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THE LIVED EXPERIENCE OF WOMEN WITH PRETERM PREMATURE RUPTURE OF THE MEMBRANES (PPROM) WHO REMAINED AT HOME UNTIL DELIVERY OF THEIR INFANTS

By

Marilynne Oskamp

A thesis proposal submitted in conformity with the requirements for the degree of Master of Science
Graduate Department of Nursing Science, in the University of Toronto

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ABSTRACT

The Lived Experience Of Women With Preterm Premature Rupture Of The Membranes (PPROM) Who Remained At Home Until Delivery Of Their Infants.

Master of Science, 1997

Marilynne Oskamp

Purpose: The purpose of this study was to describe the lived experience of women with PPROM who remained at home until delivery of their infants.

Method: The experiences of five women at home with PPROM were explored using unstructured interviews. The data were analysed using a method consistent with phenomenological research.

Results: Three dominant themes evolved from the data: 1) feeling overwhelmed at the initial diagnosis, 2) the struggle to achieve a balance, and 3) movement towards living a normal life. The third theme illustrates the dynamic process the women used to adapt to PPROM and was described in two subthemes: 1) the importance of support and 2) becoming an expert knower.

Conclusion: The women’s descriptions of their experiences revealed their initial response of feeling overwhelmed by their diagnosis, the struggles they had with their situations, and how they were able to move towards living a normal life with PPROM.
ACKNOWLEDGMENTS

I would like to take this opportunity to thank the many people who assisted and supported me during all of the stages of this thesis. In particular, I would like to thank Patricia Petryshen, the chair of my thesis committee, for her advice, support and guidance during the last four years. Her belief in the project and myself as a researcher provided encouragement during the delay in data collection and the enormous task of data analysis. I would also like to thank her for the many hours she spent reading, editing and making suggestions to the many versions of the original proposal and final drafts of this thesis. I truly feel very fortunate to have had the opportunity to work with Patricia.

I would also like to thank my other committee members, Margaret Fitch, Bonnie Stevens and Tracy Kitch for their support and guidance throughout the process. Special thanks to Margaret Fitch for her assistance during the process of data analysis. Her expertise in the phenomenological method was invaluable to me as I tried to make sense out of the data. Suggestions from all committee members were instrumental in completing the final chapter.

Also, I would like to thank Barbara Johnson for her suggestions to condense my original themes to the current three. After struggling to complete this project I was not particularly enthralled with reworking the exhaustive description but once completed I feel it has made this thesis stronger and I am appreciative.

To my friends and my family I also extend my thanks for supporting me throughout each stage of this project. I am sure they became tired of hearing me speak about my thesis or forever having to work at it, however, they always seemed to understand and offered their psychological support for which I am extremely grateful.
And finally I would also like to extend a sincere thank you to the five women and their families who welcomed me into their homes and shared their experiences with me.

Their commitment and dedication to this project was truly inspiring. As a result I am committed to sharing the findings of this study with women who are experiencing a similar situation as well as the health care providers caring for these women.

Sincerely,

Marilyne Oshamp
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Chapter I

THE RESEARCH PROBLEM

Background to the Problem

In Ontario, approximately 7,000 babies are born each year at less than 37 weeks gestational age or preterm (Ministry of Health [MOH], 1993d). Some women deliver their preterm infants spontaneously as a result of premature labour while other women experience complications with their pregnancies necessitating early delivery. In 40 to 60% of spontaneous singleton preterm births, spontaneous rupture of membranes (SROM) will precede delivery (Kierse, Ohlsson, Treffers & Kanhai, 1989). Women with preterm SROM who do not go into labour are subsequently diagnosed with preterm premature rupture of the membranes (PPROM). Because the gestational age at delivery has the greatest impact on neonatal morbidity, these women are encouraged to maintain low activity levels in an attempt to prolong their pregnancies (Taylor & Garite, 1984; Beydoun & Yasin, 1988). Although the period of time from SROM until active labour varies from hours to weeks, the majority of women deliver their infants within 7 to 10 days of SROM (Mead, 1980).

For both the mother with PPROM and her fetus, there are risks associated with waiting for labour to occur (i.e., expectant management). These risks include maternal and/or fetal infection, cord accidents, and pulmonary hypoplasia [especially if PPROM occurs before 28 weeks gestation](Beydoun & Yasin, 1988; Gunn, Mishell & Morton, 1970; Taylor & Garite, 1984). In most centres, women presenting with PPROM are admitted to hospital until delivery of their infant (Capeless & Mead, 1987). Admission to hospital provides women with access to monitoring for associated complications and immediate delivery when necessary as well as promotes rest and minimal activity (Capeless & Mead, 1987; O’Herlihy
& Turner, 1991). Although hospitalisation of women with PPROM is a well accepted practice, alternative modes of care delivery such as home management may be as efficacious (Carlan, O'Brien, Parsons & Lense, 1993). To the knowledge of this investigator, however, the research available on the effectiveness of antepartum home care is not comprehensive and, information about the psycho-social impact of remaining at home on both the woman and her household members is absent.

A review of the research literature revealed that investigators have focused on how hospitalisation affects antepartum women. Women hospitalised with various pregnancy complications, including PPROM, identified concerns about their pregnancies and separation from their partners and families as most stressful (Ford & Hodnett, 1990; White & Ritchie, 1984). In Ontario, government initiatives have encouraged a shift from inpatient to ambulatory care (MOH, 1993a). Although a primary impetus for this shift in location of care is to contain health care costs, women with pregnancy complications, in particular, women with PPROM, may benefit from being cared for in their homes providing the efficacy of hospitalisation is maintained.

In one study, 67 women with PPROM who met certain eligibility criteria (i.e., no history of a variety of medical conditions, cephalic presentation, no signs and symptoms of infection, no labour, no indications of fetal distress) were randomised to expectant management at home or in hospital (Carlan et al., 1993). There were no significant differences in the maternal and the neonatal incidence of infection or length of hospitalisation, and no differences in the gestational age at delivery or neonatal complications (respiratory distress, necrotizing enterocolitis, intraventricular haemorrhage). However, a considerable cost saving resulted from caring for women in their homes (Carlan et al., 1993).
Harmon and Barry (1989) and Miller (1990) noted several benefits associated with home care programmes that provided services to American women with various pregnancy complications including PPROM. Anecdotal descriptions of the benefits for women included: improved quality of life, decreased depression, increased familiarity with and involvement in care, greater satisfaction with care, better adherence to bed rest, and less stress in general (Harmon & Barry, 1989; Miller, 1990). In addition to the identified benefits, Harmon and Barry proposed that activity restrictions of the women led to role changes that were described as troublesome and guilt provoking. Kemp and Page (1984) also postulated that maternal activity restriction necessitates new ways of allocating family responsibilities in the home and this change may lead to family stress and guilt for the pregnant woman because of the increased burdens placed on family members.

Anecdotal reports suggest that home management or ambulatory care of women who experience pregnancy complications may remove the stressors associated with hospitalisation (Harmon & Barry, 1989; Miller, 1990). However, researchers speculate that remaining at home with activity restrictions may generate other stressors such as alterations in the maternal role which have an impact on the women, their significant others and children (Harmon & Barry, 1989; Kemp & Page, 1984). Carlan et al. (1993) found no change in mortality and morbidity outcomes of women with PPROM cared for at home and their delivered infants. However, the investigators failed to account for the psycho-social impact associated with ambulatory care for the women and their family members. An assessment of women who remain at home with PPROM is more comprehensive and accurate when the psycho-social impact of outpatient care for both the woman and other household members is included.
Problem Statement

In Ontario, ambulatory care programmes are being developed as an alternative to hospitalisation for women experiencing pregnancy complications. This shift in the location of delivery of care is congruent with government initiatives to control health care spending. Although a primary impetus of government is to contain health care costs, several Canadian studies of hospitalised antepartum women also support this change (Ford & Hodnett, 1990; Heaman, 1992; White & Ritchie, 1984). A review of the literature revealed that the consequences of ambulatory care for women with pregnancy complications and their families had not been evaluated. In this research study, the experiences of women with PPROM who remained at home until delivery of their infants is described. Exploration of the “lived” experiences of women who remained at home with PPROM is vital for planning and developing home care services that reflect the expressed needs and concerns of antepartum women with PPROM and their families.

Review of the Literature

In Canada, perinatal home care or ambulatory care programmes are beginning to be implemented as an alternative to hospitalisation. The findings of eight studies (Ford & Hodnett, 1990; Heaman, 1992; Heaman, Robinson, Thompson, & Helewa, 1994; McCain & Deatrick, 1994; Monahan & DeJoseph, 1991; Schroeder, 1996; Stainton, Harvey & McNeil, 1995; White & Ritchie, 1984) are particularly relevant to this research and will be discussed. These studies are summarised in Table 1. In two of the studies (Ford & Hodnett, 1990; White & Ritchie, 1984), investigators focused on the stressors associated with antepartum hospitalisation for women experiencing pregnancy complications. Heaman (1992) compared the influence of stressful life events, social support and mood disturbance in women with
### Table 1: Summary Of Relevant Research

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Design</th>
<th>Sample</th>
<th>Instruments Used</th>
<th>Main Findings</th>
</tr>
</thead>
</table>
| Ford & Hodnett (1990)  | Cross-Sectional Correlational | 27 Canadian women hospitalized antepartum with a variety of pregnancy complications. Data collection occurred following a mean of 10.4 days of hospitalization. | Stressors in Antepartum Hospitalization Tool (SAHT) Social Support Questionnaire (SSQ) Linear Analogue Scale | 1) A positive relationship between social support and adaptation ($r = .41, p = .04$).  
  2) No relationship between perceived stress and adaptation.  
  3) Trend towards decreased adaptation with increased length of hospitalization. |
| Heaman (1992)          | Cross-Sectional Correlational | Three study groups were compared:  
  1) 19 Canadian women hospitalized antepartum with pregnancy induced hypertension (PIH)  
  2) 17 Canadian antepartum women with PIH, who were managed at home (of similar medical risk as the hospitalized women), and  
  3) 20 Canadian antepartum women of low medical risk who received routine physician care. | Life Events Questionnaire Norbeck Social Support Questionnaire (NSSQ) The Profile of Mood States (POMS) | 1) No differences among the three study groups in relation to negative life events and social support.  
  2) Increased anxiety and depression scores in the hospitalized women when compared to the other two groups which had similar scores.  
  3) A negative life event score was found to be a significant predictor of mood disturbance. |
| Heaman et al. (1994)   | Cross-sectional Descriptive | Convenience sample of 80 women who had participated in an antepartum homecare program with a variety of pregnancy complications | Questionnaire developed for the survey | 1) 98% of women felt the program met their needs and they would participate, if necessary in a subsequent pregnancy.  
  2) The women reported being more comfortable in their home environment. |
| McCain & Deatrick (1994) | Retrospective Naturalistic Inquiry | 21 parents who had experienced a high risk pregnancy and premature delivery were interviewed retrospectively about the experience | Interviews Selected grounded theory techniques for data analysis | 1) Three stages to the high risk experience: vulnerability, heightened anxiety and inevitability.  
  2) The parents coped during the experience by seeking medical care and searched for a cause; complied with treatment which often meant bed rest, received information about their baby and what delivery would mean for their infant. |
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Design</th>
<th>Sample</th>
<th>Instruments Used</th>
<th>Main Findings</th>
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<tbody>
<tr>
<td>Monahan &amp; DeJoseph (1991)</td>
<td>Cross-Sectional Correlational</td>
<td>33 American antepartum women at risk of preterm labour and delivery and who were monitored at home. Data collection occurred following a mean of 6 weeks of activity restriction.</td>
<td>Spielberger’s State-Trait Anxiety Inventory (STAI) The Profile of Mood States (short form version) Five open-ended questions</td>
<td>1) Age was negatively correlated to scores for depression, anxiety and anger. 2) Anxiety decreased as the length of activity restriction increased. 3) Only 15 (47%) of women were able to maintain activity restrictions most of the time.</td>
</tr>
<tr>
<td>Schroeder (1996)</td>
<td>Naturalistic inquiry</td>
<td>12 women who were prescribed bed rest for more than 20 hours each day for a minimum of 3 weeks for threatened preterm labour The women in the study remained in their home environment.</td>
<td>Interview</td>
<td>1) Three themes emerged from the data: a) the experience of high risk pregnancy; b) the experience of bed rest and; c) the experience of time and bed rest in a high risk pregnancy. 2) The women described a high level of physical, emotional familial and economic hardship resulting from the bed rest experience.</td>
</tr>
<tr>
<td>Stainton et al. (1995)</td>
<td>Longitudinal Hermeneutic interpretation</td>
<td>27 women in a high risk perinatal situation were followed from early in pregnancy (n=10) or during an acute complication (n=10) or following delivery of a preterm infant (n=10) to study perinatal uncertainty.</td>
<td>Serial interview scheduled one month apart during the experience</td>
<td>1) Several dimensions exist within the experience of perinatal uncertainty: an elongation of time--waiting, feeling fear, loss of control and identity, being alone with the responsibility, changed family relationships and interaction, fatigue, grief and lock, needing to be known and understood, and mismatched realities 2) Certain care practices were described: focusing on possibility, bracketing time, becoming a mother becomes a job, protecting after previous loss, intensified giving and needing to receive, seeking meaningful information, balancing several perspectives and maintaining family relationships and functioning.</td>
</tr>
<tr>
<td>White &amp; Ritchie (1984)</td>
<td>Longitudinal Descriptive</td>
<td>61 Canadian women hospitalized antepartum with a variety of pregnancy complications (unknown mean number of days hospitalized at time of data collection). 12 of the 61 women responded a second time to the ASII after 2 weeks of hospitalization.</td>
<td>Antepartum Hospitalization Stressors Inventory (AIHSI)</td>
<td>1) Stressors relating to separation from home and family and disturbing emotions ranked the highest. 2) Following 2 weeks of hospitalization the intensity of the stressors increased, however the ranking of the stressors remained the same.</td>
</tr>
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</table>
pregnancy induced hypertension (PIH) who were hospitalised and women with PIH who remained at home. McCain & Deatrick (1994) and Stainton et al., (1995) explored the experience of high risk pregnancy with women who remained at home as well as those who were hospitalised. Monahan and DeJoseph (1991) and Schroeder (1996) described experiences of women at home with threatened preterm labour. Heaman et al. (1994), surveyed women who participated in an antenatal home care programme regarding their satisfaction with the programme. Most of the investigators (Ford & Hodnett, 1990; Heaman, 1992; Heaman et al, 1994, Monahan & DeJoseph, 1991; White and Ritchie, 1984) used a quantitative approach to study predetermined variables about women with pregnancy complications, such as PPROM, while only three papers reported qualitative data about women experiencing high risk pregnancies. None of the investigators focused exclusively on women diagnosed with PPROM who remained at home.

Antepartum Hospitalisation

Much of the literature concerning antepartum care for women with pregnancy complications has primarily focused on the stressors associated with hospitalisation. Two studies (Ford & Hodnett, 1990; White & Ritchie, 1984) have been reviewed to establish some insight into the experience of hospitalisation for the women and provide some data of how the experience changes over time.

Ford and Hodnett (1990) conducted an investigation with 27 antepartum women to determine their perceptions of stress and support and their perception of adaptation to hospitalisation. All of the women in the study were identified by their physicians as moderate to high risk for preterm delivery because of a variety of pregnancy complications, 8 of these women were diagnosed with PPROM. Perceived stress was measured using the Stressors in
Antepartum Hospitalisation Tool (SAHT), an instrument specifically designed by the investigators for their study. The Social Support Questionnaire (SSQ), also developed by the investigators, used a combination of six questions addressing emotional, informational and tangible supports to measure the women's perceptions of support received and the adequacy of this support. Both instruments had measures of reliability and validity established by the investigators (Ford & Hodnett, 1990). Adaptation was measured by having women rate on a 100 millimetre (mm) linear analogue scale with the response anchors of "not at all" to "completely" their perceptions of making positive adjustments to hospitalisation. The women also rated on a 5-point Likert scale ranging from "not at all" to "extremely" the ability of a significant other and a significant nurse to provide emotional, informational and tangible support. The data collection occurred following an average of 10.4 days of hospitalisation. A positive relationship was found between social support and adaptation (r = .41, p = .04). There was no relationship between perceived stress and adaptation. When length of hospitalisation at time of data collection was entered into the regression analysis, a trend towards decreased adaptation with increased length of hospitalisation was apparent.

