals that must be negotiated within the overall context of the mother and infant.

The methodology for this qualitative study, constructivist grounded theory (CGT), takes a relativist view to ontology, asserting that reality is multiple, processual, and constructed- not waiting to be discovered (Charmaz, 2014). From an epistemological standpoint knowledge is thought to be co-created/constructed through the mutual interpretation of meaning and experiences. In the case of a study knowledge is co-created between the researcher and the participant. CGT has its roots in Symbolic Interactionism which asserts that people are active participants in creating meaning (from words, gestures etc.) in any given situation (Charmaz, 2014). As such, the personal positionality of the researcher is of relevance to understanding the potential biases in data analysis and interpretive paths the researcher may embark on over others when seeking meaning in the data. I identify as white, Canadian, heterosexual, and am the

mother of two children (both of whom were breastfed without any major challenges or issues).

While at the time of this study I was in my late 30s and am now in my early 40s, I came to motherhood in my 20s and as a result much of my adult (personal and professional) identity is informed by being a mother. I am a professional and belong to the well-educated middle class. I believe that breastfeeding is valuable for both long-term health outcomes, but also for mother-child bonding and I enjoyed the breastfeeding relationship I had with each of my children.

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CHAPTER TWO

Methods

The aim of this study was to answer the research question “What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?” using the constructivist grounded theory [CGT] approach, and to generate a theory of older first-time mothers and the factors influencing their decisions around early breastfeeding. This chapter presents an overview of the CGT approach and the methods used to conduct this study, including: the sensitizing concepts, data analysis, rigour, and ethical considerations.

Research Design and Rationale for the Constructivist Grounded Theory Approach

CGT was developed as a less rigid alternative to the two main branches of grounded theory, namely the Glaserian and the Straussian approaches (Charmaz, 2014). Charmaz’s constructivist approach to grounded theory harkens back to the inductive, comparative, emergent, and open ended roots of grounded theory from the 1960s. CGT allows for a flexible use of methods, and a focus on meaning. The ultimate goal of a CGT is to understand a social phenomenon, while developing a theory grounded in the meaning of the data (Charmaz, 2014; Gardner, McCutcheon & Fedoruk, 2012). Charmaz (2014) describes the product of a CGT study as “an interpretive portrayal of the studied world” (p.15), culminating in a theory grounded in the meaning derived from the researcher’s interpretation of the data. This study examined the processes and factors influencing the decisions older first time mothers make about breastfeeding within the context of the growing phenomenon of delaying childbearing until ≥ 35 years of age, and developed a theory generated from the data on what factors influence the decisions first-time

mothers ≥ 35 years of age make about breastfeeding, and how these factors influence their decisions and subsequent breastfeeding practice in the first six months postpartum.

There is a long-standing debate about validity and appropriate usage amongst the Glaserian, Straussian, and constructivist approaches to grounded theory (Higginbottom & Lauridsen, 2014; Kenny & Fourie, 2015). These approaches to grounded theory were compared and considered for goodness of fit for this study in the context of the researcher's ontological and epistemological beliefs, the research question and objectives, and their relevance to clinical nursing practice. The Glaserian, Straussian, and constructivist approaches to grounded theory research share the use of constant comparative method of data collection and analysis, the use of theoretical sampling, and using memo writing as a reflexive and analytical tool (Higginbottom & Lauridsen, 2014; Kenny & Fourie, 2015). The primary points of divergence between the three approaches are their philosophical positions, coding procedures, and use of the literature (Kenny & Fourie, 2015).

Charmaz's CGT approach assumes a relativist ontological stance asserting that reality is multiple, processual, and constructed, not discovered. Epistemologically, Charmaz asserts that it is the co-creation of knowledge and mutual interpretation of meaning and experiences between the researcher and participant that stands in direct opposition to the assumed neutral stance of the researcher and objective knowledge waiting to be discovered in Glaserian grounded theory (Bryant, 2007; Charmaz, 2014; Kenny & Fourie, 2015; Mills, Bonner & Francis, 2006). In contrast to Glaserian grounded theory, but in agreement with Straussian grounded theory, CGT assumes the researcher possesses pre-existing knowledge of, and expertise in, the area of study which contributes to theoretical sensitivity (Charmaz, 2014; Higginbottom & Lauridsen, 2014; Kenny & Fourie, 2015).

Charmaz's CGT also advocates for the use of the current literature to inform the study at all phases of the project (Charmaz, 2014; Kenny & Fourie, 2015). To avoid stifling the creative process during data analysis, Charmaz recommends writing the formal literature review chapter of the CGT thesis after data collection and analysis are completed. The literature is subsequently used to inform the discussion of the newly formed theory (Kenny & Fourie, 2015). An initial scan of the literature was conducted at the onset of the study to fulfill the requirements of the research proposal. A comprehensive literature review was conducted once the data analysis and theory building phases of the study were completed (See Chapter Five). This review was utilized primarily to inform the discussion of the findings/theory, and place the study within the current research context on older mothers, breastfeeding, and motherhood studies.

The constructivist/relativist position on the nature of reality permeates the design and implementation of this study. The use of CGT provided the study with internal consistency between the ontological and epistemological beliefs of the researcher and the methodology and methods. Charmaz asserts that sensitizing concepts drawn from the tacit and formal knowledge of the researcher drive the early development and direction of the research. These sensitizing concepts are typically derived from a combination of clinical experience, expert hunches, disciplinary perspectives, and familiarity with the current literature. These were taken from the researcher's extensive clinical experience in the area, personal experience, and familiarity with the current state of the literature on both breastfeeding and issues surrounding delayed childbearing.

All three main branches of grounded theory are rooted in the principles of symbolic interactionism (Bryant & Charmaz, 2007; Charmaz, 2014; Cutcliffe, 2000). At the core of symbolic interactionism is the belief that people construct their realities from symbols around

them (for example, in words and gestures), and therefore are active participants in creating the meaning in any given situation (Cutcliffe, 2000). Unlike Glaserian or Straussian grounded theory, where the goal is explanation or prediction of events, the ultimate goal of CGT is an understanding of social phenomena (Gardner et al., 2012). Charmaz's focus on meaning and interpretation as the core of theory building fit well with the study's research question and aim to find meanings and interpretations of breastfeeding for older first-time mothers and how these influence the decisions these mothers make about breastfeeding in the first six months postpartum. An explanation of the goodness of fit between CGT and nursing research is found in Chapter Four *The Breastfeeding Experiences of Older First-time Mothers: A Constructivist Grounded Theory Study*.

Sensitizing Concepts. This section describes the sensitizing concepts which were used to guide the design of the study, and served as a conceptual framework for the data analysis, theory generation, and discussion of the theory and findings. Charmaz's (2014) CGT approach to grounded theory assumes that the researcher comes to an area of study with background knowledge, disciplinary perspectives, and personal experiences related to the topic of study; in the case of this study, the researcher comes to the work with over a decade of clinical nursing experience working directly with new mothers and infants in the roles of hospital nurse, public health nurse, and lactation consultant.

CGT methodology also advocates for the use of sensitizing concepts, otherwise known as tentative tools, to provide a starting point that can be used initially to frame the research objectives, develop the initial interview guide, and inclusion criteria (Charmaz, 2014). Mercer's (2004) theory of Becoming a Mother, the concept of breastfeeding self-efficacy, and Leff, Jefferis and Gagne's (1994) conceptualization of maternal satisfaction with breastfeeding were

used together as the sensitizing concepts to guide the early development of this study, and subsequent data analysis, theory building, and situating the study and theory in the broader context of the phenomenon of delayed childbearing and the transition to motherhood for first-time mothers ≥ 35 years of age, breastfeeding studies, and motherhood studies.

Theory of Becoming a Mother: Mercer's (2004) theory of Becoming a Mother (BAM) is a practice-orientated mid-range nursing theory that asserts women transition to the maternal role on biological, psychological, and social levels, all of which exert influence on each other within the context of each individual woman's past experiences and socially constructed expectations of motherhood (Meighan, 2010; Mercer, 2004; Mercer, 2006). The therapeutic nurse-client relationship is pivotal to the early transition to the maternal role, and helps foster early maternal confidence, competence, and positive maternal-infant attachment (Mercer & Walker, 2006).

Mercer (2004) identified four stages of transition to a maternal identity: 1) commitment, attachment and preparation (during pregnancy), 2) acquaintance, learning, and physical restoration (two-six weeks postpartum), 3) moving toward a new normal (two weeks to four months) and, 4) achievement of maternal identity (around four to six months). BAM is based on the central assumption that for each woman there exists a relatively stable *core self*. This core self is constructed over a lifetime of socialization and is separate from the roles it acts within. This self evolves over the lifespan out of the cultural context of the individual and determines how situations are defined and reacted to (Meighan, 2010; Mercer, 2004).

The first stage of BAM, prenatal commitment, attachment and preparation, was used to develop the expectations section of both the initial and follow-up interview guides (see Appendix E and F). The theory of BAM was also used to guide the data analysis at the focused coding

stage and integrated as a model during the development of the theory: *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother*.

Breastfeeding Self-Efficacy: The concept of breastfeeding self-efficacy was originated by Dennis and Faux (1999) during the development and psychometric testing of the Breastfeeding Self-Efficacy Scale. Breastfeeding self-efficacy is conceptualized as a woman's confidence in her ability to successfully breastfeed and is based on Bandura's (1977) social cognitive theory (Dennis & Faux, 1999; de Jager et al., 2015). Breastfeeding self-efficacy has been shown to be influenced by maternal motivation, expectations of outcomes, and perceived mastery of the skills of breastfeeding over time (Dennis & Faux, 1999; de Jager et al., 2015; Kingston, Dennis & Sword, 2007). For the purpose of this study, the concept of breastfeeding self-efficacy was recognized as a crucial factor influencing breastfeeding duration, and, as such, was used to guide the development of the expectations, choices, decisions, and achievements sections of the initial and follow-up interview guides.

Maternal Satisfaction with Breastfeeding: Leff, Jefferis, and Gagne (1994) conceptualized maternal satisfaction with breastfeeding during the development of their Maternal Breastfeeding Evaluation Scale (See Appendix 1). The scale was used to measure successful breastfeeding from the mother's perspective, focusing on the aspects of successful breastfeeding as defined by breastfeeding mothers. Maternal satisfaction was found to encompass the mother's enjoyment of breastfeeding, the mother's perception of how her baby was both enjoying breastfeeding and growing and how well breastfeeding fit with her lifestyle and body image. The relationship between the breastfeeding dyad from a maternal point of view, and the mothers' view of how breastfeeding has affected her life and physical body figure prominently. In relation to breastfeeding practices and experiences, maternal satisfaction with breastfeeding is associated

with a mother fulfilling her personal wishes, expectations, and needs, as well as deriving pleasure from breastfeeding for her infant and herself.

Maternal satisfaction, as conceptualized by Leff et al. (1994) was used to guide data analysis and the creation of codes, themes, and theory generation. The concept of maternal satisfaction with breastfeeding was used extensively in the generation of the recommendations for clinical practice. An in-depth exploration of maternal satisfaction with breastfeeding, as used to inform recommendations for practice based on the findings from this study, can be found in Chapter Six *Supporting Older First-time Mothers with Breastfeeding and Becoming a Mother: Insights for Clinical Practice*.

Setting. The setting was Ottawa, Ontario, Canada.

Inclusion Criteria. The inclusion criteria for this study were: being a woman who was ≥ 35 years of age at the time of her first live birth; was the birth mother of an infant three months of age or under at the time of recruitment; attempted any breastfeeding, for any period of time, and/or pumping of breast milk; and was English speaking.

Sample Description. Charmaz (2014) does not offer guidance on sample size, only that sample size be large enough to achieve saturation of the emerging categories during the theoretical sampling phase of the study. In keeping with the iterative nature of grounded theory methodology, both initial and theoretical sampling were employed. The researcher strove to include participants with a variety of experiences related to fertility, birth, healthcare providers in the antenatal period, and socio-economic circumstances. This was a challenge due to the slow pace of initial recruitment strategies and the demographic characteristics of the mothers who volunteered to participate in the study. The goal for this study was to interview 15-20 participants at two points in the first six months postpartum, three months apart, with the

understanding that as the study moved into the phase of theoretical sampling, the sample size might change to suit the goal of saturation of the emerging categories. The study ultimately included 23 participants, surpassing the initial recruitment target, 18 of whom completed both an initial interview and a follow-up interview three to four months later. In keeping with the process of theoretical sampling in CGT, the researcher and supervisor evaluated the need for further sampling as the theoretical sampling progressed once the saturation of the emerging categories of data was evident by interview #18. Five additional participants were accepted into the study and interviewed twice following saturation to ensure no new categories emerged.

Recruitment. Recruitment of participants was from June 2016 to September 2017. See Table 1 below for recruitment timeline and details. The Research Ethics Boards (University of Ottawa and Ottawa Public Health) applications and approvals can be found under Appendix K. See Appendices C & D for recruitment posters version A & B, and recruitment flyers used in the Ottawa Public Health's Healthy Babies, Healthy Children program mail-outs. Recruitment posters and advertisements were posted in midwifery clinics, at the Ottawa Birth and Wellness Centre (a midwifery birthing centre), at the Monarch Centres (outpatient clinics that specialize in postpartum support, newborn physician visits, and breastfeeding support), and at the community health and community service centres that host breastfeeding support drop-in clinics. An advertisement was also posted on Kijiji, which is a local online classified ad site.

Table 1: Recruitment Timeline

June 2016	Recruitment posters posted at area breastfeeding support drop in clinics, Midwifery clinics, the Ottawa Birth and Wellness Centre, and the Monarch Centre's two locations (~15 posted, 5 participants recruited)
Dec 2016	Ottawa Public Health's (OPH) Parenting in Ottawa distributed posters to their 25 drop-in clinic sites (primarily community resource centres and community health centres)
Jan 2017	Kijiji advertisement posted (recruited 1 via ad)
Feb 2017	Reassessed recruitment strategy due to low response rate (8 responses with 5 participants recruited between June 2016 and February 2017)
Mar 2017	Requested an amendment from both the University of Ottawa and the Ottawa Public Health Research Ethics Boards (REB) to identify mother fitting the inclusion criteria via the Healthy Babies, Healthy Children hospital discharge screens and to send a mail out invitation to any mother fitting inclusion criteria
May 2017	Amendment to send mail out invitations to participate approved by OPH and the University of Ottawa REBs
June 2017	93 mail outs sent (see Appendix J) between June 26 th 2017 and September 8 th 2017, with 17 participants recruited via mail out (18% positive response rate)
Sept 2017	Stopped formal recruitment as saturation evident by interview #18

See Chapter Four *The Breastfeeding Experiences of Older First-time Mothers: A Constructivist Grounded Theory Study* for further detail on the recruitment for this study.

Data Collection. Data was collected by means of audio-recorded, semi-structured interviews and the completion of a demographic data questionnaire with new mothers who met the inclusion criteria. The primary source of data was one-to-one semi-structured interviews with each of the 23 participants. Eighteen of the original 23 participants completed a second interview. There were 41 interviews conducted in total, ranging in length from 17 minutes to 79 minutes. The mean length of the first interviews was 50 minutes, and of the second interviews was 36 minutes. The goal of the one-on-one interviews was to explore each individual mother's expectations, experiences, and factors influencing the decision-making process about feeding her infant within the context of the social phenomenon of delayed childbearing and older first-time mothering. The goal of the second interview was to glean insight into the evolving nature of the

woman's experiences, and the factors affecting the decisions she made about feeding her infant in the second three months postpartum compared to decisions prenatally and in the first three months postpartum.

The interviews were conducted in locations of the participants' choosing in order to ensure the participant was comfortable in the surroundings and to maintain confidentiality. The interviews were conducted in participants' places of residence, coffee shops, offices, walking outdoors, sitting on park benches, over the telephone, and via Skype. All interviews were conducted by me (the researcher). Prior to each interview each participant was given a five dollar gift certificate to a local coffee chain in the spirit of reciprocity and a thank you for her time. Each participant was asked to fill out a demographic data questionnaire at the initial interview (see Appendix G) - all of the participants agreed.

The participants were informed prior to the interviews that if during the interview any issues arose that the participant found distressing or sensitive the participant could stop the interview at any time. If appropriate, I would refer the participant to community services and supports (including the participant's family physician, Family Services Ottawa, and Ottawa Public Health's Healthy Babies, Healthy Children program) for counseling and/or assistance. There were no occurrences of participants requesting the interviews be terminated or formal referrals to community supports made. I also informed the participants before commencing the interview that the researcher had a legal and moral obligation to contact local children's protection services if allegations of child abuse and/or neglect arose during the interview process. Again, there were no occurrences of disclosure of potential child abuse and/or neglect during the interviews. A semi-structured interview guide (see Appendix D) consisting of open-ended questions with prompts based on the initial literature review and the sensitizing concepts was

used to guide the initial interviews. The semi-structured interview guide (see Appendix E) for the follow-up interviews was modified on an ongoing basis based on the emerging themes/codes from the transcribed the coded initial interviews. The interview guides were modified to suit the needs of theoretical sampling as the study developed, reflecting the methodology's emergent nature.

The interviews were digitally recorded with the consent of each participant. Directly following the interview, the researcher completed additional observations in the form of memos and field notes. The digital recordings were downloaded to a password-protected laptop, with any identifiers of the participant removed upon transcription (each recording was then assigned an alphanumeric code and dated). The digital recordings were transcribed into text by the researcher and a contracted transcription service, then downloaded into NVivo® qualitative design software for data management, and stored on a password protected, secure laptop.

Data Analysis

In keeping with CGT and the use of constant comparison and theoretical sampling, data analysis was completed concurrently with recruitment and data collection, and in two sequential stages: initial and focused coding (Charmaz, 2014). Throughout the coding process Charmaz advocates that the researcher seek not only the obvious but also the meaning embedded in the data. This included the unspoken and tacit meanings rooted in the researcher's and participant's values, beliefs, and ideologies (Mills et al., 2006). In keeping with CGT methodology, I immersed myself in the data using the participant's words in the memo writing, using verbatim codes, and transcribing the interviews (Charmaz, 2014; Kenny & Fourie, 2015; Mills et al., 2006). Memo writing and field notes were completed on an ongoing basis during the data

collection and analysis stages in keeping with Charmaz's assertion that the process of memoing and keeping field notes are the crucial stage linking the interviewing and coding.

Initial Coding. The first stage of data analysis began with line-by-line open coding using gerunds, or action nouns, based in the guiding sensitizing concepts of Mercer's (2004) theory of becoming a mother, and Leff, Jefferis and Gagne's (1994) conceptualization of maternal satisfaction with breastfeeding. The initial codes were provisional, comparative, and closely grounded in the data. Extensive memo writing was employed to help to find patterns and themes in the initial codes while I transcribed the interviews, and later engaged in close reading and re-reading of the transcripts.

I initially coded the data in each individual transcript line by line using gerunds and when possible verbatim quotes. The questions, based on Charmaz (2014), *What is the main issue for the participants?*, and *How do they solve/find resolution to this issue?*, helped to guide the early stages of data analysis.

Focused Coding. The second stage of coding consisted of focused coding, in which I returned to the codes, memos, and field notes seeking both patterns and individual codes of potential theoretical significance. The codes identified throughout the process of focused coding became the final codes and categories, which, in turn, were subjected to subsequent rounds of re-focusing based on new data obtained via theoretical sampling, and ongoing reflection during the writing of memos and field notes.

The interviews were coded in the first phase of initial coding going line by line, using primarily gerunds and verbatim codes, as stand-alone interviews, then re-coded in the focused coding stage seeking themes and patterns, first with each stand-alone interview, second with all the initial interviews as a grouping, then with all of the second interviews as a grouping, and

lastly examining the first and second interviews from the 18 participants who completed a follow-up interview. Finally, the codes were taken as a whole picture, to find the metaphorical forest for the trees, and a list of primary and secondary codes for the first interviews and a list of a list of primary and secondary codes for the second interviews were developed.

Returning to the sensitizing concepts of Leff et al.'s (1994) maternal satisfaction with breastfeeding, breastfeeding self-efficacy, and Mercer's (2004) theory of becoming a mother, the codes were used to provide a qualitative description of the factors influencing the decision making process around breastfeeding in the first six months postpartum. A detailed account of the factors influencing the decision making process around breastfeeding in the first six months postpartum can be found in Chapter Four *The Breastfeeding Experiences of Older First-time Mothers: A Constructivist Grounded Theory Study*. The codes and qualitative description, again using the sensitizing concepts as a reference, were then used to develop the theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother*. The theory answers the *why* question underlying the *what* and *how* questions answered by the codes and qualitative description of the findings.

Regular meetings between my thesis supervisor and myself were held throughout the course of the study to review the progress of the study, design and implementation decisions, data analysis decisions, and interpretation of results. Ongoing consultations with members of the thesis committee and regular meetings were held to review the progress of the project, review design and implementation decisions, review analysis and interpretation, with active participation and recommendations of the committee members.

Literature Review. A second immersion in the literature following the completion of focused data analysis was completed and used to guide the discussion of the theory, provide

context, and help to gain insight into the clinical implications for nursing practice in providing breastfeeding support for the target population of this study. Chapter Five, *An Exploration of the Current State of the Literature on the Growing Phenomenon of Delayed Childbearing in Canada and Other Developed Countries: A Narrative Literature Review* provides a complete review of the literature from 2014-2019 on the topic of delayed childbearing in Canada and other developed countries.

Rigour

As researchers have an ethical obligation to demonstrate integrity and rigour, Whittemore, Chase and Mandle's (2001) Criteria for Validity in Qualitative Research was adapted to fit with Charamz's CGT. Whittemore et al.'s (2001) criteria were used to help ensure that both rigour and ethical considerations were respected throughout the course of the research design, data collection, and data analysis, and will be reflected in the future knowledge transfer phases of the study.

Whittemore et al.'s (2001) primary criteria to ensure validity in qualitative research are credibility, authenticity, integrity, and criticality. Credibility refers to the overarching goal to establish confidence through an accurate interpretation of the meaning within the data (Whittemore et al., 2001). This standard is consistent with Charmaz's (2014) assertion that the interpretations must accurately reflect the experience of the participants and the contextual realities of the case as a whole. This criterion was achieved by the use of the constant comparative method of data collection and analysis, the use of sensitizing concepts, theoretical sampling, my repeated immersion in the data through active coding and analytic memo writing, the focus on meaning in both the initial and focused coding stages, and finally by returning to the

current literature after the data analysis was complete to accurately situate the new grounded theory in the context of what is known of the phenomenon.

The criterion of authenticity, or the reflection of the participant's experiences in the findings, was fulfilled by my writing of extensive analytic memos writing throughout the study. The goal of the memo writing was to aid the researcher in sorting out biases, practising self-criticality, examining alternative meanings, and remaining true to the data (Whittemore et al., 2001). The memo writing was also used, along with the keeping of extensive field notes, to fulfill the criteria of integrity and criticality. The memo writing process was ongoing and used as a reflective tool by the researcher at all stages of the study to ensure that the researcher's professional and personal experiences were not leading the data analysis, while acknowledging that the researcher is an active participant in the construction of the meaning from the data. Rather, the analysis was driven by the raw data itself.

Whittemore et al.'s (2001) secondary criteria for increasing validity include explicitness, vividness, creativity, thoroughness, and congruence. An audit trail, in the form of memos and field notes, was kept throughout the course of the study to make decisions explicit and the emergent design unambiguous. Thick description, including the use of document reviews as a secondary data source, allowing readers to experience the phenomenon within their own context, was used to fulfill the criterion of vividness. Charmaz's (2014) CGT approach is by its very nature creative and allows the researcher to be flexible and active in the research process. The study was designed with internal consistency between my ontological and epistemological beliefs, the sensitizing concepts, the methodology, the methods, research questions, aims, and ethic issues fulfilling the criterion of congruence.

Protecting Human Rights

I recognize the importance of the ethical pursuit of knowledge and research practices. I obtained approval for this study from the University of Ottawa Research Ethics Board adhering to the boards' policies and guidelines (University of Ottawa Office of Research Ethics and Integrity, 2012), and the Research Ethics Board at Ottawa Public Health.

