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The Best and Worst Time of My Life: The Lived Experience and Meaning of Pregnancy in Women with Mild to Moderate Depression

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ABSTRACT: The notion that pregnancy can, for some women, be a time of unhappiness and depression has only recently been recognized in media and by the general public. Although researchers and clinicians have begun to study antenatal depression with regards to prevalence, associated factors, and treatment approaches and outcomes, less is known about women's lived experience of this phenomenon. A hermeneutic phenomenological study was conducted with six pregnant women who scored 10, 11, or 12 on the Edinburgh Postnatal Depression Scale, indicating mild to moderate symptoms of depression. Participants were interviewed individually regarding their experiences of depression during pregnancy. Data generated in the form of transcripts were analyzed and five themes emerged: disconnection vs. new connection and/or reconnection; loss of identity vs. new identity; fatigue and illness vs. vitality and wellness; anxiety and insecurity vs. confidence and security; and sadness and hopelessness vs. joy and expectation. The overarching shared meaning of these experiences was ambivalence. Findings provided rich, thick descriptions of the lived experience and meaning of antenatal depression. Future research and implications for counseling practice are discussed.

KEY WORDS: Pregnancy, antenatal depression, qualitative, ambivalence, lived experience, lived meaning.

INTRODUCTION

Pregnancy is often thought of as a joyous time, and for many women it is, but for some women, pregnancy is filled with unhappiness, hopelessness, and depression. Recent media attention has captured the most sensational cases of depression during

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pregnancy and postpartum. In the United States, media frenzy occurred when Andrea Yates drowned her five children in the bathtub (Houston Chronicle, 2006). In Canada, Suzanne Killinger-Johnson threw herself and her baby in front of a moving subway train (Mahar-Sylvestre, 2001). Both cases may have brought some awareness to postpartum depression; however, far more attention was paid to the sensationalized aspects of these cases than to the women's experiences leading up to these incidents.

Though postpartum depression has become a more recognized diagnosis due to recent coverage in media, depression during pregnancy, or antenatal depression, has remained poorly understood among the general population and the health and mental health care systems. Though antenatal depression is not differentiated from other forms of depression in the DSM-IV, it is unique because of the context in which it takes place, and the effects that it can have on the mother and fetus (Stewart, 2005).

Most women who are depressed during pregnancy and/or postpartum face depression in their everyday lives without proper identification and treatment (Marcus, Flynn, Blow, & Barry, 2003). However, researchers and clinicians have now begun to pay attention to antenatal depression as evidenced by reports related to diagnostic issues, prevalence, and factors associated with the condition (e.g., Bowen, Stewart, Baetz, & Muhajarine, 2009; Bennett, Einarson, Taddio, Koren, & Einarson, 2004; Marcus et. al., 2003). Still, the lived experiences of these women have very rarely been studied, leaving their voices unheard. To address this oversight, a hermeneutic phenomenological method was used to answer the following questions: What is the lived experience of pregnancy for women with mild to moderate depression? What is the lived meaning of pregnancy for women with mild to moderate depression?

BACKGROUND

Antenatal depression can be defined as major depressive disorder occurring during pregnancy. If the criteria for the diagnosis of major depressive disorder are met, and the woman is pregnant, her condition would be described as antenatal depression to reflect both the disorder and the context.

Prevalence

Bennett, Einarson, Taddio, Koren, and Einarson's (2004)

systematic review of antenatal depression provided the most comprehensive information to date regarding prevalence. They found that of the 21 articles from around the world that fit the study criteria, prevalence rates of antenatal depression varied greatly. With a confidence interval of 95% average prevalence rates of antenatal depression among the general population of pregnant women were 7.4% in their first trimester, 12.8% in the second trimester, 12.0% in the third trimester.

Associated Risk Factors

Many of the associated risk factors for antenatal depression are related to women's circumstances or surroundings along with something organic in nature. These factors include: (1) relationships, (2) financial situation, (3) educational history, and (4) employment.

Women who are unmarried, recently divorced, or have recently lost an intimate relationship have higher rates of antenatal depression. In Brazil, Lovisi, Lopes, Coutinho, & Patel (2005) researched 230 women in their third trimester comparing demographic, social, and medical information with scores on the Composite International Diagnostic Interview. Analysis revealed that divorced women and women who experienced the loss of an intimate relationship had higher scores on the depression scale. Marcus and associates (2003) found that unmarried women were at greater risk for antenatal depression in their study of 3,472 women.