White and Ritchie (1984) investigated the psychological stressors experienced by 61 hospitalised antepartum women with a variety of diagnoses using the Antepartum Hospitalisation Stressors Inventory (AHSI) developed by White (1981). A short interview with one of the researchers also provided the respondents with an opportunity to further describe their stressors and identify the events they found most stressful. Twelve (20%) women responded to the AHSI a second time following 2 weeks of hospitalisation. The stressors for women that related to separation from home and family and disturbing emotions ranked the highest, followed by stressors related to changing family circumstances, health
concerns and changing self image. The stressors related to communications with health professionals and the hospital environment were ranked the lowest. Although the intensity of stress experienced by the twelve respondents increased significantly following 2 weeks of hospitalisation, the order of the stressor ranking remained the same.

**Combination of Hospital and Home Environments**

In 1992, Heaman studied the influence of stressful life events, social support, and mood disturbance in antepartum women treated in hospital and at home. Of the 56 women in the study, 19 (34%) women with pregnancy induced hypertension (PIH) were hospitalised, 17 (30%) women with PIH of similar medical risk were cared for at home, and 20 (36%) women without any pregnancy complications received routine antenatal doctor visits. Among the three groups, there were no significant differences in gestational age (mean = 35.7 weeks) and length of time hospitalised (mean = 3.6 days) or receiving home care (mean = 4.1 days). An 82-item Life Events Questionnaire (Norbeck, 1984) modified for adult females of childbearing age was one instrument used for data collection. Women rated the life events experienced in the past year as "good" or "bad" and then rated on a 4-point Likert scale ranging from "no effect" to "great effect" the impact of specified events on their lives. Also, the Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, & Carrieri, 1981, 1983) was used to measure informational, tangible and emotional support, as well as the support network properties of number and duration of relationships, and frequency of contact. The Profile of Mood States (POMS) (McNair, Lorr, & Droppleman, 1971) was used to assess transient fluctuation in the affective states of anxiety, depression, anger, vigour, fatigue and confusion. Each of the six moods experienced during the day of data collection and the previous week were rated using a 5-point Likert scale with a response set from "not at all" to
"extremely". In addition to obtaining a score for each mood, a Total Mood Disturbance Score (TMDS) (McNair, Lorr & Droppleman, 1971) was obtained. Measurements of validity and reliability were recorded for all three instruments which have been extensively tested and used in a variety of populations.

Heaman (1992) found no significant differences among the three study groups (i.e., hospitalised PIH, home managed PIH, and routine physician care) in relation to negative life events and functional or network support. However, there were differences between the three groups in the TMDS. In particular, anxiety and depression scores increased among hospitalised women when compared to each of the other two groups (i.e., home managed PIH and routine physician care). TMDS scores were similar among home managed women with PIH and the women without pregnancy complications. When a multivariate analysis using the entire sample of 56 women was conducted, a negative life event score was found to be a significant predictor of mood disturbance accounting for 24.1% of the variance in mood disturbance (TMDS). Social support, however, was not found to have a direct effect on mood disturbance. There were no differences in social support among the three groups although the mean scores for social support (NSSQ) were lower in hospitalised women than for the other two groups who remained at home.

McCain & Deatrick (1994) in a naturalistic inquiry, retrospectively interviewed 21 parents who experienced a high-risk pregnancy and premature delivery. Using selected grounded theory techniques to analyse the data, they reported three stages to the experience; vulnerability, heightened anxiety and inevitability. The first stage, vulnerability, occurred when the parents realised their pregnancies were considered high-risk, which led them to seek medical care and search for a cause of the high-risk pregnancy. In the second stage,
heightened anxiety, women were required to comply with their treatment which often resulted in hospitalisation or bed rest. The hospitalisation or bed rest required by the women meant they had to accept assistance and support from others. In the third stage, the parents realised the inevitability of their situation and that delivery was imminent. The women and their partners dealt with this stage by receiving information about what delivery meant for their baby. The retrospective design of this study may not have allowed the parents to accurately recall all of the acute anxieties and coping mechanisms they used during each stage. Also, many of the coping strategies described for the third stage, inevitability, have been components of perinatal programmes for many years. The strategies described in the report such as tours of the intensive care nursery and consultation with neonatology are usually suggested or initiated by the health care providers rather than the women or their partners. Although these strategies would assist the parents to cope with the delivery of a preterm infant they may not have been initiated by them. The validity of introducing grounded theory in the data analysis should be questioned. Grounded theory involves asking questions that are intended to discover relevant concepts in order to generate theory and should be followed from the outset of a research project and not only during data analysis.

Stainton et al. (1995) studied perinatal uncertainty in 27 women in a high-risk perinatal situation using semi-structured, focused interviews at monthly intervals beginning at various times throughout gestation (5 - 36 weeks gestational age). The convenience sample consisted of 10 women who initially were followed as outpatients, 10 women initially hospitalised and 10 women who had delivered a preterm infant. The setting of care often changed and the schedule of interviews was not consistently followed. The authors used the hermeneutic approach for interpretation of meaning and reported several dimensions within
the experience of perinatal uncertainty: an elongation of time (i.e. waiting), feeling fear, loss of control and identity, being alone with the responsibility, changed family relationships and interaction, fatigue, grief and loss, needing to be known and understood, and mismatched realities. As a result of their situation the families developed certain care practices which were described as the following: focusing on possibility, bracketing time, becoming a mother becomes a job, protecting after previous loss, intensified giving and needing to receive, seeking meaningful information, balancing several perspectives and maintaining family relationships and functioning. Although the authors have attempted to provide a comprehensive description of the high-risk perinatal experience, they grouped together women who were considered high risk very early in pregnancy with those who had acute problems and those who delivered high risk infants. These groups of women may each have had unique experiences and it was not clear in the report whether data from all groups of women were analysed separately or all together making the interpretation and application of the results difficult.

Home Management

Monahan and DeJoseph (1991) described the outpatient management of 80 women at risk of preterm labour and delivery identified through a home uterine activity monitoring programme. Thirty-three (41%) responded to a mailed questionnaire. The questionnaire was designed to measure emotional distress using Spielberger's State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, Lushenne, Vagg, & Jacobs, 1983) and mood disturbance using a short form version of the Profile of Mood States (POMS). This shortened version of the POMS used 37 of the 65 mood and emotion descriptors described previously (McNair, Lorr, Droppleman, & Schacham, 1983). Five open-ended questions were also included to elicit
information regarding activity restrictions, family coping methods, type and amount of assistance received from family and friends, success in adhering to activity restrictions and perceived need for further supportive assistance. The data collection occurred following a mean of 6 weeks of activity restriction. For women with a history of prior preterm birth and women with no such history, there were no differences identified among the levels of depression, anxiety or anger. As well, there were no observed differences between primiparas and multiparas. As age increased, scores for depression, anxiety and anger decreased. A negative correlation was found between the length of bed rest (number of weeks) and anxiety \((r = -0.455, p < 0.01)\). The open-ended questions were analysed for frequency of responses and common themes. Women respondents received assistance most often from their partners \((n=11)\), followed by family members \((n=9)\), hired help \((n=8)\), and friends \((n=4)\). Of the 32 women who were prescribed bed rest, 15 \((47\%)\) were able to maintain activity restrictions all or nearly all of the time. Twelve \((37\%)\) women were not able to adhere to activity restrictions because they lacked assistance and thus needed to attend to their children and to do things for themselves, and 5 \((16\%)\) women were unaccounted for in the report. Women also reported that when they perceived a decreased risk of preterm delivery, they were not as concerned with restricting their activities.

Schroeder (1996), in a naturalistic inquiry, explored the experiences of 12 women who were prescribed bed rest for at least 20 hours per day for a minimum of three weeks. These women remained at home on bed rest for threatened preterm labour. Three themes emerged from the data: the experience of high risk pregnancy, the experience of bed rest and the experience of time and bed rest in high risk pregnancy. The author reported the women described a high level of physical, emotional, familial, and economic hardship resulting from
the bed rest experience. The women also reported that having an adequate income and a
supportive relative to take over household responsibilities allowed successful maintenance of
bed rest.

Satisfaction with Home Care Programmes

Heaman, Robinson, Thompson, & Helewa (1994) reported the satisfaction of patients
who participated in an antepartum home care programme. This programme cared for women
with PIH, multiple pregnancies, PPROM, preterm labour, diabetes and chronic hypertension.
A convenience sample of 80 women received a questionnaire containing 10 questions about
specific aspects of the care they received in their homes and 18 questions about their care
providers. The women were asked to rate their satisfaction on a five point scale with response
anchors of “very satisfied” to “very unsatisfied”. Sixty-six (83%) of the women responded to
the questionnaire. Most of the women (98%) felt the programme met their needs and
expectations and would participate in the programme again if necessary in a subsequent
pregnancy. The women were also asked what they liked best about the programme, what they
liked least about the programme and what one thing they would change. Most of the women
enjoyed having community nurses visit them in their homes instead of staying in hospital.
Also, they found the nurses to be friendly, caring and supportive. They reported their home
environment was more relaxing and comfortable. A few of the women reported they did not
like performing their self-assessments, however, most of the women reported no dislikes or
did not respond to the question. Suggestions for changes to the programme included having
the same nurse visit throughout and having more up to date sources of information. Most
women suggested no changes or did not respond to the question.
Implications for Research

A review of the literature of antepartum care for women with pregnancy complications revealed many stressors were associated with hospitalisation. The most common stressors were concerns about the pregnancy and separation from partners and family (Ford & Hodnett, 1990; White & Ritchie, 1984). There is evidence from one antepartum home care programme that the option to be cared for in the home instead of hospital was preferred by the majority of women who responded to a survey (Heaman et al., 1994).

In the study of Monahan and DeJoseph (1991), the activity level of women at risk for preterm labour and delivery was not similar among participants. Activity levels varied considerably from complete bed rest for some women to being employed on a part-time basis outside the home for other women (Monahan & DeJoseph, 1991). A possible reason for this variation in activity level could be that some of the women were identified only as being at risk of preterm labour and had not experienced an episode of preterm labour during their current pregnancy. Thus, although all of the women respondents were identified as being at a theoretical risk of preterm delivery, the risk was not the same for each woman in etiology and magnitude. This may account for the difference in the prescribed activity levels, as well as the need for and access to additional support services. In contrast, Schroeder (1996) described the experiences of women with threatened preterm labour who maintained almost complete bed rest. The contrast in the management of these two groups of women with threatened preterm labour (Monahan & DeJoseph, 1991; Schroeder, 1996) makes comparisons of the experience difficult.
In three of the studies reviewed (Ford & Hodnett, 1990; Monahan & DeJoseph, 1991; White & Ritchie, 1984), the investigators suggest that women's perceptions change as the length of hospitalisation or activity restriction increases. The ratings of stressors increased for 12 hospitalised women when measured soon after admission and again following two weeks of hospitalisation (White & Ritchie, 1984). Women's perceptions of their ability to adapt to hospitalisation decreased with the length of time spent in hospital (Ford & Hodnett, 1990). Anxiety also decreased the longer a woman remained on bed rest (Monahan & DeJoseph, 1991). Apart from two longitudinal studies, one of hospitalised women (White & Ritchie, 1984), and one study of women who remained at home combined with women who were hospitalised (Stainton et al., 1995), the six other studies reviewed were cross-sectional in design (Ford & Hodnett, 1991; Heaman, 1992; Heaman et al., 1994; McCain & Deatrick, 1994; Monahan & DeJoseph, 1991; Schroeder, 1996). Information was usually collected from women relatively soon after hospitalisation or admission to a home care programme. Although these data reflected the acute stressors experienced by the women, information concerning adaptive changes that may have occurred with prolonged hospitalisation or participation in a home care programme was not obtained. Monahan and DeJoseph (1991) collected data from a sample of women following a mean length of 6 weeks on bed rest and Schroeder (1996) collected data following a minimum of three weeks on bed rest. Although information was collected later in the experience, information collected following 3 to 6 weeks of bed rest may not capture the acute stressors experienced by the women at the initiation of activity restriction, particularly if the length of activity restriction was prolonged. Collection of data throughout a woman’s stay at home could provide important information related to changes that may occur over time.
Heaman (1992) showed, using the original version of the Profile of Mood States (POMS) (McNair, Lorr & Droppleman, 1971), that anxiety and depression scores were lower in women with PIH managed at home when compared to those managed in hospital. As well, the women who participated in a home care programme with a variety of pregnancy complications including PPROM reported feeling more comfortable and relaxed in their home environment (Heaman et al, 1994). These reports suggest that the experience of remaining at home may be different from the hospital experience.

The majority of women who participated in the research previously reviewed (Ford & Hodnett, 1990; Heaman, 1992; Heaman, et al., 1994; McCain & Deatrick, 1994; Monahan & DeJoseph, 1991; Schroeder, 1996; Stainton et al., 1995; White & Ritchie, 1984) were diagnosed with pregnancy complications other than PPROM. Descriptive or correlational designs were chosen by several investigators which have generated information about predetermined variables based on standardised instruments (Ford & Hodnett, 1990; Heaman, 1992; Monahan & DeJoseph, 1991; White & Ritchie, 1984). Three studies used a qualitative design to explore the women’s experience of being in hospital or at home (McCain & Deatrick, 1994; Stainton et al., 1995; Schroeder, 1996).

**Aims of this Research**

This research sought to understand the lived experience of women with PPROM who remained at home until delivery of their infants. This group of women was chosen primarily because it is common practice to hospitalise women with PPROM following diagnosis and until delivery of their infants. Although the majority of women deliver within 7 to 10 days of spontaneous rupture of the membranes (Mead, 1980), some women are hospitalised for weeks and even months. Other complications of pregnancy such as threatened preterm labour
and pregnancy induced hypertension are not as easily diagnosed and have varying degrees of acuity which result in different regimens of care. Women with PPROM are diagnosed based on a positive ferning test and a positive nitrazine test of the fluid leaking from the vagina. Once the diagnosis is made, these women follow a specific regimen of care that combines activity restriction with the monitoring for the signs and symptoms of infection and fetal distress. These standard diagnostic criteria and specific care regimen provides consistency that is lacking with other complications of pregnancy such as pregnancy induced hypertension and threatened preterm labour.

Several indications existed to further conduct research in the area of antenatal ambulatory care programmes for women with PPROM: (a) home management of women with PPROM when compared to hospitalised women shows no differences in maternal/neonatal mortality and morbidity (Carlan et al., 1993), (b) although anecdotal evidence of benefits associated with antenatal home care programmes have been reported (Harmon & Barry, 1989, Miller, 1990), this has not been extensively investigated, (c) in Ontario alternatives to hospitalisation are being developed for antepartum women with the complication of PPROM because of an expressed need by women and, (d) government initiatives are encouraging a shift from hospital to community based care. This change in location of care delivery will require specific community supports and a comprehensive evaluation from a clinical, psycho-social and economic perspective. In this research, the experiences of antepartum women with the specific complication of PPROM who remained at home until the delivery of their infants was explored. The understanding gained from this study will assist in the design and structure of alternative care delivery services offered to women with PPROM.
The aims of this research were twofold. First, it was the intent of this study to further an understanding about the lived experiences of women with PPROM who remained at home until delivery of their infants. Second, from this understanding it was hoped that insight would be gained into the benefits and difficulties experienced by women with PPROM while they were at home. The insight and understanding gained about the lived home experience will be used to assist in the planning and development of home care services that reflect the expressed needs and concerns of antepartum women.

Research Question

What is the lived experience of women with PPROM who remain at home until the delivery of their infant?
Chapter II

METHOD

Method

The research question, “What is the lived experience of women with PPROM who remain at home until the delivery of their infant?” was answered using a qualitative methodology. To date, the limited research available about the outcomes of antenatal home care programmes have used quantitative methods. Quantitative research methods are used to elicit unbiased and generalizable data to determine the extent predetermined variables of study interest are related (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). In contrast to quantitative research, qualitative methods are ideal to obtain the perspective of the consumer as they generate rich descriptions of phenomenon from the perspective of the people who have lived the experience (Leninger, 1992; Lincoln, 1992; Munhall & Oiler, 1986; Omery, 1983). The perspective of the consumer is important to consider in the planning and the evaluation of health care services (MOH, 1993a,b,c,d). The perceptions of the consumers are readily obtained using qualitative techniques.

The specific qualitative method of phenomenology was used to describe the experience of women with PPROM who remained at home until the delivery of their infants. The phenomenological method, an inductive descriptive research method, allows researchers to investigate and describe all phenomena, including the human experience in the way these phenomena appear (Colaizzi, 1978; Lincoln, 1992; Oiler, 1992; Omery, 1983). “The goal of the method is to describe the total systematic structure of lived experience, including the meanings that these experiences had for the individuals who participated in them” (Omery, 1983, p. 50). Thus, the phenomenological method was ideally suited to answer the primary
research question "what is the lived experience of women with PPROM who remain at home until delivery of their infant?" Qualitative research and thus phenomenology have certain inherent philosophical assumptions. These philosophical assumptions must be congruent with the purpose of the research (Cohen, Knafl, & Cox Dzurec, 1993; Knafl & Howard, 1984; Rudestam & Newton, 1992) and should be made explicit as they guide the methods of data collection and data analysis (Sandelowski, 1986).