A recruitment protocol was used to ensure that ethical principles governing voluntary participation, non-maleficence, and informed consent were respected throughout the recruitment process. Consent forms (see Appendix G) adhering to the University of Ottawa Research Ethics Board guidelines were reviewed with each potential participant prior to the interview allowing for questions and clarifications, and written consent was obtained from each participant. It was made clear to the participants that they could opt out of the study at any time, for any reason without penalty, and all efforts would be made to maintain the participant's confidentiality, and the data gathered to that point would be used unless otherwise specified by the participant. I explained, while reviewing the consent form that there were no direct benefits to participating in the study aside from adding to the knowledge base, which may help other mothers in the future. I also explained that while there were no foreseen risks to participating, the topics discussed might be sensitive for the participant.

As sensitive topics and/or past trauma might have been brought up by the participants in the interviews, a list of counselling resources (for example Family Services Ottawa) was given to each participant. If child abuse and/or neglect had been disclosed in the course of an interview a report would have been made to the Children's Aid Society of Ottawa (CAS); each participant was made aware of this prior to signing the consent. I had worked in the role of Public Health Nurse with a Healthy Babies Healthy Children program for over eight years at the time of the

initial interviews and had extensive experience referring clients to both child protection and counselling services.

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CHAPTER THREE

Presentation of the Findings

This chapter presents the codes and sub-codes that were used to generate the theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother*. The codes and sub-codes were derived directly from the data from the 41 interviews conducted from July 2016 to September 2017. This chapter is divided into three sections. The first section presents the demographic data and provides a description of the 23 study participants. The second section presents the codes and sub-codes from the initial interviews, the section is further sub-divided into the chronological periods of birth to six weeks and six weeks to three months. The third section presents the codes and sub-codes from the follow up interviews which constitute the period from three months to six months postpartum.

Description of Study Participants

Twenty-three participants were recruited from a large Canadian urban centre via community postings, targeted mail-outs and word of mouth from June 2016 to September 2017. At the time of their first live birth, the participants ranged in age from 35 to 44 years of age, with the mean age of the participants being 37 years. At the time of the first interview, the infants in the study ranged in age from six days to three months, with the mean age being five weeks. At the time of the second interview, the infants ranged in age from three and a half months to six months (mean of four and a half months).

All of the mothers in this study had attempted to put their infant to breast to breastfeed at least one time since the birth and/or had pumped breast milk. At the time of the first interview, 13 of the 23 participants were exclusively breastfeeding, one participant had switched from breastfeeding and pumping to exclusively formula feeding three days prior to the interview, nine

participants were practicing a combination of breastfeeding, pumping, and/or supplementing with formula, and none were using donor breast milk. At the time of the second interview, eight of the 18 participants were exclusively breastfeeding- six of the eight mothers were exclusively breastfeeding at the time of the first interview as well. Of the remaining participants, six were practicing a combination of breastfeeding, pumping, and/or formula, two were exclusively formula feeding, and two of the participants were exclusively pumping. Both of the participants who were exclusively pumping were donating their surplus milk. One was donating her surplus expressed breastmilk via online requests, and the other to a family member with a young infant.

All of the participants in this study were in stable, committed relationships with the fathers of their infants. All of the participants self-identified as middle to upper middle-class. With only one exception, all of the participants had some level of post-secondary education (15 of the 23 held at least one graduate degree). All of the participants had been employed prior to the baby's birth (three part-time, 20 full-time), and were either still working in some capacity (either part-time, taking the baby with them, or from home) or planning on returning to work within a year of the birth. The participants' occupations included: Social Worker, Professor, Dance Instructor, Registered Nurse, Civil Servant, Teacher, Graduate Student, Physiotherapist, Journalist, Optometric Assistant, and Lawyer. Eighteen of the 23 participants reported that this was their first pregnancy. Six of the 23 reported fertility treatment/fertility treatment consultations or challenges conceiving. One participant conceived via fertility treatment.

The majority of the participants birthed their baby in a hospital setting, with only one mother giving birth at a local midwife-led birthing centre. Most of the participants (19) were under physician care during their pregnancy and birth, and four of the participants were followed by midwives throughout their pregnancy, birth, and in the first six weeks postpartum. Only one

employed a doula. The majority of the participants had a vaginal birth (18 participants or 73%), with three of those births following an induction. Of the participants who birthed via caesarean-section (five participants or 27%), two were planned caesarean-sections and three were emergency caesarean-sections following unsuccessful induction attempts.

Findings: The Codes and Sub-Codes

The findings from this study are organized according to three levels of abstraction, with the highest level culminating in the CGT theory grounded in the data. These three levels present the what, how, and why from the findings. The what, how, and why relate to the participants journey through their experiences, decisions, and coming to terms with both early breastfeeding and early mothering within the context of first-time motherhood after the age of 35 in the Canadian socio-cultural climate of the new millennium. The first, and lowest level of findings, are those closest to the data, namely, the codes drawn directly from the transcripts. This first level findings are presented in this chapter. For a full presentation of the second and third levels of abstraction, namely the qualitative description of the findings and the theory see Chapter Four *The Breastfeeding Experiences of Older First-time Mothers: A Constructivist Grounded Theory Study*, and Chapter Six *Supporting Older First-time Mothers with Breastfeeding and Becoming a Mother: Insights into Clinical Practice*.

This first level answers the *what* question. Answering the *what* question was accomplished by asking the questions: what is going on here, what are the mothers describing about their breastfeeding experiences, what are their expectations of early breastfeeding, what facilitators and barriers are they identifying related to breastfeeding, what are they feeling they have achieved and regretted to date, and what decisions have these mothers made in the context

of all the aforementioned factors related to feeding their infants? See Chapter Two for details related to the coding procedures.

Table 1: List of Codes and Sub-Codes

Initial interviews: birth to six weeks	Initial interviews: six weeks to three months	Follow-up interviews: three months to six months
Code: Breastfeeding is a choice- but not really Sub-Codes: -Self-policing (& guilt) -Breast milk is magic stuff	Code: Beginning to take back control Sub-Codes: -Finding her own path -Reframing	Code: On being a mom, being a good enough mom, and being us Sub-Codes: -Being a mom to my baby -Finding and owning good enough
Code: Being blindsided by early breastfeeding Sub-Codes: -Not knowing what I needed to know -The struggles of early breastfeeding	Code: Growing mistrust of healthcare professionals Sub-Codes: -Inconsistent information/no one has any answers anyways -No truth in advertising -Wanting clear information	Code: Mistrust of the party line-seeking information not ideology
Code: Losing control of the situation and self Sub-Codes: -Reacting in the moment and questioning self -Surprise vulnerability	Code: Persisting the f* out of this Sub-Codes: -Really wanting to be a breastfeeding mom -Failure is not an option	Code: Romancing the idea of the breastfeeding mom Sub-Codes: -Self-talk/self-policing -Brussel sprouts
Code: Riding the push and pull between feelings of failure and relief		Code: Finding one's tribe and the wisdom of other mothers
		Code: Persisted the f* out of this
		Code: Moving into ownership and control Sub-Codes: -Seeking a balance between own need and baby's needs -Reframing

Codes: Initial Interviews. The codes from the initial interviews were divided into two chronological sections: the first with the codes derived from the descriptions of the period of birth to six weeks, and the second with the codes from six weeks to three months. The rationale for this division is that, in the analysis of the interviews, the first six weeks and second six weeks postpartum emerged from the interviews as two distinct periods. The period from birth to six weeks was characterized by a reliance on healthcare professionals, a lack of practical knowledge related to breastfeeding, normal newborn behaviours, a loss of sense of self and control, and breastfeeding challenges. The mothers were functioning under the idea that breastfeeding defined early motherhood. Success with breastfeeding would mean successfully becoming a mother. In the period from six weeks to three months, there was a shift where the mothers were beginning to exhibit increasing levels of competence and confidence. The mothers were also beginning to question healthcare professionals and the ideology they had internalized that linked successful breastfeeding to being a good mother. A side-effect of the questioning of the ideology of the good, breastfeeding mother was that the influence of this idea over their choices and decisions slowly began to wane.

The first six weeks: The four main codes pertaining to the first six weeks postpartum are: 1) *breastfeeding is a choice- but not really*, 2) *being blindsided by early breastfeeding*, 3) *losing control of the situation and self*, and 4) *riding the push and pull between feelings of failure and relief*. The first main code *breastfeeding is a choice- but not really* refers to the internalized pressures felt by the participants and their association of breastfeeding to the kind of mother they wanted to become/visualized themselves as being. This category includes the sub codes *self-policing (& guilt)*, and *breast milk is magic stuff*. The self-policing to keep trying to live up to the ideal of the breastfeeding mother and the notion that breast milk is the perfect food underlies

all of the other codes. This internalized binding of breastfeeding and motherhood provides the lens through which the mothers were viewing their breastfeeding experiences, making decisions related to breastfeeding, and approaching early motherhood.

Many of the mothers recounted self-talk they employed to motivate themselves to keep going, this self-talk generally took the form of self-policing and often included elements of guilt related to the internalized ideal of the good mother being the breastfeeding mother. These mothers believed at their core that the way to be a mother, and to become a mother was through breastfeeding, and they were continually applying internal pressure to continue (for some this was day-by-day, or others feed-by-feed). These phenomena, seen again and again in the interviews, become the sub-code *self-policing (& guilt)*.

I think as a mom I think, um, I want to do that, I think it's part of being a mom. P19

I'm just okay, I have to do this. For me, it's like there's no choice in the matter. Like some things you have a choice in life and some things you don't. And this is one thing that I just have to do. P16

He (husband) kind of said, "Well, it's your choice. You're the one choosing to breastfeed, you don't have to." And I said, it's not a choice. It's the best thing to do. P6

I guess just like you kind of need to realize how dependant one little child is on you and how when he needs to feed he needs to feed. You know you don't have any other options. You do obviously, but if you want to exclusively breastfeed you don't. P10

The idea that breast milk is magic stuff came up in the guise of both the science and mythos surrounding breastfeeding discourses and health promotion messages. The mothers in this study had unknowingly internalized these messages to form their own narrative around why breastmilk was so important, and in turn, fueled the extraordinary actions they were taking to keep the breastmilk flowing and to keep trying to get the baby to be able to latch.

All I remember is that we are looking at extracting the good magic stuff. P21

Breast milk is amazing stuff...for her immune system, for everything. Breast milk's a miracle. P5

It (breast milk) has everything she needs. It's got the vitamins and it's got the minerals in bioavailable forms. It has the probiotics that are alive and not that ones that have been sitting in a bottle of formula and are probably have died off. It's completely digestible. It is the perfect, perfect food. P7

The second main code *being blindsided by early breastfeeding* splits into two sub-codes: *not knowing what I needed to know*, and *the shock of the reality of early breastfeeding*. The code *being blindsided by early breastfeeding* refers to the mothers overall lack of knowledge and unrealistic expectations about early breastfeeding. These included knowledge about the intensity of early mothering, and normal newborn behaviour. The majority of the participants were stunned by how difficult early breastfeeding was, as they had expected breastfeeding to be natural, thus coming easily and requiring very little preparation or fore knowledge. Even the participants who had heard from friends and family about potential challenges (for example sore nipples, possibility of low milk supply, or having a baby with a tongue tie) reported being blindsided by the intensity, the physicality, and the seemingly never ending demands of a breastfed newborn.

The sub-code *not knowing what I needed to know* refers to the participants' overall lack of knowledge in the first few weeks regarding what normal breastfeeding looked like (including normal frequency of nursing, how to tell if baby was hydrated, normal input and output, and how to tell if something was not going well), normal newborn behavior and development, and normal life changes when caring for a newborn. The mothers did not know what they needed to know to make breastfeeding work.

The breastfeeding was the one thing I didn't know about, um, the little bit of education I got around that was just focusing on the latch, so it was like I conceptually understood that it had to look like this and not like this, but not the practice of how to like get that to happen. P3

In my mind when I heard all about this information it's like we're going to take your baby, plug your baby in and baby's going to suck... so we found out it's not a simple plug and play thing. P14

We knew nothing, we hadn't even changed a diaper... We were really scared about- and embarrassed about not knowing anything. P6

It's been kind of a trial by fire a bit, or trial by error. I was totally unprepared for the breastfeeding experience. P15

Reassurance that this is normal, is this not normal, because I think that's the biggest thing. All of it's new. So you don't know whether it's normal or not. P10

The sub-code *the shock of the reality of early breastfeeding* refers to how stunned the majority of the participants were with the reality of the first days and weeks of breastfeeding and mothering a newborn. This reality was in stark contrast to the well-established life they had before the birth of the baby. It is important to note that the mothers in this study were used to being in situations where they were able to solve problems and successfully control outcomes, unlike what they were experiencing with early breastfeeding, and this was shaking their concept of self as a competent human being.

Right now I'm in a different place in my life and it's kind of weird to have a baby at this point in my career and in my personal life and everything. I was in a completely childless world and moving forward in my career and everything. I kind of didn't expect this to happen, so it puts you in a completely different place. When you're in your 20s, you're still starting out in life. But now I'm a bit more established, so it kind of puts a big stop sign in front of your life because obviously the baby takes priority. P12

As I say perhaps it's because I am older and I had a life that basically no longer exists, especially being at home with her. Like you know I could just go for a haircut at some point. Breastfeeding is a bitch! P18

The third main code *losing control of the situation and self* refers to the loss of control the participants felt early on. This loss of control included losing control over their breasts and bodies, losing control over their own needs and time to meet the needs of their newborn, and losing control over the decisions they were making to follow the often contradictory advice of

healthcare professionals. This code divides into the sub-codes *reacting in the moment and questioning self* and *surprise vulnerability*.

In the initial interviews, the participants questioned themselves in all aspects of early mothering but especially related to what course of action they should take to make breastfeeding work, hence the sub-code *reacting in the moment and questioning self*. This lack of confidence was fueled by the lack of knowledge, seemingly inconsistent information, and, for many, an early sense of failure as breastfeeding was not going as expected. These factors led to a cycle of reactive decision making, with the mothers being heavily reliant on healthcare professionals for information and solutions.

Every time, I smash into a wall and feel completely defeated and then like, I'm back at square one even though I'm not, but in that moment that's what it feels like, nothing is going to work to make this work, and I obviously really want to make this work, so I keep trying. P1

I know we're trying to put decision making in the hand of the patients, but to be fair there's so much information that I had no idea what decision to make. P16

Like I'm latched on to them (the hospital nurses) part of the time with everything I have, you know, I'm counting on them to help keep my kid alive. P22

The sub-code *surprise vulnerability* refers to the vulnerable and passive state these new mothers found themselves in during the first few weeks postpartum. Many of the mothers in this study reported that they felt that they were unable to think clearly or make sound decisions in the early days and weeks following the birth of the infants due to being in unresolved physical pain (related to the birth and, for many of the mothers, breastfeeding) and experiencing a near constant state of sleep deprivation. That breastfeeding would be emotional as well as physical was unexpected and the intensity left many of the mothers feeling drained. They also reported that in early interactions with nurses, midwives, physicians, and lactation consultants they felt like secondary players in their own breastfeeding experience, that interventions to support the breastfeeding were being done to them, not with them, leaving a sense of exposure and

helplessness. The mothers felt that they had lost their sense of autonomy and had literally become a source of milk production for the baby.

I know he's hungry and even though I know my baby's hungry and that's why he's crying I don't want to go there because I, I mean I have to feed him and that's gonna hurt. On bad days I just feel fat and defeated, and hopeless I would say, like this is never going to change, there is nothing I can do to make this better...I had suddenly just become a milk machine. P1

I thought like there was a lot of attention being put on her and it was about her needs and everything, which makes sense cause she's the little beast that needs to be kept alive, but looking back I felt like there was no kindness, support, or understanding or follow-through with me, and I was just there as a supporting cast in all this. Whereas in the long run I'm the one who has to drive this...I was just being directed and told what to do and that it had nothing to do with me... I was just there to kind of supply the milk. P20

I've just been surviving up until now. P4

The fourth, and final code, for the period from birth to 6 weeks is *riding the push and pull between feelings of failure and relief*. This code pertains to the work of coming to terms with pumping, supplementing, and/or switching to formula. The participants expressed a push and pull between feelings of failure and regret and relief when the supplement or formula led to less stress, a happier (and in some cases actually fed) baby, and more control over their daily circumstances as others (in most cases the partner) could assume more of the baby care.

Just getting sleep too, like noticing like very dramatically, cause initially I even felt guilty giving it to her thinking "I'm just doing this so I can sleep longer. P17

It was both heartbreaking and freeing at the same time (giving formula). P20

I was really sad to not be able to breastfeed and I cried a lot about that. And now I'm just like "You know what? We're in a good place". P5

The decision to take the formula, for me it was almost like there was some relief behind it because someone else was telling me "You need to do this now, stop what you're doing, it's not helping you" It was actually a break...It ended up being really good. P1

Six weeks to three months: The second distinct period in the first interviews was six weeks to three months postpartum, the data for this period came from both the initial interviews and from the mother's reflections on this period in the follow-up interviews. The three main

codes identified in this second phase of the first three months were: 1) *taking back control*, 2) *growing mistrust of healthcare professionals*, and 3) *persisting the f* out of this*. The influence of the ideal of the good mother being a breastfeeding mother is starting to lose strength at this period for many of the mothers as they have to reconcile the reality of life with their new baby and breastfeeding.

The first main code *taking back control* is the evolution of the earlier *loss of control of the situation and self*. By six to eight weeks postpartum, most of the mothers were beginning to find some order in the chaos of their new lives with their infants and regaining some of the control over their everyday lives they had lost in the early postpartum period. Increased knowledge and skill building played a major role in the newly forming sense of order. *Taking back control* divides further into two sub-codes, each incorporating a facet contributing to the sense of increasing control. The two-sub codes are: *finding her own path*, and *reframing*.

In the first sub-code, *finding her own path*, the mothers are starting to make informed choices around feeding their infants that work well for them and their babies. They are starting to build on successes and reject practices that are not working, and are more comfortable in the choices they make without needing as much external validation. Skill building and confidence building, the growing relationship with their infant as an unique individual, and the realisation that there are no absolutes when it comes to breastfeeding and baby behaviour are key components, allowing these mothers to start moving towards trusting in themselves as experts on their babies and their own mothering.

By six to eight weeks, many of the mothers were starting to take a more active role in decision making related to infant feeding and overall parenting. It is important to note that a disproportionate number of the mothers (15 of 23) in this study had research backgrounds and in

their professional lives were skilled at finding credible sources of information and were avid consumers of information. For many of the mothers, adding the evidence they had gathered to inform their choices and feeding practice moving forward was a turning point.

The excruciating schedule lasted about 3 days and that was it! Then we got the bottle because it was like “I can’t do this”. No wonder people kept jumping in front of buses with their children because this is ridiculous, like, anybody would be going crazy...This is my second week on my own and we are establishing our own schedule...Its’ giving me a lot more freedom. P22

There’s something pretty amazing about coming out of the turmoil...Now we’re getting this pattern to emerge...we’ve been going all of these things step by step, but they’re resolving themselves bit by bit, as each one falls away we’re left now with, you know, this, like I can see, I kind of can predict a bit where she’s going to be at and that feels, that feels like a major success. P3

Like the nurse will tell you one thing, the pediatrician will tell you another thing...just understanding that people are going to have different opinions, so I take it more a suggestions...I kind of said to myself “Okay” I did a bit of Googling to see what’s out there and then made my mind up. P10

I’m kind of still keeping the textbook information as not an ultimate goal but as a reference line if you will. P14

The second sub-code under the main code *taking back control* is *reframing*. Reframing pertains to the mothers who were pumping, supplementing with formula, or, in one case, had switched to exclusive formula feeding by the time of the initial interview. A key element of reframing for these mothers was working through the grief and disappointment and moving to ownership of their new reality.

After he lost 12% and the nurse was upset and we gave him formula, everything seemed to go up since then. So that’s (the formula) been very helpful... So it was ok I guess in the end. I came to accept it. P16

He needs to eat you know, he can’t be crying and suffering because he’s hungry, so everything kind of was natural. Which is why, it was (giving the supplement) common sense, I guess. P21

So I was just so relieved to have the option. I think we’re so lucky to have the option, but I think there is so much pressure to breastfeed and I really was like, “Yeah, everyone says I can do this. It’s going to work.” So anyways. Giving her formula was like [gasp] hard but in her best interest and she took to it really well. She was hungry [chuckles].

And then it was like all these wet diapers, so I know she was doing really well and we'd made the right choice for her. P5

By the end of the first three months there was an overwhelming trend in the interviews of a growing mistrust of healthcare professionals. The mothers expressly stated that they felt that health promotion messages towards breastfeeding were unrealistic. In general, health care professionals did not have the answers the mothers needed to make breastfeeding work, especially around alleviating pain. Sources that mothers had thought would provide the answers were often viewed as being laden with pro-breastfeeding ideology, not the value-neutral information they were seeking. The code *growing mistrust of healthcare professionals* consists of the three sub-codes: *Inconsistent info/ no one has any answers anyways, no truth in advertising*, and *wanting clear information*. This code and sub-codes were not informed by the sensitizing concepts and were a novel finding that emerged from the interviews during the course of the data analysis.

In the first sub-code *inconsistent info/ no one has any answers anyways* the mothers expressed how they were let down by the very healthcare professionals they had so heavily relied on in the early days. Inconsistencies in information and advice that did not lead to lasting positive outcomes led to a feeling of mistrust of official sources. Many of the mothers chose to do their own research instead of relying on healthcare professionals as they found the inconsistent, and at times contradictory, information confusing and misleading.

So it felt like almost every day we went out to a medical appointment or to a lactation consultant. And I found the advice varied between "Make sure you're compressing or don't compress too much", or "Use a cup" or on this website it said to use a tube because the cups are like nipple confusion. I found it overwhelming because there was like no truth, like no absolutes. P16

I felt like nobody knew, nobody actually knows. P2

Yes, and I do it their way and it still isn't working out. "Well, you're holding her wrong" or "You're doing this wrong" and "You're doing that wrong." And you'll start seeing a

good result. And I was like okay, I've done exactly as they said and nothing has worked.
P7

Like there were multiple times I just didn't want to go back to the support centres, like I just don't feel like anything was helping so why would I keep going and asking people, or do I just keep going back to the same one cause then I'm not getting conflicting advice, and then who? P1

The mothers reported feeling lied to by official sources, sold a proverbial bill of goods when breastfeeding did not turn out to be the idealized and easy reality they had expected. The second sub-code in this series is *no truth in advertising*. In this sub-code the mothers actively questioned health promotion messaging. These messages included that breast is best and that formula was a distant second for infant nutrition and healthy long term outcomes, and the idea that breastfeeding is natural thus easy, and convenient.

The pressures of breastfeeding and all that. So I was like okay, you know what? Maybe it is tough. It is tough to breastfeed. I don't know. And I've asked many friends and some said "Oh, we couldn't do it". Formula- their children are the smartest. They're healthy, normal. P13

Textbook information is about how often you should feed, what the diaper output should be, tricks to protect your nipples like the creams and things like that. I thought that's what breastfeeding is and found out it's quite different, very, very, very different. I mean, yes, the way you breastfeed and things like that are one thing, but the challenges that you may experience people don't often talk about that. They talk about your cracked nipples but not the fact that you're tethered to your baby 24/7. P14

I wanted to breastfeed because I thought it would be great because you don't have to wash bottles all the time, do sterilization. You won't have to buy formula, it's economical, efficient. That's great. So I thought that would be really good. But the thing is you just think you're going to like pull out your breast and you put it in the baby's mouth and like that's it, you know. Like it's easy. It's not easy. Not at all! That's the thing. From my expectations versus, and benefits that I thought it would have, and if it works out for the baby too is all the good reasons, versus what happened is, yea, quite a disconnect. P23

Many of the mothers also felt duped by ideology laden-information. In the early days, most of the mothers were true believers in breast is best and breastfeeding as the only route to motherhood. By the three month point, they clearly wanted to make their own decisions based on their own values and life circumstances. The mothers who continued to seek professional

advice were the ones who had received clear information. Hence the sub-code *wanting clear information*.