Poverty and factors generally associated with poverty, such as unemployment and low educational attainment are related to antenatal depression. Rubertsson, Wickberg, Gustavsson, & Radestad (2005) found that unemployment was associated with higher scores on the EPDS in their Swedish sample of 2,430 pregnant women. Marcus and associates (2003) and Lovisi and associates (2005) found that education levels are related to antenatal depression. Lower levels of education were found to be a risk factor for antenatal depression (Marcus, et. al., 2003), while attaining levels of education higher than elementary school were found to be protective against antenatal depression (Lovisi, et. al., 2005).

Experiences of Pregnancy

Studies of pregnancy designed to include the pregnant woman's perspective provided a backdrop for this project. Though these qualitative inquiries are not exploring depression in pregnancy, they offer deeper knowledge about the lived experience of pregnancy among

a variety of populations and circumstances, as well as an examination of women's experiences in contrast to dominant, socially constructed notions of pregnancy and motherhood.

Armstrong and Pooley's (2005) phenomenological study was conducted to explore the lived experience of pregnancy with a focus on experiences of support. Analysis of the interviews conducted with 13 pregnant women revealed six themes: (1) support during pregnancy, including the experience of being supported, lack of support, barriers to support, and ideal support; (2) experience of pregnancy, including positive and negative experiences, mixed feelings about the pregnancy, and spiritual experiences; (3) finding information; (4) changing values; (5) model of care; and, (6) being responsible. Their findings also suggested that support and guidance may improve the women's experience of pregnancy.

Belgaumkar (2001) interviewed six women from Saskatchewan, ranging in age from 15-21 to explore adolescent women's perceptions of social support during pregnancy and post partum. Analysis revealed an overreaching theme of the importance of "not being alone." Five interrelated constructs contributed to their feelings of not being alone: (1) social networks; (2) social and personal identities; (3) experiences of support as a give and take process of exchange; (4) conflict as part of social interaction; and, (5) the importance of valuing and feeling valued within their relationships. Belgaumkar's study also acknowledged the importance of the women's own appraisals of social support, rather than relying on a standardized measure of a predetermined definition of social support.

Leichtentritt, Blumenthal, Elyassi, and Rotmensch (2005) conducted 10 focus groups with Israeli women who were hospitalized due to high-risk pregnancy with the intention of understanding the lived experience of hospitalization due to high-risk pregnancy. Analysis yielded five themes: (1) the desire and social pressure to nurture; (2) the personal and social meaning of family; (3) the loss of experiences of childbearing and of normal life activities; (4) the conflict between a woman's needs and the well-being of the fetus; and (5) sources of strength and sources of stress. An overarching theme of ambivalence was found between the feelings and experiences of the women and their perception of social norms and expectations. This research included the context in which the women lived, recognizing how the influence of culture, religion, and gendered norms impact a women's experience of pregnancy. The inclusion of context provides a more critical analysis of the everyday experience of pregnancy because it acknowledges the role societal norms and expectations play in a

woman's experience.

Houvouras (2006) suggested that dominant notions of reproduction that view pregnancy and childbirth simply as physical processes that take place in women's bodies are limited because they ignore the non-physical components of these processes. Houvouras interviewed 15 women about their conceptualizations of childbearing and found that the participants constructed their childbearing experiences as taking place in multiple locations: (1) within the female body; (2) within both the female body and a non-physical realm (e.g., emotional realm) of one or both partners; (3) detached from any particular location; and (4) within both partners bodies. Houvouras's research acknowledged that notions of pregnancy are socially constructed and noted how dominant constructions of pregnancy and childbirth, which are located in a physical realm, ignore women's own constructions of these experiences.

Rudolfsdottir (2000) investigated how healthcare discourses affect the experiences of pregnant women by analyzing medical discourses in handouts and booklets readily available to pregnant women, as well as young women's own accounts of pregnancy and motherhood. Analysis of the healthcare literature revealed four themes which Rudolfsdottir called strategies used for minimizing the agency of pregnant women: (1) the detached body; (2) emphasis on emotional instability; (3) pregnant women and new mothers infantilized; and (4) the fetus as subject. She found a contrast in the women's experiences of pregnancy and childbirth as well as criticism of the literature to which they were exposed. She found that the women who had positive pregnancy and birthing experiences placed themselves centrally in their experience, rather than their bodies, the interventions done, or the fetus as separate from themselves, thus recognizing their own agency. Women who had negative experiences attributed the experience to not being seen as autonomous agents. They felt that they had been treated as patients or children or simply as physical bodies without awareness of what was happening. Rudolfsdottir`s research suggested that the removal of a woman's agency had a negative impact on her experiences of pregnancy and childbirth. This illustrates how social discourses can have a negative impact on a seemingly natural experience.