**Philosophical Assumptions of Qualitative Research**

In qualitative research, understanding is based upon the discovery and meaning that occurs through description (Haase & Myers, 1988). Qualitative researchers assume there is not a singular reality (i.e., cause and effect) but multiple realities (Haase & Myers, 1988; Lincoln, 1992). Realities are constructed entities, they "exist in the form of mental constructions that are socially and experientially based, local and specific in nature, and dependent for their form and content on the individuals who hold them and on the groups to which those individuals belong" (Lincoln, 1992, p. 379). Thus, the effort is made in qualitative research to comprehend and interrelate varying views because any one perspective only offers a partial understanding of reality (Haase & Myers, 1988). Qualitative researchers assume the researcher and the researched subject to be interdependent. The results of the inquiry are actually created through the interaction between the researcher and the researched subject (Haase & Myers, 1988; Lincoln, 1992). In qualitative research, the world is considered to be in a dynamic state of flux and truth is found in changing patterns composed of similarities and differences (Haase & Myers, 1988). These similarities and differences are compared and contrasted in qualitative data analysis in order to come to a more informed consensus about a phenomenon (Lincoln, 1992).
Presuppositions of the Researcher

In phenomenology, the aim is to describe the experience being studied from the perspective of the participants. Recognising the unique relationship between the researcher and the researched subject, the phenomenological method requires the researcher to be reflective and question his/her own knowledge, experience, and assumptions about the world (Colaizzi, 1978; Giorgi, 1971; Oiler, 1986; Omery, 1983). Researchers must be aware of their own natural attitudes toward the world that their biography has given them (Oiler, 1986) to ensure an 'openness' to whatever data are significant for the proper understanding of the phenomenon (Giorgi, 1971). In order to uncover one's presuppositions about a research project, Colaizzi (1978) has suggested the researcher answer the following questions: (a) Why am I involved with this phenomenon? (b) How might my unique personality condition my selection of this particular phenomenon to investigate? (c) How might my personal inclinations and predispositions as to research value influence or even bias how and what I investigate? (d) What are the hidden gains that I might acquire in investigating the phenomenon, and in investigating it in this way? (Colaizzi, 1978, p. 55). The identification of the researcher's presuppositions is known as reduction (Oiler, 1986). 'Bracketing' refers to taking these presuppositions and carefully laying them aside in order to explore the appearances of phenomenon as they are given in perception, that is, before interpretation and explanation (Oiler, 1986). Bracketing occurs prior to data collection and during data analysis. A summary of the researcher's presuppositions bracketed during data collection and data analysis in this research study is described below.

As a result of the background gained from caring for women with PPROM and the knowledge base developed about the management of these women, the researcher believed
being cared for at home was a safe alternative for women and would be preferred by most. Women diagnosed with PPROM would have different perceptions from health care workers of the risks associated with PPROM for themselves and their unborn children. These perceptions would influence their experiences while they remained at home. The amount of support offered or available to the women would also influence their experiences at home.

**Sample Selection**

Sampling or participant selection was purposive, based on the philosophical assumption that multiple realities exist and that subjective data are real and valid (Cobb & Hagemaster, 1987). Informants were chosen based on the three criteria outlined by Morse (1991). First, the informants experienced the phenomenon under investigation and were willing and able to critically examine their experiences and personal responses to the situation (Morse, 1991). Second, the informants were willing to share their experiences with the researcher, and had sufficient uninterrupted time for the serial interviews (Morse, 1991). Third, the informants were approached if they spoke English with relative ease and only once they had met the eligibility criteria for outpatient management established by the hospital.

The sample sizes in qualitative research are usually small because the data gathering interviews are usually lengthy and require detailed description (Colaizzi, 1978; Giorgi, 1971; Omery, 1983). Because the task of phenomenology is to investigate and describe experiences in their fullest breadth and depth (Omery, 1983), these investigations provide us with data and insights that sheer numbers never can (Lincoln, 1992). The sample for this study consisted of five women who remained at home with PPROM until delivery of their infants.

Women were recruited from a tertiary care hospital within the regional perinatal complex in a metropolitan city where approximately 175 women are admitted with PPROM.
annually. The women recruited were diagnosed with PPROM (i.e., confirmed by a positive nitrazine and positive ferning test) and met the criteria that the hospital had established for home management of this condition. These criteria included: no fetal or maternal conditions contraindicated to home management, an initial hospital stay of 48 to 72 hours, cephalic presentation, a biophysical profile score equal to or greater than six, no evidence of vaginal bleeding, patient competence in self-monitoring (fetal movement counts, signs and symptoms of labour, infection, actions to take in specific emergency situations), access to a telephone, and residence within twenty minutes of a Level 2 perinatal centre (if less than 34 weeks GA). At the study hospital, women who present with PPROM are managed expectantly in hospital.

As one component of new ambulatory care initiatives, women with PPROM who meet specific eligibility criteria are approached to participate in a randomised controlled trial (RCT) of community based versus traditional hospital based antenatal care for women experiencing pregnancy complications. Women who agreed to participate in the RCT and were randomised to community based care, were discharged from hospital following a short inpatient stay (48 to 72 hours) and subsequently followed on an outpatient basis in the Obstetrical Day Unit. These women served as the population recruited to this study.

**Gaining Entrance to the Field**

Prior to recruitment, approval within the hospital was obtained from the Vice President-Nursing, the Program Director-Nursing for Perinatology, the Director of Maternal-Fetal Medicine, the Nursing Research and Review Committee and the Perinatal Nursing Programme Research and Education Committee.

Once approved, three perinatologists at the hospital responsible for the treatment of women receiving antepartum care informed the research assistant (Clinical Nurse Specialist,
Perinatology or a research nurse) when eligible patients were admitted to hospital. The research assistant then approached the women with a standardised introduction to the study (Appendix A) and asked permission for the investigator to contact the women to provide further information about the study. All of the women approached agreed to be contacted and the investigator visited them in the hospital. A detailed verbal and written explanation was provided (Appendix B) which outlined the purpose of the study, the participant’s role, the risks and benefits, the voluntary nature of participation, and the right to withdraw from the study at any time without affecting the care provided. The women were assured that all information provided would be held in strictest confidence and that the audio-taped and transcribed interviews would be identified only by codes to protect anonymity. Any written reports that contained verbatim comments as examples would in no way identify participants.

Following the explanation about the study, all of the women but one agreed to participate and signed a consent form (Appendix C). The woman who refused initially had agreed to participate however, following discussion with her husband declined. Each study participant received a copy of the signed consent form. Both the information sheet and consent form contained details about how to contact the researcher should the participants require clarification of any information or if they wished to terminate their involvement. Process consent was used as all women had two or more interviews. Process consent is the negotiation and renegotiation of consent prior to each interview to protect the women's rights consistent with the ongoing dynamic nature of qualitative research (Munhall, 1988).

**Participant Specific Ethical Considerations**

In this study women were asked to describe their “everyday” experiences of remaining at home with the condition of PPROM. As the goal of the study was to gain an
understanding of the women’s experience, the interviews at times evoked an emotional response due to the women’s conditions and pregnancy concerns. When the women became distressed during the interview, the researcher asked the participant if she wished to continue. In the two instances when participants were distressed they both wished to continue the interview after a few minutes and found talking about their situation helpful.

All interview tapes and transcriptions were identified by a code number to protect anonymity. A master record matching participant’s names to their study code, was kept under lock and key in the researcher’s home, separated from the data when not in use. All data in computer files were also protected by access codes. Signed consent forms will be kept in a locked cabinet for a period of six years and then destroyed.

Data Collection Procedures

The tools used for collecting data in this phenomenological study were dialogal interviews and observations of the participant and surroundings during each interaction (fieldnotes). Serial interviews spanning the women’s time at home were used to determine the lived experience of being at home with PPROM (Appendix D). All interviews, except for the second interview of one subject and the final postpartum interviews took place in the participants home at a time that was convenient to the woman and her family. The postpartum interview took place at the hospital in the participant’s room. Demographic data of the participants were collected by asking questions from the demographic data sheet (Appendix E) or were offered spontaneously during the serial interviews. Demographic data were collected to assist the investigator to accurately describe the characteristics of the participants in the final report. An accurate description of the study sample is important as it
is the perspective of these women that the results represent (Cobb & Hagemaster, 1987). A description of each data collection method follows.

**The interview.** In this study, the researcher wished to elicit information of the experiences of women with PPROM who were cared for in their homes through dialogal interviews (Colaizzi, 1978). Dialogal interviews require the investigator to be dialogally conversant with the participant. According to Colaizzi, to be dialogally conversant with the participant there must be a relationship of trust among persons on equal levels. Thus, dialogal research dispenses with the labels of 'researchers' and 'subjects' and are interactions among co-researchers. During the interviews, the investigator used what Colaizzi has termed imaginative listening. Imaginative listening required listening not only with one's ears but also one's entire personality and total being in order to contact the full richness of the woman and her verbalised experiences. Each interview lasted approximately 30 to 45 minutes and was audio-taped with consent from the participant (Appendix C). To ensure consistent wording and phrasing of the research questions, an interview guide, reviewed by an expert in the phenomenological method, was used for each interview (Appendix F). The researcher asked each participant the questions prepared for the interview and any additional questions necessary to clarify the data obtained. When clarifying information, the investigator attempted to ask questions that ensured concreteness in the data such as “Can you give me an example?” or “What was it like?” (Bergum, 1989). Although attempts were made to refrain from directing the interview by asking leading questions, at times in order to make the women more at ease and begin to talk about their experience, specific questions were asked based on information received at a previous interview.
As part of the eligibility criteria for the study, patients were hospitalised for approximately 48 to 72 hours. This time allowed for assessment of the mother and fetus and provided the information necessary to enable physicians to determine eligibility for home management. Prior to discharge from hospital, arrangements were made to interview the participant in her home on the second day following discharge. This period of time allowed the woman to experience being at home with PPROM for a day prior to the first interview. For women who remained undelivered, interviews were conducted as close to the interview schedule as possible i.e., on discharge days 2, 5, 8, 13, and then every 7 to 14 days until delivery (Appendix D). The interview schedule was based on a review of the natural history of women with PPROM at the participating hospital. This review found that of the women with PPROM who remained undelivered at 48 hours (50%), an additional 30% of women delivered within the next 5 days or within 1 week following PPROM and that only 10% of women remained undelivered 2 weeks following PPROM. Thus, the interview schedule was designed to concentrate several interviews during the first two weeks of the women being at home. Once the participants had been home for more than 2-3, weeks they really had very little new to say about the experience and thus the interviews were often spaced farther apart. After delivery of their infants, an interview was conducted to elicit information surrounding the women's experiences leading to delivery (e.g., going into labour, developing a temperature, decreased fetal movement counts, and travelling to hospital). Any data regarding the actual delivery experience were not analysed. The final interviews were conducted during the first or second day after delivery while the women were in hospital. One patient who was interviewed during this time period however, the tape recorder failed and a subsequent interview, used in the data analysis, was conducted in the woman's home a
few weeks postpartum. In Colaizzi’s method of data analysis, the researcher was required to perform a final validating step with the participants. Each of the participants was asked to compare the descriptive results with her own experience and identify any discrepancies and omissions. This step was completed by reading the descriptive summary to each of the participants over the telephone and asking the participants the question, “Is this summary reflective of your experience of remaining at home with PPROM?” All of the participants validated the descriptive summary and there were no new data that emerged during this step. Data collection took place over eight months.

Fieldnotes. Fieldnotes are records of relatively concrete descriptions of social processes and their contexts; they are often important sources of information during data analysis (Cobb & Hagemaster, 1987; Hammersley & Atkinson, 1983; Spradley, 1980). Descriptive data regarding the setting, presence of others, conscious interpretations, and insights (basically any non-verbal aspects and features of the physical surroundings) were included. Because the interviews were audio-taped, the fieldnotes contained only the areas described above, and were recorded immediately following each interview to avoid disrupting the interview process yet ensure complete and accurate information (Cobb & Hagemaster, 1987; Hammersley & Atkinson, 1983; Spradley, 1980). A fieldnote guide was used to secure complete and consistent information (Appendix G).

Data Analysis Procedures

Several methods of analysing phenomenological data have been developed (Colaizzi, 1978; Giorgi, 1971; VanKaam, 1966). Following a review of the different methodologies, Colaizzi’s method of data analysis was chosen. In this method, the researcher follows several sequential steps resulting in a statement describing the total experience that has been
validated by the study participants. Although in each of the methodologies the actual content analysis is similar, the validation steps differ. The process for data analysis described by Giorgi (1971) relies solely on the researcher’s analysis, while the process developed by VanKaam (1966) requires expert judges to review the analysis. Validation of the results with the study participants (Colaiuzzi, 1978) is preferred because one of the aims of the study was to use the understanding and insight gained from the research in the planning and development of home care services that reflect the expressed needs and concerns of women with PPROM.

Data analysis began following the completion of all the interviews with all of the participants. Bracketing occurred during data collection and during data analysis. Interviews of each participant were analysed separately and then the entire experience of each participant was reviewed as a whole. In the final step, the exhaustive description, incorporating the experiences of all the participants, was generated about the lived experience of women with PPROM who remained at home until delivery of their infants. The seven steps that were followed are outlined below.

1. In the first step the researcher read and reread the data to become familiar with the participant’s descriptions of the phenomenon. This allowed the researcher to acquire a feeling for the data, “a making sense out of them” (Colaiuzzi, 1978, p. 58).

2. The next step involved extracting significant statements from the data. Significant statements were phrases or sentences that directly pertained to the phenomenon under study. Significant statements were underlined in the transcript, noted in the space available on the right hand side of the page, and extracted from the computer transcript file and placed in a new file for each participant and labelled with the interview number. The significant
statements were read and reread from each participant and similar statements from all of the
participants were grouped together.

3. The third step in the data analysis involved formulating meanings from each of the
significant statements. This involved what Colaizzi (1978) has termed “creative insight” (p. 59). During this step the researcher, with assistance from an expert in the phenomenological method and study supervisor, was able to “discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon which are announced in the original protocols [data]”(p. 59) or move from what was said literally to what was meant by the participant. The formulated meanings and their descriptors were combined for all participants on a computer file.

4. The fourth step involved organising the formulated meanings from all of the women into clusters of themes (Colaizzi, 1978). Organising the meanings into clusters allowed for the emergence of themes common to all of the participants. Once again the cluster of themes were discussed with an expert in the phenomenological method and the study supervisor on several occasions to ensure auditability of the data analysis. The researcher then went back to the transcripts of the interviews to make sure that the clusters of themes accounted for all of the data and that they contained nothing not found in the data. If the cluster of themes is not validated, according to Colaizzi (1978), the first three steps must be examined or repeated. The clusters did not account for anything not found in the original interviews. However, the first three steps were repeated to ensure accuracy.

5. In this step all the results from the analysis were integrated into an exhaustive
description of the experience of women with PPROM who remain at home until delivery of their infant (Colaizzi, 1978).
6. In the sixth step, the researcher formulated the exhaustive description of the experience of women with PPROM who remain at home until delivery of their infant, in as unequivocal a statement as possible (Colaizzi, 1978, p. 61).

7. In the final step of analysis, the researcher validated the results with all of the participants, as outlined under data collection procedure.

Methodological Rigour

Rigour in qualitative research is often measured using the four criteria: truth value, applicability, consistency, and neutrality (Lincoln & Guba, 1985).

Truth Value

Truth value in a qualitative design resides in the discovery of experiences as they are lived and perceived by subjects rather than verifying a priori conceptions (Sandelowski, 1986). In this phenomenological study, the researcher reduced and bracketed her presuppositions prior to data collection and analysis. A qualitative study is felt to be credible “when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise it from those descriptions or interpretations as their own” (Sandelowski, 1986, p. 30). In the final step of data analysis, as described by Colaizzi (1978), validation of the researcher's descriptions and interpretations was performed by the five participants.

Applicability

In qualitative research, “fittingness” is the criteria against which applicability is evaluated (Lincoln & Guba, 1985). A study meets this criterion when the findings can fit into contexts outside the study situation and when readers find the results meaningful and applicable to their own experiences (Sandelowski, 1986). To guarantee applicability, the
investigator ensured the findings reflected both the typical and atypical elements of the life experience studied (Sandelowski, 1986). In the method used for data analysis (Colaizzi, 1978), the investigator referred back to the original data in several steps in order to validate the analysis and ensure comprehensiveness with the data.

