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Motherhood After 30: The Choice is Yours, A Workshop Manual

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A WORKSHOP MANUAL

Pamela Lusk Gween, B.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Art

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Abstract

This manuscript looks at the highly complex decisions concerning delayed parenthood for the over-30 contemporary woman. There has been a proliferation of popular literature on pregnancy and parenthood after thirty. Yet there is very little information and few resources which focus on the parenthood decision-making process. This workshop manual provides therapists and family planning consultants a vehicle by which to help women and couples over-thirty make reproductive decisions. The workshop was evaluated by 10 over-30 women who attended the workshop. The participants found the workshop to be a valuable experience.

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CHAPTER ONE

Introduction

The postponement of parenthood until the age of 30 is a recent and dramatic shift in fertility patterns of contemporary women. The women who belong to this group are faced with having to resolve this important choice at a time in their lives when childbearing has become a physical, psychological and social risk. These women and the men who are a part of their lives need information to make a healthy transition to parenthood or to permanent nonparenthood.

Recently there has been a great deal of popular literature on pregnancy and parenthood after 30, but the focus has been primarily on the biological and medical aspects. There is very little information and few resources which focus on the decision-making process involved in the over-30 parenthood choice. The process is not simply weighing the positives and negatives. It is more the sorting out of one's dreams, values and priorities within the context of all life's choices. It is asking questions, gathering information, reflection and rejecting data.

This workshop manual was developed for therapists and family planning consultants who work with women and couples who have delayed the parenthood decision and are now struggling with the decision of whether or not

to have children. This workshop provides participants an opportunity to come away with a clearer understanding of the following: (a) the psychological factors that guide their decisions about becoming or not becoming parents, (b) their reasons for wanting or not wanting children, (c) their identification of dreams and goals and how a child would fit or not fit into their lifestyle, (d) the medical risks involve with late childbearing.

Ultimately each person must take into account their own personal circumstances and come to their own decisions. There will be some questions that will always remain unanswerable reflecting the fact that there is no one perfect decision. The workshop offers those who are struggling with the parenthood decision a starting point for a greater understanding of the complexity of options, and a greater understanding of oneself and their own decision-making process.

CHAPTER TWO

Literature Review

The Postponement of Parenthood

Throughout history most women have been mothers. Children, until recently, have been considered a major goal of marriage. Having a baby is regarded as an option; it is not an assumed or automatic decision.

Today's postponement of parenthood has become an increasingly common occurrence. In the past twenty years many women have been in pursuit of educational goals and professional development, putting off the parenthood decision until a later and later date. Couples are questioning whether they want to disrupt their relationship and lifestyle in order to have children.

Because the major experiences and responsibilities still take place primarily in the lives of women, the timing of choice between parenthood/nonparenthood is more fundamental in its biological, psychological and social significance for women than men. The choice plays a life-defining role in a woman's life. And now, given the choice, many over-30 women and their mates are finding the decision one of the most difficult they have to make.

The women and men who make up this group are children of post-World War II -- the baby-boom babies.

"They have more years and higher personal and professional aspirations than any previous generation..." (Morris. 1988, p. 2). The postponement of parenthood (and even marriage) by this group has been encouraged by several powerful social forces. New methods of birth control created an atmosphere where sexual intercourse became recreational rather than procreational. The Women's Movement "legitimated freedom for sexual expression and experimentation outside of wedlock" (Morris, 1986, p. 2) and encouraged women to look beyond traditional female roles. They could now, if they wished, exercise the same option as men to make a profession rather than a family the central focus in their lives. Women were free to choose and plan the course of their lives.

As a result of this social change many complex issues have arisen. The women who first took advantage of the option of the 1960s are approaching a finite boundary line for resolving the issues of motherhood in their lives (Scott & Angwin, 1986). Although it is theoretically possible for conception to occur throughout the female reproductive life cycle (13 to 44 years), there are increased medical risks at both the beginning and end of the cycle (Scott & Angwin, 1986). Because of this biological limit, one of the major questions in the 1990s for the intentionally childfree

women over 30 is: "Shall I choose to become a mother or not?"

The Options of Choice

Of the many options available to women over the past several years, the choice that has proven the most difficult is whether or not to accept or reject the parenthood role (Fabe & Winkler, 1979; Veevers, 1980). Scott (1979), in her study to determine the factors affecting reproductive decision-making, found that the women (25-35 years) in her research group who are intentionally childless or who have delayed motherhood fit into three groups:

(a) YES: (n=18) Those who do not intend to become mothers
(b) NO: (n=11) Those who do intend to become mothers
(c) UNCERTAIN: (n=51) Those who remain uncertain

The findings indicate that for all groups the decision to delay childbearing reflected the underlying desire to be independent, free, and competent in the world, and a tendency to view motherhood as a less valued role than that of personal autonomy and freedom (Scott, 1979). The NOs expressed a consistent, conscious avoidance of pregnancy throughout their reproductive lives. The YESes expressed a more positive behavior and attitude toward pregnancy throughout their adulthood. The UNCERTAINs both did and did not want to become mothers. They believed that

they would miss the emotional experience of motherhood, but had not yet solved the question for themselves.

Veevers (1979), in a similar study with voluntarily childfree wives, found there to be two groups of women who remained childfree -- early deciders and postponers. The early deciders make their decisions early in life (adolescence), often after perceiving their own mother's life as restrictive and unfulfilling. The postponers are those who refuse to make a decision allowing relationships, professional commitment and finally nature to make the choice for them.

The great majority of women over 30 are postponers (Scott, 1979; Veevers, 1980; Bombardieri, 1981; Whelan, 1975). The major theme that identifies postponers can best be described as both a pull toward parenthood and nonparenthood, toward both achieving and nurturing, with a fear that success on one of these areas rules out success in the other (Scott, 1979). By keeping all their options open they have maintained the illusion that they can have it all. Unfortunately the resolution to this either/or decision takes on the quality of a forced choice.

Factors Affecting Parenthood Decision-Making

Instinct vs. Social Learning. There are several factors which affects a woman's decision to become a

parent. The major ones are social learning, pronatalism, biological and psychological factors.

There is much literature which would suggest that motherhood is motivated by maternal instinct. However, much that is attributed to maternal instinct may be readily explained as social learning (Veevers, 1973).

Anthropologist Margaret Mead noted that the learning process is a critical factor. She suggests that women learn to want children under socially prescribed conditions and in the same way learn not to want them (Veevers, 1973). Those who choose the later life-style, and suffer for it, do not suffer because they are denying something so biologically basic that it results in trauma, but rather because women learn they must bear children to be socially respected. Childbearing practices and the individual attitudes towards those practices depend upon how each culture values parenthood and what it teaches the young as correct behavior (Veevers, 1973).

Pronatalism. In our society we are surrounded by what is termed as "pronatalism." Pronatalism refers to "all social policies that encourage us to reproduce ourselves, preferably more than once" (Whelan, 1975, p. 22). Pronatalism is not a new concept. It dates back to the Code of Hammurabi in the 20th Century B.C.; the first recorded attempt to increase the number of

births by legislation (Whelan, 1975). The pronatalists' policies were intended to preserve the race.

The pronatalist push comes from a variety of sources; religious indoctrination, early educational training and social pressure. The dominant religious groups in the United States: Judaism, Catholicism and Protestantism, all support in varying degrees "the imperative to be fruitful and multiply" (Veevers, 1973, p. 292).

Traditional Jewish law is explicit in stating the "obligation of the individual is to marry and to propagate the race" (Veevers, 1973, p. 293). Catholic doctrine states that for a marriage to be valid in the eyes of God the union between husband and wife must be permanent for the procreation of children (Veevers, 1973). Protestant theologies view parenthood as a divinely ordained purpose of marriage. It is viewed upon as both a privilege and a responsibility to the community and to the world.

Pronatalism for the over-30 woman began as early as nursery school. The presentation of the first doll encouraged mothering and fathering games. Little girls were socialized early to develop a deep desire for motherhood later on in her life (Harper, 1980).

The books used in grade school depicted a happy three- or four-child family where the Daddy went off to work and the Mommy happily stayed home to scrub floors, cook, clean house and wash clothes. Family life in these early books was romanticized and narrow in scope. Nonparenthood or a one-child family were not considered options, because motherhood was viewed as a woman's destiny and "contraception was not advanced enough to allow couples to effectively postpone, space or avoid children" (Whelan, 1975, p. 27).

Social pressure plays a critical role in childbearing behavior (Polman, 1969). There is considerable social pressure on couples to have a first and second child. The findings in Griffith's (1973) study showed that while some wives expected to have only one child, they were likely to be under pressure not only from family and friends, but from their own concerns for the child's welfare, to have a second child. Ory's (1978) findings suggest that family size norms were supported by a widespread concensus that two or three children were considered an ideal family unit, while a childfree family unit was perceived as unnatural and undesirable.

Biological Factors. Biological factors also play an important part in the parenthood decision-making process. The over-30 woman is faced with a

biologically determined time in which to resolve the choice between parenthood and nonparenthood. Technically the female reproductive life span begins with the onset of menstruation in the early teenage years and ceases with the end of ovulation in the late 40s or early 50s. Yet many women perceive age 30 as a biological boundary line (Guest, Stewart, Guest & Hatcher, 1987). The misconception developed from medical research which correlated advancing age with increased problems during pregnancy and childbirth (Nortman, 1974). Although no age marked the beginning of extreme general risk, the medical profession designated 35 as the age at which obstetricians should consider their patient "high risk" in order to aid diagnostic decisions (Morrison, 1975). Recognizing that there is no single age at which the risks of pregnancy and childbirth suddenly escalate, medical researchers now treat the entire 30-year period between ages 13 and 44 as the reproductive life span, using age 35 to denote "advanced maternal age" (Daniels & Weingarten, 1979). Because the possibility of conceiving a child ends with menopause, the years between ages 30 and 40 form a decade of decision.