The advice was direct and concrete...You're comfortable that she knew what she was talking about, she was competent. P10

When things wouldn't go well we could ring and they would come and help. So it looked like they had all the knowledge of those early challenges and could help. They (the lactation consultants) were great...I had answers. P14

The lactation consultant, like there, I don't know, there was some kind of, like she was helpful. There's a part of it that feels a bit, um, blamey, like she was very nice and useful, but it's, I don't know, there's like a subtext you know, of, it's hard to kind of put into words. P3

The final main code from this period was *persisting the f* out of this*, which is a verbatim code that sums up the challenge-laden journey the mothers had experienced by the initial interview and the underlying feelings of frustration, at times anger, and pride in the words of the mothers. The two sub-codes associated with *persisting the f* out of this* are *really wanting to be a breastfeeding mom*, and *failure is not an option*.

There was an underlying desire in all of the interviews, regardless of the challenges or how the mother was feeding her baby at that point in time, of really wanting to be a breastfeeding mom. This was the goal that all good mothers, in the minds of the mothers, were striving towards, although not all were able to meet that ultimate goal of early motherhood.

I definitely had this idea of myself as like the semi granola-y, carry my baby everywhere, breastfeed him on the go, no problems mom, and that's not what's happening. P1

I haven't had any issues, but I feel like I don't understand why someone wouldn't breastfeed unless they had a specific reason because I'm like, it's so much better for him. I think I would maybe be a little judgemental of people who don't breastfeed because it's just uncomfortable or they're not in touch with their bodies or whatever. P15

The second sub-code *failure is not an option* refers to the recurring notion in the interviews that formula feeding simply was not an acceptable outcome for some of the mothers. These mothers hung on to the link between breastfeeding and maternal identity longer than the

others, and they planned to continue to try and provide breast milk/ breastfeed their infant.

Again, here self-talk is a prominent feature and the sub-code is closely linked to self-policing.

As P7 stated, “This was our identity, we were going to be breastfeeding.”

Just kind of focusing on okay this is for a good reason. I’ll get through this because it’s worth it for him and it’s not every day like this. I keep reminding myself. P13

I’m pushing through. I have no choice...I’m tougher than most. P12

I kept telling myself I think I can do it. So that got me through the pain and everything. It’s me. I don’t want to give up easily everything....I always look at it in life you can overcome any challenges. I don’t want to give up. P1

Codes: Follow-up Interviews (three to six months). The 18 follow-up interviews represent the time period between three months to six months postpartum. This period was characterized by active agency leading to informed decision- making, and by a growing sense of independence and empowerment as mothers. The codes in this period link directly to codes from the initial interviews and represent the evolution over time of both the decision making process, the rebuilding of self, and the attainment of the maternal role.

There were six main codes identified in the follow-up interviews representing the period from three months to six months postpartum. The six codes: 1) *on being a mom, being a good enough mom, and being us*, 2) *mistrust of the party line – seeking information not ideology*, 3) *romanticising the idea of the breastfeeding mom*, 4) *finding one’s tribe*, 5) *persisted the f* out of this*, and 6) *moving into ownership and control*, all build on the pre-existing codes from the six week to three month period.

The first main code in the period from three to six months is *on being a mom, being a good enough mom, and being us*. This code splits into the two sub-codes *being a mom to my baby*, and *finding and owning good enough*. By the second interviews, the mothers were still speaking of themselves and the baby as a dyad, but now the baby was clearly being spoken of as

a unique individual. The mothers had come to the realization that life has to go on and sometimes that means not striving for the ideal of the good, breastfeeding mother, but rather finding good enough, given their situation. The influence of the internalized ideology of breastfeeding motherhood had receded into the background for most of the mothers in this study. The mothers were starting to simply do what was working best for themselves and their babies without feeling the need to apologize or justify their choices anymore. The first sub-code in this series *being a mom to my baby* represents the mothers' expressions and stories of learning to trust their babies and their instincts to help guide their choices around infant feeding, breastfeeding, and parenting.

I think it's gotten better, again as I gained confidence, and at some point trusting the baby, getting to know the baby...So basically the experience has gone very well because I've been baaad by myself and at some point I don't know who told me, just like "drop the book." I think it may have been when we were discussing the first time, so just drop the book and just watch the baby and things like that. So I guess that's what I've done and since it's been going well. P14

I'm feeling that I have to make decisions each day about his personality and my personality and what works for us...We are setting in a routine like a little noisy machine. P16

I figure she'll (the baby) let me know what's working and nothing seems unreasonable. P3

I think once I realized that I kind of have to let everything go a bit and just go with the flow. So basically it was me, it wasn't him that was, I just had to kind of learn to sit back a little bit and just relax, not to be so uptight about everything. Once I kind of learned to do that everything's been going very well. If he's hungry and it's not quite 3 or 4 hours I just feed him anyway, just a couple of ounces to tide him over until it's feeding time, so everything's been going really well. P21

I'm not really a "trouble-maker" quote-unquote in a practical sense, but here I was just like "I'm gonna do what I need to do, too bad (referring to breastfeeding in church). I am surprised actually, I feel like, oh, if I had thought about doing it in a decision I probably wouldn't have, but because it's just following my child's more important than cultural norms. P16

The second sub-code in this series *finding and owning good enough* explores how the mothers are beginning to reject the idealized version of motherhood and make choices that are good enough in the day to day.

I mean, clearly there's no instruction manual for dealing with a baby...Everybody has an opinion and clearly I'm not doing what I'm supposed to be doing according to 95% of the population, so OK, if that's the case then I'm doing it anyways and I am well and she's well and everybody's happy on my end and, hey, I'll probably carry that over to other things too. P20

Like what's happening with the baby, I don't have enough milk, but after a while I was like, well, she's gaining weight and she's not for the most part getting upset like as if she's not getting enough. Right, so it's like, obviously, it's just my body doing and it's fine, so yea, and there was a time where I was like should I be taking all these teas and cookies and I was like trying like, I would try some of them and then I just stopped it altogether, like it's obviously fine. P9

I'm just like arrrr, but you know what? I do right by my kid as much as I can (when discussing criticisms that she was not eating an organic diet while breastfeeding). You know I'm not perfect, but it could be worse. P22

I do find it's like a special time now and I'm trying to really take advantage and enjoy it more, like sometimes while I feed him I'm just reading twitter litter. But other times I'm just trying to bond with him a little. P18

The mothers in this study expressed disillusionment with the established breastfeeding promotion groups and lactation consultants. For many of the mothers, well known groups like the La Leche League represented what were supposed to be the keepers of all breastfeeding knowledge, support, and ultimately a community of like-minded mothers on which to model themselves. But when many of the mothers reached out to these groups (primarily online) for information and support, they found the information to be loaded with subtexts and moral stances on the rightness of exclusive breastfeeding and attachment parenting. By three to six months postpartum, this philosophy was not fitting with the lived reality for the mothers in this study, or with their desire to also have a life of their own outside of the baby.

The code *mistrust of the party line – seeking information not ideology* encompasses the mothers' reactions to what they viewed as breastfeeding “militants and zealots” (this included peer support groups and public messaging) as having an agenda to promote breastfeeding at all costs. Many of the mothers felt they had been sold a bill of goods, with some stating they felt outright lied to by officials and other mothers. By four to six months postpartum the mothers

wanted information not ideology. By this time they had come to terms with what was realistically going to work for themselves and their infants and simply wanted evidence-based information to make informed decisions about infant feeding and to trouble shoot challenges as they arose.

The mothers actively questioned the marketing of breastfeeding. They agreed that breastfeeding is best, but it is also isolating and limiting. Breastfed babies do get sick, they do switch back and forth between the breast and the bottle. There are other ways to bond with your baby. It isn't bliss to do nothing but give, and sometimes healthcare professionals and other mothers simply lie about how great breastfeeding is. Due to the point that they were at in their lives before coming to motherhood, many of the mothers describe feeling that the cut to their lives was deeper. Breastfeeding was harder for them as they felt it essentially obliterated the well-established and ordered life they had had before.

The other one (a friend's baby) went on a formula fed diet and it's afforded her a freedom that I don't have, so you know when you see all your friends going to the spa for the day and you don't have enough milk in the freezer and they say "do you want to come for the day?", it looks like Hell. I keep keeping thinking of what I told you why I wanted to do it (breastfeed): Benefits for her, fair enough, but so far she's gotten sick twice and the formula fed baby hasn't. I haven't lost any more weight, and she's (the formula feeding mother) lost more. P14

And you know I have friends who can't nurse so obviously I know that they are bonding differently its' not like you have to breastfeed to bond. P18

It's just not as (pause) not as fun as I thought it would be. It's cool, like you love watching her grow up and develop, but I find it a bit lonely and it's a lot of work. P9

The mothers in this study wanted community and reliable sources of information but not ideologies that did not necessarily fit with how they were choosing to practice motherhood.

They sought neutral, realistic sources of information, tips, and advice, and felt too many official breastfeeding sites and sources had undertones of activism and lactivism. These mothers were

avid consumers of information, and many were expert researchers and found it frustrating that neutral information was so difficult to find.

I had pictured them (La Leche League) before birth as trusted sources of information, and I think I'm figuring out more now that they are breastfeeding activists more than neutral, reliable sources of information. I wish I could have had more realistic versus idealistic information...I found a lot of the narrative is to make you feel guilty, they scared me off just by the tone and stuff on their website. P14

It's tough to get resources (on pumping). I mean, I guess it's tough for everybody, who knows? But I found it difficult to get appropriate information. Both camps seem to have militant people that were going to recruit or judge you...At some point I was just on information overload, so I just kind of decided that I'm done, I'll figure it out (decreasing pumping). P20

I think it's too bad when people are so militant about it (breastfeeding) one way or the other. Like they're kind of fundamentalists I think. People just get so attached to one viewpoint over the other. So I guess I find it interesting, but I sort of stand back from all of it and go wow, this is how I'm feeding my baby. I'm not going to feel too proud or too guilty or too anything. It's just what I'm doing. P5

I don't know if it's a philosophy, it's just that I want evidence-based information. It's kind of an oxymoron but sometimes you need to say it, hmm, yea, I want science-based stuff (talking about breastfeeding resources). P18

When they did find sources of information they trusted, the mothers tended to keep referring back to those sources. The sources were generally viewed as neutral or unbiased, and always viewed as being up to date on current information and reliable sources of evidence based information.

I said trust the science at some point. If they are recommending 6 months breastfeeding, it's both the Canadian Pediatric, I mix the name, but the American Pediatric Association or Canadian Pediatric Society, if they are both recommending 6 months based on research and things like that, I am a scientist so I am going to trust the research. P14

You kind of find resources that align with how you feel, I guess, or like what your approach is, so you just, this is like the midwives were super cool in the beginning, just in the way they are so evidence based and non-judgemental and they kind of give you the options and the pros and cons without actually telling you what to do. I found that was really helpful for figuring out like, what I wanted and like how I wanted to do things and from there I was able to get resources. P17

The code *romancing the idea of the breastfeeding mom* splits into the sub-codes of *self-talk/self-policing* and *brussel sprouts*. As in the first interviews, the participants continued to use self-talk and external motivators to continue to try to reach their breastfeeding goals. The sub-code *self-talk/self-policing* is a direct continuation of the *self-policing (& guilt)* code from the initial interviews.

Sometimes I feel like shit and sometimes I use that for motivation. I like try if someone's setting an example (by breastfeeding in public). Well, she's doing it. I could be doing that. P22

I felt isolated and lonely, and I as like thinking of what I could do to make my life better, and I was seriously contemplating not breastfeeding her, maybe that would make it easier for me. And then I was like no, no, I'm not going to give up. But I thought of that. P9

But I always say "it's only a few more months". P23

There are days when I'm such a faker because people think I'm so happy and so well, and there are some days when I really wasn't. And that was really hard. But that was not just about nursing. That was like all around stuff. Yea, I feel better now but, maybe not faking it but there's days when like yea, I still feel like I don't know what I'm doing, but at least I don't feel like I'm putting on a front to people, you know? P18

The sub-code *brussel sprouts* incorporated all of the recounted moments during the interviews where the mothers were frustrated at how breastfeeding (and for the pumping mother-pumping) seemed to take over every moment of the day. Breastfeeding continued to take precedence over all other activities even once breastfeeding was well established from 3-6 months postpartum. Routine things that in their old life would have been quick and easy to accomplish require near epic efforts to make into reality- the cooking of gourmet brussel sprouts exemplifies the nature of these stories that ran throughout the second round of interviews.

I just do minimal things, thank goodness for the internet. P16

Which is lowering expectations...I was always doing something, always a project that we'd be doing, and now...Putting dinner on the table is hard...It was everything I could do to kill those brussel sprouts. And also it's like, it's almost like pumping milk like when you

first start you don't...you only get a tiny amount and there's so much effort expended just to get that, and it seems like everything else is like that, like keeping the house tidy, getting the laundry done or whatever, it's just nothing is easy. Everything's that much harder. P22

When you imagine things it's quite simple, you know? It's quite simple. I always tell my baby in the morning, I say OK, so today's going to be like this, we're going to be doing this, then we'll be doing this, and then that's not what's happening. We're going to do that and then you're going to sleep in your crib. P23

You have it in your head that maternity leave would be like, Oh, I will be able to get out and do all of these things and maybe like take a course online, I just sort of thought that it's like a break. Yea, but it's not. P9

By the second three months postpartum, the mothers in this study had moved from reliance on the advice of nurses and other healthcare providers, to seeking peer supports and finding answers in the wisdom and common lived experiences of other mothers. The code *finding one's tribe and the wisdom of other mothers* encompasses the experiences with other mothers that the mothers in this study recounted as being valuable. These encounters, both in person and online, served to normalize and validate their experiences as mothers and were invaluable sources of information on parenting.

At one point I was wondering if I had enough milk just because my breasts felt really hard like, but they are softer all the time now, and my friends all said, "The same thing happened to me, and this is normal"...They were kind of reassuring that it's ok. P10

I am on like Facebook groups. There is like, I only recently discovered it, but there is an attachment parenting, it's like Ottawa Attachment Parenting is the group. I haven't asked any questions on that but it's just one that I'm kind of following a little bit so you get kind of info from those, kind of, yea, like other parents' experiences. P17

For most of our girlfriends it's their second, so that's really nice cause I can check in with them and they are obviously experts, like they are pros at this point. P18

I joined some group, mom groups like strolling, fitness with Jules,... so you walk with another mom and you get information, for me it was, ah, yea, to ask information. P19

I actually go to check other people's blogs to see if this is normal, so it's basically, ahm, just moms....Sometimes I feel like I don't know what I'm doing, and I don't mean in a bad way because it's all new to me, so I feel the blog is very helpful...It can be like, oh, wow, ok, so I'm not alone in this. Other people are experiencing the same thing. P21

The mothers told numerous anecdotes of persisting towards their breastfeeding goals and most had found solutions to the early issues, or had chosen different paths that worked better for

them and their baby's needs. The code *persisted the f* out of this* exemplifies the mothers' expressions of having overcome, having worked through difficulties and having come out the other side as stronger, more confident mothers. Some of the mothers reported how through hard work and persistence breastfeeding simply got better over time and they felt they had met their goals and achieved the vision of the breastfeeding mother. Other mothers in the study had to work through the reality that although they had tried and tried, breastfeeding was not going to be a long term option. These mothers had to find other ways to identify as good mothers. This code is exemplified by the quote "The crap that doesn't kill you..." P13 essentially is what these mothers expressed makes them feel that they are now a mother.

I stopped using the nipple shields when it seemed like there was a problem and it still wasn't really helping and we had lots of pain again. So at that point we got a posterior tongue tie release, upper lip tie and two buckle ties released, so a bunch of work done and then a whole bunch of recovery and stretches and pretty intense stuff after that before he finally healed and things (breastfeeding) got a lot better...I mean the crap we went through to get here is, I don't know. I mean maybe it's just one of those things where what doesn't kill you makes you stronger. P1

My mom is like you should just try breastfeeding again. Just put her to the breast, see what happens. And I feel kind of anxious about it. I'm like you know what? The pumping is going well. I don't know if I want to be through the disappointment again of having it not work, so I haven't tried. P5

The final main code, *moving into ownership and control* divides into the sub-codes *seeking balance between own needs and baby's needs* and *reframing*. The first sub-code, *seeking balance between own needs and baby's needs*, refers to the continual push and pull expressed by the mothers between meeting their own needs as mothers and persons, and their baby's needs as related to feeding. At this point in time, the mothers were recognising that the baby is a unique person with needs, wants and preferences outside of the mothers. For some of the mothers in this study, by the second interview they were at a point of comfort and feeling successful in finding balance. For some, breastfeeding did prove to be the easiest option, for

others pumping and feeding expressed breastmilk provided more balance and for others formula feeding was what ultimately afforded both the mother's and baby's needs being met.

When you're a lazy mom and your baby cries and you don't really know what's going on, you just plug her to the breast and somehow everything seems to be going better. P14

And I think when we were struggling with breastfeeding it become just about being a mom and that was extra hard. And so to me it's like the balance, and I need to be healthy for my child and I want to be a good model for my child, and the only way I can do that is to sometimes put my needs before Tim's and in a way that I know it's not harming him, so for me to go out for the night does not harm him. P1

We kept the bottle so then my husband had an option to give her a bottle if need be and I could leave the house more, so we just like-I didn't want to take it away from her and then have trouble re-introducing it if need be so I just kept it a night. And I also found that using a little bit of formula before bed helped her sleep better, so then she sleeps like a 5 hour stint which is nice. I mean she gets the 5, I get the 4, but it's still nice. P17

I think coming to the university is also mentally it's...like a four hour break, it's good for myself. P19

I get my exercise and I eat well, those are the basics that I need for self-care, and then I can look after him. Whatever I do to look after myself benefits him. P22

The sub-code *reframing* encompasses the stories from the mothers in the study who by the second interview were either formula feeding or exclusively pumping expressed breast milk for their babies (and in two cases for other babies too).

It felt like a challenge at the time. I keep a really careful log of every time I pump and how many millilitres I get from each breast and when I look back I have notes of like 15ml, hooray! And now it's like 200 ml, overflowed bottle. Stuff like that. I mean it started slow and it felt painstaking, but I've spoken to other women who were just never able to get the supply up, so I feel very lucky. P5

I figured she's getting what she needs via pumping anyway, so we just decided to stick with that. At the same time ...my brother and his wife just had a baby...and it turned out that the mom was not producing milk like she wanted to either, so the fact that I was pumping rather regularly and I had a lot of extra- I have been sending milk over to baby number 2. I figured it was a couple extra minutes of unpleasantness for me a day, while it then gave the other baby all kinds of happy nutrients. P20

In Summary. The first six weeks postpartum for the participants in this study were characterized by feelings of vulnerability, dependence and a lack of ownership related to breastfeeding and mothering. The combination of not knowing what they needed to know and

the surprise at the intensity and skill required for early breastfeeding left the participants feeling out of control and in a position of relative powerlessness, resulting in the participants acting primarily as passive agents leading to cycles of early reactive decision making. The participants came to breastfeeding as *true believers* in the value of breastfeeding and had internalized both socio-cultural expectations of intensive mothering/ attachment parenting. The internalized ideology drove the participants to continue the cycle of reactive decision making.

From six weeks to three months there is a noted shift from early vulnerability and dependence towards active skill building. The largest shift in this period is the growing mistrust of healthcare professionals and health promotion messages as the mothers begin to question the lack of clear, practical, nonjudgmental, and consistent information they had received to date related to breastfeeding. The mothers' mistrusted sources that they perceived as providing information based on ideology rather than evidence-based facts. This included information from diverse sources, including online blogs, popular breastfeeding peer support organizations, and public health units.

By the time of the follow-up interviews, between three and six months postpartum, the mothers in this study had moved away from indiscriminate taking of advice and information to being active researchers and consumers of information on breastfeeding (and all other forms of infant feeding), internalizing and putting into practice in their everyday lives only the information that fit with their lifestyle, their beliefs systems, and the temperament of their individual baby. The mothers had gained knowledge, control, trust, and ownership, leading to the active agency and the participants making informed decisions. By three months postpartum, the mothers' own needs and desires had overridden the need to live up to the ideal of the good,

breastfeeding mother. The influence of the ideology of the good mother had rescinded into the background and was no longer driving the decision making process by the second interviews.

CHAPTER FOUR**MANUSCRIPT #1****THE BREASTFEEDING EXPERIENCES OF OLDER FIRST-TIME MOTHERS:
A CONSTRUCTIVIST GROUNDED THEORY STUDY.**

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Abstract

Objective: The objective of this paper is to present the results of a qualitative study that explored the factors surrounding decision-making related to breastfeeding and the experiences of early motherhood for 23 first-time mothers over the age of 35, in Ontario, Canada. Previous studies on breastfeeding have not examined older first-time mothers as a group that is unique due to their experience of coming to motherhood in the context of the growing phenomenon of delayed childbearing in the 21st century. Many older women come to motherhood with both well-established life and professional experiences, and as such their needs may differ from their younger or multiparous counterparts. The research question was: “What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?”

Design: Constructivist grounded theory

Findings: The theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* provides a lens to view the underlying processes influencing the decisions related to breastfeeding the mothers made over the first 6 months postpartum. The mothers worked through the processes of learning breastfeeding, redefining self, and defining motherhood. The mothers’ belief in breastfeeding defining motherhood, coupled with lack of knowledge and control, had a negative effect on both early breastfeeding and their transition to motherhood. In the first six months postpartum, the influence of the idea of breastfeeding equating successful mothering waned. Over the first six months, the mothers became active agents in decision-making related to infant feeding and were mothering on their own terms.

Keywords: Breastfeeding, Older Mothers, First-Time Mothers, Supports, Experiences

Introduction

Background

Since the 1990s, there has been a growing trend in Canada and other developed countries towards women delaying childbearing, with increasing numbers of new mothers being over the age of 35 at the time of first live birth (Best Start [BS], 2015; Canadian Institute for Health Information [CIHI], 2011; Mills, Smith & Lavender, 2012). Overall, births to women over 35 are increasing, for example by 2011, one in five live births in Canada was to a mother over the age of 35 (BS, 2015; CIHI, 2011, Statistics Canada [SC], 2018 A&B). In 2018, births to both primiparous and multiparous women over 35 accounted for 23.3% of total births in Canada (SC, 2018C).

Mothers over the age of 35 are at increased risk of hypertension, gestational diabetes, preterm birth, and multiple births- morbidities that are also associated with early breastfeeding challenges and cessation (BS, 2015; Brown & Jordan, 2012; CIHI, 2013; Fisher et al., 2013; Society of Obstetricians and Gynecologists of Canada [SOGC], 2012). Older first-time mothers represent a distinct demographic of new mothers due to the complex factors surrounding the multitude of reasons for, and realities of, having children later in life (Cooke, Mills & Lavender, 2012; Mills et al., 2014). Despite representing a steadily growing demographic of new mothers in Canada, the expectations, experiences, and factors influencing the decision making process about the breastfeeding practices of older first-time mothers are poorly understood and are underrepresented in the literature (Cooke et al., 2012).

The breastfeeding experiences of older first-time mothers have the potential to both negatively and positively affect breastfeeding duration and mothering behaviours and impact maternal-infant attachment, maternal mental health, and infant growth and development.

Previous studies on breastfeeding have not examined older first-time mothers as a distinct group despite the fact that they may experience unique challenges due to their often well-established personal and professional identities. As a group, they are experiencing coming to motherhood in the context of the growing phenomenon of delayed childbearing in the 21st century. Their different experiences may translate into their having different support needs surrounding breastfeeding and the transition to motherhood than their younger or multiparous counterparts.

The Study and Research Question

In order begin to address this scarcity of evidence, a constructivist grounded theory study was conducted as part of a doctorate in nursing. This article presents the findings of a study conducted with first-time mothers ≥ 35 years of age recruited from a major urban centre in Ontario, Canada between July 2016 and September 2017. The study addressed the research question *What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?*, while exploring four sub-questions based on maternal expectations, choices, decisions, achievements, and regrets related to early breastfeeding (see Table 1). The theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* was developed from the raw data of the 41 interviews conducted with 23 women during the course of this study. This theory is proposed as a theoretical basis to help inform future evidence-based nursing practices related to breastfeeding support and targeted health promotion interventions for first-time mothers 35 years of age and over.