**Consistency**

Consistency in qualitative research is measured by the auditability of the results (Sandelowski, 1986). "Auditability" refers to the ability of another researcher to follow the analyses and interpretations of the investigator as they are presented, and arrive at a comparable conclusion given the researcher's perspective and situation (Lincoln & Guba, 1985). Auditability was achieved when the researcher provided a clear decision trail concerning the study from its beginning to its end (Sandelowski, 1986). The initial decision trail is presented in this and the previous chapters while the decision trail regarding the data analysis is addressed in the Chapter III: Findings.

**Neutrality**

"Neutrality" refers to the freedom from bias during the research process and the presentation of the final product. The term "confirmability" is the criterion used in qualitative research, and is achieved when truth value, auditability, and applicability are established. Qualitative research recognises the interactive unity between the researcher and the researched subject and thus freedom from researcher bias can never be achieved. Confirmability was achieved when the researcher was able to acknowledge personal biases (bracketing) during data collection and data analysis in order to obtain credible, applicable, and auditable results.
Chapter III

FINDINGS

Characteristics of the Sample

The results of this study were obtained from the experience of five women with PPROM who remained at home until the delivery of their infants.

The Women

The women who participated ranged in age from 27 to 36 years (mean = 30.8 years). Four of the women had one child at home and one woman was having her first baby. Three of the women having their second child had delivered their previous infants at less than 37 weeks gestational age, one because of PPROM and two because of preterm labour. The gestational age at the time of PPROM ranged from 29 weeks and 2 days to 36 weeks. The women spent 4 to 69 days at home before delivering their infants. The number of interviews conducted with each patient ranged from 2 to 7. All of the women had vaginal deliveries and were discharged home with their infants.

At the time of the interviews four of the women were married and the fifth was single and involved in a stable relationship. All of the women lived in Southern Ontario in the metropolitan region of a large city. Three women had completed university degrees, one being a graduate degree. One patient had completed high school and a second was currently studying at university part time. Although at the time of the interviews none of the women were working outside of the home because of PPROM, three had been employed full time in professional positions. The two who did not work outside of the home were engaged as homemakers. Four of the women resided in apartments and one resided in a house.
The Infants

The four males and one female ranged in gestational age at delivery from 35 weeks and 5 days to 40 weeks and 3 days (mean 37.2 weeks). Their birthweights ranged from 2410 to 3540 grams. Two of the babies required one day of admission to the neonatal intensive care unit for observation following delivery and then were able to room-in with their mothers. Only one infant required phototherapy which meant two extra days of hospitalisation for both mother and baby.

A summary of the characteristics of the sample appears in Table 2.

Table 2.

Characteristics of the Sample

<table>
<thead>
<tr>
<th>Participant*</th>
<th>Age</th>
<th>GA at PPROM</th>
<th>GA at Delivery</th>
<th>No. of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>32</td>
<td>34 weeks 3 days</td>
<td>35 weeks 6 days</td>
<td>3</td>
</tr>
<tr>
<td>Anne</td>
<td>27</td>
<td>30 weeks 6 days</td>
<td>35 weeks 5 days</td>
<td>5</td>
</tr>
<tr>
<td>Susan</td>
<td>27</td>
<td>29 weeks 2 days</td>
<td>40 weeks 3 days</td>
<td>8</td>
</tr>
<tr>
<td>Beth</td>
<td>32</td>
<td>36 weeks</td>
<td>38 weeks</td>
<td>2</td>
</tr>
<tr>
<td>Mary</td>
<td>36</td>
<td>35 weeks</td>
<td>36 weeks</td>
<td>2</td>
</tr>
</tbody>
</table>

* The names of the participants are fictitious to protect their anonymity.
The Experience of Remaining at Home with Preterm Premature Rupture of Membranes Until Delivery.

The exhaustive description of the experience of remaining at home with preterm premature rupture of the membranes until delivery is contained on the following pages. Analysis of the data revealed three dominant themes. The first theme, “feeling overwhelmed at the initial diagnosis”, describes the women’s initial response to the diagnosis of PPROM and the resulting effects on many aspects of their lives. The second theme, “the struggle to achieve a balance”, explores the struggles the women experienced with their activity restrictions and how they attempted to balance what was best for their unborn babies with what was best for themselves. The third theme, “movement towards living a normal life” illustrates the dynamic adaptive process the women used to incorporate their diagnosis into their lives. This process had two main components which were described as subthemes. The first subtheme, “the importance of support”, describes the types of support the women found helpful or not so helpful while adapting to their situation at home. The second subtheme, “becoming an expert knower”, provides insight into the process the women used to assess the well being of themselves and their unborn infants while at home, and then how this information was used to make decisions about their activity level.

Each of the three themes will be described and illustrated by using direct quotes from the participants. Care was taken to ensure that all participants are represented. Each participant was assigned a name (Table 2) which appears in brackets following each quotation.
Theme 1: Feeling overwhelmed at the initial diagnosis

The women initially reported that learning of their diagnosis of PPROM was overwhelming and affected many aspects of their lives. They reported shock and disbelief with the unexpectedness of PPROM and asked themselves the questions of "why me?" and "what if?" which stimulated feelings of guilt and failure in their ability to carry a pregnancy to term. The leaking of amniotic fluid throughout the day and night was a constant reminder to the women and did not allow them to mentally escape from their situation. The unpredictability regarding the onset of labour made the women question their preparedness for the labour and delivery process. Their need to rest and limit their activity created an increased dependence on others which they found difficult to accept. The women were also concerned about the increased workload for family and friends and how the situation would affect their other children. The following paragraphs will provide insight into the women’s initial reaction to their diagnosis of PPROM and how their lives were suddenly changed.

Up until the time of PPROM the women had all experienced normal pregnancy courses without complications. The diagnosis of PPROM and hospitalisation significantly disrupted their lives. One woman stated her initial reaction was one of "...absolute panic, shock and denial really. It can’t be happening to me." (Jane) She later said that "I never expected this to happen to me, so I didn’t know what to expect. Nobody can prepare you for it." (Jane) Another woman who had delivered her first child at 34 weeks stated "...it was really scary for me when it happened I always assumed as soon as your water breaks that’s it you’re having your baby and I thought 32 weeks that’s just a little bit too soon for me." (Anne) Another woman stated that "when they said I had to go in [to the hospital] and my waters broke I thought ‘Oh my God I’m not ready, I’m not ready I don’t want to have it now
I’m not suppose to have it for weeks.” (Beth) The women had planned to prepare mentally, physically and practically for the baby during the remaining weeks before their due date and all of a sudden the amount of time they had until delivery was uncertain and unpredictable. One participant having her first child stated:

...this baby is going to be here in the next week, I’m actually going to be a Mom so soon. Cause you haven’t dealt with those things yet. I mean you have on one level you have and you know you’re going to be a Mom and a Dad and whatever, but you had a different time frame planned. We haven’t finished our prenatal classes and we haven’t learned anything about breastfeeding or anything about child care and those are the things that I banked on before I gave birth because they are the things I signed up for so that I’d learn how to do it and now I’m scared that when this baby comes next week I’m not going to know what to do with it. (Jane)

A little later in the interview she stated “I’m not ready, I’m five weeks early I..I need the five weeks, they’re they’re important to me.”(Jane) One of the participants had her membranes rupture around the same gestational age in her last pregnancy. Although she was surprised that it happened to her again she felt more relaxed about the situation as illustrated in the following quote: “But physically and mentally I’m quite good. I mean I am not too worried about what is happening, because I know that I’ve gone through this before and I am doing everything I could by doing the monitoring.” (Mary)

A few of the participants expressed feelings of failure at not being able to carry a pregnancy to term. A woman having her first baby compared herself to her friends and family members who had delivered their children at term without difficulties. She stated:
And you’re also going through feelings of um..um I’ve gone through this not guilt but I would say failure of not..not being able to carry to 40 weeks. Like most women can, why can’t I? Why did this have to happen to me? What could I have done differently to stop this from happening? (Jane)

A little later in the interview she also expressed concerns of failing her baby because it would be born at what she considered a small size: “I felt like in a way I had failed him because you know 4 and 1/2 pounds was a very scary thought for me.” (Jane) Another participant who delivered her first child at 34 weeks also expressed feelings of failure of not being able to carry to term. She had considerable feelings of guilt related to smoking throughout both of her pregnancies and wondered whether that was a contributing factor to her problem pregnancies. She stated “there’s a lot of guilt about the smoking because I feel like well maybe I caused all of this maybe I caused her to be premature because I smoked with her too.” (Anne) She had found her past experience extremely terrifying and the fact that she would inevitably deliver her current pregnancy preterm she questioned her ability to go through a subsequent pregnancy. She summarised her feelings as follows: “...I don’t know if I ever want to be pregnant again though after having two problem pregnancies and two premature babies I really don’t think I can go through it again its very hard.” (Anne) A little later in the interview she shared her terrifying past experience which provides insight into the fears associated with pregnancy complications:

...like I was so terrified when I was having her I thought what are they going to pull out of me because I had bleeding all the way through and she was early and she was breech and I had an emergency C-section and you know I was just terrified it was just awful, it was the most awful experience of my life having to give birth and it
shouldn’t be that way it should be a wonderful experience it shouldn’t be scary it shouldn’t be terrible it should be something that brings you pleasure as well you know... (Anne)

The women also reported the constant and unpredictable leaking of amniotic fluid throughout the day and night constantly reminded them of their situation and did not allow them to mentally escape their situation for any length of time. This is illustrated in the following quotes:

Even if you’re relaxed and you haven’t thought about it [having PPROM] in a while as soon as you move again it..[a gush of fluid] it reminds you..you’re right back to reality every time you move or every time you wet a pad or everytime..so you you can never forget about it and relax. (Jane)

She also stated a little later:

So there is no escaping it, so I think it stays on your mind more than if you had a cold or something because it’s always..whenever you move you get the fluid or whatever and you can’t really escape that. I think that’s what the toughest thing is that you can’t you know like if you..someone is going through something you can forget about it for hours at a time but it’s something that reminds you every 20 minutes or so and that..you can’t escape it. (Jane)

Although the women tried not to focus on their diagnosis the leaking of amniotic fluid made this very difficult and made them question the outcome for the baby and themselves. For example one participant reported:
I try hard not to focus on it too much but it's hard not to sometimes, yeah especially when I feel water gushing out of me in the middle of the night and it wakes me up and I'm thinking what if it runs out? (Anne)

The women expressed many concerns and uncertainties regarding the events surrounding the onset of labour. All of the women commented on the uncertainty of the timing of labour as conveyed in the following excerpts:

...the waiting is hard in a way because like even though they said okay they will induce me next week you don't know whether you are going to last till next week or whether you are going to go tomorrow. That's sort of difficult. (Jane)

Another participant stated: "it's just really a weird feeling knowing that I could go into labour any minute literally any minute now you know...or in two months."(Anne) Similarly another participant described her uncertainty as follows:

...so since I have been home I've just been kind of waiting you know I have every...even when I may have contractions I think maybe that's the beginning of labour and most of my feelings have been around that because I just...I don't know I just don't know when I'm going to go. (Beth)

The women were also concerned that when labour did begin they would have the supports they required available. One woman's husband was out of town on business and was not due home until the following day. She described a disturbed nights rest:

I must have fallen asleep but I kept wakening up and had different dreams about going into labour and they were all like some of them I wouldn't even make it to the hospital and I gave birth in an ambulance and things and one of them I gave birth here
on this rug...some of them I made it to hospital just like every possible scenario of going into labour. (Beth)

A little later in the interview she attributed her anxiety to her husband’s absence and the thought of labouring alone: “I think that [husband being out of town] was making me anxious about it as well the fact that I knew he couldn’t get there if anything happened and that would have been awful cause the thought of being on your own and in labour would have been horrendous.” (Beth) Another participant was concerned about physically getting to the hospital once labour began. She stated:

What if all my baby-sitters are out at the same time and I go in labour or what if everybody I had lined up for a ride is out and everybody the babysitters are out all at the same time and then I go in labour and there is nobody home and you know, I think about things like that you know I’m hoping its not going to happen but it could.

(Anne)

The women also had concerns regarding their ability to cope with the actual process of labour. One woman who had a caesarean section for her first delivery was worried about the pain associated with a vaginal delivery. She stated:

I’m worried about delivering vaginally because I had a C-section with my daughter and when I was pregnant with her the thing that scared me the most was the pain of actual...of actually pushing the baby out and I’m still terrified of that now because I don’t know what it is because I hadn’t done it with her. (Anne)

Another multiparous woman remembered her first delivery and was concerned about her ability to cope with the pain of labour a second time:
I'm going to have a much bigger baby this time. That kind of worries me having a bigger baby. I worry because now I know what it is going to be like and I don't know whether I will be able to deal with the pain again. (Mary)

The women also expressed concern about the size and health of their babies and even though they had been reassured by health care personnel that everything appeared to be fine they still had thoughts of “What if..?”. One participant stated:

It's scary wondering what's going on in there. I wish there was some test that could tell you everything is completely one hundred percent fine you know then I wouldn't worry so much I don't know what they can't see on an ultrasound I don't know if there is anything they could miss but according to the ultrasounds everything is fine but if there is something that can't be picked up by that you know that part is always there..wondering there's got to be a reason for this happening..like what if it's something wrong with the baby? (Anne)

The women also expressed concerns about developing an infection because of ruptured membranes, whether the baby would be able to breastfeed, the position of the baby and whether the baby would have to stay in hospital when they were ready to go home. They reported their concerns for the baby were not constant but would come and go. One woman reported: “It all pops in and out of my head its not constantly there but it does all pop in and out of my head.” (Anne) Another women when expressing concerns regarding the care of a premature baby and how it would differ from a full term baby summarised her concerns for her baby as being up and down like waves of emotion:

So those are very anxious thoughts that you have you go through sort of waves where depending on who called me today you go through waves where you're feeling really
good and things are fine and they wouldn’t send me home unless this baby was perfectly good and fine and so your feeling good about it and you’re accepting it and you’ve got to get on with your life and then you go through a period of ..“Oh my God next week I’m going to have this baby and its going to be premature and who knows what the weight is, it’s under 5 pounds” like all these awful thoughts creep in and again you start to feel sort of sorry for yourself “Why me?” (Jane)

The women who had other children at home were also concerned about how their diagnosis of PPROM would affect them. Being at home and having more time to spend with their children was very important to the women. Some women had identified prior to rupturing their membranes, different behaviours of their children which they attributed to a new sibling on the way. They expressed concerns related to how the diagnosis of PPROM would change the way they could interact with their children and how it would impact their usual routines. One woman describes how her three year old son could not understand that he had to go to his babysitters when she was able to stay home:

That’s been I think the hardest part even this morning when we tried to go over to my mother’s and he normally goes over there anyway, willingly, but I drive him, we had a twenty minute cry both of us because he didn’t want to go he wanted to stay home.

He said “Mommy I’ll be good I will just sit quietly, my tummy hurts too I’ll rest.”

(Mary)

A little later in the interview she stated that “..the letting go this morning was really upsetting on both sides because he didn’t understand why he had to leave and I wasn’t going anywhere.” (Mary) Another woman who had a two year old daughter at home was concerned that her daughter would be adversely affected by the altered routine.
So mainly my concerns are for my daughter like the household stuff who cares you know what I mean the house is going...there’s going to be clothes everywhere there are going to be dishes there’s nothing you can do about that but my main concern is that it doesn’t have too much of an adverse effect on my daughter. (Anne)

In a subsequent interview she explains:

My thinking is that she’s going to resent this child before it is even born for taking me away...you know like its going to take enough of my time when it comes out why does it have to take me away now. (Anne)

Due to limited activity levels the women required assistance with household tasks such as cooking, cleaning, laundry and child care. As stated by one of the participants “...when I’m relaxing there is somebody else has to take on the extra added duties.” (Mary) Assistance with these tasks was provided by their partners, other family members and friends as illustrated in the following excerpts: “She [sister] does everything for me she showed up at my door with my groceries, does my laundry and vacuuming.” (Susan) “I have a neighbour right down the hall who is going to be taking her [daughter] for a while tomorrow morning.” (Anne) “He’s [husband] got some things planned he’s going to go out and buy some things we need when the baby comes home and stuff like that so and he’s going to clean the house and stuff.” (Jane) “But then as soon as we get there my parents arrived to help, they are our landscapers these days...” (Mary)

All of the women had many offers of assistance from family and friends however, at times they found it difficult to ask for help. For example, one participant stated: “...being so independent it’s hard to...to admit you need help or to call someone to say look ‘I’m in
trouble.” (Jane) Another woman reminded herself of the reason why she needed assistance to ease her mind. She stated:

Sometimes I feel a little bit funny about my Mom doing my laundry or something like that but I think well I’m doing this for the health of my baby for my health and my baby’s health so yeah let them and don’t feel bad about it if you can help it. (Anne)

**Theme #2: The struggle to achieve a balance**

The second theme that emerged really describes the women’s struggle to achieve a balance in their lives. All of the women found it difficult to suddenly go from leading busy and active lives to resting at home. Although the women had ruptured their membranes they were physically well and reported they did not “feel sick”. The women enjoyed being at home in comparison to the hospital as they were able to follow their own routines, however, the boredom and tedium which resulted from their inactivity was extremely frustrating. Having to limit their activities meant family and friends treated them as incapacitated which they also found frustrating. The frustrations of inactivity forced the women to balance what was best for the baby with what was best for themselves. The women wanted to prolong their pregnancies because they knew that was best for the baby but it also meant they personally had to cope with the frustrations of inactivity, boredom and increased dependence. Despite the women expressing an increased readiness to deliver after being at home for longer periods of time, this struggle was still evident at the onset of labour. The following paragraphs describe the struggles the women encountered in attempting to achieve a balance in their lives.