Psychological Factors. Psychologically, one's childhood can have a major impact on the parenthood decision. Some women choose not to become a parent

because of an unhappy childhood, while for others an unhappy childhood can be the sole motivation for choosing parenthood.

Kaltreider and Margolis (1977) did a study of 33 women who indicated that they did not wish ever to have children and had chosen to have a tubal ligation. They feared that by becoming a mother they would become like their own mother and that the choice of motherhood might threaten them or their own children because of their background of maternal deprivation or violence.

Genevie and Margolis (1987) found in their study that for many women, motherhood represented a chance to relive their childhood in a happier, more perfect way. They found that the women who felt less accepted by their own mothers were often better mothers than those who felt accepted. They bent over backwards to make sure they did not repeat the negative patterns with their own children.

Before a woman makes a parenthood decision it is important to examine her own past. Family dynamics can get in the way of decision-making in the present.

The Wrong Reason for Having Children

The parenthood question is a complex one that requires as much understanding as possible. It is important that a woman examine her feelings, rather than rely on social pronouncements about what a baby

can or cannot do for a woman's life. Every woman must answer the parenthood question for herself, but some ways of making a decision are better than others. It is helpful for a woman to be aware of some ways that seem problematic. The following is a list of what might be considered the "wrong reasons for having children" (Baruch, Barnett, & Rivers, 1983, p. 131).

"Children will give my life meaning." A woman who has a child for this reason puts the burden for her self-worth on her children. This can be destructive to both the children and to herself.

"I will be miserable in my later life without children." This is a major concern for women considering the parenthood question, but there is data that supports the fact that this fear is unrealistic. Keith (1985) compared the personal and social resources and correlates of psychological well-being of parents and the childfree based upon interviews with 103 childfree persons and 438 parents 72 years and older. She found that children did not guarantee these older parents less loneliness, a more positive outlook on life or a greater acceptance of death. The findings that childlessness had little or no effect on well-being correlates with other research (Beckman & Houser, 1982; Glen & McLanchan, 1981; Rempel, 1985).

"I will be a good daughter if I have children." Women who are struggling with decisions about having a child are sometimes really struggling with pleasing their parents or being like their mothers. Love for one's parents does not mean a woman must choose the lifestyle they want for her, for that will only lead to unhappiness.

"I cannot be a real woman without having children." Some psychologists have intimated that women who choose not to have children are abnormal. Teicholz (1978), in her study compared a group of women who were planning to remain childfree with another group who planned to have children. She found there to be no significant differences between the groups in feminine

identification. Whether a woman chooses to have children or not has no bearing on her femininity.

"A baby will patch up my marriage." One of the worst reasons for becoming a mother is the desperate hope that a baby will somehow bring a husband and wife closer together. A marriage in trouble is a good reason to delay having a child until the problems can be solved, for the addition of a child creates an irrevocable commitment and responsibility for a major part of one's adult life.

A woman struggling with the parenthood decision should ask herself whether in fact she likes being with children or is she thinking about children because she is afraid of society's warnings about what great deprivation she will suffer if she remains childfree. For, if that is the case she could end up resenting the things she gave up for her children.

It is important she understand what children cannot do for her life. Although they can add variety and richness to life, it is unrealistic to assume that children will insure happiness in life. This attitude can only lead to disappointment and unhappiness.

Unrealistic View of Motherhood

Women often speak of wanting a baby, but what they forget is that an infant is only an infant for two years. In this society, children are emotionally and physically dependent on their mothers for fifteen to twenty years. The primary responsibility for childcare still falls on the woman (Stanford & Donovan, 1984) and many women are not prepared for such a huge

responsibility. Genevie and Margolis found in their study that the majority (70%) of women of all ages and educational backgrounds "were neither realistic nor pessimistic, but extremely illusionistic in their visions of what motherhood is like. The joys of motherhood were overly underestimated. The women imagined motherhood to be simple and effortless" (1987, p. 5).

LeMasters (1957) reports the parents in his study had no idea of what children were like before they had them. Unfortunately, children have been so romanticized and shrouded in mystery that most mothers are caught unprepared even though they have planned and waited for the event.

Children and Marital Happiness

While the formation of a family is a time for joy it can also be a time of added strain on a couple's relationship. Rossi (1968) in her sociological analysis of parenthood suggests that the transition to parenthood is more stressful than marital adjustment. Early parenthood is a time of uncertainty and vulnerability affecting a couple's sense of self, role behavior and communication patterns (Newman & Miller, 1978).

Pregnant couples and new parents may also experience stress around fluctuations in sexual

activity. Feldman (1971) compared couples with children to childfree couples and found that couples with children admitted to more sexual problems after parenthood than before parenthood. Since this is an area where false assumptions and misunderstandings can develop rapidly, it helps if the parents are able to clarify their individual needs and feelings on an ongoing basis (Newman & Miller, 1978).

Many new parents struggle with maintaining a relationship while struggling with the pressures of bringing up children and establishing or maintaining careers. This is an especially relevant issue for those who have delayed parenthood because many are dual-career couples. Oftentimes there is little support from extended families, but the added maturity, increased economical and professional security that the established over-30 couple often brings to parenthood can act as buffers against these pressures.

The Decision-Making Process

There are few choices a woman makes that has more far reaching consequences than the decision to become a parent. Other life choices, if made improperly, can be changed, modified or undone. In marriage, education and employment, society provides avenues for correction, "but motherhood is the only adult role that cannot be discarded once it is assumed" (Frieze, 1978,

p. 367). Robert Gould (1974) states, "There are many honorable ways to live; the whole secret in living is to find the right way for you and to follow it" (p. 198).

Step One. The parenthood decision is a process, not always orderly, but there seems to be steps or stages that are largely internal (Scott & Angwin, 1986). The first step begins with asking oneself the questions, "Do I want to become a mother? Yes... No... Maybe? Now... Never... Later?" (Scott & Angwin, 1986, p. 103). A birthday, an unexpected illness or physical vulnerability may trigger the question. For others, parenthood decision-making is attached to a sense of achievement such as a raise in salary, a job promotion or buying a house.

Family expectation, both overt and internal, can increase the pressure for some women. Parents and relatives may hint at or ask point-blank about plans for children. Internal expectations can come from suddenly realizing that one's parents are growing old, or that one's brothers and sisters all have children now.

Whatever the trigger events may be, they are subtle but powerful (Scott & Angwin, 1986). For many women turning 30 and beyond brings on a period of reevaluation of life goals on many levels and 35 marks

a life shift. Each life passage calls for subtle changes in one's perceptions of oneself and a sense of aliveness or stagnation (Sheehy, 1974). Whatever the trigger event may be, reconsideration and clarification begins with the question yes, no, maybe? and deciding where one fits in (Scott & Angwin, 1986).

Step Two. Step two is a time when most women feel they need to gather more information regarding the medical, financial, social and psychological implications of their choice. The time has come when one must consider health, work and economics, relationship and partner and personal hopes and dreams.

Step Three. Step three is all about feelings of ambivalence. All the facts are in but the right answer is somehow still missing. It is at this point that one may wish that somebody would just tell them what to do. The time has come to stop looking outside oneself, stop trying to think rationally and begin to trust and listen to one's inner voice. Dealing with confusion and uncertainty involves arguing with oneself, fantasizing and coming to terms with your feelings toward your partner, toward your career goals, toward parenthood and your parents (Scott & Angwin, 1986). Ambivalence is not a very comfortable feeling, but it is part of the decision-making process.

Step Four. Step four is a period of fantasy, integration and letting go. A mental rehearsal begins after an internal decision has begun to take form. We begin to say good-bye to the road not taken. Transitions begin by leaving something behind. The Latin root of the word decide means "to cut off" (Bombardieri, 1981, p. 5). Cutting off involves a mourning process for the choices that must be given up, for the path that will never be explored. Fantasizing about the road not taken and the road that will be taken are important aspects of this stage.

Step Five. Step five is the final stage which requires a decision to be made and action to be taken. Feelings of uneasiness are normal at this stage. There is no way of knowing for sure that this is the right decision. What is critical is the ability to justify to oneself whatever decision is made and be willing to accept the consequences of either motherhood or nonmotherhood (Whelan, 1975). Although there is an element of risk, the parenthood decision can be an opportunity to confront one's dreams and fears to discover new possibilities for commitment, self-awareness and growth (Scott & Angwin, 1986).

Medical Concerns With Delayed Childbearing

When should a woman have a baby? There are three age related biological factors which influence a

woman's physical ability to have a child: the reproductive life span, risks of pregnancy and fertility problems. The possibility of pregnancy begins with the onset of menstruation and ends with the end of ovulation in the late 40s and early 50s.

Infertility. Medical risks for the over-30 woman increase so there is some cause for concern. Reproductive risks form a J-shaped curve, with the incidence of problems higher during the teen years than the 20s, with medical risks rising progressively during the 30s and 40s. There is evidence that fertility decreases with age (Menning, 1977), although age alone does not predict a fertility problem (Daniels & Weingarten, 1979).

Factors likely to cause infertility are low sperm count, hormonal deficiencies and blockage of the fallopian tubes. Other factors which might decrease fertility are fibroid tumors and endometriosis in women and prostate troubles in men. Older couples are recommended to come in for comprehensive medical check-ups and tests if they have not conceived after six months (Menning, 1977).