Social Construction of Pregnancy and Motherhood

These studies suggest that, although pregnancy and childbirth are naturally occurring phenomena, they occur within a social context that creates expectations and parameters that are not inherently found in

the experience. These expectations and parameters are the socially constructed elements of an experience. In addition to social constructions of pregnancy and birth, there are constructions of motherhood. Woollett and Boyle (2000) described a social construction of motherhood in their editorial introduction to a special issue on motherhood:

> Motherhood is constituted as compulsory, normal, and natural for women, for their adult identities and personal development, and is regulated through binary oppositions in which the warm, caring and `good` mother is contrasted with 'bad' mothers, selfish, childless, and career women, and empty and deficient infertile women. (p. 309).

They continue with a description of the appropriate parameters in which motherhood should take place. These parameters include women who are married, heterosexual, economically stable, able-bodied, and are not too young or too old.

> After researching the social construction of motherhood, Hays (as cited in Arendell, 2000) coined the term intensive mothering to describe the dominant expectations of motherhood in North America. According to this ideology, mothers are the ideal, preferred caretakers of children. Intensive mothering is expert guided, emotionally absorbing, and labor intensive. Arendell (2000) interprets the mother in this type of mothering as being devoted to the care of others, self-sacrificing, without needs and interests, and the "good" mother. These requirements are based on a social construction of the ideal family, which is comprised of a heterosexual, middle-class couple (Medina & Magnuson, 2009). Thus, women who do not wholly fulfill this role are not good mothers.

A review of the literature identified a substantial body of quantitative research regarding diagnostic issues, prevalence, and associated factors of antenatal depression. Qualitative inquiries have examined the lived experience of pregnancy in general and extraordinary circumstances but have not explored women's lived experience and meaning of pregnancy with depression. Women's perspectives of pregnancy and childbirth in contrast to dominant notions of these experiences, along with analysis of the social construction of motherhood provide a context for inquiries about childbearing.

METHOD

Participants

Six women were recruited for participation in the study. Access to participants was gained through the larger quantitative study, "Feelings in Pregnancy and Motherhood." The criteria used in selection of the six participants were to ensure that the information provided was rich and full in description and free from circumstances which may cause unnecessary distress to the participant. Participants were pregnant; self-identified as having never lost a child; and scored 10, 11, or 12 on the Edinburgh Postnatal Depression Scale, indicating mild to moderate symptoms of depression.

Many depression inventories are inadequate in identifying depression in pre and postnatal women. Items on these scales are closely associated with the somatic features of pregnancy and postpartum (weight gain or loss, fatigue). However, the Edinburgh Postnatal Depression Scale (EPDS) excludes these physical symptoms of pregnancy as indicators of depression. This scale was designed to assess depression specifically in women in the postpartum phase. It identifies depression in postpartum women better than other inventories because of its sensitivities to the physical symptoms of pregnancy (APA, 2000). The EPDS has also been validated in antenatal populations (Murray & Cox, 1990) and across a variety of languages and ethnic populations (e.g., Adouard, Glangeaud-Freudenthal & Golse, 2005; Gausia, Fisher, Algin, & Oosthuisen, 2007; Mazhari & Nakhaee, 2007).

The six women ranged in age from 23 to 33 years old. This was the first pregnancy for four of the participants, the second pregnancy for one participant, and the fourth pregnancy for one participant. One of the pregnancies was unplanned. All of the women were in committed, long-term relationships with the father of their child. Four of the women were married and two were engaged to be married.

Levels of education varied from obtaining a high school diploma being the highest level of education attained for two participants, Bachelor degrees for two participants, and two participants were working on their Master's degrees. Four of the participants were working full-time at the time of the interview and two were employed part-time. The financial status of the participants ranged from less than $20,000 per year to more than $60,000 per year.

Four of the participants were living with their partners (and children) full-time. One of the participants lived with her fiancé part-

time, as her fiancé worked away from home. One participant was living alone while her partner was in another province in the Armed Forces. Four of the participants owned their own home.