When the women first went home after spending a few days in hospital they described feelings of being more relaxed, more comfortable, less stressed and happier in their familiar
home surroundings. Although they were concerned about the diagnosis of PPROM and the outcome of their pregnancies, being at home made their situations better. For example one woman stated:

I'm not a doctor, I don't know everything, I don't pretend to but I know where I feel better, I know where I feel more relaxed and less stressed and I feel more relaxed here [home] than I do there [hospital]. (Anne)

Another women stated “its nice nice being home I think it...it makes you feel more comfortable in...in your own surroundings cause you know..you know what your home is like its not like being in the hospital.” (Beth) All of the participants enjoyed being able to follow their own schedules and no longer being subjected to hospital routines. Taking care of themselves and following their own routines at home, made them feel less dependent on others. For example one woman stated: “in the hospital everyone was doing things for us and...and everything was out of our hands.”(Jane) Another participant enjoyed being able to eat her choice of foods at home. She stated:

You know I can get up and cook whatever I want for breakfast, I mean in the hospital you get what they give you and that’s it so if I have a craving for whatever I want I get up and I have it. (Susan)

Despite enjoying being at home, all of the women found it particularly difficult to restrict their activities because they did not feel sick and had not planned to take time off from work. One woman described her situation as follows:

If you were feeling sick, but you feel well except that for you should remain as sedentary as possible. And so your mind is..is active and everything else about you is active except for the fact that physically you can't be doing the things that you use to
be doing. So that’s tough, that’s one of the hardest things is to be able to lie down and
to force yourself to it especially with anyone who is in this situation uhm won’t have
planned it that way. (Jane)

Similarly another participant stated: “I am not used to staying home given all of this free time
to do whatever I wanted and not being able to do anything with it either”. (Mary)

The women found not being able to do as they liked very frustrating. One woman
reported:

I can’t do all the things that I like to do you know and I know I have to set a limit on
what I can and can’t do and sometimes its frustrating like I would like to take my
daughter to the park on a nice day which I really can’t do you know but there’s
always Grandma for that too or Daddy or Uncle or somebody else who could do it but
I want to do it! (Anne)

The women who were used to working outside of the home reported they missed their
work. They found time during the day passed very slowly because they were out of their
usual routine. One participant stated:

...I’m more or less I should say I’m, more or less bored. I mean I grab a book and I
read and everything but still you know it’s you’re used to getting up in the morning
and get going..going to work but but I’m home and I’m like ‘Oh my gosh what can I
do?’ (Susan)

Similarly another woman who found her job stimulating was bored staying at home. She
reported:

For myself boredom is a relative term. You go through peaks and troughs I mean
there is some good things on TV, I’ve you know got a good book I can read and I’m
enjoying it I’m getting some work done on my computer, it’s just the length of the day it seems so much longer than when you’re out working. (Jane)

The women who had children at home also helped with childcare which meant engaging their children in low energy activities that would allow them to sit down as much as possible, such as reading, colouring and doing puzzles.

So I did little things like colouring with him and playing with his train sets which meant sitting on the carpet but it wasn’t too comfortable and he [son] said “it’s okay Mommy just get a pillow” I said, ‘Yeah that worked before it doesn’t work anymore.” So I just laid down on my side and then every once and a while I could feel the movement of the baby and but uh it was still pretty relaxing so I wasn’t too worried about it. (Mary)

At times the women found it difficult to look after their other children because they could not really understand why their mothers needed to rest. When this happened the women found having someone to take care of their child for a while really helped. This time alone allowed them to relax and rest. One participant shared the following:

I find I’m short on patience I don’t know if that has anything to do with anything but I find I’m more short on patience than I was say two weeks ago..I guess because I know I have to be resting and I can’t always do that you know. “Mommy come jump on the bed with me” or “Mommy come do this” and you know and then I’ll say “Okay Mom can you take C. for a while and give me a bit of a break.” (Anne)

The women’s activity restrictions also created struggles with their families and friends. They described feeling frustrated when they were treated by others as though they were ill or incapacitated. Often friends or family members would not allow them to do the
little things they felt they were able to do around their homes. One woman summarised her conversations with family members as the following:

...I’m like ‘I’m not handicapped you know’. They’re like ‘You can’t move around’, they cook my supper and I’m like they call ‘What are you doing? Are you out of bed?’ ‘Yeah I can walk around its okay you know! ‘Are you sure’ ‘Yes its okay’.

(Susan)

Similarly another participant needed to reassure her mother-in-law regarding her discharge from hospital. She stated:

And you find out after a while it gets sort of frustrating that they were treating you like a semi-invalid as well..and they kept saying ‘Are you sure you were suppose to come out of the hospital’ and I said, ‘Yeah yeah everything is fine I’m paying attention to what’s going on, I can do almost the same things they do for me, it’ll be fine, we just wait now.’ (Mary)

Although all participants described frustrations with their activity restrictions the women who remained at home longer reported increased levels of frustration. One participant during her third interview, which occurred following a week of being at home, stated:

I’m getting really frustrated I find that I can’t do what I would like to do I can’t go to the park I can’t clean my house I can’t you know I can’t do all the things that I’d like to do, so I find that my patience level is very low my frustration level is very high.

(Anne)

Later in the interview she qualified what she found frustrating. She stated:

...I don’t want to go in labour, I just you know I act I get a little frustrated with sitting around and not doing a lot. Not going for walks and to the park and little things like
that, you miss that, you don’t realise how much a part of your life just going to the corner is until you stop doing it. It’s a treat for me to hop on the bus. I said to my husband last night, ‘I get to go on the bus tomorrow’ [to her hospital appointment]. I hate the bus I mean it shouldn’t be a thrill for me, it was. (Anne)

Having to restrict their activities and waiting for labour to begin created a struggle for the women when they attempted to balance their own needs with those of the baby. The women felt maternal by wanting to do what was the best for the baby which meant resting in order to maintain their pregnancy as long as possible. They understood that the closer to term they were at the time of delivery the less chance their babies would suffer from the morbidities of prematurity. However, the longer the women waited the more they wanted their labour to begin in order to end their struggles and move on with their lives. One woman likened this struggle of doing what was best for the baby versus doing what was best for Mom, as being of two minds; one selfish and one maternal. (Jane) She felt boredom played a role in her wanting the waiting process to end. She stated:

I think its part boredom. And that makes me feel selfish. Like you know ‘Jane take some boredom like because the longer the baby’s there the better the baby is’ you know so.. its boredom for me but its better for the baby so just live with it. You feel selfish about wanting it over with. (Jane)

Similarly another woman describes a situation when she decided to be more adventurous with her activity level and then later questioned her responsibility for the uterine contractions she experienced later that day. She stated:

I was thinking afterwards that maybe I had over done it because of the going to McDonalds®, going to my mother-in-law’s then having my parents over, I don’t know
whether I actually then brought on the tightenings during the next...the following night or what. (Mary)

Some of the women did not express a desire to end the process of waiting until they had reached a gestational age when their concerns for the baby had decreased. One participant who was 31 weeks at the time of PPROM wanted to reach 34 weeks which was the gestational age at which her daughter had been born. She felt if she was able to make it the three weeks then she would not worry as much about the baby. After being at home for three weeks she reported being pleased that she had been able to prolong her pregnancy and also expressed her readiness to deliver. She stated:

Yeah, yeah, let’s face it he is going to come early but the three weeks that I have had I’m more use to it and yeah, just I’m glad its taken this long. Some days I feel like oh just get it over with then other days well it would be nice to get it over with but when I get it over with I’m going to have two kids..look at it that way. (Anne)

Most women expressed a desire to have a plan of care which included the time of induction should they not labour on their own. They felt this would give them an end point on which to focus. Some of the women also expressed fears that their doctors would tell them they must continue to wait when they had really hoped to have their labour induced. This is illustrated in the following excerpt offered by one participant:

Then..then its Monday again and then its like next week is the week its going to happen whether its earlier or they induce me later in the week. But I think I would be very upset if they..if I sort of focus on that and then all of a sudden on Monday Dr. P. goes ‘We’ll let you go another week’. I’m not sure how I’d handle that. Because you you sort of need something to focus on and since I know that he is on call next
Thursday that’s probably when they’re going to induce me is next Thursday but because he did say at 36 weeks and that’s two days past 36 weeks. So hopefully he doesn’t throw me a curve on Monday and say ‘You’re doing so well we are going to wait another week’ I think that would probably put me over the edge, even though I think it would be better for the baby maybe but who knows? (Jane)

All of the women who had their labour induced were relieved when their doctor’s made the decisions for them regarding the timing of delivery. Not only did it end the process of waiting for the women but it relieved them of the responsibility of doing something to initiate their labour. One woman was admitted to the hospital because she had experienced episodes of contractions. At the time of her second interview she was scheduled for an induction of labour the next day if she did not labour over night. She stated:

...now in the hospital I’m stuck..waiting. I haven’t had any tightenings..hardly any regular ones at all. In the last half hour to forty minutes when I’ve had dinner I didn’t even feel a thing so I have a feeling that I’m not even going to go into labour. So I’m glad Dr. M. had made the decision. I could probably drag this out for who knows how many more days. This way the decision has been made, I don’t have to worry about it and it will probably be a little faster. (Mary)

Although the woman had reported a desire to end the process and deliver, the women who laboured spontaneously expressed disbelief at the onset of labour. Thus despite wanting the waiting process to end there was still evidence of a struggle to achieve a balance when labour finally began as illustrated in the following excerpt:
...the cramps were happening every once and a while and then um around 9 o’clock I knew it was labour so...and you sort of go through mixed emotions you think “Oh thank goodness its here, and Oh my God like its here”...sort of thing... (Jane)

**Theme #3: Movement towards living a normal life with PPROM**

Movement towards living a normal life with PPROM emerged as the third theme of the women’s experiences of remaining at home with PPROM. They described how they adapted to their diagnosis and were able to cope with the struggles they experienced. All of the women felt that being at home with PPROM was better than being in hospital. Being in a familiar environment surrounded by their own things and their significant others as well as following their own routines was comforting, relaxing and allowed them more rest. They did not perceive a great difference in the care received at home in comparison to the care they had received in hospital and were comfortable monitoring their own condition. They felt that remaining at home was more convenient for everyone involved and was worth any extra effort required.

The women found the physical and psychological support they received from family and friends was crucial for them to adapt to their diagnosis of PPROM. Although the women initially found the activity restrictions frustrating, they soon became expert knowers of their own bodies and as a result were able to learn what they could and could not do. The women used their assessment skills to determine continued personal and fetal well being. Continued personal and fetal well being allowed the women to justify their activities and reassure themselves and their families that what they were doing was right. These coping mechanisms are represented by two subthemes which constitute the third theme: “the importance of support” and “becoming expert knowers”.
Theme #3: Subtheme 1 - The Importance of Support.

The support, both physical and psychological, that the women received from family and friends was a crucial factor that allowed the women to move towards living a normal life with PPROM. Having people available to assist them with household tasks and childcare gave the women the time they needed to relax and rest. Talking to someone about the experience allowed them to move through the process and just knowing other women had lived through the experience and had strong healthy children gave them hope and incentive to continue.

The women reported being at home made things easier in general for themselves, their significant others and their children. It allowed the women to access to their usual support systems and maintain their familial roles. The women perceived it was easier on their significant others if they did not have to spend time travelling to and visiting them in the hospital. For example one women stated, “It's hard on my husband I mean he works and he comes to the hospital with my daughter so she can see me and he’s not getting any rest and we are better off all around this way.” (Anne) In a subsequent interview she stated:

...it would be more work if he had to come to the hospital everyday because I couldn’t go a day without seeing my daughter. I mean I would go crazy I would just go crazy. So I mean...he brought her in everyday that I was in too when I was in for the weekend so its more work around the house for him but I think he would rather do more work around the house than spend two hours on the subway everyday coming to see me at the hospital. (Anne)

Similarly another participant described her husband’s situation as follows:
...now that I am home, he can take his mind off me being in the hospital he knows that when he comes home I’ll be there and that we can talk about it and whatever, I think it has taken the stress off him too. Just to go from work to the hospital I want him there as soon as he can get there to keep me company which means he’s to get supper somewhere along the line and whatever and he was going home at like 8:00 o’clock at night and then everyone was calling him here and he just never was ever ever had time to sit down and think about it himself. Whereas here he comes home he knows I’m here, you know and we can sort of carry on as opposed to..being in a sterile situation where it was costing money and it was costing time and it was more inconvenient to go to the hospital than it is to just..just come home. (Jane)

All of the women who had children at home missed them during their stay in hospital. Although they were confident that their children were being well cared for, they were very happy to spend more time with them at home. For example one woman stated, “her [daughter] routine has changed she’s not with me as much but she is still with me a lot more than she would be if I were in the hospital..and that’s the important thing to me”. (Anne)

Similarly another participant said, “...[I] get to see my son more and as I say although I know he was well taken care of its nice to see him and I want to be here so I that’s you know you just want to be home.” (Susan) Another woman stated:

If I had been in hospital this whole week it would have been awful. I think I would have been almost..I would have been so depressed..cause I wouldn’t have seen her. She’s a lot of work but when I was in hospital I used to think about her when she wasn’t there and think I wonder when she’ll come in and what she’ll do so I think if I
hadn’t seen her for a whole week I would have been starting to get a bit depressed.

(Beth)

They found the physical and psychological support they received from family, friends, and health care providers was crucial to adapt to their situations. The women found not only their friends and family were there to support them but people they hardly knew also offered assistance. Many of the participants expressed surprise regarding the amount of support they were offered. One woman stated: “In the last couple of days the response from my colleagues and my friends has been incredible, it’s been really very heart warming cause everybody knows somebody who has been in a predicament like this...” (Jane) The women also felt comfortable being at home knowing people were around to help them if necessary and that they lived close to the hospital as all women were required to be within a 20 minute drive of the hospital. One woman stated, “I feel more comfortable being here [home] just knowing I can get back there [hospital] in a hurry when I have to.” (Anne)

The women found it reassuring to know that they were not alone, that other women had experienced PPROM and that they and their babies had done well. One woman stated:

...its the women who have gone through it or the men who have gone through it with their wives and have children who have...are thriving and doing well, that’s what you need to hear and that’s what you need to see to make you feel better about what’s going on. Everybody’s trying to make you feel better about what’s going on everybody’s trying to give you hope and everybody’s trying to keep your mind focused on the fact that this is going to be great but uh its the women that and the men who have had experience with it and have gone through it and their kids are great and
doing well that makes you feel okay..calm..this is fine everything is going to be fine.

(Jane)

The women also found having someone to talk to and someone who would listen to them helped. One participant found soon after PPROM her husband was not quite sure how he could help her through the process and she shared in the interview: “I kept saying ‘Just be here and just talk to me.” (Jane) The women found sharing their thoughts and feelings assisted them to move through the process. Usually this psychological support was received from their significant others or friends but also from their health care providers and this researcher. One participant during her postpartum interview stated:

...it is nice because you you move through it in your mind and to express it is nice because you sort of..if this can help any other women or help then its worth it you know. And the thing is I can’t..I have no choice I mean I’ve got to live it... (Jane)

Similarly another participant shared the following at her postpartum interview:

I really enjoyed having you come to visit me though. Yeah, I found it very helpful to have you to talk to through it all. It was totally reassuring, I know I was going down there [hospital] twice a week but having you come to see me too I don’t know it was very..I felt supported, you know what I mean, I felt more comfortable that way.

(Anne)

She later recommended that if it became the routine care for women with PPROM to remain at home that the occasional home visit would be helpful.

The women also found being with others helped to pass the time and helped them to relax even if they physically did not do anything. One participant spent time at her mother-in-law’s one afternoon and found just getting out of the house helped her to relax. She stated:
It was actually nice because I was out of the house and talking to somebody else just in a new environment, different news, with different people so it...I found it...it wasn’t too bad and so that when we did go home around three-thirty I was more relaxed.