Constitutional Complications. There can also be complications of pregnancy and childbearing. Medical literature divides these complications into two main categories: constitutional complications which result

from pre-existing disorders; and obstetrical complications arising from the temporary condition of pregnancy (Morrison, 1975).

The pre-existing diseases the over-30 woman should be concerned with are diabetes, fibroids tumors and cardiovascular disease. Diabetes can, according to Daniels and Weingarten (1979), increase risk of toxemia of pregnancy, postpartum hemorrhage and infection. Diabetes' adverse effects become more severe with age. Fibroids, although they usually have no effect on pregnancy, occasionally grow large enough to interfere with gestation and endanger the fetus. Hypertension and cardiovascular disease can also contribute to complications of pregnancy.

Obstetrical Complications. Obstetrical complications are defined as "medical problems that occur only if a woman is pregnant" (Daniels & Weingarten, 1979, p. 11). Obstetrical complications include miscarriage, toxemia of pregnancy, hemorrhage and dysfunction labors, all prevalent among women over 35 (Scott & Angwin, 1986). Other major obstetrical complications such as prolonged labor, sepis (infection), and ectopic pregnancy have no relationship with age (Morrison, 1975).

The over-30 woman faces a higher risk of delivery by cesarean section. Daniels and Weingarten (1979)

cite one study in which women 35 and over were five times more likely than younger women to be delivered by cesarean even though in two out of three cases the indications for a cesarean delivery were doubtful. It is unclear whether this study is directly related to age or to the tendency of doctors to treat their older patients with more caution (Morrison, 1975).

Chromosomal Complications. Chromosomal defects are of major concern for older women. The only major genetic defect for which age makes a difference is Down's syndrome. It is usually characterized by mental retardation, slight facial abnormalities, shortened hands and trunk, defective internal organs and extra chromosomal material (National Institute of Child Health and Human Development, 1979). Down's syndrome, along with other chromosomal defects can be diagnosed inutero. A woman who chooses to become pregnant later in life can through choronic villi sampling, amniocentesis, and selected abortions, greatly reduce this increased risk (Rubin, 1980).

Twining can also increase with age. As a woman ages, there is a slight increase in the incidence of the body releasing more than one egg during ovulation. Due to high quality prenatal care and healthier women, more fertilized eggs are surviving. There is some evidence that women on the Pill may increase their odds

of bearing twins if they become pregnant soon after going off. Twin births reach a peak at the age of 37 (New Woman, May, 1989).

Stillbirths and miscarriages also increase with age. This increase may be due in part to general medical problems, but a large portion is due to genetics. One study (cited in Scott & Angwin, 1986) of 44,000 pregnancies shows stillbirths and miscarriage rates for women 20 to 30 years of age to be 12 per 1,000. For 30 to 40-year-olds the rate rose 27 to 1,000. There were 49 miscarriages and stillbirths per 1,000 in the 40 to 50 year old range (Scott & Angwin, 1986).

There is some natural selection in pregnancy. "Twenty-one to 24 percent of Down's syndrome fetuses are miscarried and as many as 50 percent of all conceptions end in spontaneous abortions" (Scott & Angwin, 1986, p. 24).

Genetic counseling is highly recommended for the over-30 woman. It consists of collecting the parents genetic history and reviewing the genetic make-up of the unborn child. The review is undertaken through amniocentesis and a newer procedure called choronic villi sampling.

Prenatal Diagnosis

Major chromosomal abnormalities such as Down's syndrome and other genetic disorders can be detected through diagnostic tests in early pregnancy. It is important beforehand that genetic counseling be done to determine which tests may needed. There are many genetic problems which can be detected prenatally, but there are also hundreds of other fetal problems which cannot be detected. A woman may have every possible prenatal test done, but this does not guarantee a healthy infant. Tests are not 100 percent perfect (Stewart, Guest, Stewart & Hatcher, 1987).

Amniocentesis. This is a safe and effective diagnostic procedure that allows doctors to determine the presence or absence of 70 or more metabolic disorders and of all known chromosomal defects. This procedure involves withdrawing a sample of amniotic fluid into a hollow needle carefully inserted through the woman's abdomen into the uterus. Fetal cells within the fluid sample are cultured and the chromosomes are photographed, magnified and examined for defects (Morrison, 1975). The cell culture takes three to four weeks and will yield information on chromosomal abnormalities and the sex of the infant (Scott & Angwin, 1986).

Amniocentesis is usually performed somewhere between the sixteenth and eighteenth week after the last menstrual period. Analysis requires an additional three to four weeks (Morrison, 1975). Ultrasound is used in conjunction with amniocentesis to find the location of the fetus inside the uterus and identify the accessible area where the fluid can be obtained (Daniels & Weingarten, 1975). The risks of amniocentesis for both fetus and mother are small. Studies show that there is less than 1 percent rate of problems (O'Brien, 1984). The amount of risk is directly associated with the skill of the practitioner.

Choronic Villi Sampling. This procedure is a recent alternative to amniocentesis. Samples are taken from the villi (small projections in the lining of the uterus), which are the basis for the placental attachment. This procedure is performed seven weeks after the last menstrual period. Because the villi are part of the developing placenta and are started from the same cells as the fetus, no cell culturing is required (Scott & Angwin, 1986). The sample that is taken is enough for chromosomal analysis and often results are available within 48 hours (Daniels & Weingarten, 1979).

The advantage to chronic villi sampling is a six to eight week time savings over amniocentesis. The

risks and complications of choronic villi sampling are not well documented, but there seems to be a slightly increased risk of spontaneous miscarriage (Stewart, Guest, Stewart & Hatcher, 1987). Choronic villi sampling cannot detect some conditions that amniocentesis can (e.g. spina bifida).

Despite the general pattern of reproductive risk, age alone provides little indication of pregnancy and childbirth risks for any particular woman. The level of risk today for women over 30 corresponds generally to the risk for all women 20 years ago (Daniels & Weingarten, 1979). A woman in good health and with access to adequate prenatal and postpartum care can offset the increase in childbearing risks attributable to advancing age (Daniels & Weingarten, 1979).

Ultrasound. Ultrasound during pregnancy can provide a clear view of the uterus, amniotic sac, and the fetus. It is precise enough that some birth defects can be identified relatively accurately 20 weeks into pregnancy (e.g. severe heart defect, kidney defects, neural tube defects). Ultrasound can be used to monitor fetal growth and development (Stewart, Guest, Stewart & Hatcher, 1987).

Ultrasound is used to evaluate suspected twin pregnancy, possible tubal pregnancy and threatened miscarriage. It is also used with amniocentesis and

choronic villi sampling to pinpoint the location of the fetus and placenta before sampling begins (Stewart, Guest, Stewart & Hatcher, 1987).

Up to this point, there have been no adverse effects documented in infants or women from ultrasound during pregnancy (McKaughan, 1987). Specialists view the procedure as very helpful during pregnancy (McKaughan, 1987).

Knowledge, good medical care and the willingness to take an active role in providing the best conditions for nurturing a healthy baby are keys to a safe and normal pregnancy.

Babies and Career

The reality of life in the 1990s is that having a baby is not a signal for retirement. It is still primarily the woman who experiences the occupational consequence of parenthood. Although many couples plan to share child care responsibilities equally, there are relatively few social and institutional supports for this arrangement. Some employers have established flex-time, job sharing, maternity leave and child care facilities, but these remain the exception rather than the rule. One study which surveyed 200 human resource managers on child care issues, found that while most respondents were sympathetic to problems of working

parents, they felt child care was a parental responsibility (LaBosco, 1986).

In spite of the best planning there is often an initial shift to more traditional male/female roles after the birth of a child. Dual career couples may have a particularly difficult struggle to maintain their professional commitments, both because most career-oriented jobs do not have flexibility demanded of child rearing needs and because the baby may be powerful, positive competitive force (Daniels & Weingarten, 1979).

Career women may fear that adding a second major role in their lives may interfere with their professional goals. McKaughan (1987) found in her survey that the women who were already established in their careers were not hindered by parenthood nor did they have to take less demanding jobs. Surprisingly, many over-30 women find themselves questioning goals that were formerly etched in granite. They find that after being with their babies, mothering is more worthwhile for them than working (Baruch, Barnett & Rivers, 1983).

The Child Care Dilemma

In the U.S. good, affordable day care is not widely available and when it is, often it is not of

high quality. Child care in this country remains inadequate in quantity and quality.

The increase of children in day care and after-school programs doubled in 1970 and there has been a 45 percent increase since 1982. Three-quarters of the nation's children (up to age 12) will be in some form of day care (American Health, 1988). Unfortunately, there is not enough child care, for the supply is not keeping up with the demand (Nollan, 1989).

There is less than 50 percent of quality day care available in the U.S. (Newsweek, February 13, 1989, p. 70). Because of the lack of standards and regulations in most states, day care workers are often untrained and underpaid. Often they try to cope with too many children in a tight space. Massachusetts, Maryland and Kansas are the only states that require the three-to-one child ration considered a minimum for infants and toddlers (American Health, September, 1988, p. 62). The turn-over rate of day care workers is high due to low pay and high stress. As a result quality suffers.

Not only is there not enough quality day care available, but high quality child care is expensive. "Full time care costs upwards of $150 a week for infants and between $50 and $100 a week for

pre-schoolers" (American Health, September, 1988, p. 62). The average annual away-from-home child care costs is $3,000 per child (Nollan, 1989).