Data Generation

One interview was conducted with each woman. Interviews ranged in time from 45 minutes to 90 minutes. Interviews questions were guided by Max van Manen's lifeworld existentials: corporeality (lived body), relationality (lived relationship), temporality (lived time), and spatiality (lived space). Though van Manen's lifeworld existentials are generally used as an analytical framework (van Manen, 1990), they were used as an exploratory tool in this study. The guided interview was designed to facilitate about the four lifeworld existentials as a way of encouraging the participants to reflect on and express all aspects of their experience. Reflecting on their experience through the lenses of corporeality, relationality, temporality, and spatiality provided a more complete or holistic account of the experience and meaning of pregnancy for the women in this study. Interviews were audio recorded for purposes of transcription and analysis.

Thematic Analysis

Analysis of the transcripts was completed using van Manen's (1990) three approaches to thematic analysis of text. First is the holistic or sententious approach. This approach involves reading larger sections of text and determining broad, overarching themes. The second approach is called the selective or highlighting approach. This approach involves the researcher attending to pieces of text which stand out, or pieces of text, which seem to be repeated, and determining the themes of these important sections of the text. The third approach is called the detailed or line-by-line approach. In this approach the researcher attends to each individual line of the text and pulls specific themes from each line. All three of these approaches were used to create a comprehensive thematic analysis from which an overarching shared meaning and five sub-themes emerged.

RESULTS

Shared Meaning: Ambivalence

"It was the best and worst time of my life."

All of the women described experiences that seemed dissonant. They described both positive experiences and negative experiences. Of course, human experiences are complex and, therefore, are rarely completely positive or negative, but this seemed more significant than the usual good and bad parts of life. Instead, the positive and negative experiences were connected to each other and became one whole dissonant experience resulting in ambivalence about their experiences.

Further analysis uncovered sub-themes of dissonant experiences. These five themes are distinct enough to stand as categories; however, they are strongly interconnected with each other and with the shared meaning of ambivalence. These themes include: (1) Disconnection versus New Connection and/or Reconnection; (2) Loss of Identity versus Newfound Identity; (3) Fatigue and Illness versus Vitality and Wellness; (4) Anxiety and Insecurity versus Confidence and Security; and (5) Sadness and Hopelessness versus Joy and Expectation.

These dissonant sub-themes are presented and described as a conflict structure (i.e., versus) because these experiences appeared to have a push-pull affect on the participants. The words dissonance and ambivalence, rather than dichotomous or contradictory, are used because the relationship is not only one of conflict, but rather mutual in that the push-pull creates a transformative experience. Thus the experiences of two seemingly separate phenomena become one complex experience.

Theme 1 – Disconnection Versus New Connection and/or Reconnection. All of the participants experienced a sense of disconnection and new connection or renewed connection during their pregnancy, although they varied in who they experienced disconnection or new connection with.

Chloe illustrated this theme when she discussed the disconnection she felt from her parents upon telling them she was pregnant:

> *So, with my parents, I feel a lot more alienated from them. I feel like they don't, like I don't have their approval or acceptance for it. So that's kind of a barrier, like when I told them, they both just stood there like a deer in the headlights and then we didn't talk*

> *about it again for days. And you know, they live in Ontario and I was there visiting for a week. Like we went just to tell them and it just got kind of dropped and ignored, so that kind of made me feel ashamed about the whole thing. I started questioning myself. So that's kind of made me feel a bit of a separation from them.*

Chloe experienced disconnection from her parents when their response was different than she had expected. However, she felt a new connection with her mother as she was about to become a mother herself:

> *I know it gives me a better understanding of why my mom treated me the way she treated me my whole life. And that was very good. And she was very overprotective and just always really worried about me and I used to get so annoyed by that because I was like, stop worrying about me… But now that I have a daughter, it's terrifying. Like every time I feel a little bit of a twinge or a cramp, I immediately go into that mother mode… And so, now I understand and I don't think I ever understood that capacity to love another person, so I appreciate how much my Mom loves me now because I know how much I love my child and it's not even born yet.*

Like Chloe, all of the participants experienced disconnection and connection with various individuals in their lives. Experiences of disconnection often resulted in feelings of loss, lack of support, isolation, and guilt. Connection and reconnection created feelings of support, love, intimacy, and solidarity. Though the new and renewed connections may have created some balance for the negative feelings associated with disconnection, we cannot assume that either of these experiences was dominant in all or any of the participants. The simple fact that each of the participants described both phenomena suggests that disconnection and connection were important experiences in their pregnancies.

