Being Pregnant: A Qualitative Study of Women's Lived Experience of Pregnancy

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Full Text: Headnote ABSTRACT: Few studies of pregnancy have been designed to include the pregnant woman's perspective. This qualitative study was conducted to explore women's perspectives of their experience of pregnancy. Semi-structured interviews were conducted with 13 pregnant women (24-39 years). The analysis revealed six major themes: support during pregnancy; experience of pregnancy; finding information; changing values; model of care; and being responsible. Results suggest that women's experience of pregnancy may be enhanced offering guidance and enabling access to multiple sources of support. Future research into the health-care professional's role, and the ways in which pregnant women connect with each other, is supported. KEY WORDS: Pregnancy, qualitative, social support. INTRODUCTION Over the past century, pregnancy has come to be viewed predominantly as a physical and pathological experience, framed within a medical model of care, and has focused primarily on the physical survival of a woman and her developing baby (Bondas &Eriksson, 2001; Salisbury, Law, LaGasse, &Lester, 2003). Research conducted from a medical perspective has resulted in numerous technological advances and improved physical pregnancy outcomes for women and babies. More women, and their babies, now survive the experience of pregnancy than their pregnant predecessors who did not have access to advanced technology. However, even with the availability of advanced technology, a significant number of women and their babies continue to experience poor pregnancy outcomes that cannot be accounted for by biomedical factors alone (Korenbrot &Moss, 2000; Rini, Dunkel-Schetter, Wadhwa, &Sandman, 1999). The medical model of care is characterized by a focus on risk assessment and complications. Pregnancy and birth care within this model is standardized and based predominantly on the physical aspects of care (Howell-White, 1997). Alternatively, the midwifery model of care focuses on pregnancy and birth as a normal and natural life event. The midwifery model is characterized by a holistic approach, taking into account each pregnant woman's unique experiences. The quality of women's experiences during pregnancy can be influenced by their choice of model of care. Pregnant women's choice of model of care has been associated with the woman's perception of risk in relation to pregnancy and birth (Howell-White, 1997). Women who perceive pregnancy and birth as a medical condition that is risk oriented are more likely to choose an obstetrician as their careprovider than a woman who perceives pregnancy and birth as a normal and natural life event. In an effort to better understand pregnancy experience and outcomes, researchers have increasingly focused on examining the psychosocial experience of pregnancy (Collins, Dunkel-Schetter, Lobel, &Scrimshaw, 1993). In the last three decades, pregnancy has been described as a stressful life event (Levy-Shiff, Dimitrovsky, Shulman, &Har-Evan, 1998; Park, Moore, Turner, &Adler, 1997), a major life transition requiring adaptation (Bost, Cox, Burchinal, &Payne, 2002; Harrison, Neufield, &Kushner, 1995; Rini et al., 1999; Salmero-Aro, Nurmi, Saisto, &Halmesmaki, 2001), and a maturational crisis (Aaronson, 1989; Bondas, &Erikkson, 2001). Furthermore, prenatal maternal stress has been identified as a negative psychosocial experience during pregnancy, and has been linked with adverse pregnancy outcomes, such as preterm birth and low birth weight (Stanton, Lobel, Sears &DeLuca, 2002). Preterm birth, a birth that occurs prior to 37 weeks gestation, and low birth weight, under 250Og, have been identified as significant risk factors for young children developing negative health outcomes such as hyperactivity, developmental delays, and autism (Huizink, Robles de Medina, Mulder, Visser, &Buitelaar, 2003). Recently, prenatal maternal stress has been conceptualized as a multidimensional concept incorporating stress-provoking (e.g., life events, daily hassles), stress-mediating or moderating (e.g., social support), and stress-resulting (e.g., perceived stress)