The Path to Nonparenthood

A woman may arrive at the nonmotherhood decision early in her adolescence or she may arrive there by making a series of postponements. The greater majority of women postpone by refusing to make a decision, allowing relationships, professional commitments and finally nature to make their decision (Scott, 1979; Veevers, 1980; Bombardieri, 1981; Whelan, 1980). Veevers (1973), who has done extensive research in the area of voluntary childlessness, found there was a gradual, yet distinctive four-stage pattern.

The first stage involves postponement of children for a definite period of time. In the second stage, the couple is still committed to having children, but they are distracted with careers, travel and other activities. It is the third stage that the couple acknowledges to themselves and perhaps to each other, that they may never have children. This realization may come as a shock to them at first, one they may reject before they fully accept. And finally the fourth stage, when the couple decides they will not have children. They may even discuss sterilization,

but they are more likely to carefully use contraception to avoid parenthood.

Society and Motherhood. Society makes motherhood a far more time-consuming experience than it need be, but it is also difficult not to become a mother. Even today in our culture not being a mother brings with it a social stigma. Women are seen as deficient or even pathetic (Sanford & Donovan, 1984). Society does offer a few positive role models in the way of Georgia O'Keefe, Katherine Hepburn and Marlo Thomas, but the message behind these role models is that it is all right to be childless "only if you do something really spectacular in your life" (Sanford & Donovan, 1984, p. 149). Society makes a woman feel that she must prove herself exceptional in some area in order to make up or compensate for her failure to be a real woman and bear children.

Feelings Around the Nonparenthood Choice. There are many feelings for women around the decision not to become a mother. The primary feelings are of loss, fear, and relief (Pies, 1988). A woman may experience a feeling of missing out on the experience of having children in her life and the things associated with having children. This may have to do with the indoctrination most of us have received while growing up that told us that we must have children. "Even if a

woman is choosing not to have children, the subtle longing instilled by our socialization may remain" (Pies, 1986, p. 136). The feelings of loss may be on a physical level, feelings of missing the experience of physically having a child and experiencing the growth, birth and bonding involved in the process (Pies, 1986).

A woman may second guess her decision not to become a parent, knowing deep down that she has made the right decision for herself. There will probably be various times in a woman's life when she yearns for a child, while knowing that she does not want the responsibility that goes with raising one. There will always be some ambivalence associated with the choice, but it is a normal response (Pies, 1986).

Although a woman knows what she is <u>not</u> choosing, she may be fearful of what she <u>is</u> choosing. With the decision not to become a parent there is now reason for other choices. With so much time and energy spent in the decision-making process it will take time to redirect one's thoughts and energy into other areas of interest (Harper, 1980).

After a decision is made there comes with it an element of relief. The same is true with the decision not to become a parent. There is not only the relief of having made a decision, but a decision that feels

right, even though it is a decision most women never thought they would have made.

In conclusion, it is evident that the decision to become or not to become a parent for the over-30 woman is highly complex. She has reached a point in her life when childbearing has become a physical, psychological and sociological risk. Because of so little information and few resources which focus upon the after-30 decision-making process, it is important that therapists and family planning consultants provide the support, openness and an appreciation of the significance of reproductive choice in their clients' lives.

The after-30 parenthood decision is a process that needs support. It is simply not weighing the positives and negatives. "It is more like a puzzle and it begins by finding all the pieces that will make up the edges to get a sense of what the area is and how and where all the other pieces might fit in" (Pies, 1986, p. 7).

The development of this manual provides a starting point for those struggling with the parenthood question, assisting them in making a conscious decision. Ultimately each person's questions must be answered on an individual basis while taking into account the qualities of a woman's personality and her marriage.

CHAPTER THREE

Method

Subjects

The subjects were 10 married career women who signed up to attend the Motherhood After 30: The Choice is Yours workshop (see Appendix A). Their ages ranged from 32 to 40 years of age. They were asked to complete an evaluation/questionnaire (see Appendix B) after the completion of the workshop.

Materials

An evaluation/questionnaire (see Appendix B) consisted of eight questions. Two questions were answered by indicating a score on a scale of one (lowest rating) to 10 (highest rating). The remaining questions were fill in the blanks. The goal of the questionnaire was to determine how valuable the ideas and concepts were, how effective the presentor was in imparting the information, how effective the exercises were and how the workshop could be improved.

Procedure

The workshop manual was developed (see Appendix A) to provide the following: (a) the reasons behind postponement of parenthood; (b) the five steps of the parenthood decision-making process; (c) the factors affecting the reproductive decision-making; (d) an

overview of the medical concerns with delayed childbearing.

The exercises provided the participants the following: (a) a better understanding of the reasons why they did or did not want children; (b) a better understanding of their goals and aspirations of how a child would fit or not fit into their lifestyle; (c) the psychological factors that would guide their decisions about becoming or not becoming parents.

The workshop was evaluated by the 10 participants.

CHAPTER FOUR

Results

The evaluation from the 10 participants indicate that the workshop was an effective tool in the over-30 parenthood decision-making process.

One hundred percent of the participants agreed that the ideas and concepts presented in the workshop were valuable. One hundred percent of the participants found the presentation to be highly effective.

Sixty percent found factors affecting parenthood decision-making most helpful. Twenty percent found clarification of goals most helpful. Ten percent found the five-step decision making process most helpful, while 10 percent found reasons for wanting or not wanting children helpful.

Table 1

Response to Question #3

1.	Factors affecting parenthood decision-making	60%
2.	Clarification of goals	20%
3.	Five-step decision-making process	10%
4.	Wanting/not wanting children	10%

Note: See Appendix B for complete questionnaire.

Fifty percent found all the information to be helpful. Thirty percent found the medical information to be least helpful, while twenty percent found the information on nonparenthood to be least helpful.

Table 2

Response to Question #4

1. All information helpful	60%
2. Medical information least helpful	20%
3. Nonparenthood information helpful	10%

Note: See Appendix B for complete questionnaire.

Fifty percent found the exercise Hopes and Dreams to be most helpful. Thirty percent found Childhood Memories to be most helpful, while twenty percent found "We Have Our Reasons" to be most helpful.

Table 3

Response to Question #5

1.	Lifeline	60%
2.	Childhood Memories	20%
3.	We Have Our Reasons	10%

Note: See Appendix B for complete questionnaire.

Eighty percent found all exercises to be helpful. Ten percent found the Lifeline exercise to be least helpful, while 10 percent found Childhood Memories to be least helpful.

Table 4

Response to Question #6

1.	All exercises helpful	80%
2.	Lifeline least helpful	10%
2.	Childhood Memories least helpful	10%

Note: See Appendix B for complete questionnaire.

Eighty percent found that all areas had been covered. Ten percent wanted information on how childfree women can live a full life, while 10 percent wanted information on the primal urge to reproduce.

Table 5

Response to Question #7

1.	All areas were covered	80%
2.	How childfree women can lead a full life	20%
3.	The primal urge to reproduce	10%

Note: See Appendix B for complete questionnaire.

Seventy percent found that nothing needed to be changed, added or eliminated. Ten percent found Childhood Memories was "too heavy for an overview workshop". Ten percent wanted information on adoption, while 10 percent wanted to sit in a circle.

Table 6

Response to Question #8

1. Nothing needed to be added, changed or eliminated	70%
2. Childhood Memories too heavy for an overview workshop	10%
3. Adoption	10%
4. Want to sit in a circle	10%

Note: See Appendix B for complete questionnaire.

General comments ranged from excellent and informative to well prepared and professionally done.

Discussion

The workshop was received very well. Sixty percent of the participants found the factors affecting reproductive decision making very helpful. Many were especially intrigued to discover how one's childhood can impact on the parenthood decision. Some of the participants were shocked to learn that their reason for not wanting children was their fear that they would repeat the rejection and abuse they had experienced from their own mothers. Kaltreider and Margolis

(1977) found that the women in their study were fearful of becoming mothers. Because of their own background of maternal deprivation and/or violence they were fearful they would repeat this behavior with their own children.

One of the participants expressed a desire to become a parent, vowing that the experiences she had endured as a child would never be repeated with her own children. Genevie and Margolis (1986) found in their survey of 1,100 mothers, the mothers who were rejected by their own mothers, often did not go on to repeat their mothers' rejecting behavior. Instead, they tended to bend over backwards to make sure they did not recreate the same negative pattern with their children.

Parental pressure is also a factor which effects the parenthood decision. One of the participants shared with the group how her father dearly wanted a grandchild. He told her he would give her anything (i.e., car, airplane, money) if she would only bear him a grandchild. This went on for some time until her father accepted her decision of waiting until she and her husband felt emotionally ready. There is a great deal of social pressure placed on couples to have a first or second child. Pohlman (1969) found that social pressure plays a critical role in childbearing behavior. Much of this pressure can come from parents.

One participant felt that the five-step decision-making process really validated her own process. She was relieved to learn that ambivalence is a normal part of the process. Much of what she is struggling with is internal. Scott and Angwin (1986) note that the decision-making process is largely an internal one. This would certainly concur with the participant's experience.

While 60 percent of the participants indicated that all the information was helpful, 40 percent found the medical information to be the least helpful in their decision-making process. The group as a whole was well educated and has given serious thought to the parenthood decision. Because much of the literature on parenthood over 30 focuses primarily on the medical and biological aspects, it may be that the participants have already acquainted themselves with the medical considerations for the over-30 childfree woman.

The exercises, Lifeline (50%) and Childhood Memories (30%), were viewed as the most helpful exercises. Many stated that this was the first time they actually wrote down their dreams and goals. They felt that this was very helpful in determining what was important and not important in their life. It also helped them to see how a child would fit or not fit into their life.