Theme 2 – Loss of Identity Versus Newfound Identity. The four participants who were to be mothers for the first time experienced a loss of identity and a newfound identity. The two participants who were already mothers did not talk about this experience and I did not ask them about it as this theme emerged after data was collected. The four participants who were expecting their first child experienced a loss of identity. They had some understanding of how their life was changing with pregnancy and how it was about to change with the

birth of their first child. For some, it was the loss of their roles in their career. For others, the sense of loss was regarding their individuality. However, they also sensed new identities and roles for themselves. The expected new role of mother brought mixed feelings in terms of excitement and overwhelm. Some of the participants described this new role in terms of a fantasy. Some recognized the overwhelming sense of responsibility. Others thought about the kind of mother they would like to be.

Daphne illustrated this theme when discussing the changes in her career path as she was about to become a mother:

> *All of a sudden it was like, ok it's never going to be just about me anymore. And now I am completely fine with that, but just for that first stage. And then starting to wonder career-wise, and things that I haven't done yet. Ok, I haven't traveled as much as I wanted to maybe. And a promotion came up at work that's going to involve a lot of national travel and I started to think about maybe not… maybe holding off on trying to get pregnant to explore this job for a year or two and see how that went. Then I found out I was pregnant and went, oh ok I guess… and now I'm still going to interview for the job and can still do it, but obviously it is going to change things because I'll only be able to do it for maybe a year instead of two if I'm on mat leave. So I think that too, that was part of me being selfish… because all of a sudden it's real.*

The loss of identity and experience of finding a new identity speaks to the significance of the transition these first time expectant mothers were experiencing. The recognition of their new responsibilities, sacrifices, and loss of autonomy brought feelings of discomfort and grief and consequently guilt; however, all of the women were simultaneously experiencing a sense of newfound identity as mothers. Though this was scary and unknown, the women prepared to integrate this new role into their identity by sorting through knowledge gained through their own experiences of being parented, literature, and societal norms.

Theme 3 – Fatigue and Illness Versus Vitality and Wellness. All of the participants experienced exhaustion, fatigue, nausea, and vomiting in their pregnancy. The shear volume of data gathered regarding these experiences speaks to the significance of them. These experiences played a large role in how the women felt physically and emotionally during their pregnancies. Chloe had an understanding of

the connection between her physical health and her emotional well-being:

> *Really, really rotten and just constantly felt like I was sick and felt like I had stomach flu for three solid months and didn't want get off the couch and didn't want to go outside…And I think that when you feel that way, like your body is really sick then it makes your mind… it's really hard on your emotional state too.*

In contrast, the participants described experiences of wellness and vitality even within their periods of fatigue and illness. For some, this was experienced as a newfound energy. Others noticed changes in their bodies that they felt were symbolic of wellness. Taking better care of their bodies during pregnancy seemed to account for some of this vitality and wellness, but Chloe described this experience as something new, something that she had not experienced previous to becoming pregnant and therefore attributed the experience to pregnancy:

> *I feel very… I don't know the word. Alive!.. It's the difference of looking at a black and white TV versus a color TV. And I feel that before everything about me was just a black and white TV. You know, it was fine, there was nothing wrong with it, but now it's like everything is so much more vibrant and I feel like my body is this amazing machine that's doing this amazing thing and it's just so much more exciting now. It changes every single day. So that's really exciting.*

Though all of the participants experienced fatigue and physical illness, they noticed a new level of energy that they had not experienced before. This energy and wellness was described both in terms of physical wellness (i.e., nail and hair growth, vigor) and psychological wellness (i.e., alertness, receptivity, and zest). The awareness of these changes seemed to also create a sense of awe about their bodies.

Theme 4 – Anxiety and Insecurity Versus Confidence and Security. The participants described feelings of anxiety and insecurity that they attributed to pregnancy; however, they also found that pregnancy brought a new sense of confidence and security. Some of the anxious experiences were about their changing bodies and the resulting insecurities about their relationships. Uncertainty about their own health and the health of their babies also caused anxiety for some of

the women.

Alison talked about the anxiety she felt about her parents' reaction to her unplanned pregnancy:

> *Yeah just because my image in their minds I still feel like I'm 17 and you know, so the fact that I'm getting married… That's another thing, like whoa, she's getting married while she's… she's so young.*

Though Alison was 24 years old when she became pregnant, she described feeling like a pregnant teenager. On one hand, pregnancy made her feel young and insecure, but on the other hand pregnancy became a catalyst for asserting herself about her choices. Alison expressed this new assertiveness when describing an ongoing conflict she has had with her parents about her fiancé being in the army.