(Mary)

Despite the importance of psychological support at times the women reported they had too many phone calls from friends and family. At times they also found the comments and advice received tiresome and irritating. For example, one woman who had been at home for many weeks was very anxious to deliver and found it irritating when her family told her to be patient. She stated: "...but they’re [family] just trying to say the right things and yeah you know its just irritating that’s it." (Beth) Similarly another participant found she received some strange comments regarding the management of her condition. She reported the following:

I don’t think people really realise..like people say to me “Oh but generally if your waters have broken there’s nothing in there to hold the baby up’ and I thought people say such strange things you think, they have weird misconceptions about what your waters actually do. Even some women who have had babies themselves have said these things to me..I think ‘No, no its not really that big a deal...” (Beth)

Theme #3: Subtheme 2- Becoming expert knowers

The most frustrating aspect of life with PPROM was coping with the activity restrictions. Engaging in some type of activity helped to ease the boredom and frustrations of inactivity. During their time at home the women were able to learn what they could and could not do and then by slowly increasing their activity levels they were able to significantly decrease their frustrations. The women learned what they could and could not do by
becoming expert knowers of their own bodies. They constantly assessed their own condition and that of the baby in regards to any task or activity they performed. Their assessments allowed them to reassuring themselves and their family and friends regarding their care and activities. The women’s knowledge and assessment skills regarding their condition made them expert knowers of their own bodies and was an important factor that allowed them to move towards living a normal life with PPROM.

All of the women felt the self-monitoring regimen they were required to perform twice daily and their twice weekly visits to the hospital were equivalent to the care they had received while in the hospital. One woman stated:

Here I got up and got my temperature taken and I did it around late afternoon and before I go to bed you know...and because I know I know the baby’s moving, I can feel it moving the fetal monitor they did at the hospital is pretty much the same thing so...I don’t see what the difference is in terms of care, except for the the scariness about infection and that sort of thing. But that can happen at the hospital or at home.

(Jane)

Similarly another participant stated:

I mean I laid there and I ate my way through those meals and I watched TV and the nurse came to visit me every once and a while. I mean it wasn’t as if they could do anything more for me at that point at the hospital either unless I go into labour.

(Mary)

Thus, while at home, the women were empowered to care for themselves and became the experts regarding their condition. Because the women were able to assess their own condition they were also able to learn what they could or could not do during their time at
home. The women found by simply engaging in some type of activity their frustrations eased, however, the actual activities in which they engaged varied with the length of time they spent at home.

Initially the women reported only doing simple activities things that they knew would not take much energy or cause any physical strain. This involved reading, watching television and making themselves something to eat. One woman stated: “…just getting up to go to the washroom, getting up to make myself something to eat you know, getting up when you’re going a little stir crazy this sort of thing, that’s all you should be doing.” (Jane) Similarly, another participant stated: “…she’s going to do my dishes later because I’m not going to stand up long enough to do things like that like I’m not doing any housework either you know” (Anne) However, the women soon found these activity restrictions to be frustrating and they began to look for more things to do.

The women attempted to learn what activities they could and could not do by thinking about the activity and then trying them out. One participant described this process as follows: “…you try to find things that you can actually do that aren’t stressful and heavy at the same time you really have to work it out.” (Mary) Another participant noted that if she was too active she would leak more amniotic fluid but doing little things did not seem to make a difference. She stated: “Although if I am too active I do leak more, but if I get up and do little things it doesn’t necessarily mean I am going to leak or if I lay still it doesn’t mean I’m not going to leak so it happens either way.” (Anne) Once the women were comfortable with the unpredictability of the amniotic fluid leaking they were able to judge the types of activities they were able to do and plan their days. One participant found planning her time at home helped her to cope with her activity restrictions. She stated: “You have to have some sort of
of goal because otherwise you’re just wandering around wondering what to do, and you get even more restless and stressed out so you do have to make an effort to plan things out in your..in your day.” (Mary)

As the time the women spent at home increased they became more comfortable with their condition and became more adventurous with their activities. One patient during her fourth interview stated: “I’m still trying to take it easy but I’m not paranoid with every step I take like I was at first.” (Anne) In fact, the same participant who previously stated she would not stand long enough to do the dishes, reported the following during an interview 2 1/2 weeks after discharge from hospital:

...the other day I found I was doing a little too much I cooked supper and I washed the dishes and I was straightening up and then whoosh and I thought ‘Oh oh, time to go and sit down I did too much that day and then I just stayed off my feet for the rest of the day. (Anne)

The women used the amount of fluid that leaked or whether they experienced any contractions to validate personal and fetal well being during activities. One patient needed to justify her activities around her home to her husband. She reported her conversation with him during an interview:

Sorry, but I have to stretch my legs its been a couple of hours you know, let me get up it doesn’t matter it seems I could be laying here for three hours reading a book and I still have water come out you know or I can get up and go do dishes for fifteen minutes and no water comes out. So its you know I can do little things its not going to do anything I don’t think..I’m not moving any furniture but..I think washing a few dishes now and then is okay. (Anne)
Similarly another participant decided to be more adventurous with her activity levels and went with her husband and son out for breakfast. She describes her experience as follows:

So basically I sat most of the time but as soon as I’d get up it would trickle and I’d be aware of it and like I should be doing things but I’m not doing things. If I were at home I would be even getting up more often than this instead of just sitting here and reading the newspaper...so I wasn’t too worried about it and the movements were fine and my temperature was fine... (Mary)

The validation process the women used to justify their activities remained constant, however the activities they justified changed with the length of time they were at home and as they became more comfortable with their condition. The same participant who justified her household activities to her husband above later in the same interview reported being frustrated with her activity restrictions and debated whether she might try walking a block or two outside. She attempted to justify this activity using activities she had successfully completed. She stated:

Then again I’ve gone to the hospital and back twice and I’m not in labour yet, no problem, so you know with every trip I take out to the hospital gives me a little more confidence Let’s see maybe it would be okay if I took my daughter for a walk to the corner and back or you know, put her in a stroller and away we go, just to get her out for awhile instead of waiting for everyone else to do it all the time. (Anne)

Two of the women continued past 38 weeks gestational age and required induction of labour. These women actually resumed their normal activity levels because their concerns for their babies had decreased. One woman upon reaching her due date described her activities as follows:
...I was doing everything I went to the mall, I shopped, I cleaned, I went to the movies I did anything that I think..you know at that point I just wanted to keep busy to do stuff to think I took the stairs you know just hoping for a little contraction, anything a little pain then I would know that’s it...” (Susan)

These women continued to monitor fetal well being, however, no longer justified their activities to themselves but continued to justify their activities to family and friends. One participant stated:

So nobody wants me to do anything you know they come down and they are doing everything that I really don’t..I mean I used to say “It’s okay I’ll do it” but they insist and I say okay if they want to be Molly Maid and do everything for me, fine. (Susan)

The women’s assessments of well being may have taken the form of personal monitoring of fetal movements and body temperature, to more formal testing such as ultrasound scans, non-stress tests or bloodwork completed during their hospital visits. For example, one woman stated:

I think its great to get the chance to go into the hospital because that’s really reassuring when you get the fetal monitor done and you see the heart beat and the acceleration and the fact that you’re not having contractions, that’s to me is..it saves me. Because like I..I yesterday I mean I was sitting around all day and you know things are fine but its nice to visually see that so I think being able to go in every other day and getting that done is real..its a booster for you it gives you sort of the strength to go home and handle it again cause you know you’re doing the right thing.

(Jane)

Similarly another patient reported:
I had my doctor’s appointment...my hospital appointment which was quite nice because then you can get hooked up to the monitor and had my blood done which makes you feel like you’re fine again...because when you’re at home and even though you’re taking your temperature you still kind of worry a little bit. (Beth)

It was only by performing serial interviews during the women’s experiences that allowed the dynamic process of the women’s movement toward living a normal life with PPROM to emerge. The three themes and their subthemes really describe the struggles that arose, the methods the women used to cope with these struggles and the crucial components in their lives that were necessary to enable the women to incorporate the diagnosis of PPROM into their lives.

Although the women described during later interviews that they had fallen back into more normal routines their awareness of incorporating the diagnosis into their lives was not always clear to them. For example, one participant who had been at home over 3 weeks with PPROM describes the following experience:

It was weird the other day when I took C. [daughter] to the doctor. I put her in the stroller the wheels don’t work...not very well they go to the one side and its a lot of work to get it to push straight in front of you and I tried pushing C. in the hallway just to see if it would be a strain or not and it was like I found it wasn’t a good idea for me to walk her so I had to call someone to walk up to the doctor’s with me to push the stroller so that was kind of weird..like I couldn’t take her out myself I had to get someone to push the stroller for me. So that was strange whereas if I wasn’t ruptured I would have just taken her I would have just pushed the stroller. [Interviewer: “Right”]
But I can’t do that because like I did ..I did try but the strain on the one side and the
whoosh came out and I thought ‘Oh oh I don’t think this is too smart.’ Uhm its really, nothing much as changed other than I’m more relaxed. You know every week, every week now every week I get more relaxed, I’m more comfortable with it [PPROM].

(Anne)

In this example the woman described the experience not as frustrating or in a negative way but as “weird” and compared it to what she would have done had she not had PPROM. She also described how she assessed whether she would be able to push the stroller or not and the actions she took in response to the situation. In fact she described the situation as though it was a normal part of her life and only upon reflection thought there was something weird or strange about it. At the end of the excerpt she goes on to say that nothing had really changed except that she was more relaxed and comfortable with PPROM. This example illustrates how the women actually moved towards living a normal life with PPROM. It was something that occurred gradually and almost unnoticeable to the women until they reflected upon their situations. In fact at the beginning of most interviews the women said that nothing had really changed since their previous interview. It was only when the descriptions of their activities and their feelings from each interview were analysed in sequence that the movement towards living a normal life with PPROM became apparent. This can be illustrated by summarising excerpts from interviews of the same participant as above (Anne) also used to illustrate the themes in the exhaustive description. When she first arrived home from the hospital she reported she was more relaxed and was confident it was the best place for her. Her activities were minimal and although she assisted with childcare she did not want to stand long enough to do dishes. As time passed she found not being able to do anything that she liked to do very frustrating, in fact she actually looked forward to taking the bus trip to the hospital, just to get
out. She later validated to her husband that doing most household activities was okay and described making dinner, cleaning up and doing the dishes. Because she found not being able to go outside frustrating she debated about walking to the corner and back and had not yet decided that it was okay. Then she described the above situation where it was not walking to the doctor that concerned her but whether she could push her daughter in the stroller as well. Although it was the participant’s activities that have been highlighted, it must be understood that it was only by moving through the struggles associated with her diagnosis and adapting to life with PPROM that she was able to alter her activity level.

Not all of the women remained at home as long as Anne, and thus the women were at varying levels of incorporating the diagnosis of PPROM into their lives at the time of delivery. All of the women however, did describe events and experiences that supported the three themes presented and were moving toward living a normal life with PPROM. Evidence of their progress is found in the following excerpts taken from the latter interviews of the four other participants. In the first excerpt the participant described her weekend just before she laboured on the Monday:

The weekend was nice..uhm mainly because I had someone around and I was able to get around a little a bit..not too much but ah I went for a you know car ride and stuff like that to just to..to get out and so it was really..it was a nice relaxing weekend and I wasn’t too stressed out it was what ever happens, happens sort of thing. (Jane)

The fact that this participant described feeling relaxed, not too stressed, got out of the house and was willing to accept what ever happened in reference to going into labour shows movement toward living a normal life with PPROM.
In the next excerpt the woman described how she had settled down into a routine and no longer really thought about the fact that she had PPROM. She stated: “I’ve kind of gotten used to this now you know laying resting, reading something, watching TV, you know finding something to keep me busy for the time being uhm you know” (Susan) and a little later in the interview she continued:

I guess because I you know I’m into the routine. I’m doing stuff in the daytime you know to occupy my time and you know I don’t think about it I mean you know probably once in a blue moon I’ll think ‘Oh it could be tomorrow’ but for now no, I’m not really thinking about it. (Susan)

She no longer thought about going into labour when during her initial interview it was something that she described as being foremost on her mind: “..that’s something that I..I think about throughout the day, foremost in my mind..like when is it going to be tomorrow is it going to be today?” (Susan) This example also shows movement toward living a normal life with PPROM.

The next excerpt is from a woman who ruptured her membranes during her 36th week of gestation and because she was so close to term she did not really restrict her activities at home. However, she did enjoy being at home because it allowed her to go about her business also suggesting movement towards living a normal life with PPROM. She stated:

It’s nice in a way because when your..if your waters break and there’s everythings fine, there’s no reason for you really to be in hospital I don’t think. It’s not doing you any good I’m sure it’s not doing..other than getting a rest but you can do that at home. When I was at home at least you can kind of go about your business and then if it happens it happens.. (Beth)
In the last excerpt the participant had just been admitted to hospital because of contractions she had experienced in the morning and her doctor had decided to induce labour the following day. She described her feelings surrounding her admission:

Back to the hospital which was very hard to take when he (doctor) said you have to stay here. I was really getting comfortable at home and had gotten into some sort of uhm some sort of routine, not so much a routine but an idea of what I could do and what I couldn’t do and my limitations. And now being back in here its uhm I’m even more limited than before. (Mary)

Again the participant described feeling comfortable at home and had been able to determine her limitations which seemed to make her second hospitalisation more difficult. Once again this excerpt gives a sense of the participant’s movement toward living a normal life with PPROM.

Thus for the women in this study remaining at home with PPROM until delivery progressed from feeling overwhelmed at the initial diagnosis to movement toward living a normal life with PPROM. This evolved from their struggles to achieve a balance and their ability to adapt to life with PPROM through the support of friends and family and becoming expert knowers of their own bodies. Being in the familiar and comfortable surroundings of their homes helped them in their struggles and to move toward living a normal life with PPROM. The process was difficult, gradual and virtually remained unnoticed by the women. They did report over time they felt more comfortable with their diagnosis, were able to relax more and felt they had established some sort of a routine. In fact it was only upon reflection that they compared what they did with PPROM to what they would have done without this complication.
Descriptive Summary

The purpose of this study was to describe the experience of women with PPROM who remained at home until delivery of their infants. Indepth, unstructured interviews with 5 women throughout their experiences were used to gain an understanding of the experience of being at home with PPROM. The women found being at home in a familiar and comfortable environment allowed them to relax and rest. However, initially the diagnosis of PPROM meant the women had to alter many aspects of their lives to accommodate their change of pregnancy status. It was difficult for the women to switch from leading busy and active lives to resting at home. It often meant they had to struggle with the frustrations and boredom of inactivity in order to prolong their pregnancy. The women found the activity restrictions difficult and often just wanted to deliver to end the process however, at the same time they knew that it was better for the baby if they were able to cope with the boredom of inactivity to prolong the pregnancy. Thus the women also struggled to achieve a balance. They wanted to do what was the best for the baby and felt maternal but at the same time they wanted to deliver to end the waiting for themselves and felt selfish. As the women worked through their struggles they began to adapt or move toward living a normal life with PPROM and found the physical and psychological support they received from family, friends and health care providers a crucial component of the adaptation process. Talking to someone about the experience allowed them to move through the process and just knowing other women had lived through the experience and had strong healthy children gave them hope and incentive to continue. One of the most difficult aspects of the experience involved coping with activity restrictions. The women found that as they became more comfortable with their condition and were able to learn what they could and could not do, they became more adventurous with
their activities which eased their frustrations. The women used their assessment of fetal and maternal well being to validate the decisions they made to reassure themselves and their families regarding their care and the activities in which they engaged. Thus for the women in this study remaining at home with PPROM until delivery progressed from an initial reaction of shock and disbelief and limited activity to movement toward living a normal life with PPROM. The process was difficult, gradual and virtually remained unnoticed by the women except for an increased comfort level with their diagnosis, a more relaxed feeling and a willingness to accept either labour and delivery or more waiting.
Chapter IV

DISCUSSION AND IMPLICATIONS

The results of this study suggest that the women who remained at home with PPROM until delivery were able to adapt to their situation by incorporating their diagnosis into their lives and move towards living a normal life with PPROM. This process of adaptation has not been previously reported in response to a high-risk pregnancy. It does however, relate to other published work which will be discussed.

Discussion

In the first theme of this study the women described their initial reaction to the diagnosis of PPROM. They described feelings of shock, disbelief, failure at not being able to carry a pregnancy to term and guilt if the women perceived they had done something that may have caused their membranes to rupture. These emotions in relation to a high risk pregnancy are similar to those reported by other investigators (Clauson, 1996; Curry, 1987; Kaplan & Mason, 1965; McCain & Deatrick, 1994) and are also similar to the first stage of the grieving process described by Engel (1964). Initially the loss of a normal pregnancy is significant to the women and they grieve their loss. However, the women have not lost the fetus and as a result they continue with PPROM and learn to adapt to a high risk pregnancy.