Childhood Memories elicited many moving responses and stories during group processing. One woman had blocked out much of her childhood and now understood better her strong feelings toward nonparenthood. She felt that if she could examine her own background with a therapist, this would be very helpful in coming to some decision regarding parenthood.

While Lifeline and Childhood Memories were favorites for the greater majority of participants, they were found to be the lest helpful (20%) for some. One participant found Childhood Memories "too heavy" for an overview workshop.

Eighty percent of the participants found that the workshop covered everything. One participant wanted more information on how childfree women can live a full life. This topic will be covered in greater depth during the six-week class. Childfree women and couples will be brought in to share with the class how their lives are full and rewarding. Another participant wanted information on adoption. Again, this subject will be covered during the class. One participant wanted to hear about the "primal urge" to reproduce. This could easily be incorporated into the introductory workshop.

Overall, the participants found the workshop to be excellent and they were glad they came. The workshop

evaluation result support the need for more information on the over-30 parenthood decision-making process.

Recommendations for future workshops included a medical expert presenting the medical concerns for late childbearing. In addition, some of the participants' suggestions would be incorporated into future workshops.

APPENDIX A

Workshop Manual

WORKSHOP MANUAL

MOTHERHOOD AFTER 30: THE CHOICE IS YOURS

TABLE OF CONTENTS

How To Use This Manual

This workshop manual was developed for therapists and family planning consultants who work with women and couples who have delayed the parenthood decision and are now struggling with the decision whether or not to have children. This three-hour workshop targeted for women, was designed with the intention of using it as an introduction to a six-week, two-hour, decision making class for couples

In addition to being a workshop guide, the manual can be used on an individual basis, providing the reader with useful information and thought inducing exercises. Some readers may choose to read the manual from beginning to end or they may choose only to use it for exercises.

Workshop Objectives

The following workshop manual was designed to help therapists and family planning consultants assist clients with the parenthood decision. As a result of this workshop, participants will have a better understanding of the following:

1. The psychological factors that guide their decisions about becoming parents.
2. Their reasons for wanting or not wanting children.
3. Their identification of dreams and goals and how a child would fit or not fit in with their lifestyle.
4. The medical risks involved with later childbearing.

OUTLINE

8:30 - 9:00	Module 1
	Registration (30 minutes)
9:00 - 9:10	Module 2
	Workshop Objectives
	Intent of Workshop (10 minutes)
9:10 - 9:40	Module 3
	Presentation: Decisions, Decisions (15 minutes)
	Exercise on reasons for wanting/not wanting children (15 minutes)
9:40 - 9:50	Discussion and Feedback (10 minutes)
9:50 - 10:05	Exercise on clarifications of hopes and dreams (15 minutes)
10:05 - 10:15	Discussion and Feedback (10 minutes)
10:15 - 10:30	BREAK
10:30 - 10:45	Module 4
	Presentation: Factors affecting reproductive decision-making (15 minutes)
10:45 - 11:05	Childhood memories exercise (20 minutes)
11:05 - 11:15	Discussion and Feedback (10 minutes)

11:15 - 11:30	Module 5 Presentation: Medical Concerns With Late Childbearing (15 minutes)
11:30 - 12:30	LUNCH
12:30 - 12:45	Module 6 Presentation: Path to Nonparenthood (15 minutes)
12:45 - 12:50	Reading: "The Road Not Taken" (5 minutes)
12:50 - 1:10	Module 7 Evaluation (20 minutes)

WORKSHOP AGENDA

8:30 - 9:00	Registration
9:00 - 9:10	Introduction
9:10 - 9:40	Presentation: Decisions, Decisions
	"We Have Our Reasons" Exercise
9:40 - 9:50	Discussion and Feedback
9:50 - 10:05	Hopes and Dreams Exercise
10:05 - 10:15	Discussion and Feedback
10:15 - 10:30	BREAK
10:30 - 10:45	Presentation: Factors Effecting Reproductive Decision-Making
10:45 - 11:05	Childhood Memories Exercise
11:05 - 11:15	Discussion and Feedback
11:15 - 11:30	Medical Concerns With Late Childbearing
11:30 - 12:30	LUNCH
12:30 - 12:45	Presentation: Path to Nonparenthood
12:45 - 12:50	Reading: "The Road Not Taken"
12:50 - 1:00	Evaluation

MODULE 1: REGISTRATION

Module 1: Guide For Conducting Registration

1. Have coffee and tea available.
2. Participants sign in.
3. Handout name tags.
4. Handout packets.
5. Direct participants regarding restrooms.
6. Announce that there is to be no smoking during the workshop.

MODULE 2: INTRODUCTION

Module 2: Guide For Introducing Workshop

1. Introduction of presenter.

2. Introduction from all the participants including a brief statement of what they hope to gain from the workshop.

3. Review of workshop agenda.

WORKSHOP AGENDA

8:30 - 9:00	Registration
9:00 - 9:10	Introduction
9:10 - 9:40	Presentation: Decisions, Decisions "We Have Our Reasons" Exercise
9:40 - 9:50	Discussion and Feedback
9:50 - 10:05	Hopes and Dreams Exercise
10:05 - 10:15	Discussion and Feedback
10:15 - 10:30	BREAK
10:30 - 10:45	Presentation: Factors Effecting Reproductive Decision-Making
10:45 - 11:05	Childhood Memories Exercise
11:05 - 11:15	Discussion and Feedback
11:15 - 11:30	Medical Concerns With Late Childbearing
11:30 - 12:30	LUNCH
12:30 - 12:45	Presentation: Path to Nonparenthood
12:45 - 12:50	Reading: "The Road Not Taken"
12:50 - 1:00	Questions and Answers
1:00 - 2:00	Evaluation

MODULE 3: DECISIONS, DECISIONS

Module 3: Presentation Guide

Decisions, Decisions

The question of whether or not to become a parent may be the most emotion-laden decision the over-30 woman faces. The issue of motherhood rarely arose in the past. "A married woman who could have children did. Motherhood was a woman's destiny." (Baruch, Barnett & Rivers, 1983, p. 104).

Today the postponement of motherhood is becoming an increasingly common occurrence. In the past 20 years many women have sought to pursue educational and career goals, delaying the parenthood decision until a later and later date. Because the major experiences and responsibilities of parenthood still take place primarily in the lives of women, timing of the choice between motherhood/nonparenthood is more fundamental in its biological, psychological and social significance for women than men. This choice plays a life-defining role in a woman's life.

Recently there has been a great deal of popular literature on pregnancy and parenthood after 30, but the focus has been primarily on the biological and medical aspects. There is very little information and few resources which focus on the decision-making process involved in the after-30 parenthood choice.

The process is not simply weighing the positives and negatives. It is more the sorting out of one's dreams, values and priorities within the context of all life's choices. It is asking of questions, gathering information, reflecting and rejecting data.

The intent of this workshop is not for the participant to come away with an answer to the parenthood question, but to provide a thoughtful decision-making process, for ultimately each person must take into account their own personal circumstances and come to their own decisions. some questions will probably remain unanswerable reflecting the fact that there is no one perfect decision. This workshop offers a starting point for a greater understanding of oneself and their own decision-making process.

The postponement of parenthood, and even marriage has been encouraged by several powerful social changes. The Pill allowed sexual intercourse to become entirely recreational rather than procreational (Morris, 1986). The Women's Movement encouraged women to look beyond traditional female roles. They could now, if they wished, exercise the same option as men to make a profession rather than a family the central consuming interest in their lives.

As a result of this social change many complex issues have arisen. The women who first took advantage of the options of the 60s are approaching the finite boundary line for resolving the issues of motherhood in their lives. Although it is possible for conception to occur throughout the female reproductive life cycle (13 years to 44 years), there are increased medical risks at both the beginning and end of the cycle (Scott & Angwin, 1986). Because of this biological limit, one of the major questions in the 1990s for childfree women over 30 is: "Shall I choose to be a mother or not?"

There are three groups of women who are intentionally childless: Those who do intend to become mothers, those who do not intend to become mothers, and those who are still uncertain (Scott, 1979). A large majority of women fall into the "uncertain" category. The major theme that identifies these women can best be described as a pull toward both motherhood and nonmotherhood, toward both achieving and nurturing, with the fear that success in one of these areas rules out success in other (Scott, 1979). By keeping all their options open they have maintained the illusion that they can have it all. Unfortunately the resolution to this either/or decision takes on the quality of a forced choice.

There are few choices a woman makes that has more far reaching consequences than the decision to become a parent. Other life choices, if made improperly, can be changed, modified or undone. In marriage, education and employment society provides avenues for correction, but "motherhood is the only adult role that can not be discarded once it is assumed" (Frieze, 1978, p. 367). The parenthood decision requires as much understanding as possible. Robert Gould states, "there are many honorable ways to live; the whole secret in living is to find the right way for you and to follow it" (1974, p. 198).

The parenthood decision is a process, not always progressive or orderly, but there seem to be steps or stages that are largely internal (Scott & Angwin, 1986). The first step in this process begins with asking oneself the question, "Do I want to become a mother? Yes... No... Maybe... Now... Never? Later?" (Scott & Angwin, 1986, p. 103).

Oftentimes this question is set off by what are called "trigger events." Trigger events can be a birthday, an illness which causes thought of potential aging, a job promotion, a raise in salary or buying a house. Whatever they may be, they are powerful. The 30s for many women are a time when they begin to

reevaluate their life goals and their perceptions of themselves. Whatever the trigger event may be, reconsideration and clarification begins with the question Yes?, No?, Maybe? and deciding where one fits in.