Table 1: Research Question and Sub-Questions

Research Question	What factors affect how first-time mothers ≥ 35 years of age make decisions about breastfeeding, and how do these factors affect the decisions they make related to breastfeeding in the first six months postpartum?
Sub-Questions	
1.	“What are the prenatal expectations about breastfeeding of first time mothers ≥ 35 years of age?”
2.	“What are the factors influencing the choices first time mothers ≥ 35 years of age made about feeding their infants in the first six months postpartum?”
3.	“What are the facilitators and barriers affecting the decisions first time mothers ≥ 35 years of age make about breastfeeding their infants in the first six months postpartum?”
4.	“Given the decisions that are made about breastfeeding, what do first time mothers ≥ 35 years of age identify as their achievements and regrets about their experience breastfeeding their infants in the first six months postpartum?”

Methods

Design

Methodology. This study was conducted following Charmaz’s (2014) constructivist grounded theory (CGT) methodology. CGT harkens back to the inductive, comparative, emergent, and open ended roots of grounded theory from the 1960s, but with a flexible use of methods. CGT focuses on meaning, with the ultimate goal being to understand a social phenomenon while developing a theory grounded in the meaning of the data (Charmaz, 2014; Gardner, Fedoruk & McCutcheon, 2012). Charmaz describes the theory as “an interpretive portrayal of the studied world” (p.15).

CGT’s goodness of fit with nursing research is evident in the mirroring of the emergent nature of grounded theory research design, the use of constant comparative methods of data analysis and collection, and the ongoing reflection and assessment in the memo writing process.

These features of CGT parallel the nursing process where issues, problems, and morbidities are constantly in a state of flux, influencing nursing decision making and care. Furthermore, the constructivist worldview is found to be common in nursing, as understanding the subjective experience of the patient is central to therapeutic relationships and the provision of appropriate nursing interventions and care (Gardner et al., 2012; Higginbottom & Lauridsen, 2014).

Setting. The study was conducted in a major urban centre and surrounding areas in the province of Ontario, Canada.

Participants and Recruitment. The inclusion criteria were: being a first-time mother 35 years of age or older at the time of first live birth, having an infant who was three months of age or younger at the time of the first interview, and having attempted breastfeeding or pumping at least once following the birth. The participants were recruited via a combination of community posters, online via Kijiji, and through targeted mail out recruitment packages from the local health unit from June 2016 to September 2017.

Data Collection. The primary source of data was 41 semi-structured interviews with 23 participants. Initial interviews were conducted with all 23 participants. Eighteen participants completed a follow up interview three to four months later. The interviews were conducted in locations of the participants' choosing, including local coffee shops, walks in local neighborhoods, the participant's places of residence, and the participant's places of employment. The interviews were digitally recorded with participant consent. Written, informed consent was obtained from each participant before the start of the initial interview.

A short demographic data questionnaire was completed by each participant. For a summary of the demographic data see Table 2. Participants were free to withdraw from the study at any time, for any reason, without penalty. All participants were given a list of

community resources for new parents (including free breastfeeding and mental health supports) before the start of the initial interview and a \$5 coffee card as a thank you for their time.

Table 2: Demographic Data Summary

Questionnaire Questions	Participant Answers
Maternal Age (at time of birth of baby)	Mean Age: 36.7 years Range: 35-44 years of age
Age of Infant (1 st interview)	Mean Age: 4.7 weeks Range: 6 days - 3 months
Age of Infant (2 nd interview)	Mean Age: 4.5 months Range: 3.5 - 6 months
Relationship Status	Single- 0 Common Law- 6 Married- 17
Highest Educational Attainment	College Diploma- 2 Undergraduate Degree- 4 Graduate Degree- 15 Not disclosed- 1
Employment (prenatal or current)	Full Time- 20 Part Time- 3
Do you plan to return to work?	Yes- 23
(1 st Interview) Are you <ul style="list-style-type: none"> • exclusively breastfeeding (BF), • formula feeding (F) • expressed breastmilk feeding (EBM) • mixed feeding your baby? 	BF = 10 F = 1 EBM = 1 Mixed Feeding = 11 BF + F = 4 BF + EBM = 2 BF + F + EBM = 4 EBM + F = 1
(2 nd Interview) Are you <ul style="list-style-type: none"> • exclusively breastfeeding (BF) • formula feeding (F) • expressed breastmilk feeding (EBM) • mixed feeding your baby? 	BF = 5 F = 2 EBM and donating EBM = 2 Mixed Feeding = 9 BF + F = 4 BF + F + EBM = 5
Are you or have you expressed breastmilk?	No- 4 Yes- 19
Number of pregnancies	1 (18), 2 (3), 4 (2)
Antenatal care provider and place of birth	Place of birth Hospital birth (22) Birthing Centre (1) Antenatal care provider

	Physician (19) Midwife (4) Care provider through labour and birth Physician (19) Midwife (3) Physician and Midwife (1)
Type of birth	Vaginal birth (18- 3 with induction) Cesarean- section (5 – 3 emergency)
Any issues with conceiving or use of fertility treatments?	No- 17 Yes- 6

Data Analysis

In keeping with CGT and the use of constant comparison and theoretical sampling, data analysis was carried out concurrently with recruitment and data collection. The analysis followed the two sequential stages of initial and focused coding. The researcher was immersed in the data using the participant's words in the memo writing, using verbatim codes, and transcribing the interviews while seeking the meanings embedded in the raw data. The questions *What are the main issues of the participants?*, and *How do they solve/ resolve these issues?* helped to guide the analysis and facilitate the search for early categories (Charmaz, 2014; Kenny & Fourie, 2015).

Initial Coding. The first stage of data analysis employed line-by-line open coding using gerunds (Charmaz, 2014). This stage was guided by Mercer's (2004) theory of becoming a mother, and Leff, Jefferis & Gagne's (1994) concept of maternal satisfaction with breastfeeding. The initial codes were provisional, comparative, and closely grounded in the data. Extensive memo writing was employed to help to find patterns and categories in the initial codes.

Focused Coding: The second stage of coding consisted of focused coding, in which the researcher returned to the transcripts, open codes, memos, and field notes seeking both patterns and individual codes of potential theoretical significance. The interviews were re-coded in the

focused coding stage, seeking categories and patterns. The first round of re-coding was with each stand-alone interview. The second round of re-coding was with all the initial interviews as a grouping, next with all of the second interviews as a grouping. Lastly, the interviews were re-coded examining the first and second interviews from the 18 participants who completed a follow-up interview. Finally, the codes were taken as a whole picture, to find the metaphorical forest for the trees. The codes were used to guide the creation of the core category and the three secondary categories at the theoretical level.

Literature Review

In keeping with Charmaz's (2014) CGT methodology, a second immersion in the literature following the completion of focused data analysis was conducted. This narrative review was used to guide the discussion of the theory, provide current context to the study, and help to gain insight into the clinical implications for nursing practice providing breastfeeding support for mothers ≥ 35 years of age.

Findings

The theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* was developed from the codes and categories grounded in the data. The core category identified was *under the influence of breastfeeding being the key to motherhood*, and the three interrelated secondary categories were *learning breastfeeding*, *redefining self*, and *defining motherhood* (Figure 1).

For the mothers in this study, success with early breastfeeding and being a *good* mother were inextricably tied together. The participants came to breastfeeding as true believers in the value of breastfeeding and had internalized the dominant socio-cultural expectations of intensive mothering and attachment parenting (Sears & Sears, 2001). If breastfeeding went well, then they

believed they would act like mothers, feel like mothers, and have met their expectations of who they were going to be as mothers. Occurring under the influence of the belief in breastfeeding being the key to motherhood, were the three simultaneous processes that the mothers navigated in the first six months. The first process was learning breastfeeding, the second was redefining self, and the third was defining motherhood.

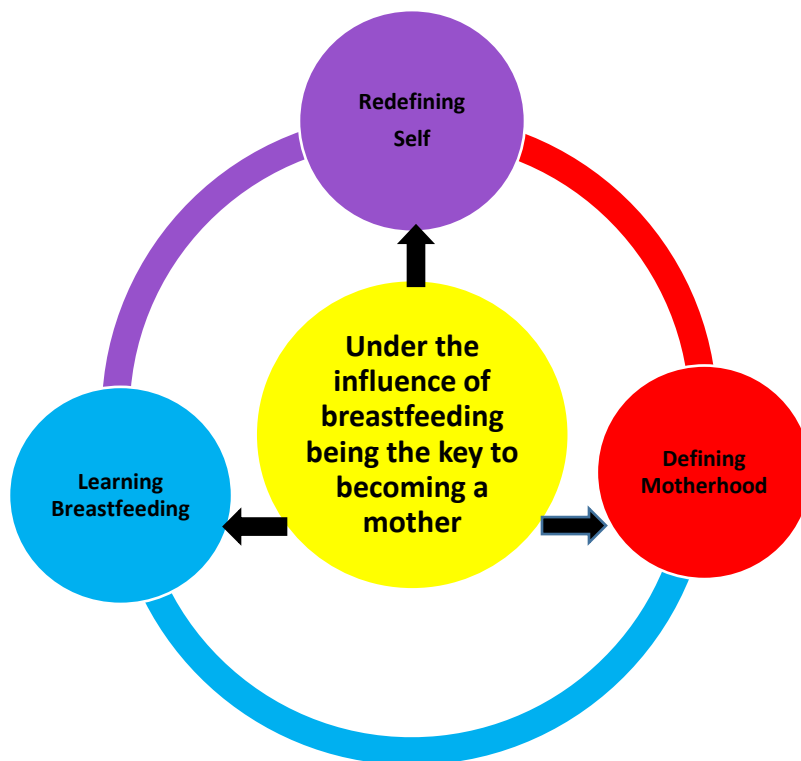


Figure 1: The theory of *From ideology to independence: Older first-time mothers, breastfeeding, and becoming a mother*. Above is a map of the relationship between the core category and the three secondary categories.

Learning Breastfeeding. In the first six months postpartum, the mothers in this study gained knowledge, trust, control, and ownership of both their infant feeding and mothering practices. The four areas of knowledge, control, trust, and ownership, helped the mothers work through the simultaneous processes of learning to breastfeed, redefining self, and defining motherhood. In the first six weeks postpartum, the mothers in this study were blindsided by the reality of early breastfeeding. For the most part they had expected breastfeeding to be natural,

with the baby simply being able to feed when put to breast every three hours. Even the mothers in the study who had been told by friends and family that there could be issues were surprised by the physicality of early breastfeeding.

In my mind when I heard all this information it's like we're going to take your baby, plug your baby in, and your baby's going to suck....So we found out it's not a simply plug and play thing. P14

The mothers' lack of knowledge about normal newborn behaviour, development, and the technical aspects of breastfeeding heightened the sense of not meeting their own expectations of themselves as mothers. Adding to feelings of not successfully performing in their new role as mothers was a sense of chaos as the mothers experienced a lack of routine, the cycle of moving from one issue to another related to breastfeeding, and the lack of consistent information from healthcare professionals. Overall, the mothers found the first six weeks was a time when they were vulnerable due to the lack of control, pain, lack of knowledge and sleeplessness. To compound the feelings of lack of control, they felt frustrated by the seeming lack of clear protocols and consistent advice from healthcare professionals.

I was totally unprepared for the breastfeeding experience. I read a lot about all the birthing and post-births and like that, but I had no idea about the breastfeeding, really. I thought I did. P15

I smash into a wall and feel completely defeated (with breastfeeding progress). P1

By six to 12 weeks postpartum, the mothers were beginning to take back some control over their daily lives. This sense of increased control was directly related to the increased skill and knowledge the mothers had acquired about breastfeeding and pumping. For most of the mothers, the early issues with breastfeeding were resolving (or had resolved) and they were feeling increasingly confident in their breastfeeding and mothering abilities.

As the mothers became more confident, they began to take a more active role in decision making and to reflect on the quality of early advice and help they had been given primarily by

healthcare professionals. The mothers questioned why there was such a lack of consistency with the messaging and advice from healthcare professionals, why the information they had been given prenatally was not realistic (or at least did match the experiences they had had), and why there was a lack of answers and practical solutions to the issues they had struggled with (primarily related to pain) in the early postpartum period.

It was like every day we went out to a medical appointment or to a lactation consultant. And I found the advice varied...I found it overwhelming because there was like no truth, like no absolutes. P16

It was like amateur hour (advice from hospital nurses). P22

By six weeks, the mothers who had switched to pumping and/or formula feeding had gone through a process of reframing their views on how breastfeeding fit with being a good mother who was not exclusively breastfeeding. These mothers reported a sense of being pushed and pulled between feelings of failure and relief with having to supplement, feed expressed breastmilk, or formula feed. One mother summed up what many expressed when she said “It was both heart-breaking and freeing at the same time (giving formula)” P20.

After mourning the loss of breastfeeding (or exclusive breastfeeding) they focused on the positives of feeding from a bottle- especially the increased autonomy and control this afforded them in their daily and professional lives. They justified that they too were good mothers because they still wished they could breastfeed (thus had appropriate guilt) but had to make a choice to do what was best for their baby.

Giving her formula was hard...but she was really hungry, and then there was all those wet diapers, so I knew she was doing really well and we'd made the right choice. P5

By the time of the follow-up interviews, learning breastfeeding was mainly behind the mothers. They were now making well-researched choices that fit with their values and lifestyles as individuals and mothers. They were now researching on their own, and confident in their

ability to seek out trusted, non-judgemental, and reliable sources of the information as they needed it. Their trusted sources of information increasingly included other mothers with similar infant feeding experiences and parenting styles. In this period, peer support had become one of the primary means the mothers used to make their decisions. The other was their own research from sources they judged as being evidence-based, scientifically grounded, and philosophically aligned to their broader mothering goals.

I wish I could have had more realistic versus idealistic information. P14

It's just that I want evidence-based information. P2

Redefining Self. For the participants in this study, the first six weeks of motherhood was a period of instability where their notion of self was threatened by their sudden loss of autonomy and control due to the all-encompassing nature of breastfeeding. To complicate matters, the participants did not feel they had the knowledge or skills necessary to take control of the situation and found themselves both physically and emotionally vulnerable.

I'm older, I was well established in my career, had a certain way of life, and I found the cut (to her life) was even deeper I guess with the breastfeeding than it would have been with a bottle. P14

Perhaps it's because I am older and I had a life that basically no longer exists, especially being at home with her. Like you know I could just go for a haircut at some point. Breastfeeding is a bitch! P18

By six to eight weeks postpartum, the participants were actively working towards regaining control over their lives and their autonomy as a person who is now also a mother. The mothers were now able to build on successes and tailor their breastfeeding practice to find some order in the chaos of early life with a baby. For some, this included adding formula or pumping to allow them some freedom from the demanding schedule of breastfeeding and to share the feedings with their partners. At this period the mothers had

developed enough of a skill and knowledge base to start actively moving away from a reliance on healthcare professionals and to research their own solutions to issues as they arose. Due to experience, skill, and knowledge building the mothers were also now more confident to trust their ability to read their baby's cues and feed according to their baby's behaviour.

I think it's gotten better, again, as I gained confidence, and at some point trusting the baby, getting to know the baby...So, basically the experience has gone very well because I've been baaad by myself and at some point, I don't know who told me, just like "drop the book"...so "Just drop the book and just watch the baby"...So I that's what I've done and since it's been going well. P14

At the time of the second interviews, the participants were firmly entrenched in the active process of redefining themselves as themselves, but also as mothers. An important detail is that the participants spoke of themselves as mothers to their own infant in particular, taking pride in their relationship with the baby as a unique individual who was also shaping how they would mother. The participants saw themselves and their babies as a team, and were making choices specific to the needs of the baby and themselves.

Defining Motherhood. During the first six weeks postpartum, the mothers defined motherhood as inextricably tied to breastfeeding. Breastfeeding was viewed as a choice, women were free to choose not to breastfeed, but *good* mothers choose to breastfeed, and they were going to be good mothers. The mothers in this study had internalized the cultural ideal of the breastfeeding mother as the good mother, and they were striving to be good mothers. Thus, to breastfeed or bottle feed was not really a choice for them. The mothers self-policed to motivate themselves to keep seeking solutions to the issues they were having and to continue through pain, tongue tie procedures and physiotherapy, sleep deprivation, feelings of isolation and depression and grueling 24 hour-a-day devotion to breastfeeding (or pumping). As one mother

put it “I think there’s women who love breastfeeding. I wouldn’t say I love it. I do it because I think it’s important for him” P9. Breast milk (no matter how it got in the baby) was raised to almost magical status in the musings of the mothers and fueled much of the self-policing and drive to continue. The mothers were very goal oriented at this point and were persisting at all costs because meeting the breastfeeding goals meant meeting the goal of performing successfully as a new mother.

By six to 12 weeks postpartum, some of the mothers had begun to let go of the idea that breastfeeding was the only route to good motherhood. This shift was mainly out of necessity for some as by this point it was clear that they were going to have to pump or formula feed. For the mothers who either did not have enough milk or were having issues with latching their infant, supplementing was necessary to feed the baby. For some of the mothers, supplementing was a way to maintain professional obligations that required leaving the baby with alternate caregivers. For others, the need to supplement was a result of a combination of these factors.

For the mothers in the study who were not having challenges with early breastfeeding, the idea that the breastfeeding mother was the superior mother persisted well into the second 6 weeks. These mothers spoke of persisting at all costs and the payoff was becoming the breastfeeding mother they had envisioned themselves as being. Like the other mothers in the study, they were also starting to question if in fact breastfeeding really was so important to mothering and bonding. Yet, at the same time, these mothers upheld the ideal of the morally superior breastfeeding mother in statements that questioned why other women were not as tough, or as persistent as they had been.

By the time of the follow-up interviews, all of the mothers were defining motherhood on their own terms, based on their own life and mothering experiences up to that point.

Breastfeeding was no longer central to mothering, rather just a piece of mothering and being with the baby. The relationship to the baby as an individual person and their own sense of themselves (including their values and life experiences) was now at the forefront of being a mother. Good enough mothering was now what was defined as successful mothering.

I do right my kid as much as I can. You know I'm not perfect, but it could be worse. P22
I do find it's a special time (breastfeeding) now and I'm trying to really take advantage and enjoy it more, like sometimes while I feed her I'm just reading twitter litter. P7

Discussion

Knowledge, control, trust, and ownership. The concepts of knowledge, control, trust, and ownership ran throughout all the interviews. As the mother's capacity increased in these four areas, the idea of breastfeeding defining motherhood waned. In the first six weeks, the mothers were driven by lack of knowledge, feelings of being out of control, and loss of themselves due to their newly developed sense of vulnerability. The mothers compensated in this early period by being reliant on healthcare professionals for information and to make decisions for them. Many of the mothers reported feeling that their vulnerability was mistaken for inability by healthcare professionals, and the focus on the baby's needs left them feeling they were treated as secondary players in their own breastfeeding experiences. As one of the mothers said, "I was just there as a supporting cast in all of this....I was just there to supply the milk" P20. The mothers reported feeling that their vulnerability was being taken for a lack of ability. To compound the issue, all of the mothers complained of a lack of consistent information among healthcare professionals. This lack of consistency was problematic on two fronts. First, the mothers began to feel that no one actually knew what they are talking about. Second, as the mothers were caught in a cycle of reactive decision making, each new healthcare professional

they consulted sent them down a different path, with different advice, which the mothers found confusing and frustrating.

The period from six weeks to three months was characterized by increasing knowledge and skill building, leading to increasing feelings of being able to take back some control over their lives and thus feeling some ownership over their breastfeeding practices. The mothers had had time to reflect on their early experiences and overwhelmingly expressed that they had lost trust in the advice of healthcare professionals. This loss of trust was primarily due to the inconsistencies in information they had received. The mothers also questioned the underlying subtext of the breastfeeding mother being the *good mother* that many of them perceived to be in much of the breastfeeding information they had encountered (in both health promotion materials and online sources, including blogs). The mothers felt it undermined the legitimacy of the information as unbiased and scientific.

By the time of the second interview, three to six months postpartum, the mothers had moved from the early state of vulnerability and dependence to independence and empowerment. This period was characterized by active agency and informed decision making as the mothers were now relying on their own research, the shared experiences of their peer group, and the few trusted professional sources that they had chosen to keep as references. The professionals that the mothers continued to consult were easily available (either at consistently staffed community drop-in clinics or physicians' offices), gave consistent information, were viewed as having a current knowledge base, and providing practical advice that gave the expected results. The mothers were confident consumers of information at this stage, increasing their own knowledge base and making decisions that actively increased their sense of control over their own lives. Although all of the mothers in this study had male partners, they very seldom spoke of them in

the interviews. The mothers' focus was overwhelmingly on themselves and the infant. In this period, ownership took the form of no longer apologizing for their choices around infant feeding and recognizing that they had to mother as the person they were, not the idealized good mother, and to mother the baby as an individual person, not the idealized child. For a visual map of the progression of knowledge, control, trust, and ownership, and the factors influencing the decisions related to breastfeeding early postpartum see Figure 2.

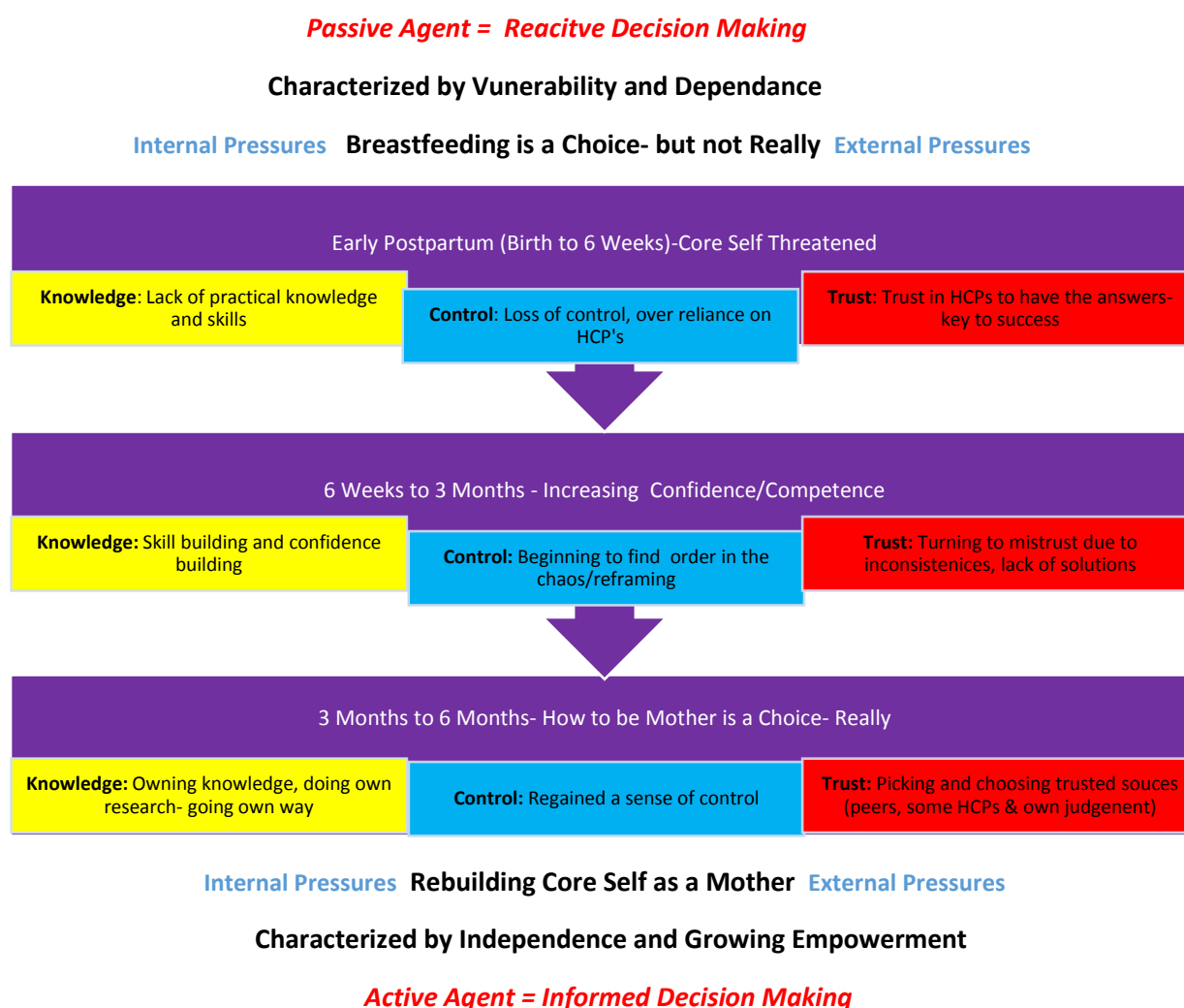


Figure 2: Map of the Factors Involved in Decision Making Related to Breastfeeding/Infant Feeding in the First Six Months Postpartum

The current literature on the transition to motherhood for older first-time mothers.