> *Yeah it [pregnancy] has changed it [relationship with her parents]. Umm, pregnancy is/was a truth kind of. Like, no this is the way it's got to be now. Like I don't care what you think of the military or your political views or whatever, you know. That is just the way it's going to be now.*

All of the participants experienced forms of anxiety and insecurity related to their pregnancy. For some, it was the changes in their bodies, particularly gaining weight that made them feel insecure about themselves and in their relationships with their partners. For some, the possibility of complications and miscarriage and the uncertainty of what pregnancy would bring created vulnerability and anxiety. However, all of the participants gained a newfound confidence and security. A few of the participants expressed a satisfaction with their growing bodies. Some participants found purpose through being pregnant. An appreciation for their purpose and worth along with a protective feeling for their babies led to confidence and assertiveness in their relationships.

Theme 5 – Sadness and Hopelessness Versus Joy and Expectation. The women experienced feelings of sadness and hopelessness during their pregnancy. They also felt feelings of joy and expectation about their pregnancy and becoming a mother. All of the participants experienced periods of sadness and hopelessness. All of them attributed some of this to the nausea and vomiting they were experiencing in the pregnancy. They were acutely aware of the connection between their emotions and the physical sensations in

their bodies. They described how feeling nauseous caused feelings of sadness and low mood and how in turn their low mood intensified their feelings of exhaustion. Fallon illustrated this connection between her body and mood:

> *I just felt down everyday. Felt gross and like what am I doing? You know, this is not fun. You always hear the stories, Oh pregnancy is so much fun and I just love it and you know. I wasn't feeling that. I hated it because I was uncomfortable and I was sick and just not feeling good at all and just feeling so tired and so off from what I used to feel.*

Though Fallon experienced low times, which she connected to her physical health, she also experienced joy and anticipation:

> *I'm excited and I'm full of joy and I'm full of… the anticipation is killing me to know… We aren't finding out what the sex is but on the same token it's like, ok you're in there and I just saw you on the screen and I really want to know what you are. So that's really exciting, but also the suspense of it is exciting too. I've always wanted that where you see the movies where they're in labor and going through wicked pain and then it's a boy or it's a girl at the end… I want to hear that.*

Like Fallon, all of the participants experienced joy and expectation in their pregnancies. All of the participants experienced both periods of sadness and hopelessness while experiencing other periods of joy and expectation. The periods of sadness and hopelessness were strongly connected to the experiences of physical illness and fatigue. The periods of joy and expectation came from a variety of sources including, enjoying their belly; the anticipation of giving birth; the fulfillment of dreams; and the completion of family.

DISCUSSION

The findings of this study can be positioned within the existing literature about ambivalence, the social construction of pregnancy and motherhood, antenatal depression, as well as popular notions of pregnancy and depression.

Weigert`s (1991) discussion of ambivalence is valuable and pertinent to the current study. He builds upon Merton`s theories of how sociological ambivalence is the result of contradictory

expectations. This theory accounts for the social constructs in which a person lives, rather than suggesting that ambivalence is simply a psychological phenomenon as Freud had suggested (Weigert, 1991). Furthermore, he suggests that ambivalence can result from contradictory normative expectations within a role, role set, or status. As such, an individual feels ambivalence when the expectations of their role are not congruent with another role in which they occupy, or when the expectations of their role are not congruent with their emotions.

Ambivalence is sentinel to the current study. Revisiting the discussion of the social construction of motherhood through the lens of normative expectations of a role or role set, illustrates the context in which expectant mothers acquire knowledge of what it means to be a mother. Furthermore, the dominant ideology of intensive mothering creates stricter parameters and greater expectations of what it means to be a "good" mother. Thus, pregnancy is not only a physical transformation of a fetus to a birthed baby, but a transformation from a childless woman to a mother. In making meaning of this transformation, and subscribing to the expectations of motherhood, there is undoubtedly some inner conflict with regards to what must be sacrificed physically, emotionally, psychologically, and logistically resulting in some ambivalence. This is illustrated in the theme loss of identity versus newfound identity. The participants were realizing what they had to give up in order to fulfill their expectations of motherhood. The contradictory experiences created between the normative expectations of motherhood and the symptoms of depression could also result in ambivalence. This was illustrated in the themes sadness and hopelessness versus joy and expectation, as well as anxiety and insecurity versus confidence and security.