Step Two is a time when most women feel they need to gather more information regarding the medical, financial, social and psychological implications of their choice. The time has come when one must consider health ("Can I have a healthy baby? How long can I wait?"); work and economics ("How will my decision affect my work and career goals?"); relationship and partner ("How will this affect my marriage?"); and personal hopes and fears ("What do I want to accomplish with my life?").

Step Three is all about feeling of ambivalence. All the facts are in but the "right" answer is somehow still missing. It is at this point that one may wish that somebody would just tell them what to do. The time has come to stop looking outside oneself, stop trying to think rationally and begin to trust and listen to one's inner voice. Dealing with the confusion and uncertainty involves arguing with oneself, fantasizing and coming to terms with your feelings toward your partner, toward your career goals,

toward parenthood and your parents (Scott & Angwin, 1986). Ambivalence is not a very comfortable feeling, but it is part of the decision-making process.

Step Four is a period of fantasy, integration and letting go. A mental rehearsal begins after an internal decision has begun to take form. We begin to say goodbye to the road not taken. Transitions begin by leaving something behind. The Latin root of the word decide means "to cut off" (Bombardieri, 1981, p. 5). Cutting off involves a mourning process for the choices that must be given up, for the path that will never be explored. Fantasizing about the road not taken and the road that will be taken are important aspects of this stage.

Step Five is the final stage which requires a decision to be made and action to be taken. Feelings of uneasiness are normal at this stage. There is no way of knowing for sure it this is the right decision. What is critical is the ability to justify to oneself whatever decision is made and be willing to accept the consequences of either motherhood or nonmotherhood (Whelan, 1975). Although there is an element of risk, the parenthood decision can be an opportunity to confront one's dreams and fears, to discover new

possibilities for commitment, self-awareness and growth (Scott & Angwin, 1986).

Module 3: We Have Our Reasons Exercise

1. Exercises will be written on flip chart. Explain exercise. Write down and complete these two sentences:

   a. I want a child because...
   b. I don't want a child because...

   Think of as many answers as you can for each sentence. There are no right or wrong reasons. Your reasons may change over time, but for now these are your reasons. Choose a partner and brainstorm on number one. After you are finished, take a few seconds, clear your head, change partners and work on number two. You will have 10 minutes to complete this exercise.

2. Answer any questions.

3. Wait for participants to finish.

4. Ask participants to share their answers with the group. Allow for time so that the group can process their feelings and reactions.

Source: Pies, C. (1988) Considering parenthood, San Francisco: Spinsters/Aunt Lute, pg. 20.

Module 3: Lifeline Exercise

1. Exercise instructions written on flip chart. Explain exercise. This exercise will give you a chance to identify some of your hopes and dreams. Make a list of all the things you want to accomplish and/or experience in your lifetime. Include things related to work, home life, family, money, travel, relationships, etc.

2. Make a list of the things you will do during the next five years to begin moving toward some of the life goals.

3. Make a list of the things you will do during the next year to begin working on this five-year plan.

4. Participants will have 20 minutes to complete exercise.

5. Answer any questions and wait for participants to complete exercise.

6. Discuss exercise. (See Module 3: Discussion of Exercise).

Source: Pies, C. (1988) Considering parenthood, San Francisco: Spinsters/Aunt Lute, pg. 23.

Module 3: Discussion of Exercise

1. How did it feel to do this exercise? Was it difficult, easy, stimulating, discouraging?

2. What was it like to be so deliberate about identifying your life goals? Did it seem real to you?

3. How does a child fit into your life plan? Is this what you expected?

4. Were there any surprises in doing this exercise? What were they?

5. This exercise can be shared with a partner. Look at similarities and differences in each other's life plans, point out where there might be problems and where compromise may be needed. Problems which come up in discussion of this exercise need not be solved, but it is good to be aware of how each individual's life plans are similar and different.

Module 3: Pie Exercise I

1. Write instructions on flip chart. Explain exercise. Make a list of all the activities you do during the week. Include sleeping, eating, working, exercising, time spent alone, etc. Think about how much time you spend doing each activity and assign it an hourly amount. Some activities can be lumped into general categories such as "leisure time" (reading, movies, walking) or "house chores" (laundry, cleaning the house). Keep a list of what you have included in each category.

2. There are 168 hours in a week. Add up the hours in your week. Now divide it into sections proportionate to he amount of time you spend doing each activity. The circle graph will give you an actual picture of how you currently spend your time.

3. Participants will have 30 minutes.

Source: Pies, C. (1988) Considering parenthood, San Francisco: Spinsters/Aunt Lute, pg. 25.

Module 3: Pie Exercise II

1. Instructions written on flip chart. Explain exercise. Imagine you have a child. Be aware of the age of the child you have in mind. Make a list of all the activities that would now be in a typical week. Assign an hourly amount to each activity. Draw another circle graph, divide it according to the activities you do with this child. You will have 30 minutes for this exercise.

2. Answer any questions.

3. Wait for participants to finish.

4. Discuss exercise. (See Module 3: Discussion of exercise).

Source: Pies, C. (1988) Considering parenthood, San Francisco: Spinsters/Aunt Lute, pg. 25.

Module 3: Discussion of Exercise

1. What did you learn from this exercise?

2. Were there any surprises? What were they?

3. How did you feel about doing this exercise?

4. How did the way you spent your time change when you added a child? Which specific activities changed? How did it feel when you began to realize that these activities would have a different place in your week's time?

5. How old was your child?

MODULE 4: FACTORS AFFECTING REPRODUCTIVE DECISION-MAKING

Module 4: Presentation Guide

Factors Affecting the Reproductive Decision-Making Process

What motivates a woman to choose or not choose motherhood? There is much literature which would suggest that motherhood is motivated by maternal instinct. However, much that is attributed to maternal instinct may be readily explained as social learning (Veevers, 1973).

Anthropologist Margaret Mead noted that the learning process is a critical factor. She suggests that women have to learn to want children only under socially prescribed conditions and in the same way learn to not want them. Those who choose the latter life style and suffer for it, do not suffer because they are denying something so biologically basic that it results in trauma, but rather because women learn they must bear children to be socially respected. Childbearing practices and the individual attitudes toward those practices depend upon how each culture values parenthood and what it teaches the young as correct behavior (Whelan, 1975).

In our society we are surrounded by what is termed pronatalism. Pronatalism refers to "all social

policies that encourage us to reproduce ourselves, preferably more than once" (Whelan, 1975, p. 22).

Pronatalism is not a new concept. It dates back to the Code of Hammurabi in the 20th century B.C. in Babylon, which legislated an increase in the number of births. During the reign of Caesar Augustus between 18 B.C. and A.D. 9 legislation encouraged marriage and children: fathers, depending upon the number of children they had, were given preference in public office; mothers were allowed to wear distinctive jewelry and clothing (Whelan, 1975). The pronatalist policies were intended to preserve the race, but in this day and age not everyone must have children in order to propagate our society. However, social pressures still exist.

The pronatalist push comes from a a variety of sources. It can be found in religious indoctrination. The Catholic Church views a couple's primary role in life to perform the function of parenthood. Jewish law explicitly states that it is the obligation of the individual to marry and propagate the race. Although the Protestant codes may accept, in principle, the idea of birth control, nowhere in their theology is there ever mentioned the possibility of an intentionally childless family.

Pronatalism can also be found in our very early years of educational training -- the nursery. In the nursery the presentation of the first doll encourages mothering and fathering games. Little girls are socialized early to develop a deep desire for motherhood later on.

The books used in grade school depict a happy three- or four-child family where the Daddy goes off to work and the mother happily stays home to scrub floors, cook, clean house and wash clothes. This is a very narrow and limiting view of what family life is all about.

Social pressure plays a critical role in childbearing behavior. Parents are very likely to put pressure on their children to produce grandchildren for them. As parents get older their lives can become empty and the "pressure of having a new life facet to alleviate potential loneliness may be strong" (Whelan, 1975, p. 29). This can be especially true for the older woman. Because of the differences in life span and age at marriage between male and female, she is more likely to be left alone. Also because her childbearing days are over, by becoming a grandmother she may feel revalidated as a woman. Grandchildren

provide an opportunity for grandparents to live vicariously through them.

Friends who find out a couple has chosen not to have children may accuse them of being selfish, of having too much fun with all their freedom. They are not carrying their share of the load in society. There is a subtle attitude in our society that women who choose to remain childfree must somehow pay the price for avoiding the trouble of children (Whelan, 1975).

An individual or couple does not need pressure from either proparenthood or antiparenthood factions. In the final analysis the decision about parenthood is a uniquely personal choice.

Biological and psychological factors also play an important part in the motherhood decision-making process. The over-30 woman is faced with a biologically determined time in which to resolve the choice between parenthood and nonparenthood. Technically, the female reproductive life span begins with the onset of menstruation in the early teenage years and ceases with the end of ovulation in the late 40s or early 50s. The medical community treats the entire 30-year period between ages 13 and 44 as the reproductive life span, using age 35 to denote advanced maternal age (Daniels & Weingarten, 1979; Morrison,

1975). Because the possibility of conceiving a child ends with menopause, the years between ages 30 and 40 form a decade of decision.

One's childhood also has an important influence on a woman's decision to parent or not. Some women are hesitant to become parents because of their poor relationship with one parent or both. Some professionals suggest "that those who choose nonparenthood are acting out of their parents' unconscious desire not to have them" (Bombardieri, 1975, p. 65).