The current literature on older first-time mothers focuses primarily on the transition to motherhood, the ramifications of the internalized myth of the ‘good mother’, and general recommendations for healthcare professionals working with this population (See Chapter Five for further details). The literature is not specific to breastfeeding experiences, practices or support needs of older first-time mothers. In the literature, older first-time mothers were overwhelmingly found to have the advantage over their younger counterparts in the areas of increased maturity, resources (social and financial), and security (Southby et al., 2019). But, as a group they expressed feelings of anxiety and unrealistic expectations of early motherhood (Carolan, 2005; Carolan, 2007; Choi, 2005; Shelton & Johnson, 2006), and often took months longer to make the successful transition to the maternal role than their younger counterparts (Aasheim, Walderstrom, Rasmussen, Esphaug & Schytt, 2014).

The experiences of the mothers in this study were consistent with mothers’ reports in the literature that the reality of motherhood was vastly different from what they had expected (Aasheim et al., 2014; Carolan, 2005; Carolan, 2007; Choi, 2005; Shelton & Johnson, 2006). The mothers in this study reported feelings of cognitive dissonance as the beliefs and expectations they had internalized related to early breastfeeding and how they felt (both physically and emotionally) in early motherhood turned into a very different reality. Breastfeeding was hard, and the commitment to breastfeeding and their infant essentially obliterated their pre-baby way of life.

In the literature, the dominant discourse internalized by older first-time mothers is that of the attachment-focused, child-centred good mother. The mythos of the *good mother* comes in many forms depending on the cultural context, but generally she is a breastfeeding mother who

instinctively knows how to care for her infant (mothering comes completely naturally for her). She is the contently all giving, all sacrificing nucleus of a *happy* family, and her baby also fits the ideal of the quiet infant who sleeps and breastfeeds well (Charbrol et al., 2004; Choi, 2005; Crossely, 2009).

Over the six month period in the study, the majority of the participants began to reject the need to live up to the good mother myths. An integral part of their transition to motherhood was redefining good motherhood on their own terms. The skills they had mastered and knowledge they had gained over the course of learning to (or letting go of) breastfeed, combined with taking ownership over motherhood on their own terms allowed the mothers in this study to keep the parts of the good mother myth that fit with them as mothers and reject the others.

The mothers expressed a strong desire that the breastfeeding related information and supports they were accessing should not demonstrate an underlying ideology. They wanted clear, evidence based, non-judgemental information to base their decisions. They wanted these decisions to fit with their lived reality, not the ideal that they either viewed as unattainable or undesirable, especially if the choices presented limited their freedom.

Carolan (2007) summarized the experiences of the disconnect between the expectations and realities of early motherhood for older first-time mothers as the “nightmare of early mothering” (p.769) which is characterized by feelings of shock and being out of control in the first months postpartum. This experience leaves many new mothers without any models to help them come to terms with their new reality, or to navigate that new reality (Aasheim et al., 2014; Fisher et al., 2013; Shelton & Johnson, 2006). The mothers in this study described feelings of being completely out of control in the early weeks. Many felt they had assumed the status of secondary players in their own lives as the needs of the baby took precedence.

Many older first-time mothers, including those in this study, reported having gone from a life with a strong sense of independence, and a fully formed adult identity, to a life of seeming confinement, chaos, and never ending demands in their new role as mother (Aasheim et al., 2014; Carolan, 2007; Choi, 2005; Fisher et al., 2013; Shelton & Johnson, 2006). Many of the mothers in this study also reflected on this life change. Many found that the 24/7 demands of early breastfeeding made the transition to their new normal more challenging as they were less able than their bottle feeding peers to leave their infants and resume any sense of normality and independence. Many found that the point they were at in their career did not allow them to fully take maternity leave. Balancing continuing professional obligations and breastfeeding was especially challenging.

Shelton & Johnson (2006) found that stories from older first-time mothers often reflected resistance and ambivalence towards the dominant discourse of the good mother, and what they *should* be doing in during early motherhood. These seemingly imposed ways of mothering often resulted in their sense of identity as a person being undermined. The mothers in this study struggled with the threat to their autonomy by the loss of control and freedom brought on by the demands of early motherhood. The mothers underwent an active process of working to regain their autonomy and control through knowledge and skill building, finding like-minded mothers for support (both in person and online) and learning to trust their own judgment and their baby's cues. The mothers often asserted their own independence by rejecting the discourse of the all-giving mother and allowing themselves space for themselves and their needs. By the time of the follow up interviews, the majority of the mothers reported feeling like themselves as persons, not just mothers.

In the literature, the transition to motherhood for older mothers was found to take longer and to encounter more resistance and require more identity work as they often needed to deconstruct and reconstruct their very sense of self to fit with their new role of being a mother (Aasheim et al., 2014; Carolan, 2007; Carolan & Nelson, 2007). Studies by both Carolan (2005) and Aasheim et al. (2014) found that in contrast to Mercer's (2004) older works on becoming a mother older first-time mothers took three to four months longer than younger mothers to transition to the maternal role. By four to six months postpartum, older first-time mothers were found to come to the realization that not only were their babies unique persons, but that they had to find their own definitions of motherhood that fit them as unique persons, allowing for balance between being a mother and their pre-existing selves and life-goals. But it was not until six to eight months postpartum in both Carolan (2007) and Aasheim et al.'s (2014) studies that the mothers reported they "felt like mothers", and had achieved confidence and competence in the role. In this study, by three to six months the mothers had achieved this sense of role mastery.

Implications for Practice

As the trend of older first-time motherhood continues to grow in Canada and other developed countries, there is a need for nurses and other healthcare providers to shift how they approach supporting this demographic of new mothers. This shift needs to occur not only with providing breastfeeding supports but also to include supporting mother-centred maternal role transition through working to increase maternal satisfaction, empowerment and confidence. Nurses and lactation consultants have the potential to play a pivotal role in both optimizing the breastfeeding outcomes of older first-time mothers and in empowering these mothers to transition to motherhood on their own terms.

The literature supports the concept of self-efficacy with breastfeeding as an indicator of breastfeeding success (Dennis, 1999; Dennis, 2006; Kingston, Dennis, Sword, 2007). If a mother is confident in her ability to succeed with breastfeeding, she is more likely to perceive issues as challenges to be overcome and find solutions and supports to help her reach her goals (Dennis, 2006). Although this study focused on postpartum experiences, it is in the prenatal period, and arguably preconception through a life time of exposure to cultural norms and biases, that women form the base for their later levels of self-efficacy with breastfeeding. Dennis (1999), based on the earlier work of Bandura (1977), identified four sources of information that influences levels of self-efficacy with breastfeeding. These areas are: performance accomplishments, vicarious experiences, verbal persuasion, and physiological and affective states (Dennis, 1999).

During the prenatal period healthcare providers can aid mothers to normalize the challenges of early breastfeeding by providing realistic information on what to expect in the first six weeks postpartum. Interventions that increase breastfeeding self-efficacy in the prenatal period in the key areas of vicarious experiences and verbal persuasion should be integrated into routine prenatal appointments and prenatal classes. Kingston et al. (2007) found that vicarious experience had the largest impact on early breastfeeding self-efficacy. Opportunities to see other mother's breastfeeding was crucial. This could be in person, or simply leading mothers to realistic and positive online videos (for example having an up-to-date selection of YouTube videos for prenatal clients to view). Healthcare providers can also reinforce the message that it is normal for early breastfeeding to be challenging, and provide mothers with information on where they can get supports once their baby is born.

The key recommendations for nurses and other healthcare professionals providing postpartum breastfeeding support to this demographic of mothers are to work collaboratively with new mothers respecting their agency and abilities, and to help normalize their breastfeeding and early mothering experiences. Healthcare providers need to recognize that while providing early breastfeeding support they must be cognizant of the effects of breastfeeding challenges on the early transition to motherhood and empower this group of mothers to be themselves a mothers.

The quality of breastfeeding supports has been found to be more important than frequency (Kingston, 2007). Schmeid et al.'s 2011 metasynthesis of women's perceptions of breastfeeding support found that professionals who were facilitative and authentic were viewed by mothers as helpful and positive. These professionals were seen to create an environment where the mother felt listened to, where she was allowed to learn from her own experience and she was encouraged to be an active collaborator in the supports provided.

The mothers in this study had already internalized the health promotion messages, the cultural norms, and the idealized versions of the attachment based, all giving, breastfeeding mother. As such they did not need more ideology mixed in with breastfeeding supports and information they were receiving. In fact, by six weeks postpartum the mothers had begun to view any information that they perceived as ideology-laden with mistrust and suspicion. This perception that much of the information they were accessing related to breastfeeding from sources as diverse as online blogs, La Leche League, and health units as ideology laden was new to this study and is an area that warrants further research. The mothers wanted clear, evidence based, non-judgemental information on which to base their decisions. They wanted these decisions to fit with their lived reality not the ideal that they either viewed as unattainable or

undesirable. It severely limited their freedom as an individual who also happened to be a mother. Healthcare providers can help by providing clear, unbiased, practical, skill based information that fits with the goals and circumstances of each dyad at each pivotal point of early breastfeeding. By taking a collaborative approach with each mother to help her identify her needs, goals, and desires related to breastfeeding, we can empower this group of mothers to take an active role in decision making earlier and take earlier ownership over breastfeeding.

We are starting to see official moves in the direction of more mother-centred breastfeeding supports, for example in the UK the 2012 *UNICEF UK Breastfeeding Friendly Initiative (BFI)* has integrated these principles and the concept of maternal satisfaction into the new standards for maternity, neonatal, health visiting and children's centre services. The new standards clearly recognize the importance of fostering positive early relationships between mothers and infants, and working in collaboration with mothers to meet their goals (UNICEF UK, 2012). In Canada, current initiatives like those of the BFI of Ontario, are helping to move hospital based-breastfeeding supports in the direction of professional consistency. One example of a BFI Ontario project is a recently announced *BFI Crib Card* for use in hospitals and by midwives in Ontario (BS, 2019). This resource will have key topics for early postpartum teaching, and is being designed to increase consistent messaging to new parents related to breastfeeding.

The mothers in this study reported they lacked basic knowledge related to early breastfeeding and early infant behaviour and development, which directly lead to feelings of losing control and overreliance on healthcare professionals. As with any population of new mothers, healthcare providers need to provide mothers with basic and realistic information on newborn behaviour, normal early breastfeeding, and normal challenges (including pain, fatigue

and feelings of isolation). Normalizing difficulties with early breastfeeding, providing positive reinforcement of a mother's performance accomplishments, and validating her experiences through verbal persuasion (essentially cheerleading) can help to increase mothers' self-efficacy with breastfeeding, and help to reframe issues into manageable, solvable, and controllable challenges

To more effectively support older first-time mothers to meet their breastfeeding goals, healthcare providers need to work with mothers to increase their capacity in the areas of knowledge, trust, control and ownership. An in-depth discussion of strategies to support mothers in the four areas of knowledge, control, trust, and ownership, can be found in Chapter Six *Supporting Older First-time Mothers with Breastfeeding and Becoming a Mother: Insights for Clinical Practice*. As the mothers gained skills and competence in these four areas they were able to let go of the idea that being a successful mother was completely dependent on successful breastfeeding and were able to relax in their role and focus on other areas of mothering including balancing their own needs as a person with their baby, finding peer groups and supports, and building their relationship with the baby as a person outside of infant feeding.

Limitations

Although the participants in this study varied in birth experiences, cultural backgrounds, antenatal care providers, and early breastfeeding experiences and challenges, they were a homogenous group with respect to maternal age, educational attainment, middle class life style, marital and professional status. The mail-out recruitment packages from Public Health only went to mothers identified by the health unit as low risk for socio-economic risk factors, no history of, or current mental health challenges, and having delivered full-term, healthy, singleton

infants. The majority of the mothers in this study conceived naturally, had low rates of history of miscarriages, and only one underwent fertility treatments (embryo transfer in a foreign country).

Conclusion

In summary, over the first six months postpartum the mothers in this study gained knowledge, trust, control, and ownership of both their mothering and infant feeding practices. These four areas helped the mothers work through the simultaneous processes of learning to breastfeed, redefining self, and defining motherhood. This work was occurring despite the influence of the internalized idea of breastfeeding being the key to becoming a mother having a negative effect on early breastfeeding and transition to motherhood. As the mothers progressed through the first 6 months postpartum, the influence of the idea of breastfeeding being the route to becoming a mother waned and the mothers became increasingly active agents in decision making around infant feeding and their overall mothering practices. As increasing numbers of women are delaying childbearing into their mid-30s and 40s, it is important that healthcare providers understand the unique needs of this population when providing breastfeeding supports.

Conflict of interest

The authors declare no potential conflicts of interest with respect to the authorship, research, and/or publication of this article.

Ethics approval and consent to participate

Ethical approval was obtained prior to the study from the Research Ethics Board at the University of Ottawa, and from the Research Ethics Board at Ottawa Public Health.

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CHAPTER FIVE**MANUSCRIPT #2****AN EXPLORATION OF THE CURRENT STATE OF THE
LITERATURE ON THE GROWING PHENOMENON OF
DELAYED CHILDBEARING IN CANADA AND OTHER DEVELOPED COUNTRIES:
A NARRATIVE LITERATURE REVIEW.**

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Abstract

Objective: The objective was to answer the question: *What is the state of the current literature on the growing phenomenon of women delaying childbearing until they are 35 years of age and older in Canada and other developed countries?*

Background: The incidence of delayed childbearing in Canada and other developed countries has been steadily increasing over the last three decades. Delayed childbearing has potential ramifications on maternal health, infant health, breastfeeding, and the transition to motherhood.

Design: Narrative literature review

Method: The CINAHL, PUBMED/MEDLINE, and ERIC databases were searched. Canadian government documents and grey literature were also included.

Results: Older first-time mothers are different from their younger and multiparous counterparts in three major areas. There are distinct social, economic, and cultural factors influencing the timing of first births and women's decisions to delay childbearing. The transition to motherhood and realities of the early postpartum period are experienced differently by older first-time mothers due to their life experiences and social context. Lastly, the real and perceived risks to mother and child associated with delayed childbearing have an impact on early motherhood.

Keywords: Advanced maternal age, delayed childbearing, transition to motherhood, maternal role transition.

Background

Since the 1990s there has been a growing trend in developed countries towards women delaying childbearing, with increasing numbers of new mothers being over the age of 35 at the time of first live birth (Best Start [BS], 2015; Canadian Institute for Health Information [CIHI], 2011; Mills, Smith & Lavender, 2012). By 2018, one in five live births (23% of total births) in Canada was to a mother over the age of 35 (Statistics Canada, 2018A), with first births to women over 35 accounting for 11% of all Canadian births (Society of Obstetricians and Gynecologists of Canada [SOGC], 2012). The total births to women over 35 represents an increase of 47% over the number of live births to women over the age of 35 in 1998 (BS, 2015; CIHI, 2011). In the province of Ontario alone, births to women over 35 years of age in 2014-2016 accounted for a nearly quarter of all births (23.1% of all hospital births) in Ontario, with 15.1% of those births being to first-time mothers 35 years of age or over (Better Outcomes Registry & Network [BORN] Ontario, 2019).

Older first-time mothers represent a distinct demographic of new mothers due to the complex factors surrounding the multitude of reasons for, and realities of, having children later in life (Cooke, Mills & Lavender, 2012; Mills et al., 2012). Despite the steadily growing numbers of first-time mothers over the age of 35, a trend which is mirrored in many other developed countries, including the United States, Australia, and the UK (SOGC, 2012), there is little information synthesizing what is known in the literature on the phenomenon of delayed childbearing and first-time mothers over the age of 35. Delayed childbearing in this paper is defined using the SOGC (2012) parameters; a woman who has her first live birth at or over 35 years of age.

Literature Review Purpose/Guiding Question

Literature Review Purpose

The purpose of this review was to conduct a comprehensive review of the literature spanning the past 15 years (2004-2019) on the phenomenon of women delaying childbearing until their mid-30s to early 40s in Canada and other developed countries. This review explores the social and economic factors behind the growing trend of waiting to have children later, the potential ramifications of delayed child bearing for both the mother and infant, the potential impact of delayed child bearing on maternal role transition, and the incidence of delayed childbearing in the Canadian context. The results of this review can be utilized to increase the knowledge of nurses, midwives, and other healthcare practitioners who work with older mothers in the perinatal period.

Guiding Question

The question posed to guide this narrative literature review was: *What is the state of the current literature (2004-2019) on the growing phenomenon of women delaying childbearing until they are 35 years of age or older in Canada and other developed countries?*

Methods: Narrative Literature Review

Search Methods

This narrative literature review examines the literature on the topic of delayed childbearing from the years 2004-2019. The CINAHL, PUBMED/MEDLINE, and ERIC databases were searched using the keywords, keyword combinations, and inclusion criteria from Table 1. For search details see the Prisma diagram located in Appendix H. A hand search based on the reference lists of the peer reviewed publications chosen for full text review was conducted using the same inclusion criteria as for the database searches.

Table 1: Search databases, terms, and criteria

Databases	CINAHL, PUBMED/MEDLINE, & ERIC
Key Words	Advanced maternal age, delayed childbearing, breastfeeding, older first-time mother, and primiparous
Combinations	Advanced maternal age + primiparous
Inclusion Criteria	Peer reviewed, full text, published from 2004-2019, primiparous, advanced maternal age, delayed childbearing, older, first-time mother, normal pregnancy outcomes, risks associated with advanced maternal age (ages 35-44 years), factors related to delayed childbearing, English or English translation available, developed countries
Exclusion Criteria	NICU, medically complex infants, multiple births as only topic, and fertility treatment and/or prenatal screening as only topic, cancer, very advanced maternal age (ages 44 years+), non- English text, developing countries

An online search using Google Chrome was conducted for Canadian federal and provincial government statistics and grey literature pertaining to the phenomenon of delayed childbearing, including rates of pregnancy and live births. As government publications and statistics are updated regularly only those from 2009-2019 were included in this search. Government publications were included if they met the inclusion criteria, and were relevant to the topic of first-time mothers in Canada.

Qualitative and quantitative studies were included, as the primary purpose of this review was to conduct a comprehensive examination of the current literature on the trend of women delaying childbearing until their mid-30s to early 40s in Canada. In order to create a complete picture of the phenomenon and provide a broad understanding to help guide nurses and other healthcare professionals when intervening with this population, the narrative review methodology was chosen as this method allows for the flexibility to include multiple forms of research (Collins & Fauser, 2005). The freedom to integrate grey literature and government publications with the peer reviewed literature makes the narrative review a valuable tool to inform clinical practice (Collins & Fauser, 2005).

Results

For the purposes of this review the literature was divided into the three major topics found in the peer reviewed literature: A) the social, economic, and cultural factors influencing the timing of first births and women's decision to delay childbearing, B) the transition to motherhood and realities of the early postpartum period for older mothers, and lastly, C) the risks to mother and child associated with delayed childbearing. In order to provide context to the literature this review first presents and examines the trends in Canadian fertility and births from the mid-1800's to present.

Trends in Canadian Fertility and Births (Mid-1800s to present)

As this literature review was initially conducted to inform a study on the breastfeeding experiences of first-time mothers aged 35 years and over in a major Canadian urban centre, the fertility and birth trends in Canada were examined to provide context. The statistics from other high income/developed countries including the United States, England, and Australia share similar trends and patterns over the last three decades, with increasing rates of first live births to women 35 years of age and older (Matthews & Hamilton, 2014; Mills, Rindfuss, McDonald & Velde, 2011; SOGC, 2012; SC, 2018B). For example, in the United States the average age of women having their first baby has been steadily increasing over the past 40 years, and first births to women 35 and older has been increasing since the mid-1970s (Matthews & Hamilton, 2014). The United States National Centre for Health Statistics (NCHS) reports that from 2000-2012 first live births to women 35-39 years of age rose by 24%, and first live births to women 40-44 years of age rose by 35% in most states (Matthews & Hamilton, 2014). In the US, as in Canada, first live births to younger women (especially those under 20 years of age) have steadily declined

over the same period as first births to older mothers have been increasing (Matthews & Hamilton, 2014; Provencher, Milan, Hallman & D'Aoust, 2018).

Historically, until the mid-1800s Canada was a “high fertility” and mainly rural society, for example, the estimated total fertility rate in 1851 was 6.56 children per woman (SC, 2018C). Large families were the norm and women had children from the time they were married (generally in their 20s) and continued to bear children until the end of their reproductive years (SC, 2018C). Women having children into their early forties (until perimenopause and menopause) was common in Canada until the 1970s and is not a new development (Veniza & Turcotte, 2009). What is new is the increasing numbers of women having their first child in their 30s and 40s (BS, 2015; SOGC, 2012; SC, 2018C; Veniza & Turcotte, 2009).

There were fluctuations in the fertility rate in Canada throughout the late 1800s and early-mid 1900s. These fluctuations were influenced by a multitude of factors including increasing urbanization, the rising cost of raising children, the Great Depression, two world wars, the declining influence of organized religion, the post war baby boom, reliable and available contraception, education and employment opportunities for women (Provencher et al., 2018; SOGC, 2012; SC, 2018B). For example, the estimated total fertility rate in Canada in 1937 was 2.64 children per woman, as compared to 3.94 children per woman in 1959 at the peak of the baby boom; it then began to significantly decline in the late 1960s, and was down to 1.54 children per woman in 2016 (Provencher et al., 2018; SC, 2018C). The record low was tied between 2000 and 2002 with 1.51 children per woman (SC, 2018B).

The last year that the replacement-level fertility was reached in Canada was 1971, with a rate of 2.1 children per woman. Every year since 1971, the Canadian fertility rate has failed to meet the requisite 2 children per woman required, not for population growth through births, but

rather to avoid population decline as deaths begin to outnumber births in any given year (SC, 2018B). This correlates with another Canadian trend that began in the mid-1970s, namely women marrying later (SC, 2018B; Veniza & Turcotte, 2009). By the 1970s and 1980s, with the ability to better control family planning, the number of years within which women had their children shrank. As a result, they had fewer children, had those children closer together and were generally finished having their families younger than previous generations who often continued to have children to the natural end of their biological reproductive years (BS, 2007; SC, 2018C). In the 1990s another new trend emerged, with women still having fewer children but waiting until they were older to have their first child (BS, 2007; SC, 2018C). At that point the rate of first-births to women over 35 began to increase, which is a trend that continues to the present day (BS, 2007; SC, 2018A&C).

When examining the age-specific fertility and birth rates, two trends emerge in the 1990s. The first is that the birth rate to women at the youngest end of the reproductive spectrum, those 19 years of age and under, has been steadily declining (BORN, 2008; SC, 2018C). In 2016, for the first time in Canadian history, the youngest mothers were having fewer babies than the oldest mothers, with a rate of 8.4 children per 1000 women for mothers under 19 years of age compared to the 11.5 children per 1000 women for mothers 40-44 years of age (SC, 2018B). The second trend, is that at the older end of the reproductive spectrum (generally before the onset of perimenopause), the fertility rate for women 35-44 years of age is increasing, including the number of first-births to this demographic (Provencher et al., 2018; SC, 2018B). In 2010, for the first time in Canadian history, the number of births to women 35-39 surpassed the number of births to women 20-24 (SC, 2018B). The overall trend in Canada is that women are waiting

longer to have their first child and having fewer children in total, with the birth rate for Canadian women over 35 years of age doubling between the years 1990-2003 (BS, 2007).