Weigert (1991) discussed how ambivalence is often experienced as an undesirable state. He suggested that ambivalence feels uncomfortable because in an individualistic and competitive society, ambivalence is seen as indecision, a sign of a weak ego, or as blurred values. In the current study, the participants made reference to this either in the interview process or after the interview, when I asked them about the process. They shared how their uncertain feelings were things they could not talk about with others. The expectation was that they were filled with joy when they were feeling well, or they were feeling negative when they were sick or had a difficult day. They perceived others' expectations to be black or white about their experiences. In reality they were feeling contradictory feelings most of the time and felt uncertain, or "wishy-washy" or "like I don`t know how

I`m feeling, so how can I describe it to you?" However, ambivalence could be seen as functional, rather than as weak or undesirable (Weigert, 1991). Ambivalence shows women's ability to identify and perhaps confront issues related to their experiences of pregnancy. Lichtentreit and associates (2005) also suggest a positive side to ambivalence. They suggest that ambivalence is a dialectical concept that can have a calming influence on an individual because of the possibility of positive outcomes. For example, the women in the current study had positive feelings which contradicted their negative feelings in each of the five themes.

When we examine popular notions of the two components of antenatal depression, pregnancy and depression, we gain some clarity around our expectations of these two phenomena. Popular notions of pregnancy include concepts of joy, anticipation, glow, motherhood, calm, and relationships with partner, family, and the unborn child, etc. All of these notions are generally positive and evoke a sense of beauty and goodness. Popular notions of depression tend to be very negative. Concepts like sadness, lethargy, gloom, isolation, uncertainty, loss of identity, and illness evoke a sense of darkness and misery. As such, popular notions of pregnancy and depression, or antenatal depression are dissonant. If we are to assume that a woman with antenatal depression has "symptoms" of both pregnancy and depression, we might assume that she would encounter a very dissonant experience, and thus feel ambivalent about her circumstances. As such, we could tease apart the dissonant themes found in this study to align with pregnancy: connection, newfound identity, vitality and wellness, confidence and security, and joy and expectation; and with depression: disconnection, loss of identity, fatigue and illness, anxiety and insecurity, and sadness and hopelessness. When these themes were experienced simultaneously, dissonance and a resulting ambivalence occurred.

Two qualitative studies about high-risk pregnancy were particularly relevant to the present study. Though these studies were not about antenatal depression, they succeeded in giving voice to pregnant women"s experiences. These were particularly relevant in confirming findings of ambivalence.

A qualitative inquiry conducted by Bender (2008) investigated child-bearing decision making in three adolescent women. The study explored the pregnant teens' experiences of deciding to keep the baby, put the baby up for adoption, or abort the baby. The findings indicated a considerable amount of ambivalence in the girls' descriptions. This ambivalence was categorized into three themes: (1) ambivalence about

pregnancy; (2) ambivalence about keeping the child; and (3) ambivalence about motherhood. Though the participants in the study were teens, Bender noted that the participant who experienced the greatest level of ambivalence was the oldest participant at 20 years of age.

Two of the themes in Bender's study paralleled findings in the present study: ambivalence about pregnancy and ambivalence about motherhood. Ambivalence about pregnancy in Bender's (2008) study was illustrated in one participant's comment, "One minute there was great joy . . . and everything extremely bright and happy; then the other minute, it was like everything collapsed." She went on to say: "This is too early for me, I am too young. I think I should have accomplished something more" (p.879). This parallels Daphne's experience of realizing that she had not completed everything in her career that she had intended to complete before becoming pregnant. Ambivalence about motherhood in Bender's (2008) study was expressed in terms about not being ready for the responsibility of motherhood and wanting to remain a teenager. This parallels Alison's experience of feeling like a pregnant teen. She doubted if she was ready for the responsibilities of motherhood. The themes of ambivalence in Bender's study are congruent with some of the themes found in the present study. A phenomenological study conducted by Leichtentritt and associates (2005) explored the experiences of 57 pregnant women who were hospitalized for complications during their pregnancies. The essential theme of their experiences was one of ambivalence:

> They feel anxious about and resentful of the situation, only to be filled with hope and confidence in the outcome of this pregnancy. They perceive themselves as being emotionally in yet physically out of the family household. They wish to give birth as soon as possible and at the same time hope to prolong the pregnancy as much as possible for the welfare of the fetus. They define themselves as both sick and healthy, and they attempt to minimize the feeling of risk while seeking and desiring the high level of medical attention demanded by their high-risk condition (p.46).

Though their experience of hospitalization is very different from the participants in the present study, the core themes of ambivalence are congruent.