An unhappy childhood can also be the sole motivation for choosing motherhood. Genevie and Margolis (1987) in a survey of 1,100 mothers, asked why they wanted children. The answers women gave affirmed their need and desire to nurture, but they found that under the surface women wanted to be nurtured. For many of the women, motherhood represented a chance to start over, reliving their childhood in a happier, more perfect way.

Some women considering the baby decision fear they will become <u>their</u> mothers, so instead they will respond by making a choice that seems to contradict whatever their mother stood for. By not stopping and examining this fear, a woman may not realize that she is

imitating her mother by responding to her subtle pressure. By abandoning parenthood she has in essence chosen someone else's life decision -- her mother's.

Before a woman makes a parenthood choice it is important to examine her own past. It is only natural when thinking about parenthood to associate oneself with one's own parents and the feelings of long buried resentments. Family dynamics can get in the way of decision making in the present. It is hard to make a decision without taking the time to determine how one's past has impacted on their present life. Without enough information a thoughtful and conscious decision cannot be made.

Module 4: Discussion of Exercise

1. What part of this relationship would you like to keep, leave behind, change if you were to have a child?

2. How would you want your parenting to be similar or different from the kind of parenting you received?

3. End the exercise with a brief statement.

4. "We are all a product of our environment in which we grew up. Our environment includes not only people we were close to and our relationships with them, but also our attitudes of the community around us, our religious upbringing, and our cultural values. Our decisions regarding parenthood have a lot to do with the interplay of all these elements."

Module 4: Photo Album Exercise

1. Explain exercise. When you think about parenthood do you consider every stage from infancy to young adulthood? Do you focus more on the positive aspects while ignoring the problems and frustrations of parenthood or visa versa? This exercise will help you focus on how you feel about children at different ages. Close your eyes, relax and visualize the images that I will call out.

   * A wailing, red-faced newborn.
   * A peaceful nursing three-month-old baby.
   * A cranky teething seven-month-old.
   * A red-haired eight-month-old eating her first ice cream.
   * A one-year-old grinning about the bowl of spaghetti he just poured on the floor.
   * A toddler taking his first steps and following with an expression of surprise.
   * A toddler rolling on the floor, kicking and screaming.
   * A six-year-old reading her first book.
   * A seven-year-old saying to her mother, "Why don't you stay home like my friend's mother?"
   * A nine-year-old boy serving you lunch in bed.
   * An 11-year-old winning a blue ribbon for her exhibit at the science fair.
   * A 13-year-old sniffing glue in her bedroom.
   * A 17-year-old saying, "At last I'm old enough to get out of this house!"

Source: Bombardier, M. (1981) The baby decision: How to make the most important choice of your life. New York: Rawson, Wade Publishers, Inc., pg. 36.

Module 4: Discussion of Exercise

1. How well did you stay with these pictures? Did you find yourself wanting to skip over some? If you are leaning toward parenthood, you may have focused only on the good parts. If you focused on the negative aspects, you may be learning toward nonparenthood.

2. End the exercise with a few final statements.

3. Women who speak of wanting a baby frequently forget about the fact that a baby is only a baby for two years. In this society, a child is emotionally and physically dependent on her/his mother for the next twenty years. The joys of motherhood are easily imagined, but the responsibilities of motherhood are often underestimated (Genevie & Margolis, 1987).

MODULE 5: MEDICAL CONCERNS WITH DELAYED CHILDBEARING

Module 5: Presentation Guide

Medical Concerns

When should a woman have a baby? There are three age-related biological factors which influence a woman's physical ability to have a child: the reproductive life span, risks of pregnancy and fertility problems. The possibility of pregnancy begins with the onset of menstruation and stops with the end of ovulation in the late 40s and early 50s.

Medical risks become a major factor for the over-30 woman. There is some cause for concern. Reproductive risk form a J-shaped curve, with incidence of problems higher during the teens then the 20s with medical risks rising progressively during the 30s and 40s. There is also evidence that fertility decreases with age (Menning, 1977) although age alone does not predict a fertility problem (Daniels & Weingarten, 1979). Factors likely to cause infertility are low sperm count, hormonal imbalance and blockage of the fallopian tubes. Other factors which might decrease fertility are fibroid tumors (benign tumors in the uterus) and endometriosis (a condition in which tissue resembling the uterine linking grows elsewhere in the pelvic cavity) in women and prostate troubles in men.

There can also be complications of pregnancy and childbearing. Medical literature divides these complications into two main categories: obstetrical complications arising from the temporary condition of pregnancy; and constitutional complications which result from pre-existing disorders (Morrison, 1975).

The pre-existing diseases the over-30 woman should be concerned with are diabetes, fibroid tumors and cardiovascular disease. Diabetes can, according to Daniels and Weingarten (1979), increase the risk of toxemia of pregnancy, postpartum hemorrhage and infection. Diabetes' adverse effects become more severe with age. Fibroids, although they usually have no effect upon pregnancy occasionally grow large enough to interfere with gestation and endanger the fetus. Hypertension and cardiovascular disease can also contribute to complications of pregnancy.

Obstetrical complications are defined as "medical problems that occur only if a woman is pregnant" (Daniels & Weingarten, 1979, p. 11). Obstetrical complications include miscarriage, toxemia of pregnancy, hemorrhage and dysfunctional labors, all prevalent among women over 35 (Scott & Angwin, 1986). Other major obstetrical complications such as prolonged

labor, sepsis (infection), ectopic pregnancy have no relationship with age (Morrison, 1975).

The over-30 woman faces a higher risk of delivery by cesarean section. It is unclear whether this is directly related to age or to the tendency of doctors to treat their older patients with more caution (Morrisson, 1975). Daniels and Weingarten (1979) cite one study in which women 35 and over were five times more likely than younger women to be delivered by cesarean even though in two out of three cases the indications for a cesarean delivery were doubtful. The increase in dysfunctional labor may be caused by doctors' more conservative treatment for the over-30 patient (Scott & Angwin, 1986).

Chromosomal defects are of major concern for older women. The only major genetic defect for which age makes a difference is Down's syndrome. It is usually characterized by mental retardation, slight facial abnormalities, shortened hands and trunk, defective internal organs and extra chromosomal material (National Institute of Child Health and Human Development, 1979). Down's syndrome, along with other chromosomal defects can be diagnosed in utero. A woman who chooses to become pregnant in later life can, through choronic villi sampling, amniocentesis, and

selected abortion, greatly reduce this increased risk (Rubin, 1980).

Another genetically linked risk related to age is twining. As a woman ages, there is a slight increase in the incidence of the body releasing more than one egg during ovulation and with higher quality prenatal care and healthier mothers, more fertilized eggs are surviving. There is some evidence that women on the Pill may increase their odds of bearing twins if they become pregnant soon after going off. Twin births reach a peak at the age of 37 (New Woman, 1989, p. 28).

Stillbirths and miscarriage also increase with age. One study (cited in Scott & Angwin, 1986) of 44,000 pregnancies shows stillbirths and miscarriages rate for women 20 to 30 years old to be 12 per 1000 for 30-40 year olds rate rose to 27 per 1000. There were 49 miscarriages and stillbirths per 1,000 in 40-50 year old range (Daniels & Weingarten, 1975). This increase may be due in part to general medical problems, but a large portion is due to genetics. There is some natural selection in pregnancy. "Twenty-one to 24% of Down's syndrome fetuses are miscarried and as many as 50% of all conceptions end in spontaneous abortions (Scott & Angwin, 1986, p. 24).

Genetic counseling is highly recommended for the over-30 woman. It consists of collecting the parents' genetic history and reviewing the genetic make-up of the unborn child. The review is undertaken through amniocentesis and a newer procedure called choronic villi sampling.

Amniocentesis is a safe and effective diagnostic procedure that allows doctors to determine the presence or absence of seventy or more metabolic disorders and of all known chromosomal defects. Amniocentesis involves withdrawing a sample of amniotic fluid into a hollow needle carefully inserted through the woman's abdomen into the uterus. Fetal cells within the fluid sample are cultured and the chromosomes are photographed, magnified and examined for defects (Morrison, 1975). The cell culture takes three to four weeks and will yield information on chromosomal abnormalities and the sex of the infant (Scott & Angwin, 1986).

Amniocentesis is usually performed somewhere between the sixteenth and eighteenth week after the last menstrual period. Analysis requires an additional three to four weeks (Morrison, 1975). Ultrasound is used in conjunction with amniocentesis to find the location of the fetus inside the uterus and identify

the accessible area where the fluid an be obtained (Daniels & Weingarten, 1975). The risk of amniocentesis for both fetus and mother are small. Studies show that there is "less than one percent rate of problems" (O'Brien, 1984). The amount of risk is directly associated with the skill of the practitioner.

Choronic villi sampling is a recent alternative to amniocentesis. Samples are taken from the villi (small projections in the lining of the uterus), which are the basis for the placental attachment. This procedure is performed seven weeks after the last menstrual period. Because the villi are part of the developing placenta and are started from the same cell as the fetus, no cell culturing is required. The sample that is taken is enough for chromosomal analysis and often results are available within 48 hours (Daniels & Weingarten, 1979).

The advantage of CVS is a six- to eight-week time savings over amniocentesis. The risks and complications of CVS are not well documented, but there seems to be slightly increased risk of spontaneous miscarriage (Stewart, Guest, Stewart & Hatcher, 1987). CVS cannot detect some conditions that amniocentesis can.

Despite the general pattern of reproductive risk, age alone provides little indication of the pregnancy and childbirth risks for any particular woman. The level of risk today for women over 30 corresponds generally to the risk for all women 20 years ago (Daniels & Weingarten, 1979). A woman in good health and with access to adequate prenatal and postpartum care can offset the increase in childbearing risk attributable to advancing age (Daniels & Weingarten, 1979).