It is important to remember that women having babies in their 40s is not a new phenomenon in Canada. However, the growing number of women having their first child in their mid-30s to early 40s is new, and the numbers, especially in urban centres, are significant, which means that there may also be significant ramifications for nurses and other healthcare professionals serving this growing demographic of new mothers and their infants.

The Current Literature on Delayed Childbearing (2004-2019)

Upon establishing that there is a growing and significant trend towards delayed childbearing in Canada and other developed countries over the past four decades, it is necessary to ask, so what? Is there really anything different other than age, between a woman who has her children in her 20s and a woman who does not begin having hers until her 30s or even 40s? In the age of the internet and mass media are there factors outside of those we saw historically influencing the decisions on when to time childbearing for women in the new millennium? For example, in their examination of portrayals of older mothers in the British media Shaw and Giles (2009) found older mothers were overwhelmingly framed as being outside of the norm, and painted as being selfish, needy, and even accused of violating “the natural order” (p. 221).

Social, economic, and cultural factors influencing the timing of first births and women’s decision to delay childbearing. When the question of why people postpone parenthood was explored, current research has found that increasingly high levels of education for women was one of the primary factors driving the trend towards delayed childbearing in most of the Organization for Economic Co-Operation and Development countries (Lemoine & Ravitsky, 2015; Mills et al., 2011; Southby, Cooke & Lavender, 2019). Surrounding educational

attainment was a cluster of other underlying social forces and factors including: effective contraceptive options, career path options, financial pressures, waiting for the right time to have children (secure finances, right partner, established career), individualistic family model, and the continued uneven distribution of household labour (Lemoine & Ravitsky, 2015; Mills et al., 2011; Southby et al., 2019). Many of these factors, as argued by Guedes and Canavarro (2014B) and Cooke et al. (2012), are not always within an individual woman's control. Thus, the decision to delay childbearing is not always a conscious one; rather in many cases it is the outcome of social forces, changing norms and values, and external pressures. For example, the societal shift over the last few generations towards extended adolescence (well into the 20s) and the delaying of many life stages (some due to the increasing educational and professional requirements for career advancement and economic security) is beyond the control of the individual who is living within the circumstances and expectations of her peers, family, and society as a whole (BS, 2015; Cooke et al., 2012; Friese, Becker & Nachtigall, 2008; Guedes & Canavarro, 2014B; Shaw & Giles, 2009; SC, 2018B).

In Canada gender equality is increasingly a reality, and women have the same general opportunities as men to enter most professions and to pursue most educational paths (provided they have the economic resources). The pursuit of many educational and career paths requires large amounts of time devoted to study and professional advancement. It is very challenging for women to achieve the same level as their male counterparts if they have children (Mills et al., 2011). This is especially true as the bulk of the burden of household tasks and child care still primarily falls to women, and quality, affordable childcare is not always readily available (Mills et al., 2011; Veniza & Turcotte, 2018).

The search for the ideal partner and changes to marital realities (including second marriages) are also contributing to the phenomenon of delayed childbearing (BS, 2015; Cooke et al., 2012; Guedes & Canavarro, 2014C; Power, 2015; Nislem, Waldenstrom, Hjelmsted & Rasmussen, 2012; Mills et al., 2011; Southby et al., 2019). Power (2015) argues that this is part of a broad social and historical process in developed countries where not only are there pressures around career and education, but also that the expectations on romantic relationships have changed. Marriage in the 21st century is less central to the social and economic lives of young adults. Their expectations of the relationship within marriage, when they do marry, are very different from those of previous generations, with young adults seeking emotional and sexual fulfillment as opposed to social and economic security (Power, 2015). The by-product of these changing expectations in a life partnership is that relationships become more transient as self-actualization becomes an important goal (Power, 2015). The second important by-product is that shorter, more transient relationships seem to be leading many women to wait longer to have children (BS, 2015; Cooke et al., 2012; Guedes & Canavarro, 2014C; Power, 2015; Mills et al., 2011; Nislem et al., 2012; Southby et al., 2019).

Over the last 30 years, options around life decisions such as marriage, the seeking of personal fulfillment, and choosing when to become, or if to become, a parent are more flexible due to the breakdown in the strict constraints of socially accepted roles (Friese et al., 2008; Guedes & Canavarro, 2014B). For many women, expectations about the life course in general have shifted, and roles are less rigid (BS, 2015; Friese et al., 2008; Guedes & Canavarro, 2014B; Power, 2015). Friese et al. (2008) make the case for older motherhood as part of the phenomenon of the new possibilities that are emerging in response to changing social, cultural,

economic, and physical (since women in their 40s are often in good physical health) realities, and in turn part of the “profile of the new middle age” (p. 66).

That is not to discount the findings of Mills et al. (2011) that educational attainment was the primary driver influencing women’s decisions related to the timing of their first child.

Verniza and Turcotte’s (2009) secondary analysis of the Canadian 2006 census data related to age, education, professions, and births supports Mills et al.’s assertion that education is a primary factor influencing the decision to delay child bearing for many women. Verniza and Turcotte argue that societal changes have resulted in the bar being higher for educational attainment to enter many professions, and, as a result many women are staying in school longer.

Verniza and Turcotte (2009) found that the highest numbers of first-time mothers over 35 in Canada were those who belonged to professions that required the longest number of years of post-secondary education. Women over 40 who were physicians, engineers, lawyers, and university professors were the most likely to have children under the age of four years, and to have been a first-time parent over the age of 35. Physicians had the highest rates of delayed childbearing, with 22% of female physicians in Canada over the age of 40 having their oldest child preschool aged. Women who were both highly educated and new immigrants to Canada represented the group with the highest rated of first-time motherhood over 40. Older first-time mothers were represented in the highest percentages in Canada’s major urban centres with 89.6% older first-time mothers living in cities.

Transition to motherhood and realities of early postpartum experience for older mothers. The second distinct area of literature on the phenomenon of delayed childbearing in developed countries explores the transition to motherhood and the realities of early motherhood for older first-time mothers (Aasheim et al., 2014; Carolan, 2005; Carolan, 2007; Choi, 2005;

Nelson, 2004; Shelton & Johnson, 2006). This group of studies focuses on older mothers' transition to the maternal role, ramifications of the internalized myth of "the good mother" versus the lived realities of early motherhood, and general recommendations for healthcare professionals serving this demographic. The take-away message from the studies examined in this section is that older first-time mothers are different from their younger counterparts. While older first-time mothers often have the advantage of increased maturity, resources, and security (Southby Cooke & Lavender, 2019), as a group, they report high levels of anxiety, and may take longer to make the successful transition to the maternal role than younger first-time mothers (Aasheim et al., 2014).

For the majority of new mothers in the studies represented, the reality of motherhood was vastly different from what they expected (Aasheim et al., 2014; Carolan, 2005; Carolan, 2007; Choi, 2005; Nelson, 2004; Shelton & Johnson, 2006). The dominant discourse internalized by these new mothers is that of the attachment-focused, child-centred, and intensively mothering good mother. The mythos of the good mother comes in many forms depending on the cultural context, but generally she is a mother who instinctively knows how to care for her newborn/infant (mothering comes completely naturally for her), is the contently all giving, all sacrificing nucleus of a happy family, and her baby also fits the ideal of the quiet infant who sleeps and breastfeeds well (Choi, 2005; Shelton & Johnson, 2006). For older first-time mothers, life with her new infant is often a reality shock. Since older first-time mothers are generally lacking any alternate discourse of what real motherhood looks and feels like, they report high levels feelings of failure, anxiety, feelings that they are not meeting expectations and inadequacy in the early maternal role when neither they nor their infants fit the myth (Carolan, 2007; Choi, 2005; Nelson, 2004; Shelton & Johnson, 2006). Carolan (2005) summarized it well as the

“nightmare of early mothering” (p.769), a nightmare for many older first-time mothers that is characterized by feelings of shock and being out of control in the first months postpartum. This experience inevitably leaves a void for many new mothers in which they do not have a social discourse that matches how they feel to help them come to terms with their new reality, or how to navigate that reality with their sense of themselves intact (Aasheim et al., 2014; Fisher et al., 2013; Shelton & Johnson, 2006).

Not surprisingly, given the overwhelming disconnect between the expectations and realities of early motherhood, anxiety and worry are common threads throughout the studies exploring the experiences of older first-time mothers (Carolan, 2005; Carolan & Nelson, 2007; Southby et al., 2019). Southby et al. (2019) found that the idea of “now or never” was central to the experience of older first time mothers. This sense of urgency because this may be their last chance to have a baby and do it right, puts a pressure on early motherhood, which for many results in high levels of anxiety. Ironically, this anxiety seems to lead to over-active information seeking and information overload actually seems to increase anxiety levels (Carolan, 2007), which may be leading to cases of feeling the more you know, the more you realize you know nothing at all.

Nurses and other healthcare professionals may be setting the tone for this anxiety during pregnancy with increased surveillance and testing of older mothers, even healthy ones with minimal risk factors (Carolan, 2007). The use of risk-laden language by healthcare professionals when describing the pregnancies and possible birth outcomes for older mothers may also be compounding the social discourse of risk that this group of mothers is already exposed to in the media and broader cultural narratives. Healthcare professionals may inadvertently be reinforcing

the cultural message to these mothers that they are different right from the start (Carolan & Nelson, 2007; Shaw & Giles, 2009; Southby et al., 2019).

Older first-time mothers are also facing dual life transitions. Those in their late 30s and 40s are negotiating the transition to motherhood and at the same time may be beginning to experience the transition to middle age with all of the cultural expectations and baggage associated with aging in arguably youth-obsessed western cultures (Aasheim et al., 2014; Nelson, 2004). Adding to the challenge of transitioning to both motherhood and beginning to contemplate middle age simultaneously many of these mothers reported having gone from a life with a strong sense of independence and a fully formed adult identity, to a life of seeming confinement, chaos, and never ending demands in their new role as mother (Aasheim et al., 2014; Carolan, 2005; Choi, 2005; Fisher et al., 2013; Shelton & Johnson, 2006). Stories from older first-time mothers reflected resistance and ambivalence towards the dominant discourse of the *good mother* and what they *should* be doing in during early motherhood. These seemingly imposed ways of mothering often resulted in a sense of identity as a person being undermined (Shelton & Johnson).

Older first-time mothers do transition successfully to motherhood just as their younger counterparts do. However, the transition has been reported to take longer, to encounter more resistance, and require more identity work as older mothers often need to deconstruct and reconstruct their very sense of self to fit with their new role of being a mother (Aasheim et al., 2014; Carolan, 2007; Carolan & Nelson, 2007). Many older mothers (especially those in professional positions) were found to try to find balance between maintaining some of their previous existence and their new maternal responsibilities (Shelton & Johnson, 2006). In the early postpartum period, seeking balance between the intensity of caring for the new baby and

often unsupportive, demanding, or inflexible workplace cultures was a struggle for many women (Kim, Rotondi, Connolly & Tamin, 2017; Metcalfe, Vekved & Tough, 2014). By four to six months postpartum, older first-time mothers were found to come to the realization that not only was their baby a unique person, but that they had to find their own definitions of motherhood that fit them as unique persons, allowing for balance between being a mother and pre-existing self and life goals (Caralon, 2005).

By six to eight months postpartum in both Caralon (2005) and Aasheim et al.'s (2014) studies, the mothers were finding they felt like mothers, and had achieved confidence and competence. This finding is in contrast to Mercer's (1986) earlier work on becoming a mother in the general population of first-time mothers, where the same role mastery had occurred by three to four months postpartum. Caralon (2005) postulates that lack of pregnancy engagement (due to being labeled as high risk and fears of losing the baby) and maternal distancing may be contributing to a longer than expected period of adjustment to the maternal role. It may take more time for the reality of the baby to sink in.

Older first-time mothers are often coming to motherhood with unrealistic expectations (Caralon, 2007; Choi, 2005, Guedes & Canavro, 2014A; Nelson, 2004; Southby et al., 2019). The reality shock of the life change to the maternal role from that of an independent autonomous and, in many cases, high achieving adult, is compounded with the confusion of information overload. Social and professional supports were found to be crucial in aiding to reduce anxieties, and help ease the transition to the maternal role. Support from nurses and healthcare professionals was essential to normalize the experiences of this group of new mothers. Nurses and other healthcare professionals should invest time in the new mother and baby allowing opportunities for questions and reassurance. Time spent empowering this group of mothers is

important, as many of these mothers feel inadequate (Choi, 2005). One strategy that was found to work well with this demographic is reframing technical information into lay terms, to help to normalize the experience, allowing the mother to feel a sense of control and for the nurse to work more collaboratively with the new mother (Carolan, 2007). Another strategy was to assess and provide extra supports for the emotional wellbeing of the mother due to the potential intensity of mid-life mothering and increased levels of anxiety (Morgan et al., 2012). Social and peer supports were also found to be crucial to normalizing and decreasing feelings of isolation for first-time older mothers (Kim et al., 2017; Morgan et al., 2012). Kim et al. (2017) found that for older mothers, who may not have friends and family with young children, this social support often came from communities of parents and adults that were linked through child care and later on their child's school community.

The medical, and medicalized risks to the mother and child associated with delayed childbearing. The third major category of literature on the phenomenon of delayed childbearing focuses on the topic of medical risk, namely the risks and perceived risks to the mother and fetus/newborn. As seen in the previous section, this risk-based view is not lost on the mothers themselves and has consequences for levels of maternal confidence and anxiety, which may be negatively affecting maternal role transition (Carolan, 2007).

The terms advanced maternal age, late maternal age, elderly primips, or the currently accepted term: delayed childbearing, all refer to the phenomenon of women who have children at the end of their natural reproductive cycle, or over the age of 35 (SOGC, 2012). The SOGC (2012) sums up the current literature on the risks of delayed childbearing as follows: “delayed childbearing is associated with increased risk of infertility, maternal comorbidity, pregnancy and birth complications, and increased maternal and fetal morbidity and mortality” (p.1).

What the SOGC (2012) terms as the “consequences” of delayed childbearing fall into three categories of risk. The first category is risk to fertility. As maternal age increases the incidence of maternal age-related subfertility and eventual infertility increases as well (SOGC, 2012). Fertility begins to decline in most women’s early 30s. Subfecundability (not being able to conceive naturally within one menstrual cycle) and the incidence of miscarriage for those women who do conceive spontaneously increases (SOGC, 2012). Older women also have increased incidences of pre-existing medical conditions including endometriosis, fibroids, polyps, obesity, hypertension, and diabetes, that may negatively affect fertility (CIHI, 2011; SOGC, 2012). Decreases in natural fertility lead to increases in use of assistive reproductive technologies (ART) in women over 35 seeking to conceive, which come with their own associated risks (including that of multiple and preterm births) (SOGC, 2012).

The second category of risk is to the fetus. Maternal age-related risks include genetic conditions, congenital anomalies, and suboptimal outcomes for the fetus and newborn (CIHI; SOGC). The incidence of chromosomal aneuploidy (primarily trisomies), gene abnormalities, and some congenital malformations (including cardiac defects, hypospadias, and craniostynosis) all increase as maternal age increases (CIHI, 2011; SOGC, 2012). For example, the rates of chromosomal disorders for women over 35 years of age was 4 times higher than those of women 20-34 years of age (SOGC, 2012).

The third category of risk includes those related to maternal health, pregnancy, and birth-related outcomes. Women over the age of 35 are at higher risk for most adverse pregnancy and birth-related outcomes including (but not restricted to) miscarriage, small for gestational age (SGA) and low birth weight (LWB) babies, preterm labour, placenta abnormalities, ectopic pregnancy, pregnancy-induced hypertension, preeclampsia, induction, multiple births,

interventions during labour, and delivery via caesarean section (CIHI, 2011; SOGC, 2012; SC, 2018A). Most notable were the increased rates of caesarean sections, gestational diabetes, and placenta previa in women over 40 (Bayrampour & Heaman, 2011; CIHI, 2011; SOGC, 2012). The incidence of placenta praevia was found to be 10 times higher in nulliparous women over 40 compared to those between 20-29 years of age, and the incidence of caesarean section in women over the age of 40 is over 50% compared to the rates in the general obstetrical population of approximately 25% (SOGC, 2012).

Lemoine and Ravitsky (2015) assert that the growing phenomena of delayed childbearing and advanced maternal age in developed countries are in fact a public health issue, and should be addressed as such by governments and public health authorities. There are a multitude of issues associated with increasing numbers of women delaying childbearing into their mid-30s to 40s and beyond that place a higher burden (and financial cost) on the healthcare system (CIHI, 2011; SOGC 2012). Lemoine and Ravitsky (2015) question how well informed the public is about the risks of delayed childbearing. They do acknowledge that there is a fine line between advocating for earlier motherhood and impinging on women's autonomy and reproductive rights, but they argue that, due to the reality of the medical risks and the lack of information that women receive on those risks (including the risks and cost of artificial reproductive technologies) there needs to be social, economic, and political support to empower women to have children earlier.

On the flip side, many researchers are actively questioning the significance of the rates of risk (for example the frequency of interventions during pregnancy, labour, and birth), theorizing that physicians may have an unnecessary lower threshold for interventions when providing care to older mothers (Bayrampour & Heaman, 2010; Cooke, Mills & Lavender, 2010; Marques, Palha, Moreire, Valente, Abramtes & Saldanh, 2017; SOCG, 2012) and may intervene sooner

(and thus more frequently), especially concerning relatively routine procedures such as caesarean sections and inductions (Bayrampour & Heaman, 2010; Carolan et al., 2011; Cooke et al., 2010). Recent studies by both Caralon et al. (2011) and Marques et al. (2017) found no statistically significant levels of correlation between advanced maternal age and the rates of birth defects, prematurity, and low birth weight in their analysis of older mothers as compared to their younger counterparts. The emphasis by healthcare professionals on medical risk when managing pregnancies and births for otherwise healthy older women may be a significant contributing factor to the high levels of anxiety experienced during the perinatal period among this population and may be also be contributing to the delayed transition to the maternal role as these mothers may see themselves as abnormal and in need of extra attention and worry (Caralon & Nelson, 2007). Caralon and Nelson (2007) argue that current perinatal healthcare regimes do not meet the needs of otherwise healthy, but older, women and may be leading to self-fulfilling prophecies through increased levels of routine interventions (including caesarean sections, prenatal screening, induction of labour) leading to clinically poorer outcomes, reinforcing for these mothers that they and their infants are in fact less healthy or more fragile than younger mothers and their infants. Compounded by exposure to negative framing of older mothers in the media and social discourses (Shaw & Giles, 2009), the increased medicalization of older motherhood may be a major contributing factor to the increased levels of anxiety and slower transitioning to the maternal role for this population of women.

Recommendations

Nurses have the potential to play a pivotal role in optimizing outcomes for older first-time mothers. The key recommendations informed by this review are A) To work collaboratively with mothers and medical professionals towards normalization of older motherhood, B) To

provide clear, unbiased information in lay terms to help avoid information overload, and C) To provide appropriate emotional and mental health assessments, screening, and supports in the postpartum period.

As the trend towards older first-time motherhood continues, there is a need for further research on how best to support this demographic of new mothers. As with new mothers of all ages, appropriate support in areas of maternal role transition, mental health, breastfeeding, peer supports, and community building are important to optimize the perinatal and long term health outcomes over the life course.

Conclusion

This narrative literature review provides the historical and present context of fertility, births, and delayed child bearing in Canada and examines and analyzes the literature on delayed childbearing in the context of western, developed nations over the last 15 years (from 2004-2019). Women's delay of childbearing into their mid-30s to early 40s is a growing trend in Canada and many other developed nations which is driven by a multitude of complex and interrelated social, economic, and cultural forces. These factors include, but are not limited to higher levels of educational attainment, prolonged adolescence, changes in the role of marriage and romantic relationships, and career opportunities for women. Older first-time mother are perceived by the medical system as a group of mothers that is at-risk for adverse outcomes in the antenatal period as they have higher rates of maternal and infant morbidities than the general obstetrical population and are subject to higher rates of interventions during pregnancy, labour, and birth. As with mothers of all ages, they are also found to be at-risk for high levels of anxiety and experience disconnects between expectations and reality in the early postpartum period, as well as delayed transition to the maternal role. All of these factors come together, meaning that

older first-time mothers are a vulnerable and distinct population of mothers who are at high-risk for poor antenatal and postpartum outcomes in the areas of both physical and mental health.

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CHAPTER SIX**MANUSCRIPT #3****SUPPORTING OLDER FIRST-TIME MOTHERS WITH BREASTFEEDING AND
BECOMING A MOTHER: INSIGHTS FOR CLINICAL PRACTICE.**

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Background: Older First-Time Mothers

Since the 1990s, there has been a growing trend in developed countries towards women delaying childbearing, with increasing numbers of new mothers being over the age of 35 at the time of first live birth (Best Start [BS], 2015; Canadian Institute for Health Information [CIHI], 2011). For example, in 2018 one in five live births (23% of total births) in Canada was to a mother over the age of 35 (Statistics Canada SC, 2018), with first births to women over 35 accounting for 11% of all Canadian births (Society of Obstetricians and Gynecologists of Canada [SOGC], 2012). However, the expectations, experiences, and factors influencing the decision-making processes around the breastfeeding practices of older first-time mothers are poorly understood (Cooke, Mills & Lavender., 2012). To complicate matters, due to older mothers having high rates of maternal and infant morbidities, which are correlated with poor breastfeeding outcomes, mothers over the age of 35 are especially at-risk for early breastfeeding challenges and cessation (BS, 2015; Brown & Jordan, 2012; CIHI, 2011; Fisher et al., 2013).

Older first-time mothers form a group that is more likely to come to motherhood with fully-formed adult identities and well-established personal and professional lives (Shelton & Johnson, 2006). As such, this group of new mothers may experience early breastfeeding and motherhood differently and have support needs that are different from those of their younger or multiparous counterparts. The purpose of this paper is to explore recommendations for clinical practice for healthcare providers supporting older first-time mothers with breastfeeding. The recommendations are based on the results of a constructivist grounded theory study conducted with 23 first-time mothers ≥ 35 years of age in Canada, in relation to their breastfeeding experiences in the first six months postpartum and their transition to motherhood. This paper discusses strategies for healthcare providers to increase knowledge, control, trust, and ownership

for older first-time mothers in order to support their breastfeeding practices, and facilitate a healthy transition to the maternal role.

The Study: The Breastfeeding Experiences of Older First-Time Mothers

This paper is based on a qualitative study that addressed the research question: *What factors affect how first time mothers ≥ 35 years of age make decisions about breastfeeding in the first six months postpartum, and how do these factors affect the decisions they make related to breastfeeding in the first 6 months postpartum?* The semi-structured interviews explored maternal expectations, choices, decisions, achievements, and regrets related to early breastfeeding. Between July 2016 and September 2017, 23 first-time mothers who were 35 years of age or over, had attempted breastfeeding or pumping at least once, and had an infant under three months of age at the time of the first interview, were interviewed at two points in time, three to four months apart, during the first six months postpartum. The practice level nursing theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* was developed from the findings.

The theory frames how the mothers in this study moved simultaneously through learning breastfeeding, and redefining themselves as mothers, ultimately defining what motherhood was for them as individuals. These processes occurred under the internalized ideal of breastfeeding being what defined a good mother or the key to motherhood. This ideal had negative repercussions in the early postpartum period as the mothers were not able to live up to their own expectations of breastfeeding and early motherhood. As the mothers in the study gained knowledge, control, trust, and ownership over their breastfeeding practices, they established a new, more realistic sense of themselves in the maternal role. The influence of the idea of

breastfeeding as being the key to their idealized version of motherhood waned as they found a version of motherhood that fit with their lives.