The women initially found the leaking of amniotic fluid during the day and night was a constant reminder to them of their situation and did not allow them to mentally escape their situation. Investigators to date have not specifically targeted the pregnancy complication of PPROM and this experience has not been previously reported. The expressed desire to escape is consistent with the first stage of the grieving process where
the individual wishes to forget about the loss (Engel, 1964). The women found the loss of a normal pregnancy was reinforced by the constant leaking of amniotic fluid. However, in coping with their condition the leaking of amniotic fluid became a part of their assessment strategy to learn what activities they could and could not do.

In addition to reminding the women of their diagnosis, the leaking of amniotic fluid elicited concerns for them about the outcome of the baby. Concerns for infant welfare are common for women at home or in hospital with a high-risk pregnancy and have been reported by many authors (Curry, 1987; Loos & Julius, 1989; McCain & Deatrick, 1994; Monahan & DeJoseph, 1991; Schroeder, 1996; Stainton et al., 1995; White & Ritchie, 1984). The women's concerns for their unborn children are also consistent with the maternal task of pregnancy described by Rubin (1976), of seeking a safe passage for their infant. Rubin proposed four interdependent tasks of pregnancy that women must complete: “seeking the safe passage for herself and her child through pregnancy, labour, and delivery; ensuring the acceptance of the child she bears by significant persons in her family; binding-in to her unknown child; and learning to give of oneself” (p. 369). Each of these tasks begins in the first trimester and have specific manifestations in each trimester. According to Rubin, women in the third trimester of a normal pregnancy experience a heightened awareness of vulnerability to danger from the environment for themselves and their infants. Thus, with the diagnosis of PPROM, an actual threat to the pregnancy, the women’s concerns for their unborn children should be anticipated.

The unpredictability of the onset of labour with the diagnosis of PPROM made the women in the current study question their preparedness for the labour and delivery
process. To prepare themselves, the women recalled past experiences, sought information regarding the labour process, planned their transportation to the hospital and identified the supports they required. This finding is similar to Stainton et al. (1995) who reported that women reminisced about past experiences and further postulated that by reminiscing women could enhance or decrease the elements of uncertainty of their experience. Preparing for labour and delivery is also included in the maternal task of seeking a safe passage for the infant (Rubin, 1976).

In the second theme, “the struggle to achieve a balance” the women described the difficulties related to the sudden change in their activity level. They reported that resting was particularly hard because they did not ‘feel sick’. Not feeling sick has been reported by other women during high-risk pregnancies (Josten, Savik, Mullett, Campbell & Vincent, 1995; Stainton et al., 1995) and in particular has been identified as one of the reasons that women do not comply with bed rest (Josten et al., 1995). The frustrations with activity restrictions reported by the women in the current study have been reported by other investigators who have studied antepartum hospitalisation and bed rest in pregnancy (Curry, 1987; Heaman et al., 1994; Loos & Julius, 1989; Kemp & Page, Josten et al., 1995; McCain & Deatrick, 1984; Monahan & DeJoseph, 1991; Schroeder, 1996; Stainton et al., 1995; White & Ritchie; 1984). The feelings associated with activity restrictions seem to differ among reports. However, because many investigators did not comment on the type of bed rest or activity restrictions the women were required to maintain, comparisons across studies are difficult.

In contrast to the current study, women hospitalised and those at home on bed rest with a variety pregnancy complications have reported feelings of loss of control and
powerlessness (Loos & Julius, 1989; McCain & Deatrick, 1994; Schroeder, 1996; Stainton et al., 1995). It is difficult to determine whether these emotions reflect the hospital setting of care (Loos & Julius, 1989; McCain & Deatrick, 1994; Stainton et al., 1995), the amount of bed rest prescribed (Schroeder, 1996), or another unknown variable. Heaman (1992) attempted to differentiate the effects of the setting and compared women with PIH who remained at home with those who stayed in hospital. She reported women who remained at home had lower total mood disturbance scores as well as lower anxiety and depression scores than their hospital counterparts (Heaman, 1992). The women with PIH who remained at home reported mood disturbances and levels of anxiety and depression similar to low risk women (Heaman, 1992). Results of the current study support Heaman’s findings and that keeping women in their familiar home environment may decrease the adverse emotional effects of a high-risk pregnancy. The results also showed that the women with PPROM who remained at home struggled with Rubin’s maternal tasks of normal pregnancy. Perhaps it is the completion of these tasks of pregnancy, enhanced by remaining in their familiar home environment, that decreases the adverse emotional impact of a high risk pregnancy on women and their families.

In the second theme, the women also described struggling with feelings of being maternal by wanting to do what was the best for the baby and while also wanting to do what was best for themselves. The longer the women remained at home the more they wanted their labour to begin to end the waiting and move on with their lives. This struggle is similar to that of hospitalised women as reported by Curry (1987). Curry combined the themes of “wanting pregnancy over for self” and “wanting pregnancy over for fetus” into an overarching theme of “wish for pregnancy to be over”. Feelings of guilt
were associated with wanting the pregnancy to end (Curry, 1987) which are similar to the feelings of selfishness reported by the women in the current study. The feelings of ambivalence regarding delivery in the current study continued throughout the experience and were also reported by the women when their labour began or when an induction was ordered. This struggle is also consistent with Rubin’s description of the pregnant woman’s task of seeking a safe passage for her infant (1976). Rubin reports in the third trimester that women want to end the pregnancy but do not necessarily want to go into labour and deliver (p. 370). This struggle to achieve a balance is also consistent with the description of the maternal task of binding-in to their unknown children. During the third trimester women want their unborn children they just no longer want the pregnancy (Rubin, 1976, p. 373). The wish to end the pregnancy is tempered by the fear for the welfare of the child and for herself, and by the demands involved in the labour and delivery process (Rubin, 1976).

Thus, in the current study, the women’s struggles to achieve a balance are consistent with the normal maternal tasks of pregnancy proposed by Rubin (1976). They are consistent with the tasks of seeking a safe passage for the infant and binding-in to the unknown child. The struggle to achieve a balance with activity restrictions is well documented in the literature for women at home and in hospital. There is some evidence that being at home may decrease the emotional impact of a high risk pregnancy to that of a low risk pregnancy (Heaman, 1992). Findings of the current study support Heaman’s data as the struggles the women with PPROM experienced while remaining at home are similar to those described by Rubin as the maternal tasks of women in a normal
pregnancy. The timing of the tasks may be altered depending on the gestational age at PPROM.

The coping strategies the women used to adapt or move towards living a normal life with PPROM, are also significant findings as they can readily be communicated by health care professionals to women remaining at home with PPROM. In the current study, the women described the physical and psychological support they received from family, friends and health care providers as crucial for them to adapt to their pregnancies with PPROM. Several investigators have tried to link the perceived amount of social support with women’s adaptation to a high risk pregnancy (Ford & Hodnett, 1990; Heaman, 1992). Both studies failed to show any associations between the amount of social support received by the women and their ability to to adapt to hospitalisation in a high risk pregnancy (Ford & Hodnett, 1990); or as a buffer to the effects of negative life events for women with pregnancy induced hypertension (Heaman, 1992). The women in the current study found the support they received from family and friends was crucial for them to adapt to their situation. The women also reported feeling surprised at the amount of support offered to them, suggesting they had more than enough support to meet their needs. Although they required support to adapt to their situations at times the women found the non-stop telephone calls and comments regarding their management irritating and tiresome, suggesting the support offered in addition to a positive effect, could also have a negative effect.

Social support having both positive and negative effects may offer an explanation for why the amount of social support did not help women adapt to hospitalisation or act as a buffer to the effect of negative life events. A minimal level of support was required
by the women in the current study. However, at times support offered by friends and family may have had a negative impact. The women seemed to only want support that would allow them to move towards living a normal life with PPROM. Both a positive and negative aspect of social support has been described by Kirschling, Tilden and Butterfield (1990) in a study of the concept of social support for family members who were caring for a terminally ill relative enrolled in a hospice programme. The authors reported that more social support is not always better. The investigators suggested the degree of support should be evaluated in terms of the extent of reciprocity in the relationships, the costs of the support and the level of conflict (Kirschling et al., 1990).

The physical and psychological support received from others may have assisted the woman to complete the second maternal task of pregnancy, that of having the child accepted by significant others (Rubin, 1976). Rubin reports that during the third trimester the woman’s sensitivity to rejection increases to vulnerability (p.372). Having supportive friends and family members may decrease the vulnerability experienced by women with PPROM and assist them in completing this task while remaining at home.

The women found knowing they were not alone and that others had been through the experience of PPROM and had strong healthy children was helpful and gave them hope. It is this particular reason that many self-help groups are formed. The shared experience creates a feeling of acceptance, understanding and support which in turn create a sense of hope (Rootes & Aanes, 1992). The participants also found having someone to talk to or listen to them was helpful because it allowed them to express their thoughts and feelings and move through the process. This finding is consistent with Stainton et al. (1995) who reported women in a high risk pregnancy found participating in
the research interviews to be therapeutic. This finding is also consistent with reported general benefits of participating in research interviews (Hutchinson, Wilson & Wilson, 1994).

In addition to the support received, the women found that by completing various activities they were able to decrease their frustrations related to their activity limitations. In all of the literature reviewed, women in high risk pregnancies were required to maintain various levels of activity restrictions and thus activity was not always an option for them. To date, investigators have quantitatively studied bed rest compliance in pregnancy through self reports (Josten et al., 1995; Monahan & DeJoseph, 1991). No one has actually followed women to see how their activity levels change over time or how they make the decision to change their activities. Noncompliance with activity restrictions has been associated with feelings of guilt for women (Monahan & DeJoseph, 1991; Schroeder, 1996; Stainton et al. 1995). Maloni (1996), in a review of bed rest for high-risk pregnancy, has advocated for more thought and restraint when prescribing bed rest. Current evidence suggests that bed rest for high risk women has adverse physiological effects on the mother without demonstrated improvements in infant outcome. Although reduced activity levels were encouraged in the current study, the women were given the freedom to make personal decisions about their activities. Involvement in different activities decreased the women’s levels of frustration and allowed them to relax.

The women described a process they used to learn what activities they could and could not do. This learning process involved assessing the amount of amniotic fluid that leaked and whether they experienced any uterine activity during or after the activity.
Although not previously described in the high risk pregnancy research literature, this learning process does have similarities to Bandura’s self-efficacy theory (1977). In this theory, Bandura believes cognitive processes play a prominent role in the acquisition and retention of new behavioural patterns. The theory is based on efficacy expectations or “the conviction that one can successfully execute the behaviour to produce the outcome” (p. 43). Self-efficacy is acquired from four sources of information of which performance accomplishments or past personal experiences are considered the most influential (Bandura, 1977). Thus, the successful completion of one task will enhance self-efficacy for the completion of a subsequent, perhaps more difficult, task. This is similar to the description of the activities completed by the women in the current study. After successfully completing small tasks the women became more adventurous with their activity levels until they reached a point when they no longer felt frustrated with their activity restrictions.

The women were able to decide what they could and could not do by using their self assessment skills to validate continued personal and fetal well being. By validating continued personal and fetal well being, the women were able to justify their activities and reassure themselves and their families that what they were doing was all right. The women usually relied on their personal assessments of well being but were also reassured during their hospital visits when their personal assessments were confirmed. This finding is different from that of Schroeder (1996), who reported that some women maintaining bedrest at home for threatened preterm labour did not like going to their doctor’s appointments because of the increased uterine activity they experienced. Schroeder found that because the women felt they could not refuse to go to their physician visits it resulted
in the women experiencing loss of control. The women in the current study were partners in their care and their opinions regarding their clinical condition were elicited and valued. The women were provided with the knowledge and skills necessary to care for themselves. Support systems were established for the women to answer any questions they had or to discuss concerns. In fact, the women were empowered to care for themselves and assume control over their pregnancies. According to Feste and Anderson (1995), empowerment provides people with an awareness to make informed choices and freedom to choose how to live their lives and be responsible for their choices. Empowerment is also believed to assist people to integrate a chronic disease into their lives (Feste & Anderson, 1995).

All of the women felt that being at home with PPROM was better than being in the hospital. The home environment was reported to be more comfortable and relaxing by the women in the current study corroborating data previously reported by women who participated in an antepartum home care programme (Heaman, Robinson, Thompson & Helewa, 1994). In the current study, the women compared their time at home to the initial time they spent in hospital and described feeling more stressed, tense and anxious in the hospital. The association of stress with hospitalisation has been reported by several investigators (Ford & Hodnett, 1990; Heaman, 1992; Loos & Julius, 1989; White & Ritchie, 1984). Separation from home and family have been ranked as the most stressful components of antepartum hospitalisation (White & Ritchie, 1984) and were the reasons most often stated by the women in the current study for wanting to go home.

Despite decreasing the stress associated with separation from home and family, several investigators have raised concerns that home management would impose
unknown stressors on women especially those related to alterations in the maternal role (Harmon & Barry, 1989; Kemp & Page, 1984). Although the women in the current study felt that being at home was the best situation for themselves and their families, they still had concerns about the effects of PPROM on their children and significant others similar to those reported by Stainton et al., (1995). Although the women continued their mothering role, they often were required to alter or adapt the activities they performed with their children. The ability of the women to continue to maintain family relationships and care for family members during the high-risk experience also was reported by Stainton et al. However, Schroeder (1996), reported that women felt guilty because they were unable to perform their usual roles at home. Guilt related to the maternal role was not reported by the women in the current study. Although the women reported they were unable to perform many of the physical aspects of their role, just being at home and interacting with their families eased their concerns regarding the stress and adverse effects of their situation on other family members. Schroeder’s study differed from the current study by the amount of bed rest which was prescribed, 20 to 24 hours per day. This difference may explain why the women felt guilty because of their severely limited activities.

Investigators have reported increased stress with prolonged hospitalisation (White & Ritchie, 1984), a trend to decreased adaptation with prolonged hospitalisation (Ford & Hodnett, 1990) and higher scores for anxiety and depression in hospitalised women (Heaman, 1992). All of the participants in the present study anticipated a significant amount of mental stress had they required prolonged hospitalisation corroborating the above reports (Ford & Hodnett, 1990; Heaman, 1992; White & Ritchie,
Thus, although the women described many stressors associated with hospitalisation that have been previously reported (Curry, 1987; Ford and Hodnett, 1990; Heaman, 1992; Stainton et al., 1995; White & Ritchie, 1984), their main focus was to describe how being at home helped to ease these stressors and made them feel more comfortable and relaxed. Being at home with PPROM was a difficult experience for the women, even though it was a better experience for them than being in the hospital.

Because antepartum hospitalisation is extremely stressful for women and their families and home management eases their stress, an impetus is provided to develop and implement safe alternatives to hospitalisation.

Movement toward living a normal life with PPROM emerged as the third theme in the experiences of women who remained at home until delivery of their infants. This theme emerged only after the women’s serial interviews were analysed in sequence. It suggests the experience is a dynamic adaptive process that allows the women to cope with the stressors experienced as a result of PPROM occurring in their pregnancy. This process of adaptation has not been previously reported in response to a high-risk pregnancy.

To date, most investigators have focused on the experience or stressors associated with antepartum hospitalisation (Curry, 1987; Ford & Hodnett, 1990; Loos & Julius, 1987; White & Ritchie, 1984), the experience of a high-risk pregnancy (McCain & Deatrick; 1994; Stainton et al., 1995), or women’s experience of bed rest for threatened preterm labour (Monahan & DeJoseph, 1991; Schroeder, 1996). All of the studies but two (Stainton et al., 1995, White & Ritchie, 1984) were cross-sectional in design or collected data at one or two time points during or after the women’s experiences (Curry, 1987;
Ford & Hodnett, 1990; Loos & Julius, 1987; McCain & Deatrick, 1994; Monahan & DeJoseph, 1991; Schroeder, 1996). Thus, as a result of the research design most investigators were unable to comment on the process of adaptation to a high risk pregnancy. Stainton et al., followed women longitudinally from early in pregnancy or soon after delivery to 6 to 12 months postpartum. The sample, however, consisted of women with a variety of maternal or fetal complications of pregnancy and this lack of uniformity of pregnancy complication may have prevented trends for certain patient groups to emerge. Although longitudinal in design, the spacing of a month between interviews may have been too far apart to identify any adaptive processes that the women with acute pregnancy complications may have experienced. In the current study, the women who had not delivered after one month had already showed a movement towards living a normal life with their diagnosis.