To summarize, the overarching theme of ambivalence found in the

current study adds to a growing body of research on experiencing ambivalence in pregnancy. The theory of sociological ambivalence could be helpful in further explorations of pregnancy and motherhood. Popular notions of pregnancy, motherhood, and depression illustrate dissonant experiences, which when experienced simultaneously can create ambivalence.

Future Research

Limitations and results of the current study suggest possible future research directions in antenatal depression. First, the homogenous sample of the current study may limit our understanding of antenatal depression. Further qualitative inquiry could investigate the lived experience and lived meaning of pregnancy among women of other ethnic groups, socioeconomic classes, and other age groups could bring a greater understanding of these experiences. Furthermore, qualitative research exploring these experiences in women with more severe symptoms of depression could give the research community deeper insight into the experience and the meanings women attach to their experiences.

The findings of the current study indicate that further research could be completed with a similar population in terms of postpartum reflections on their experiences.

Because pregnancy is a transitional stage in a woman's life, reflection on that stage after moving through it may provide some insight into how the transition affected her as a woman and as a mother.

Implications for Counseling Practice

Counselors need to adopt theories of practice that engage, accept, and are beneficial to pregnant women and mothers. Counselors must be aware of their own biases and belief systems that could impede the counseling process. An awareness of the social construction of motherhood and the expectations created by the dominant ideology of intensive mothering could, at the very least, help counselors acknowledge the expectations their clients carry and, perhaps, help the counselor to be conscious of their own adopted values. Medina and Magnuson (2009) suggest two useful theories to guide counselors who work with mothers: social constructivist theory and feminist therapy.

Social constructivist theory provides a framework where the counselor attempts to understand the meanings a client attaches to her experiences. The counselor encourages the client to explore the

origins of those meanings and evaluate them. The client can then choose to adopt the original meaning with a new understanding, or make new meaning of her experience. In the context of pregnancy and motherhood, the counselor could encourage the client to explore the origins of their beliefs about what makes a good mother. This provides the client with the opportunity to gain deeper insight into her expectations of herself and the expectations she feels are imposed upon her. She can then begin to integrate a new system of meanings if she chooses.

Feminist therapists are concerned with empowering women and helping them have more choices in their lives. The therapist strives to engage the client in an egalitarian and mutual therapeutic relationship. Another strength of feminist therapy is the recognition of a woman's personal life being intertwined with the political sphere. Thus, a woman's presenting problem is rarely seen as pathological, but rather as a best attempt at coping with the constraints of a restrictive and oppressive environment. In the context of pregnancy and motherhood, the feminist therapist would help the client explore the constraints and restrictions she experiences because of the social and political context in which she lives. The therapist would most likely attribute the symptoms of depression to those constraints and restrictions and help the client seek alternatives.

The literature about ambivalence also indicates some therapeutic avenues for pregnant women. Weigert (1991) and Leichtentritt et al (2005) suggested positive views of ambivalence. Ambivalence can be viewed as functional and as a calming influence for individuals experiencing it. Using a strength-based approach, the counselor could plan interventions with the goal of acknowledging the ambivalence and determining the benefit the individual receives from feeling ambivalent. In the context of pregnancy and motherhood, the client could be encouraged to accept the ambivalence experienced during a transitional stage in her life. The client could also view ambivalence as a process of keeping a balanced approach to their feelings and experiences.

The lifeworld existentials were used as an exploratory tool in this study. The participants were able to provide rich descriptions about their experience when reflecting on the questions based on corporeality, relationality, spatiality, and temporality. These questions could be used as an informal assessment with clients in the counseling setting. Asking a client about how her body, relationships, space, and time are experienced during pregnancy would provide her with the opportunity to reflect on her situation in a more holistic way. Her

descriptions of those experiences could provide the counselor with a greater understanding of the client's situation from her own perspective.

This inquiry suggests that as researchers and counseling practitioners, we cannot simply rely on statistical data to assess, diagnose, and treat. The human experience and the social context in which that experience takes place must be acknowledged and validated to better understand, guide and celebrate our clients.

CONCLUSION

In conclusion, this study explored the lived experience and meaning of pregnancy in women with mild to moderate depression. It provided six women with the opportunity to bring their voices to this experience and begin to create an awareness among other women, and health care and human service providers, about the lived phenomenon of antenatal depression. Their experiences revealed a shared meaning of ambivalence; the women described their experience of pregnancy as being the best and worst time in their lives. Five related and interconnected sub-themes further illuminated women's experience of ambivalence during the antenatal period. This study contributes to existing qualitative literature about ambivalence in pregnancy and introduces a qualitative component to the existing literature on antenatal depression.

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