In the first six weeks, the mothers experienced a lack of knowledge and feelings of being out of control. Due to their new-found vulnerability, they compensated by being overly reliant on healthcare professionals. The downside to this dependence was that many were treated by healthcare professionals who gave the baby's needs precedence as secondary players in their own breastfeeding experiences. The mothers overwhelmingly reported being told what to do by healthcare professionals and felt that their vulnerability was being taken as lack of ability or desire for agency. To compound the issue, all of the mothers complained of a lack of consistency in information provided by healthcare professionals. This lack of consistent (and sometimes conflicting) information was problematic on two fronts. First, the mothers began to feel that no one actually knew what they are talking about, which eroded their trust in healthcare providers as reliable experts on breastfeeding. Second, as the mothers were caught in a cycle of reactive decision making, each new healthcare professional they consulted sent them down a different path, with different advice. The mothers found this lack of consistency confusing, frustrating, and counterproductive, adding to their feelings of loss of control over their bodies and their lives.

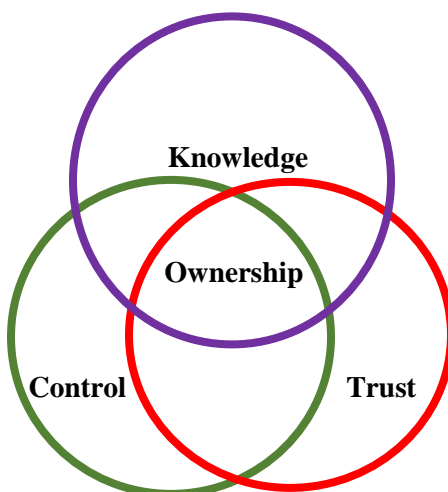


Figure 1: The Relationship between Knowledge, Control, Trust, & Ownership of Breastfeeding and Mothering

From six weeks to three months postpartum, the mothers built a base of knowledge and skill related to breastfeeding/infant feeding that led to increased feelings of control over their lives and thus felt some ownership over their breastfeeding/ infant feeding practices. The mothers had had time to reflect on their earlier experiences and overwhelmingly expressed that they had lost trust in the advice of healthcare professionals. Inconsistencies and an underlying subtext of ideology of the good mother /attachment-parenting in much of the information they were accessing led to disillusionment.

By the second interviews, between three to six months postpartum, the mothers in this study had moved from the early state of vulnerability and dependence in their decision-making and breastfeeding/baby feeding practices, to independence and empowerment. They were now relying on their own research, the shared experiences of their peer group, and the few trusted professional sources that they had chosen to keep as references. At this point, ownership took the form of no longer apologizing for their choices around infant feeding and recognizing that they had to mother as the person they were, not the idealized good mother, and to mother their baby as an individual person, not the idealized child.

It is important to note that 15 of the 23 mothers in this study had research backgrounds. In their professional existences they were skilled at finding credible sources of information and were avid consumers of information. For many of the participants, adding evidence they had gathered to inform their choices and feeding practice moving forward was a turning point towards feeling like themselves again and making decisions that actively increased their sense of control over their own lives.

The Loss of, and Redefining of, the Core Self

In Mercer's (2004) theory of becoming a mother (BAM), the transition to the attainment of a maternal identity occurs under the central assumption that in each person there exists a relatively stable core self. This self evolves of the cultural context of the individual over the lifespan out and determines how an individual defines and reacts to situations and life changes, motherhood being a pivotal life change (Meighan, 2010; Mercer, 2004). The mothers in this study had come to motherhood as adults with well-formed personal and professional existences. Consistent with the concept of a pre-existing and well developed core self, the mothers in this study often spoke of needing to continue being themselves and feeling resentful at losing their old self in the loss of their old life.

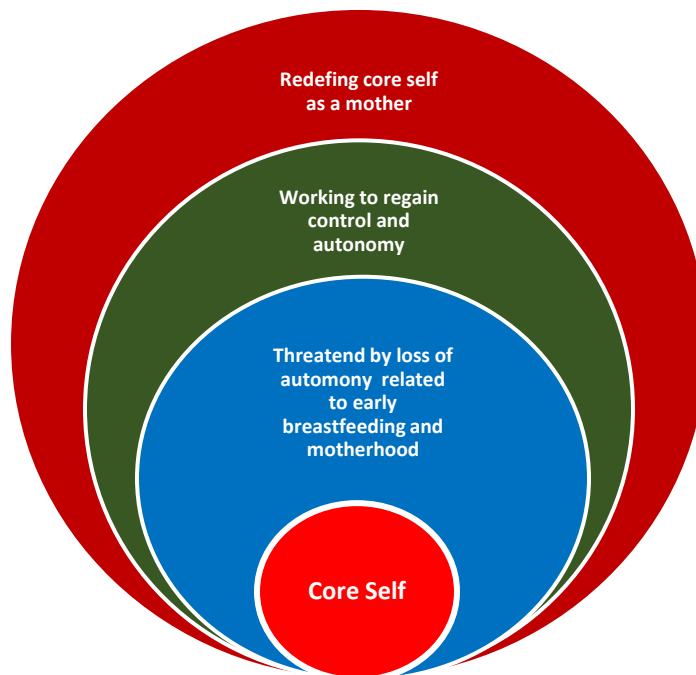


Figure 2: Core Self: From early threat to self, to the rebuilding of self in the role of mother

The bottom circle of Figure 2 represents the core self that each mother in this study had prior to the birth of her baby. For the mothers in this study, the first 6 weeks of

motherhood was a period of instability. Their notion of self was threatened by their sudden loss of autonomy due to the intensity of early breastfeeding and the loss of their well-established, pre-baby lives. By six to eight weeks postpartum, the mothers were actively working towards regaining control over their lives and their autonomy as a person who was now also a mother. Increasing levels of knowledge allowed the mothers to take more control and, in turn, ownership over breastfeeding.

At the time of the second interviews, at three to six months postpartum, the mothers were firmly entrenched in the active process of redefining themselves (their core selves) as mothers. An important detail is that the participants spoke of themselves as mothers to their infants in particular, taking pride in the baby as a unique individual who was also shaping how they would mother. It was only at this point that the mothers spoke of having a relationship with the baby. They now spoke of themselves and their babies as a team.

It is important to remember that these are women in their mid-thirties to mid-forties for whom a sense of self was firmly established before their baby arrived. The protecting of the core self - she who was there before baby - seemed to come through small acts of resistance to the recommendations of healthcare professionals that focused on breastfeeding, breast milk feeding, and weaning. The eventual rejection of the good mother ideal was the main act of resistance. This allowed the mothers the space to take control of feeding their babies, and to begin mothering on their own terms.

Recommendations for Practice:

Supporting Breastfeeding and Empowering Motherhood for Older First-Time Mothers

For nurses, lactation consultants and other healthcare professionals, there are three key take-away messages from the literature, as well as the findings of this study, that are relevant to

everyday clinical practice. The first is that healthcare professionals should incorporate the concept of maternal satisfaction with breastfeeding as originally proposed by Leff, Jefferis and Gagne (1994) as an indicator of success when providing breastfeeding support to older first-time mothers. The second is that healthcare professionals need to take the time to help older first-time mothers disentangle their performance of breastfeeding from how they are performing as new mothers. Lastly, healthcare professionals should provide information without an undercurrent of ideology about the role of breastfeeding in motherhood. As the mothers had already internalized the health promotion messages and ideology of breast is best, healthcare professionals were actually doing a disservice by incorporating ideology with information. The mothers in this study wanted clear, consistent, practical information, not healthcare professionals reinforcing that breast was best. This was especially true of mothers who were having challenges with breastfeeding or were required by factors like low milk supply and professional responsibilities to supplement or discontinue breastfeeding.

Table 1: Key Recommendations for practice to providing mother-centred breastfeeding feeding support to first-time mothers ≥ 35 years of age from birth to six months postpartum

<i>Key Recommendations</i>	<i>Birth to six weeks postpartum</i>	<i>Six weeks to three months postpartum</i>	<i>Three months to six months postpartum</i>
To support increasing knowledge base & To support growing sense of control	-realistic information on what to expect (pain, fatigue, lack of schedule) -information on infant development/behaviour and effects on breastfeeding -offer practical, pragmatic, and skill based solutions to issues as they arise	-realistic information on what to expect -information on infant development/behaviour and effects on breastfeeding -offer choices of practical, pragmatic solutions to issues as they arose and choices about realistic options	-realistic information on what to expect -information on infant development/behaviour and effects on breastfeeding -offer choices of practical, pragmatic solutions to issues as they arise and choices about realistic options
To support growing sense of ownership &	-Normalize challenges of early motherhood and breastfeeding	-Listen to how she wants to mother and her goals	-Be a bias free resource of evidence-based information

To foster positive maternal identity and active agency	<ul style="list-style-type: none"> -Strength-based approach for each individual dyad -Meet the mother where she is at in the moment -Help to untangle breastfeeding from mothering, reframe as only one aspect of being a new mother -Explore what would bring her satisfaction with breastfeeding 	<ul style="list-style-type: none"> -Direct to sources of reliable information (books, online, etc.) -Help to reframe situation (if need be) to focus on positive aspects for mother and baby -Acknowledge that she is still her adult self, just herself in the mothering role 	<ul style="list-style-type: none"> -Provide praise and affirmation on how she is choosing to mother acknowledging her and her baby as two unique people with unique circumstances and needs
To support trusting relationships with nurses/healthcare professionals	<ul style="list-style-type: none"> -Be consistent -Take a collaborative approach, while acknowledging early lack of confidence, vulnerability, and lack of knowledge -Admit when you don't have the answer, help mother to find one 	<ul style="list-style-type: none"> - Offer only clear, evidence-based information without biases, judgement or ideology -Answer questions clearly and consistently -Ask what is working for her and her baby, and what she needs 	<ul style="list-style-type: none"> - Offer only clear, evidence-based information without biases, judgement or ideology -Answer questions clearly and consistently -Ask the mother what is working for her and her baby, and what she needs

Maternal Satisfaction with Breastfeeding

Leff et al. conceptualized maternal satisfaction with breastfeeding to provide guidance for healthcare professionals in order to work more collaboratively with new mothers to explore the mothers' perceptions of their breastfeeding experiences on a more human and relationship-based level than most quantitative approaches to breastfeeding assessments. This approach includes exploring maternal enjoyment and the relationship between the breastfeeding dyad, maternal perceptions of the baby's breastfeeding experience (including if the mother thinks the baby was thriving), and how the mother feels breastfeeding is affecting her lifestyle and body image. Exploring these topics with new mothers while providing breastfeeding support allows the mothers to identify areas where they feel they are doing well. It also allows mothers to identify areas where healthcare providers could work with them to find more balance between themselves

and their babies, or to provide interventions to promote early maternal-infant attachment. Offering options, not prescriptions, allows the mothers to pick areas to work on that are important to them. This also includes helping mothers investigate different approaches to breastfeeding and infant feeding (whether that be including some pumping, or working on strategies to breastfeed comfortably in public) in an unbiased manner.

One striking feature of the initial interviews from this study was that the mothers seldom spoke of the relationship with their new baby, or if they spoke of it, it was in negative terms. The baby was viewed as the cause of the breastfeeding issues, the sleep deprivation, or the loss of control over the mothers' lives. The mothers were so driven by the need to make breastfeeding (and mothering) succeed at all costs that they lost sight of the importance of the relationship with their infant. The loss of focus on the dyad's relationship has also been found in the literature on breastfeeding and the general population of new mothers where due to the focus on quantitative measures of breastfeeding success, the fostering of the early maternal-infant relationship was overlooked (Avishai, 2007; Regan & Ball, 2013).

In the broader literature, practicing infant feeding on their own terms has been found by many mothers to be vital to feeling satisfied with their breastfeeding experience, even when they were not exclusively breastfeeding, or feeding expressed breast milk (Andrew & Knaak, 2013; Labarere, 2012; Spencer, Greatrex-White & Fraser, 2014; Symon, Whitford & Dalzell, 2013). Mothers whose outcomes included being satisfied with their breastfeeding experience were found to be flexible about the rules (Andrews & Knaak, 2013) and to actively redefine what successful breastfeeding was for them in order to fit with their unique circumstances and needs (Labarere, 2012; McBride-Henry, 2009; Spencer et al., 2014; Symon et al., 2013). As the first six months progressed, the mothers in this study followed the same trend found in the literature,

and not only actively redefined breastfeeding but also what *good enough* motherhood looked like for them. However, it took them four to six months to do so. An early focus on maternal satisfaction with breastfeeding could help mothers reach this point of ownership and control sooner.

Other studies have found that when professionals providing breastfeeding support adopted a facilitative approach combined with an authentic presence, mothers perceived the supports more positively (Schmeid, Beake, Sheehan, McCourt & Dykes, 2011). These professionals were seen to create an environment where the mother felt listened to, where she was allowed to learn from her own experience, and she was encouraged to be an active collaborator in the supports provided (Schmeid et al., 2011). The mothers then felt that their individual circumstances and needs were taken into account.

Although the research on maternal satisfaction with breastfeeding is limited and dated, there is consensus from the researchers involved that a shift in thinking is needed towards a normative view of successful breastfeeding that encompasses a mutually satisfying relationship between a mother and her infant, while meeting the infant's nutritional needs (Dykes, 2010; Edwards, 2018; Leff et al., 1994; Labarere et al., 2012; Symon et al., 2013). The pressure to perform and produce reported by mothers needs to be at the very least mitigated by supporting the relationship-based aspects of breastfeeding (Dykes, 2010; McBride-Henry, 2009). Women-centred models of care call for empowering new mothers by focusing on the factors they feel are important to them in the context of their lives (Pratt & Fahy, 2011). The approach of emphasizing maternal satisfaction with breastfeeding in clinical encounters opens the door for increased collaboration and interventions that are led by the needs of the mother (Edwards, 2018).

Untangling breastfeeding success from successful early mothering

As found with the mothers in this study, when belief that breastfeeding is tied to success with mothering, early breastfeeding challenges can be a hindrance to transition to the maternal role. This finding mirrors those in the broader literature, where unrealistic expectations around early motherhood, fueled by the dominant discourse of the good, breastfeeding mother leaves many new mothers feeling like failures in their new role (Aasheim et al., 2014; Crossley, 2009; Dykes, 2010; Fisher et al., 2013; Ludlow et al., 2012; Shelton & Johnson, 2006). When providing breastfeeding support, it is necessary to be aware that early breastfeeding issues may be undermining a mother's sense of herself as a competent mother and, in turn, undermining maternal mental health.

Recent studies on maternal satisfaction with breastfeeding found that how mothers measured success was not necessarily based on the absence or presence of breastfeeding issues, but rather in how the mothers viewed situations and challenges (Cooke et al., 2007; Labarere et al., 2012). Many of the mothers in these studies had experienced common challenges (sore nipples, engorgement etc.) but saw these as a normal part of breastfeeding, and reported feeling happy and satisfied when they were able to work through them (Cooke et al., 2007; Labarere et al., 2012). Mothers who were able to reframe their expectations positively, were flexible, and had access to realistic information on normal challenges of breastfeeding, had higher self-reports of satisfaction with breastfeeding despite having issues, and breastfed for as long or longer than they anticipated (Cooke et al., 2007; Dietrich Leurer & Misskey, 2015; Labarere et al., 2012; McBride-Henry, et al., 2009). How a mother views breastfeeding issues has also been found to be linked to her levels of levels of self-efficacy (or her confidence) related to breastfeeding (Dennis, 2006). Mothers with high levels of breastfeeding self-efficacy have been shown to

view issues as challenges to be overcome (Dennis, 2006). There is a need for future research on the links, if any, between breastfeeding self-efficacy and maternal perceptions of satisfaction with their breastfeeding practices and mothering.

In this study the majority of the participants began to reject the need to live up to the dominant cultural ideal of motherhood as the mother who exclusively breastfeeds at all costs. An integral part of their transition to motherhood was redefining *good* motherhood on their own terms and to fit with how they were mothering. This included accepting how they were choosing to breastfeed, and reframing both pumping and formula feeding as doing what was best for themselves and their babies. By six months postpartum the ideal of the good mother, that held so much influence on the beginning over their definition of successful motherhood and learning breastfeeding, had begun to retreat into the background.

Healthcare providers can help mothers separate breastfeeding from the rest of motherhood by normalizing challenges and taking a strength-based approach to help mothers see the other aspects of mothering and infant care where they are succeeding. By increasing the older first-time mother's knowledge, control, trust in herself, and ownership over how she is choosing to breastfeed, healthcare providers can promote a healthy early transition to the maternal role that fits with the rest of the new mother's life and pre-existing sense of self.

Providing clear, practical information, not ideology

Over and over again, the mothers in this study reported that they took the classes, went to the meetings, read the books, saw the videos, but were still not prepared for the challenges and the intensity of early breastfeeding. They understood that breast is best and breast milk was the healthiest option, but not how to make breastfeeding actually work between themselves and their infants. The mothers in this study lacked basic knowledge and a realistic understanding of infant

behaviour, infant care, and what normal breastfeeding looks like. They were not prepared for the time commitment and intensity of early breastfeeding both physically and emotionally. The mothers lacked clear and consistent guidance to increase their knowledge and control in the early weeks. As healthcare providers, we need to provide mothers with basic and realistic information on newborn behaviour, normal early breastfeeding, and normal challenges (including pain, fatigue, and feelings of isolation). In other words, we need to normalize the early postpartum period by providing clear information that promotes realistic expectations from the prenatal period onward, not only for older first-time mothers, but for first-time mothers of all ages.

The mothers in this study had already internalized the health promotion messages, cultural norms, and the idealized versions of the attachment-based, all giving, breastfeeding mother. They did not want more ideology mixed in with breastfeeding supports and information. In fact, in this study, by six weeks postpartum the mothers had begun to view any information that they perceived as ideology-laden with mistrust and suspicion. They accessed information from both official sources (health units, government websites) and unofficial sources (including blogs, popular online parenting websites, and social media pages of local mothers) and expressed a strong desire to not have ideology underlying breastfeeding-related information and supports. They wanted information that they perceived as clear, evidence based, non-judgemental on which to base their decisions. The provision of information that fits with each mother's goals and context is essential to fostering ongoing, trusting therapeutic relationships with older first-time mothers, and arguably, mothers of all ages.

Conclusion

As the trend of older first-time motherhood continues to grow in Canada and other developed countries, there is a need for nurses and other healthcare providers to shift how they

approach supporting new mothers in this demographic. This shift needs to occur not only with providing breastfeeding supports, but also by including support for a mother-centred maternal role transition through working to increase maternal satisfaction and empowerment. Nurses and lactation consultants have the potential to play a pivotal role in both optimizing the breastfeeding outcomes of older first-time mothers and in empowering these mothers to transition to motherhood on their own terms. By helping mothers find satisfaction with breastfeeding, and providing clear, consistent, realistic, practical and evidence-based information, nurses, lactation consultants, and other healthcare providers can work collaboratively with older first-time mothers to provide breastfeeding supports that help them meet their goals, feel more confident as mothers, and promote the maternal-infant relationship.

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CHAPTER SEVEN

Recommendations for Future Research and the Conclusion

The practice level nursing theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* provides a framework for viewing the underlying processes influencing the decisions related to breastfeeding that older first-time mothers make over the first six months postpartum. In the early postpartum period, the mothers worked through the processes of learning breastfeeding, redefining self, and defining their own motherhood, while being under the influence of the belief that breastfeeding was the key to motherhood. In the first six weeks, the belief that breastfeeding defined motherhood, coupled with lack of knowledge and control had a negative effect on breastfeeding and transition to motherhood. In the first six months postpartum, the influence of the belief in breastfeeding equated with successful mothering waned, and the mothers became active agents in decision making related to infant feeding. The mothers had moved beyond trying to live up to their internalized ideal of the good breastfeeding mother, and were practicing mothering on their own terms.

In summary, the mothers in this study came to breastfeeding as *true believers* in the value of breastfeeding and had internalized socio-cultural expectations of intensive mothering/ attachment parenting. The internalized ideology, coupled with a lack of knowledge, control, and ownership over early breastfeeding and mothering drove the mothers into an early, negative cycle of reactive decision making.

Table 1: Manifestation of knowledge, control, trust, and ownership: birth to six weeks

<i>Knowledge</i>	Lack of practical knowledge and skills
<i>Control</i>	Loss of control and overreliance on HCPs
<i>Trust</i>	Trust in HCPs to have the answers- to have the key to success
<i>Ownership</i>	Lack of ownership

From six weeks to three months there was a noted shift from early vulnerability and dependence towards active skill building. The largest shift in this period was the growing mistrust of healthcare professionals and health promotion messages as the mothers began to question the lack of clear, practical, nonjudgmental, and consistent information they had received to date related to breastfeeding.

Table 2: Manifestation of knowledge, control, trust, and ownership: six weeks to three months

<i>Knowledge</i>	Skill building and confidence building
<i>Control</i>	Beginning to find order in the chaos
<i>Trust</i>	Turning to mistrust due to inconsistencies, lack of answers, and underlying ideology
<i>Ownership</i>	Beginning find to ownership

By three to six months postpartum, the mothers in this study had moved away from indiscriminate taking of advice and information to being active researchers and consumers of information on breastfeeding (and all other forms of infant feeding), internalizing and putting into practice in their everyday lives only the information that fit with their lifestyle, their beliefs systems, and the temperament of their individual baby. By this point, the mothers' own needs and desires had overridden the need to live up to the ideal of the good, breastfeeding mother. The influence of the ideology of the good mother had receded into the background and was no longer driving the decision making process by the second interviews.

Table 3: Manifestation of knowledge, control, trust, and ownership: three months to six months

<i>Knowledge</i>	Owning knowledge, doing research, going their own way
<i>Control</i>	Renegotiating their sense of control
<i>Trust</i>	Picking and choosing trusted sources
<i>Ownership</i>	Ownership- growing independence and empowerment

Recommendations to Inform Nursing Clinical Practice and Education

The proposed theory of *From Ideology to Independence: Older First-time Mothers, Breastfeeding, and Becoming a Mother* requires evaluation and testing for reliability,

transferability, and validity with larger samples, different geographic regions, and different demographics of new mothers. The three potential key recommendations for clinical practice informed by the theory are: A) incorporating the concept of maternal satisfaction with breastfeeding into interventions as both a tool and as an outcome, B) working with older first-time mothers to disentangle breastfeeding from the performance of early mothering, and C), to provide ideology-free information. The full discussion of the potential recommendations can be found in Chapter Six *Supporting Older First-time Mothers with Breastfeeding and Becoming a Mother: Insights for Clinical Practice*. It is important to note that the recommendations focus on the mothers, not on the mothers and their partners, even though all of the participants in this study identified as being in relationships with a male partner. The mothers' focus during the interviews was overwhelmingly on themselves and their individual experiences. For the most part, the partners were mentioned as being either supportive or not, but not as key factors in the mothers' breastfeeding experience or decision making around breastfeeding.

In clinical practice, nurses have the opportunity to provide interventions to older-first time mothers that take into account the beliefs and values the mothers bring to breastfeeding and mothering. As with any population of new mothers, when working with this population, nurses need explore with each new mother how she views the role of breastfeeding in early mothering and what factors would create satisfaction with breastfeeding (and early mothering) for her. Tailoring interventions and information to the needs of each individual mother would help to increase maternal capacity early on in the key areas of knowledge, control, and ownership over breastfeeding and mothering. A one-size fits all approach to breastfeeding support and education does not work, as the mothers perceive this style of support as rhetoric and not reliable, evidence-based information.

Healthcare providers would benefit from adopting a woman-centred approach which adapts the concept of maternal satisfaction with breastfeeding to older first-time mothers' simultaneous learning breastfeeding, defining motherhood on their own terms, and redefining self. This approach would allow nurses to support all three areas of transition to the maternal role while providing practical, hands-on breastfeeding supports. Another key facet of early interventions is the normalization of breastfeeding and the early challenges of motherhood for this demographic of new mothers. Nurses and other healthcare providers can begin to do this by demystifying breastfeeding with the provision of consistent, realistic information. Linking new mothers to appropriate peer supports would also be useful to help normalize breastfeeding and of early motherhood, and provide role models to help with their transition through redefining self and defining motherhood

Recommendations for Future Research

The results from this study raise questions related to the ideology of the good mother as the breastfeeding mother that underlies much of current breastfeeding promotion. Are healthcare providers, breastfeeding activists, and government health agencies strongly associating breastfeeding with successful motherhood, or is it the case that new mothers are interpreting otherwise neutral, evidence-based information in this way? If it is the case that in there is a strong association between breastfeeding and successful early mothering in the information provided, are health promotion agencies and healthcare professionals doing mothers a disservice with this messaging? Further research into the effects of internalized pro-breastfeeding ideologies on the transition to motherhood, early maternal-infant attachment, and maternal mental health, is warranted to better understand the full range of effects of breastfeeding challenges on new mothers at various stages of life.