Stainton et al. (1995) also reported that the women expressed feelings of fear, loss of control, and being alone with the responsibility for the pregnancy. The women in the current study expressed concerns for their infants and the outcomes of the pregnancy. However, the fear, loss of control and being alone with the responsibility for the pregnancy were not evident. Initially during their short hospital stay the women were alarmed at having ruptured their membranes and felt a loss of control. Once the women went home and assumed responsibility for their fetal and personal well being, the women felt they were doing everything they could to ensure the safety of their pregnancies and were very much in control. Perhaps the women did not express a feeling of being alone with the responsibility because they were in their home environment with support from friends and family and were empowered to care for themselves.
Movement towards living a normal life with PPROM was the essence of the experience described by the women who participated in this study. The emphasis in the current study on one pregnancy complication, PPROM, the longitudinal prospective design, the interview schedule based on the natural history of PPROM and the ambulatory care programme of the current study are unique when compared to published reports. Further research is required to replicate these findings and to determine if similar experiences exist for other pregnancy complications and in other settings.

**Implications for Nursing Practice**

The results of this study have several implications for nurses and other health care professionals who provide antenatal care to women and their families. Implications for nursing practice in the hospital setting and in ambulatory programmes will be discussed.

Several struggles to achieve a balance in their lives have been identified by the women who participated in the current study. Nurses caring for women with PPROM are the ideal care providers to anticipate these struggles and assist the women to cope with the many changes occurring in their lives. The assistance and support received from nurses may ease the transition from a normal pregnancy to a pregnancy with PPROM for the women and their families.

Women identified several coping strategies which helped them to adapt to their pregnancies with PPROM. They described the physical and psychological support received from family and friends as crucial for them to adapt to life with PPROM. They also found talking to someone throughout the experience helped them move through the adaptation process. As well, knowing other women and their families had lived through
the experience of PPROM and had strong healthy children, gave them hope and strength to continue. These strategies are important for nurses to consider and incorporate into any new or existing programmes. Continuity of care provider both in the hospital and ambulatory programmes is required to ensure that the important supportive relationships described by the women are established. A careful assessment of the women and her family regarding the amount and types of support available to the women is required. Because the women found it difficult at times to ask for and accept help, assistance from nurses in linking them with available community supports may be beneficial. Nurses could also be instrumental in the development and initiation of “hot lines” or a support network of women who have experienced similar complications of pregnancy and are willing to volunteer their time to talk to and support other women as they move through the experience. Similar types of support networks are available to women having multiple births and families who have experienced the birth of a preterm infant and have been described by women accessing the support as extremely helpful.

Many of the hospital and ambulatory programmes for women with a variety of pregnancy complications described in the literature advocate bed rest or limited activities. Women have reported that maintaining activity restrictions is difficult and frustrating (Josten et al., 1995; Monahan & DeJoseph, 1991). As a result, bed rest may exacerbate anxiety or depression or not provide the women with the opportunity to use their usual coping mechanisms to alleviate these feelings (Heaman, 1992; Loos & Julius, 1987; Maloni, 1996; Monahan & DeJoseph, 1991). Nurses providing antenatal care should be aware that activity restrictions may lead to anxiety and depression. Further, at present there is no empirical evidence to demonstrate improved neonatal outcomes with maternal
bed rest. Thus, nurses need to critically analyse the literature on bed rest and pregnancy complications and develop educational programmes that will provide women with the knowledge and skills necessary to make informed decisions regarding their activity levels. Feelings of anxiety or depression could potentially be decreased by exploring with the women possible alternative activities in which they could engage. As well, nurses should discuss with patients the process other women have used to determine which activities they could or could not do and how to adapt to life with PPROM.

Empowering women to care for themselves and their infants helped the women in the current study to adapt to their situation at home. Empowerment means providing women with the knowledge and skills necessary to make informed decisions about their care. Nurses are the ideal health care providers to empower women. Nurses have extensive patient contact and while caring for these women can provide them with the knowledge and skills necessary for them to make informed choices about their care. Although empowerment is crucial for women who remain at home, not all women experiencing pregnancy complications will be eligible for ambulatory care. Women who must remain in hospital should also be empowered to care for themselves and their unborn children as much as possible and thus retain control over their pregnancies. Nurses could develop and initiate innovative inpatient programmes that promote self care. Self-care programmes will allow the women to develop their own routines, to adapt gradually to an appropriate activity level for themselves, and ultimately to assist them to maintain control of their pregnancies.

The investigators studying the effects of antenatal hospitalisation for women with pregnancy complications and their families have overwhelmingly concluded that
hospitalisation is stressful for the entire family (Ford & Hodnett, 1990; Heaman, 1992; White & Ritchie, 1984). Although the women found being at home better than being in the hospital, having PPROM was still a difficult experience. Thus, as ambulatory programmes are being developed, care must be taken to ensure they reflect the expressed needs of antenatal women. Because nurses will be providing much of the care to women who remain at home, they are the ideal care givers to initiate comprehensive programme evaluations and/or ensure they occur. Comprehensive programme evaluations are necessary to ensure the programmes continue to meet the expressed needs of women and their families.

The women made it clear that they felt being at home with PPROM was better than being in the hospital. At the present time, there are only a few centres that provide outpatient care to women with PPROM. The safety of managing women with PPROM as outpatients has not been established from a scientific perspective, nor has the efficacy of hospitalisation for PPROM. Thus, women should be empowered to choose the setting that will meet their needs, understanding the risk and benefits and the supports in the community and hospital available to them should the need arise. Ambulatory programmes only will be successful if they are able to meet the expressed needs of the women and thus must be evaluated on an ongoing basis. Nurses must become involved in the development of alternatives to hospitalisation because of their holistic approach to patient care as well as their ability to critically analyse the available literature and develop evidence based protocols.

In summary, as more ambulatory programmes are developed, many exciting opportunities are available for nurses. Nurses must become involved in the assessment
and discharge planning of women which includes ambulatory care. This step is crucial to ease the transition for women and their families from an inpatient environment to ambulatory care. Experienced perinatal nurses are the ideal caregivers to follow and support women who remain at home and act as a liaison with other inpatient and ambulatory services. The awareness of the struggles experienced by women and their families and the strategies they used to cope with their situation will provide a framework for ongoing assessments and interventions. Empowering women to care for themselves and become partners in their care will be rewarding for nurses and also could positively influence job satisfaction.

**Future Research**

The results of the current study have implications for future research. In this study, the women described methods they used to adapt to their situation. Previous research reports mainly have focused on the stressors associated with high-risk pregnancy and antenatal hospitalisation. Anecdotal reports of what women found helpful or speculations by the researchers as to what could help ease the stressors for the women are available. Further research regarding the methods women use to cope with their diagnosis of PPROM as well as other complications of pregnancy is required.

Many caregivers continue to prescribe bed rest and often hospitalisation for women with a high-risk pregnancy. However, there is a lack of evidence supporting improved infant outcomes with bed rest in pregnancy. Further, Maloni (1996) in a review described many adverse physiological effects for women as a result of bed rest. Research regarding the effects of setting (home versus hospital) and treatment programme (bed rest versus activity limitations) for various pregnancy complications are required. In addition
to maternal and fetal outcomes, compliance with activity restrictions and changes in activity level that occur over time should be addressed.

The women in the current study did not report feeling a loss of control or powerless as was reported by other investigators who followed women with a variety of pregnancy complications in hospital (Curry, 1987; Loos & Julius, 1987; McCain & Deatrick, 1994; Stainton et al., 1995) or with threatened preterm labour at home (Schroeder, 1996). This may be due to the women being empowered to care for themselves and their infants. Further research is necessary to determine which components of inpatient or ambulatory care promote positive patient experiences. Whether a relationship exists with these components and the concept of empowerment would also be important to investigate.

In addition to gaining an understanding about women who remain at home with PPROM, many questions for further research were generated from this project. The design of the study allowed rich data to be produced about women who remained at home with the pregnancy complication of PPROM. The women moved toward living a normal life with PPROM. Although this adaptive process has not been previously described in relation to high risk pregnancy, some of the struggles described by the women are similar to the maternal tasks of normal pregnancy proposed by Rubin (1976). Further research with a longitudinal design is required to expand upon the present findings. These may include studies to: determine if this adaptive process is present for other complications of pregnancy; determine the effects of a home or hospital setting, and further explore the relationships with Rubin’s maternal tasks of pregnancy.
Information from the current study will assist other centres which are developing antenatal ambulatory programmes for women with pregnancy complications. In order for programmes to be successful they must reflect the expressed needs of antenatal women. As more programmes are developed more research must be done to further the understanding of women’s experiences with high-risk pregnancies. These data then must be used to modify existing programmes to provide the optimum care to women and their families.

Concluding Statement

The purpose of this study was to describe the lived experience of women with PPROM who remained at home until delivery of their infants. Three dominant themes emerged. The first theme, “feeling overwhelmed at the initial diagnosis”, described the women’s initial response to the diagnosis of PPROM and the resulting effects on many aspects of their lives. The second theme, “the struggle to achieve a balance”, explored the struggles the women experienced with their activity restrictions and how they attempted to balance what was best for their unborn babies with what was best for themselves. The third theme, “movement towards living a normal life” illustrates the dynamic adaptive process the women used to incorporate their diagnosis into their lives. This process had two main components which were described as subthemes. The first subtheme, “the importance of support”, described the types of support the women found helpful or not so helpful while adapting to their situation at home. The second subtheme, “becoming an expert knower”, provided insight into the process the women used to assess the well being of themselves and their unborn infants while at home, and then how this information was used to make decisions about their activity level. The women’s
descriptions of their experiences have helped to further an understanding and provided insight into the experience of being at home with PPROM. This information is crucial to care for these women and to develop and implement outpatient programmes that meet their expressed needs.
REFERENCES


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APPENDIX A

Introduction of the Study to be Used by the Research Assistant
When Approaching Mothers

There is a study being conducted by a registered nurse who is a graduate student from the University of Toronto, about the experience of women with preterm prelabour rupture of membranes (PPROM) who remain at home until delivery of their baby. There are two main reasons why the study is being conducted. The first is to gain an in-depth insight and understanding about the experience for the women. The second is to use this understanding and insight in the planning and development of home support services that reflect the needs of women. Your physician has determined that you are eligible to go home and be followed through the Obstetrical Day Unit.

Marilynne Oskamp is the nurse who is conducting the study and would like to have the opportunity to tell you more about it. Your decision is voluntary and, by agreeing to learn more about the study this does not mean you have agreed to participate, only to hear what the study involves. It is important that you know your decision will in no way affect the care you or your baby receive.

Would you be willing to learn more about this study? Could I give Marilynne your name and room number so she can visit you and explain her study in more detail?

If the woman agrees, please inform her that I will come to see her as soon as possible.

Name of woman:

Room #:

If the woman declines, please thank her for her time in listening to your explanation about the study.
APPENDIX B
Information Sheet

Title of Research Project: The lived experience of women with preterm prelabour rupture of the membranes who remain at home until delivery of their infant.

Investigator: Marilynne Oskamp RN, BScN
Telephone #: (416) 203-1559

University of Toronto Supervisor:
Patricia Petryshen, RN, PhD
Assistant Professor
Graduate Department of Nursing,
University of Toronto
Program Director Nursing, Perinatology
Mount Sinai Hospital
Telephone #: (416) 586-5077

Purpose of the Research:

My name is Marilynne Oskamp and I am a registered nurse and a graduate student with the Faculty of Nursing at the University of Toronto. I am presently doing a study to understand more about the experience of women with preterm prelabour rupture of membranes who remain at home until delivery of their baby. It is hoped that the results of this study will be used in the planning and development of home support services that reflect the needs and concerns of these women.

Procedure:

Taking part in this study will involve a series of interviews to be arranged at a time convenient to you and your family, lasting about 45 minutes each. The interviews will occur in your home on discharge day 2 (the day after you leave the hospital), discharge days 5, 8, 13, and then weekly until you deliver. Interviews in your home will stop as soon as you deliver. Thus you may only have one or two interviews at home. In order to incorporate into the study your experience leading to delivery of your baby, a final interview will occur following your baby’s birth while you are still in the hospital. This interview will occur in a private room or office to maintain confidentiality. Also, in order to accurately describe the characteristics of the women whose perspective I am reporting, I would like to ask you some general questions about yourself which you may or may not choose to answer. There are no right or wrong answers to any of my questions. I am simply trying to understand how you think and feel about the experience. I would also like to contact you following the data analysis of all the participants to review the descriptions I have generated to confirm that it reflects your experience. This
may occur several months following the delivery of your baby. In the final report you will not be personally identified, however, you may recognize your own words in examples used to illustrate the experience.

To accurately record everything you will share with me, I would like your permission to audio-tape the interviews. All tape recordings will be transcribed by myself following the interview. A code number will be assigned to you and be used to identify the tapes, the transcriptions and any other information collected about you to maintain confidentiality.

**Risks/Benefits:**

There are no anticipated risks to you or your baby by participating in the study. There are also no direct benefits to you from participating however, you may find having the opportunity to discuss your experience helpful. By sharing your experiences with me it is hoped that programs being developed for women with PPROM will reflect the needs that you and the other participants address.

**Voluntary Nature of Participation**

It is important that you realize your participation is your choice. Your decision to participate, or not to participate, will in no way affect the care you or your baby receive now or in the future. Should you agree to participate you are free to withdraw from the study at any time and, I will ask for your verbal consent prior to each interview to confirm your continued participation.
APPENDIX C

Consent Form

**Title of Research Project:** The lived experience of women with preterm premature rupture of the membranes who remain at home until delivery of their infant.

**Investigator:** Marilynne Oskamp RN, BScN
Telephone #: (416) 203-1559

**University of Toronto Supervisor:**
Patricia Petryshen, RN, PhD
Assistant Professor
Graduate Department of Nursing,
University of Toronto,
Program Director Nursing, Perinatology
Mount Sinai Hospital
Telephone #: (416) 586-5077

I __________________________ acknowledge that the research study described on the attached form and of which I have a copy has been explained to me by Marilynne Oskamp. She has answered any questions I have asked to my satisfaction. I understand that my participation is voluntary and that there are no anticipated risks or direct benefits to me by participating. I know that I may contact Marilynne at the above telephone number should I have any questions concerning this research study now or in the future. I have been assured that all information I disclose will be kept confidential and that no information will be printed that would personally identify me.

I understand that I am free to withdraw from the study at any time and that this decision will in no way affect the care I or my baby receives.

I hereby consent to participate in the above named study. I agree to have the series of interviews audio-taped. Yes ____ No ____

Name of Participant (please print) __________________________ Name of Witness (please print) __________________________

Signature of Participant __________________________ Signature of Witness __________________________

Date ___________ Date ___________
APPENDIX D
Interview Schedule

Women recruited to the Study
(those who meet the inclusion criteria)

Discharge Day 1: Women are discharged from hospital to home

Discharge Day 2: First Interview in participant’s home

Discharge Day 5: Second interview in participant’s home

Discharge Day 8: Third interview will in participant’s home

Discharge Day 13: Fourth interview in participant’s home

Discharge Day 20: Fifth interview in participant’s home

Note: Twenty days after discharge, interviews will occur every
7 days until delivery (e.g., day 27, day 34...)

Following delivery the final interview will be completed in hospital.
APPENDIX E
Demographic Data Sheet

Participant’s Code Number: 

Maternal Data:
 Age: 
 Marital Status: 
 Education: 
 Occupation: 
 Parity: 
 OB History (if relevant): 
 EDC: 
 Date diagnosed with PPROM: 
 Gestational age at PPROM: 
 Date delivered: 
 Days spent at home: 

Infant Data:
 Gestational age at birth: 
 Apgar scores: 
 Birthweight: 
 Immediate Neonatal Course: 


APPENDIX F
Interview Guide

First Interview:
Describe what it has been like for you since you have been at home.

Second and Subsequent Pre-delivery Interviews
Since our last interview, describe what it has been like for you being at home.

If required: How do you feel about what has happened?

Post-Delivery Interview
Describe your experiences leading up the delivery of your infant.

Given the overall experience, is there anything else about the experience that you would like to share?
## APPENDIX G

### Fieldnote Guide

**General Setting:** Describe the general setting (i.e., house or apartment, general neighbourhood, proximity to hospital(s), number of staircases, general layout of the dwelling, access to washroom, telephone).

**Specific Setting:** Describe the room where the interview took place. Were there any distractions (e.g., TV playing, animals, street noises)?

Describe any attempts that were made to make it easier for the woman to maintain activity restrictions.

Who was in the woman’s home at the time of the interview?

**Mood:** Describe the woman’s mood at the beginning of the interview.

Describe the woman’s mood at the end of the interview.

Was there any body language that influenced your response to the situation?

Were you aware of any of your own body language which may have influenced the woman’s response?

**Other:** Describe any other pertinent observations made regarding the interview.