Ultrasound. Ultrasound during pregnancy can provide a clear view of the uterus, amniotic sac, and the fetus. It is precise enough that some birth defects can be identified relatively accurately 20 weeks into pregnancy (e.g. severe heart defects, kidney defects, neural tube defects). Ultrasound can be used to monitor fetal growth and development (Stewart, Guest, Stewart & Hatcher, 1987).

Ultrasound is used to evaluate suspected twin pregnancy, possible tubal pregnancy and threatened miscarriage. It is also used with amniocentesis and choronic villi sampling to pinpoint the location of the fetus and placenta before sampling begins (Stewart, Guest, Stewart & Hatcher, 1987).

Up to this point, there have been no adverse effects documented in infants or women from ultrasound during pregnancy (McKaughan, 1987). Specialists view the procedure as very helpful during pregnancy (McKaughan, 1987).

Knowledge, good medical care and the willingness to take an active role in providing the best conditions for nurturing a healthy baby are keys to a safe and normal pregnancy.

Are there any health issues for women who choose not to have children? There is some evidence that women who postpone or do not bear children are more likely to develop endometriosis (Daniels & Weingarten, 1979; Stewart, Guest, Stewart & Hatcher, 1981). This condition often disappears with the end of ovulation (Daniels & Weingarten, 1979).

Birth control is the major health concern for childfree women. Although birth control pills are very effective the over-30 woman must be aware that the risk of pill-related blood-clotting disorders increase with advancing age. There is evidence that women who smoke and use birth control pills increase the risk of blood-clotting disorders. Stewart, Guest, Stewart and Hatcher concur that "by about 40, the risk of death

from birth control pills is higher than the death risk of full time pregnancy" (1981, p. 177).

Women who are certain that they do not want children might consider tubal ligation. Others might use one or a combination of other effective birth control options, such as IUD's, diaphragms, condoms, foam and basal body techniques (Boston Women's Health Collective, 1976).

DOWN'S SYNDROME INCIDENCE

Age	Incidence
20	1 in 2,000
25	1 in 1,200
30	1 in 885
35	1 in 365
40	1 in 109
45	1 in 32

In all ages -- 1 in 600 births involve Down's syndrome

Annual incidence -- 5,100 (total number diagnosed per year in U.S.)

Prevalence -- 44,000 (total number living in U.S. 20 years old.

Source: National Foundation, March of Dimes

Medical Risks in Later Childbearing

Maternal Risk

* Infertility
* Complications of pregnancy
* Complications of childbirth
* Mortality

Infant Risk

* Prematurity (low birth weight)
* Birth defects
* Mortality

MODULE 6: THE PATH TO NONPARENTHOOD

Module 6: Presentation Guide

The Path to Nonparenthood

At various points in history women have been told that the only path to self-fulfillment is through motherhood or through remaining voluntarily childless. There is no true path toward self-fulfillment for all women. The choice to remain childless or to become a mother is a very personal choice.

There are many feelings for women around the decision not to become a mother. The primary ones are loss, fear and relief (Pies, 1988). A woman may experience feelings of missing out on the experience of having children in her life or she may feel the loss in a physical way -- "missing the experience of physically having a child and experiencing the growth, birthing and bonding involved in that process" (Pies, 1988, p. 136).

A woman may feel fear with her decision not to become a parent, wondering what is wrong with her that she does not want children. Is she being too selfish? Is she too independent to have a child in her life? These questions reflect a true knowledge about herself and a recognition of the lifestyle that is most comfortable for her.

She may second guess her decision not to become a parent, knowing deep down that she has made the right decision for herself. There will always be feelings of ambivalence surrounding the nonparenthood decision. Yet once a decision is made not to become a mother there is a sense of relief and a feeling inside that the decision was the right one.

Most people who have made the decision to remain childfree have asked themselves, "What do I really want to do with my life I live with the trade offs that are necessary for me to be able to do that" (Harper, 1980, p. 136). With so much time spent in the decision-making process, it will take time to redirect energy into other avenues of pursuit (Bombardieri, 1981).

Choosing nonmotherhood does not mean that a woman wishes not to have children in her life, it just means that she does not want the responsibilities associated with being a mother. Spending time with a child on a regular basis or being a friend to a child are ways of having children in one's life (Pies, 1989). It is helpful to be aware that there are alternative forms of generativity besides procreation.

We live in a time in which motherhood is expected but not supported. It is not necessary that all women

choose to raise children. What is necessary is that each woman feel supported for the choice she does make.

In deciding whether or not to have a child, it is wise to take your time to ask questions, get some answers and then reflect on all the data gathered. The parenthood decision is a complex one, but the key is to "know thyself." Know who you are singly and as a couple. Know what your strengths and weaknesses are. KNow what you have to offer a child.

It helps to know that there will always be feelings of ambivalence no matter what decision you finally choose. Remember that there is no universal, right decision, for the final decision will depend upon the unique qualities of your personality and your relationship with your partner.

MODULE 7: CONCLUSION

Module 7: Conclusion

1. Tell the participants that you would like to leave them with a parting thought. Read the Robert Frost poem, "The Road Not Taken."

2. Ask the participants to please fill out the evaluation form before they leave and thank them for coming.

The Road Not Taken

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first of another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I
I took the one less traveled by,
And that has made all the difference.

Source: Frost, R. (1986) Collected Poems of Robert Frost. Cutchogue, New York: Buccaneer Books, pg. 131.

APPENDIX B

Questionnaire

Motherhood After 30 Workshop Evaluation

Feedback is essential. Please share yours!

Please circle one number of the scale for each question.

1. How valuable were the ideas and concepts to you?

10 9 8 7 6 5 4 3 2 1

HIGHLY FAIRLY SLIGHTLY NONE

2. How effective was the presentation?

10 9 8 7 6 5 4 3 2 1

HIGHLY FAIRLY SLIGHTLY NONE

3. What information was most helpful to you?_____

4. What information was least helpful?_____

5. What exercises were most helpful?_____

6. What exercises were least helpful?_____

7. Are there any areas that were not covered that you feel would have been helpful?_____

8. Is there anything about the workshop that you would like changed, added, or eliminated?_____

_____

9. General Comments:_____

_____

_____

Thank you!

APPENDIX C

Glossary

GLOSSARY

AMNIOCENTESIS

The removal of a small amount of amniotic fluid by the use of a hollow needle placed through the abdomen and into the uterus.

AMNIOTIC FLUID

The fluid that surrounds the developing fetus contained within the amniotic membranes. This fluid acts as a protective mechanism for the fetus and can be used for diagnosing certain fetal abnormalities, fetal maturity, and placental function.

BIRTH DEFECTS

Any physical or mental abnormalities present at birth; they may be of genetic or environmental origin.

CESAREAN SECTION

The birth of a baby through the abdomen by surgical incisions into the abdominal and uterine walls.

CHORONIC VILLI BIOPSY

Removal of small portion of tissue from the surface of the chorion (a precusor of the placenta) for diagnostic assessment. The procedure is performed at approximately the eighth

week of pregnancy by insertion of a catheter into the uterus through the vagina.

CHROMOSOMES

Microscoptic units located within the nucleus of every cell which contain the basic hereditary factors in the form of genes. There are 46 chromosomes in every cell except the reproductive cells (egg and sperm cells), which contain 23.

DIABETES ABNORMALITY

Abnormality in the body's ability to produce insulin and, therefore, to process sugars. Age at onset and severity have both genetic and environmental components.

DOWN'S SYNDROME

Also called mongolism. A chromosome abnormality involving the presence of an extra chromosome (47 in all), usually present in all cells of the body; there are three #21 chromosomes instead of the normal two. Many associated physical abnormalities can be present in addition to mental retardation. Occurrence increases with advanced age.

DYSFUNCTIONAL LABOR

Labor that does not seem to work effectively toward birth.

ECTOPIC PREGNANCY

Abnormal implantation or attachment of the embryo outside the uterus. The most common site is within a fallopian tube (tubal pregnancy), but implantation can occur elsewhere in the abdomen.

ENDOMETRIOSIS

The presence of endometrial tissue (tissue that normally lines the interior of the uterus) elsewhere in the abdomen. The tissue can adhere to and block normal functioning of other organs, such as the ovaries and fallopian tubes, causing infertility.

FALLOPIAN TUBES

The portions of the female reproductive system through which an egg passes enroute from the ovary (where it is formed) to the uterus (where implantation normally occurs).

FIBROIDS

Benign growths in the uterus that are composed of fibrous and muscle tissue; they occur more frequently in older women.

HEMORRHAGE

A copious discharge of blood from the blood vessels.

HYPERTENSION

A sustained elevated blood pressure.

GESTATION

The carrying of young in the uterus.

MENARCHE

First occurrence of the menstrual discharge.

MENOPAUSE

Cessation of the menstrual cycle.

PLACENTA

A spongy structure implanted in the uterine wall during a pregnancy. It supplies vital oxygen and nutrients to the fetus and removes waste products via the umbilical cord.

SEPSIS

A toxic condition resulting from the spread of bacteria or their products from a focus of infection.

SPINA BIFIDA

A defect in the spinal column that occurs as early as four week's gestation. It can be a closed or an open defect, which can be totally asymtomatic or else more severe, involving the spinal cord.

TOXEMIA

An abnormal condition associate with the presence of toxic substances in the blood.

ULTRASOUND

A noninvasive diagnostic test based on high-frequency sound waves that are transmitted via a fluid. An image is reproduced on a screen and photographed for diagnostic purposes.

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