Further research is warranted to explore if other groups of mothers (older and younger mothers) also go through a similar process of learning breastfeeding and transitioning to motherhood while influenced by pre-existing beliefs and attitudes about good mothering. Future research to replicate this study and to develop a clinical tool, or scale, to measure maternal satisfaction with both breastfeeding and breastfeeding supports for older first-time mothers is necessary to help verify and validate the findings from this study. The development of a tool, or maternal breastfeeding satisfaction scale for primiparous mothers over 35 years of age, would also provide a means to assess breastfeeding and maternal role transition in a variety of clinical settings, and to provide help to guide breastfeeding supports for this population of new mothers.

Nurses and lactation consultants have the potential to play a pivotal role in both optimizing the breastfeeding outcomes of older first-time mothers and in empowering these mothers to transition to motherhood on their own terms. While waiting for future research and the development of appropriate clinical tools, healthcare professionals can use the concepts of maternal satisfaction with breastfeeding to provide clear, consistent, realistic, practical, and evidence-based information. To help mitigate the negative effects of lack of knowledge and control during early breastfeeding and the transition to motherhood, nurses and other healthcare providers, can work more collaboratively with older first-time mothers when providing breastfeeding supports.

The majority of the mothers in this study conceived naturally, had low rates of miscarriages, and only one went underwent fertility treatments (embryo transfer in a foreign country). There is a need for further research to answer question as to whether experiencing the antenatal period as being perceived as at high-risk affects early breastfeeding and mothering. Other factors that may affect the experience of being an older first-time mother and breastfeeding

warrant exploration including: undergoing fertility treatments to conceive, breastfeeding self-efficacy for older first-time mothers, type of healthcare provider in the antenatal period, ethnicity, social support network, or other variables such as pregnancies with multiples.

The first step in the knowledge translation and dissemination of the findings from this study will be peer-reviewed publications (see Chapters Four, Five, and Six for the manuscripts of the first papers to be submitted for peer review from this study), and extensive dissemination of the findings at national and international nursing, lactation professional, and women's health focused conferences. The goal is ultimately to reach hospitals, health units, faculties of nursing, midwifery, and medicine, and community agencies to help educate front-line healthcare providers about the support needs of older first-time mothers related to breastfeeding and maternal role transition.

Study Strengths and Limitations

Strengths: This study included mothers with a wide variety of experiences related to conception, labour and birth experiences, types of antenatal care providers, and early breastfeeding experiences, and types of challenges. Although no formal information was taken regarding ethnicity, the mothers in the study were ethnically diverse. The retention rate from first to second interview was 18 of the 23 participants and is representative enough to draw conclusions from the data in the follow-up interviews.

Despite a wide variety of birth experiences, cultural backgrounds, antenatal care providers, and early breastfeeding experiences and challenges, in the areas of educational attainment, middle class life styles, married status, and professional status, this study had a relatively homogenous group of the participants. The variety of perinatal experiences and the demographic similarities of the mothers in this study fit with profile of women having their first children in

their mid-30s to 40s in Canada at the time of the interviews. They have been identified as ethnically diverse, primarily centred in urban areas, professional, with wide ranging pre-conception, prenatal and postpartum experiences (See Chapter Five for further details). Since these characteristics are congruent with the Canadian statistical data on women delaying childbearing (even accounting for the small sample size drawn from one Canadian urban centre) this sample may be representative.

Limitations: The mail-out recruitment packages from Ottawa Public Health only went to mothers identified by the health unit as being low risk for socio-economic risk factors, not having a history of or current mental health challenges, and having delivered full term, healthy, singleton infants. Including mothers with the risk factors (primarily mental health risks and socio-economic risks) excluded from the mail-out recruitment packages might have affected the results. The lack of inclusion of women identified with socio-economic and/or mental health risk factors may have led to the sample not being representative of some of the women ≥ 35 giving birth to their first child in Ottawa between June and Septembers of 2017. As this is a small, exploratory study the lack of diversity in the sample in these areas may be a limiting factor to the transferability of the findings.

As the study did not collect complete information on the mothers' birth experiences, previous perinatal loss, and maternal and/or newborn complications, there may be factors that influenced the findings and have not been fully accounted for in the analysis. Neither breastfeeding self-efficacy nor postpartum mood disorders were measured/screened for in this study. As both self-efficacy with breastfeeding and postpartum mood disorders have been shown to positively and negatively affect breastfeeding outcomes further study is warranted to explore

the effects of both of these factors on the breastfeeding experiences and outcomes for this population.

The mothers in this study all identified as being with a male partner (although not necessarily heterosexual). It is possible that there is a heteronormative bias to the sample and replicating the study with first-time mothers in different circumstances regarding relationships, and sexual or gender identities may produce different results.

In Conclusion.

As the trend towards older first-time motherhood continues to grow in Canada and other developed countries, the findings for this study suggest a need for tailored strategies to support and meet the needs of new mothers in this demographic. This study was conducted to address the scarcity in evidence related to breastfeeding supports for first-time mothers ≥ 35 years of age. This study has found that older first-time mothers are a group with unique needs in terms of breastfeeding support because they tended to bring pre-existing beliefs and attitudes about breastfeeding and motherhood to their early breastfeeding experiences that did not match their reality, especially in the first few weeks postpartum.

In conclusion, in this study, the core belief in breastfeeding being tied to the successful performance of early motherhood was found to be negatively affecting the process of transitioning to the maternal role in the first six to eight weeks. The mothers felt they were unable to meet their own expectations of themselves and breastfeeding or meet perceived external standards. Over the first six months, the mothers began to reject what they perceived as ideologically based information, and actively sought sources of support and information that fit with their lived experiences and emerging identity as a mother. As the first six months unfolded,

the mothers were able to untangle breastfeeding from being a mother, take ownership of mothering, and have a sense of themselves, as individuals and as mothers to their infants.

Appendix A: The Maternal Breastfeeding Evaluation Scale (Leff, Gagne & Jefferis, 1994)

Maternal Enjoyment and Role Attainment Subscale (key phrases)

Felt wonderful
 Nurturing, maternal experience
 Felt inner contentment
 Enjoyed nursing
 Special time with baby
 Made me feel confident as a mother
 Like a high of sorts
 Felt extremely close to baby
 Satisfying to produce baby's food
 Made baby feel secure
 Baby and I worked together
 Important to be able to nurse
 Felt very relaxed
 Soothing to baby
 Comfortable
 Helped baby be healthy
 Helped baby fight illness

Infant Satisfaction and Growth Subscale (key phrases)

Baby gained weight well
 Worried about baby's weight
 Baby did not gain weight fast enough
 Baby not interested
 Baby's growth excellent
 Baby did not relax
 Baby loved to nurse
 Baby was eager to breastfeed
 Baby was happy
 Upset if baby didn't take breast
 Did not help baby settle
 Baby had trouble at first
 Felt rejected when baby wouldn't feed

Lifestyle and Body Image Subscale (key phrases)

Felt tied down
 Being baby's source of food was a burden
 Anxious to have my body back
 Felt self-conscious about my body
 Felt like a cow
 Emotionally draining
 Feeding schedule fit with other activities
 Physically draining
 Bothered by leaking breast milk

Appendix B: Recruitment Posters

What are the Breastfeeding Experiences of First-Time Mothers Who are 35 & Over?

Are you a first-time mother 35 years of age or over?
Do you have a baby who is 3 months old or younger?



Are you interested in sharing your experiences about breastfeeding your baby?

My name is Rosann, I am a graduate student in the School of Nursing at the University of Ottawa.

I am interviewing first time mothers over the age of 35 about their breastfeeding experiences.

This research study will be in English only

For more information or to join the study, please contact:

Rosann Edwards at _____ (call or text) or email _____



uOttawa

What are the Breastfeeding Experiences of First-Time Mothers Who are 35 & Over?

Are you a first-time mother 35 years of age or over?
Do you have a baby who is 3 months old or younger?



Are you interested in sharing your experiences about breastfeeding your baby?

My name is Rosann, I am a graduate student in the School of Nursing at the University of Ottawa.

I am interviewing first time mothers over the age of 35 about their breastfeeding experiences.

This research study will be in English only, on a first come first served basis

For more information or to join the study, please contact:

Rosann Edwards at _____ (call or text) or email _____

Appendix C: Recruitment Script

You are being invited to participate in a research study exploring the breastfeeding experiences of first time mothers aged 35 and over, and if:

- **You are a mother of an infant 3 months of age or younger**
- **You were 35 years old or older when your first baby was born**
- **You have breastfeed or pumped your breastmilk at least once since the birth of your baby**

If you are interested in more information on the study and/or how to participate please contact: Rosann Edwards at _____ (call or text) or email _____

*This study is being conducted by a student in the School of Nursing at the University of Ottawa as part of a Doctoral Dissertation.

Appendix D: Semi-Structured Interview Guide (First Interviews)

Sample Interview Guide Questions

Expectations:

- Tell me about how you pictured yourself feeding your baby when you were pregnant
- What did you expect breastfeeding would be like when you were pregnant?
- When you were pregnant how did you picture life for you and your baby?

Choices:

- What choices did you have to make about feeding your baby?
- Did you feel supported, did you have the information you needed...?
- What would have helped you make decisions about breastfeeding?

Decisions:

- What or who helped you make decisions about breastfeeding?
- What were some of the decisions you made about breastfeeding
- What made the decisions easier to make?
- What made the decisions harder to make?
- Were there any decisions you struggled with? If so, why?

Achievements:

- How confident do you feel about your ability to breastfeed your baby? Is there anything that has helped you build (or lose) your confidence?
- How confident do you feel today about breastfeeding your baby?
- Tell me about feeding your baby...
- What were the early days like breastfeeding your baby?
- What do you feel proudest of?
- What do you and your baby do best together?

Regrets:

- Tell me about a day when things didn't go well with feeding your baby...
- Tell me about the things that were different from what you imagined between you and your baby...with breastfeeding....

***The interview guide will include 2-3 prompts per question and will be revised on an ongoing basis

Appendix E: Semi-Structured Interview Guide (Follow-up Interviews)

Sample Follow-up Interview Guide Questions

Expectations:

-Tell me about how your experience so far is like or unlike what you expected breastfeeding to be like?

Choices:

-Tell me about the choices you have made about breastfeeding in the past 3 months?

Decisions:

-What or who helped you make decisions about breastfeeding?

-Were there any decisions you struggled with? If so, why?

-What made the decisions easier to make?

-What made the decisions harder to make?

Achievements:

-How confident do you feel today about breastfeeding your baby?

-Is there anything that has helped you build (or lose) your confidence?

-Tell me about feeding your baby now...

-What do you feel proudest of?

Regrets:

-Tell me about what hasn't been going well with breastfeeding in the past 3 months

-Tell me about the things that were different than you imagined between you and your baby...with breastfeeding now

***The interview guide will include 2-3 prompts per question and will be revised on an ongoing basis

Appendix F: Demographic Data Questionnaire

Study ID:

Question	Answer
Age	
Age of Infant	
Relationship Status	<input type="radio"/> Single <input type="radio"/> Common Law <input type="radio"/> Married <input type="radio"/> Other (describe):
Highest Educational Attainment	<input type="radio"/> High School <input type="radio"/> College Diploma <input type="radio"/> Undergraduate Degree <input type="radio"/> Graduate Degree
Occupation	<input type="radio"/>
Employment (prenatal or current)	<input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Casual
Do you plan to return to work?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> If yes, when _____
Are you exclusively breastfeeding, formula feeding or mixed feeding your baby?	<input type="radio"/> Breastfeeding <input type="radio"/> Formula feeding <input type="radio"/> Both (mixed feeding) <input type="radio"/> Donor milk
Are you or have you expressed breastmilk?	<input type="radio"/> No <input type="radio"/> Yes
Number of pregnancies	<input type="radio"/>
Any issues with conceiving or use of fertility treatments?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> If yes, describe

Appendix G: Consent Form (Printed on official University of Ottawa letterhead)**Consent Form****“The breastfeeding experiences of older first time mothers”**

Researchers: Rosann Edwards RN MScN PhD(c) IBCLC
Doctoral Candidate
School of Nursing
University of Ottawa

Betty Cragg RN PhD
Professor Emeritus
School of Nursing
University of Ottawa

Invitation to Participate:

I am invited to participate in the above mentioned research study conducted by Rosann Edwards, supervised by Betty Cragg because I am a first time mother who was aged 35 years or over at the birth of my baby, and have attempted to breastfeed or express breastmilk at least one time since the birth of my baby, and I am willing to share my experiences related to breastfeeding and making decisions about breastfeeding.

Eligibility:

To take part in this study I must be:

- 1) A first time mothers 35 years of age or over at the time of the birth of my baby; AND
- 2) Have attempted to breastfeed or express breastmilk at least one time since the birth of my baby;
AND
- 3) Have an infant who is 3 months of age or less at the time of the first interview.

Purpose of the Study:

To learn about the factors influencing the decisions first time mothers aged 35 and older make about breastfeeding their babies.

Participation:

My participation will consist of two in-person interviews with Rosann Edwards to be scheduled a minimum of 3 months apart.

Each interview will last about one hour.

During the interview I will be asked questions pertaining to my expectations, choices, decisions, achievements and regrets related to breastfeeding my baby in the first 6 months postpartum.

The interview has been scheduled for _____ (*place, date and time*).

The follow-up interview has been scheduled for _____ (*place, date and time*).

Risks:

There are no major risks associated with participating in this study. My involvement in this study will mean that I share personal experiences, which may cause me to feel uncomfortable or bring up sensitive topics. I understand that I can refuse to answer any question and can choose to end the interview at any time.

Benefits:

I will not directly benefit from my participation in this research. This research may be used to help nurses create better supports for mothers and their infants, and provide future mothers and their infants with better programs and nursing care.

Confidentiality and anonymity:

I have received assurance from Rosann Edwards that the information I share will remain strictly confidential. I understand that my confidentiality will be protected by the removal of all identifiers including my name and my baby's name. All transcripts will be assigned a random code. The researchers will not use any identifiers in reports, publications, presentations, or in discussion of the findings of this study.

I understand that the interviewer must, by law, report concerns about child safety. For example, if she has serious concerns about the safety of a child, she will have to report these concerns. In this situation confidentiality cannot be maintained.

Conservation of data:

The data collected via digital recording be kept in a secure manner by downloading to a secure, password protected laptop that is transported in a locked bag. All recording will be assigned a random identifying code and all identifying information will be removed. The digital recorders' memory will be erased following the downloading of the data. The original materials will be kept for a period of five years, locked securely in the office of Betty Cragg at the University of Ottawa

Compensation:

At the beginning of the interviews, I will receive a \$5 coffee card to Starbucks in appreciation for my participation in this study. I will receive the gift card even if I chose to withdraw from the study, at any point, for any reason.

Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I may request that all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____ (*Name of participant*), agree to participate in the above research study conducted by Rosann Edwards, of the School of Nursing, in the Faculty of Health Sciences at the University of Ottawa, under the supervision of Betty Cragg.

I agree to be audio recorded during the interview:

- Yes
- No

If I have any questions about the study, I may contact Rosann Edwards at _____ or Betty Cragg at _____.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.:

Email:

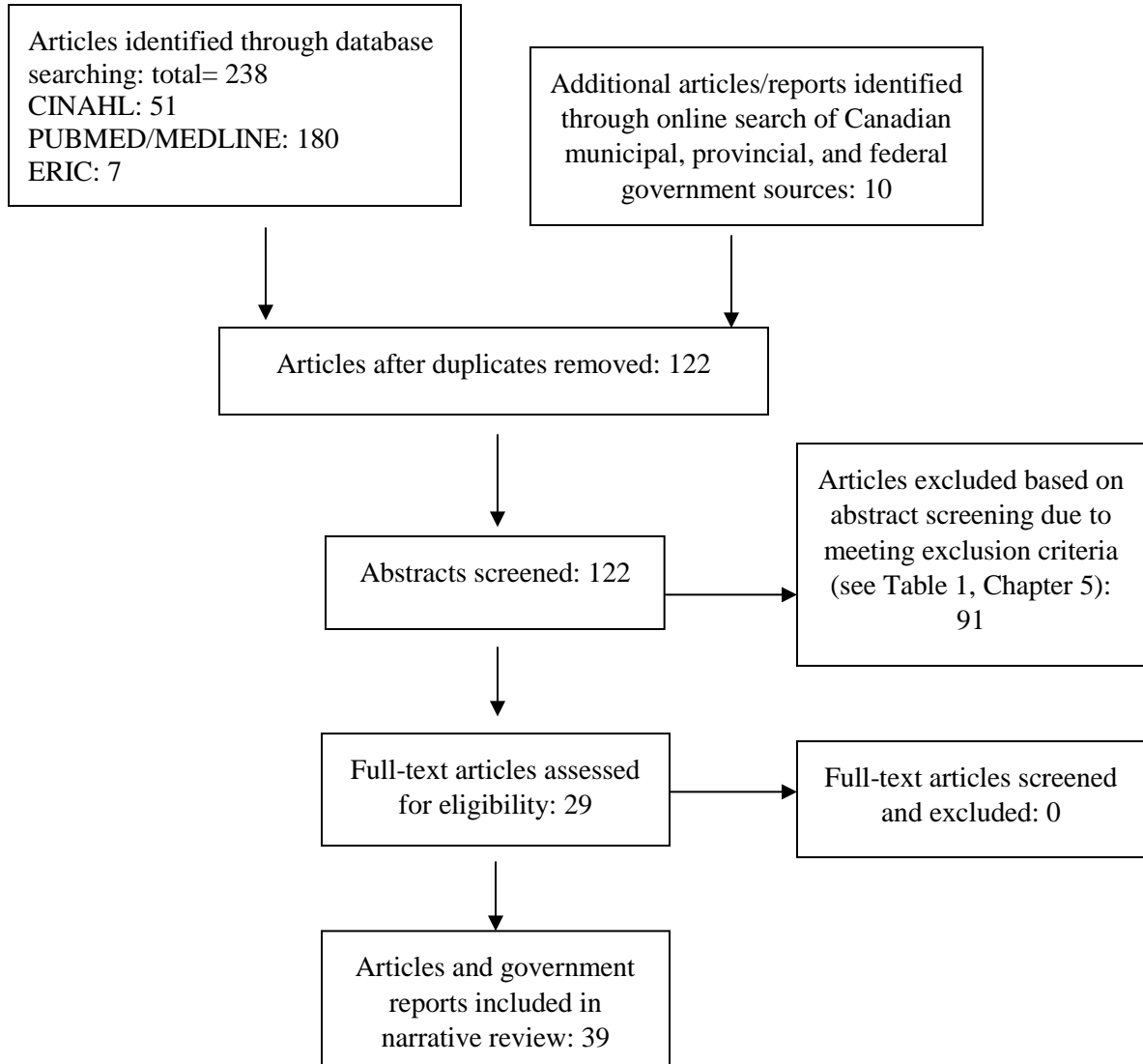
There are two copies of the consent form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:

Appendix H: Narrative Literature Review Prisma Diagram

Appendix I: Timeline

Year	2016			2017			2018	
	Jan-June	July-Aug	Sept-Dec	Jan-Apr	May-Aug	Sept-Dec	Jan-Apr	May-Aug
Est. of Community Contacts for recruitment								
Data Collection								
Recruitment of Participants								
Data Analysis								
Writing of Dissertation								
Submission of Dissertation								
Defence & Revisions								

*Timeline based on feasibility of doctoral study

Appendix J: Mail-Out Recruitment Script

The Breastfeeding Experiences of Older First Time Mothers

You are being invited to participate in a research study exploring the breastfeeding experiences of first time mothers 35 years of age and over because based on your information from your Healthy Babies, Healthy Children hospital discharge screen you are...

- The mother of an infant 3 months of age or younger
- 35 years of age or older at the time of your baby's birth
- This is your first baby
- and you have attempted to breastfeed or pumped breast milk at least once

If you are interested in more information on the study and/or how to participate please contact: Rosann Edwards at _____ (call or text) or email _____.

*This study is being conducted by a student in the School of Nursing at the University of Ottawa as part of a PhD thesis

October 25, 2019

Research Ethics Board
Ottawa Public Health
100 Constellation Crescent,
7th Floor West
Ottawa, ON K2G 6J8

Ms. Rosann Edwards
PhD Candidate
IBCLC School of Nursing
University of Ottawa

Dear Ms. Edwards:

**Re: Research Project #224-16
The Breastfeeding Experiences of Older First Time Mothers: A Constructivist Grounded Theory Study**

I am pleased to inform you that the Ottawa Public Health Research Ethics Board has reviewed and accepted your research proposal entitled, ‘The Breastfeeding Experiences of Older First Time Mothers: A Constructivist Grounded Theory Study.’ You may begin data collection per the schedule you have established.

Although this is not a requirement, one of the delegated reviewers made the following suggestion for your consideration, “I suggest that you include specific questions about what support they receive or don’t receive from the people around them and what information these people may find useful.”

You are reminded to inform the Board if you have any major changes in your proposal by completing Appendix F (attached). At the end of your study, you are to submit an end of project report using Appendix H (attached). Please submit the completed forms as indicated to the Ottawa Public Health Research Ethics Board Secretariat via email.

The term of approval ends on November 17, 2017. Should you require additional time, please contact the REB secretariat to obtain a renewal document which must be submitted in order to extend the time frame of the project.

File Number: H05-16-04

Date (mm/dd/yyyy): 06/16/2016



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Betty	Cragg	Health Sciences / Nursing	Supervisor
Rosann	Edwards	Health Sciences / Nursing	Student Researcher

File Number: H05-16-04

Type of Project: PhD Thesis

Title: The Breastfeeding Experiences of Older First Time Mothers: A constructivist Grounded Theory Study.

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/16/2016	06/15/2017	Approved

Special Conditions / Comments:

N/A

File Number: H05-16-04

Date (mm/dd/yyyy): 06/16/2016



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Betty	Cragg	Health Sciences / Nursing	Supervisor
Rosann	Edwards	Health Sciences / Nursing	Student Researcher

File Number: H05-16-04

Type of Project: PhD Thesis

Title: The Breastfeeding Experiences of Older First Time Mothers: A constructivist Grounded Theory Study.

<u>Approval Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
06/16/2016	06/15/2017	Approved

Special Conditions / Comments:
N/A

File Number: H05-16-04

Date (mm/dd/yyyy): 05/12/2017



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
C.E. Betty	Cragg	Health Sciences / Nursing	Supervisor
Rosann	Edwards	Health Sciences / Nursing	Student Researcher

File Number: H05-16-04

Type of Project: PhD Thesis

Title: The Breastfeeding Experiences of Older First Time Mothers: A constructivist Grounded Theory Study.

<u>Renewal Date (mm/dd/yyyy)</u>	<u>Expiry Date (mm/dd/yyyy)</u>	<u>Approval Type</u>
06/16/2017	06/15/2018	Renewal

Special Conditions / Comments:

N/A



May 16, 2017

REB Application Number: 224-16

Ms. Rosann Edwards
IBCLC School of Nursing
University of Ottawa

**Re: Project # 224-16 – The Breastfeeding Experiences of Older First Time Mothers:
A Constructivist Grounded Theory Study.**

Dear Ms. Edwards:

Further to your letter on March 17, 2017, requesting modification to the approved REB application "The Breastfeeding Experiences of Older First Time Mothers: A Constructivist Grounded Theory Study", we are pleased to inform you that your request has been accepted.

The term of approval ends on May 15, 2018. Should you require additional time, please contact Mohamed Taher the Research Secretariat at oph.ethics@ottawa.ca or by phone at 613-580-6744, extension 16542 to obtain a renewal document which must be submitted in order to extend the time frame of the project.

Sincerely,

A handwritten signature in black ink, appearing to be "MS" or similar initials, written in a cursive style.

Marguerite Soulière

Chair, Research Ethics Board
Ottawa Public Health