factors (Lobel, DeVincent, Kaminer, &Meyer, 2000; O'Connor, Heron, &Glover, 2002; Park et al., 1997). In a recent study of 418 pregnant women, type and timing of stress during pregnancy was examined, qualitatively and quantitatively, throughout the second and third trimesters (Roesch, Dunkel-Schetter, Woo, &Hobel, 2004). Prenatal maternal stress was found to be a predictor of gestational age, and pregnancyspecific anxiety, experienced over the course of pregnancy, was found to be influential in predicting adverse outcomes. Pregnancy-specific anxieties are characterised as fears and worries linked to the experience of being pregnant. Indicators of pregnancyspecific anxiety are fears experienced by the pregnant woman related to her own health, the health of her developing baby, and the forthcoming birth (Roesch et al., 2004). Pregnant women experiencing fear are inclined to experience higher levels of pain and stress in labour and birth, and fear during pregnancy has been associated with a greater risk of having a caesarean section. In a quantitative study conducted to investigate the association between fear during pregnancy and caesarean birth, 1981 pregnant women completed questionnaires during their third trimester (Ryding, Wijma, Wijma, &Rydhstrom, 1998). Fears relating to childbirth during the third trimester were found to be associated with an increased risk of having a caesarean section birth. A general research trend appears to be a focus on the deleterious aspects of our life experiences, however, to enhance quality of life it has been suggested that researchers begin to focus on examining the positive aspects of life experiences (Seligman &Csikszentmihalyi, 2000). In relation to pregnancy, whilst researchers have also previously focused on the deleterious aspects of women's experiences, recently, researchers have also begun to include the positive aspects of women's pregnancy experience as a focus of their study. Over the past two decades, researchers investigating women's positive experience of pregnancy have examined constructs, such as, uplifts, constructive thinking, optimism, and social support (Dipietro et al., 2002; Lobel et al., 2000; Park et al., 1997; Thompson, Murphy, O'Hara, &Wallymahmed, 1997; Walker &Grobe, 1999). In a quantitative study examining hassles and uplifts during pregnancy, women reported experiencing the most intense uplifts in early pregnancy and as pregnancy progressed, their experience of these uplifts diminished (Thompson et al., 1997). Constructive thinking, characterised as the capacity to effectively think and problem-solve in such a way as to enhance daily life (Epstein &Meier, 1989), has also been related to positive pregnancy experiences. In a study conducted by Park et al. (1997), the impact of constructive thinking and optimism on pregnant women's perceived stress was examined. Women using constructive thinking were found to experience more positivity and less anxiety in the last trimester. An additional pregnancy experience of benefit to women is receiving social support. Social support, defined as an exchange of resources (Collins et al., 1993), has been linked to participation in positive health behaviours (Hurdle, 2001). Importantly, for women, social relationships are seen as one of the primary vehicles for social support. The importance of quality social relationships emerged as an influence on perceptions of social support in a qualitative study of women's choices of informal support through a life transition (Harrison et al., 1995). The participants in this study, of whom six were pregnant, defined social support as someone who listened while they explored issues, and refrained from giving advice. The women preferred support to come from people with whom they shared history, emotional ties, and similar experiences. In addition, they indicated that barriers to social support were feeling like a burden, an inability to reciprocate support, and not wanting to appear inadequate. Social support is argued to be of particular importance to pregnant women and their developing babies (Feldman, Dunkel-Schetter, Sandman, &Wadhwa, 2000). In a quantitative study of 247 women and their families it was identified that women who received different dimensions of support from varied sources gave birth to babies of higher birth weight. Schaffer and Lia-Hoagberg (1997) examined the influence of social support on the prenatal care and health behaviours of low-income women. Whilst partner support was found to be an important influence on the initiation and continuation of prenatal care, female family members and female friends were pivotal in the provision of social support that influenced health behaviours. The authors argued that paraprofessionals with similar life experience would likely be beneficial to pregnant women (Schaffer &LiaHoagberg, 1997). In exploring women's lived experience of pregnancy, Bondas and Erikkson (2001) found that women characterised

pregnancy as a time of deep joy and of deep suffering. The authors argue that women's suffering intensifies when support is inadequate. Therefore, for optimal development of the expectant mother and her baby, the pregnant women needed to exist in a caring culture, be seen as unique, grieve the losses associated with being pregnant, and to talk about her experiences with others, especially other pregnant women and new mothers. Whilst a quantitative approach has been utilized to ascertain associations of social support with specific outcomes for pregnant women, and their developing babies, few researchers have utilized a qualitative approach to gain insight into the experience of social support for expectant mothers. The importance of pregnant women receiving social support from other women with similar experiences has been highlighted in the aforementioned studies. Therefore, the purpose of this study is to utilize a qualitative approach to explore women's experience of pregnancy, and their access and barriers to receiving social support from other women with similar experiences. METHODOLOGY Participants For the present study a qualitative approach was adopted utilizing purposive sampling where 13 (ranging from 24-39 years) pregnant women participated in response to information fliers placed at various locations (maternity stores, pregnancy resource centres, and yoga centres) and advertisements in local newspapers. Of the 13, five participants were experiencing a first pregnancy, five participants were experiencing a second pregnancy (one expecting twins) and three participants were experiencing a third pregnancy (one as a sole parent). The women were at various stages in their respective pregnancies ranging from the first to third trimesters and were utilizing different models of health care; planning a homebirth, utilizing a private obstetrician and utilizing public hospital care. Data Collection The data for this study was gathered by conducting semi-structured interviews which lasted for approximately one-hour. An open-ended interview guide, based on the question typology of Patton (2002), was designed and utilized to facilitate participant conversation. Data Analysis Following each interview data was transcribed and coded through the identification of recurring themes. New themes were created from units of meaning that did not fit with existing themes. Propositional statements were written to identify common characteristics of emerging themes and were compared to determine their relative importance and connections to each other. Final themes were peer reviewed to confirm findings and reduce potential biases. The analysis was complete when no new information emerged. The data was therefore analyzed using the constant comparative method which involves comparing the meanings from the data as they emerge (Maykut &Morehouse, 1994). FINDINGS AND INTERPRETATIONS Thirteen themes emerged following analysis of the data. As some of the themes are linked, a decision was made to cluster the themes into six categories. The final six categories to emerge are: support during pregnancy, experience of pregnancy, finding information, changing values, model of care, and being responsible. Support during Pregnancy The first major theme to emerge from the data was support during pregnancy. Four sub-themes emerged relating to support during pregnancy: experience of support, lack of support, barriers to support, and ideal support. Experience of Support. The sub-theme of experience of support reflects pregnant women's experiences of receiving support that was helpful to them. It is proposed that pregnant women feel supported when they have opportunities to connect with other pregnant women and new mothers, and this may occur through family, existing friendships, the working environment, and structured activities, such as support groups: "You can guarantee that someone else has gone through it or they know someone else that's gone through it... and it's a brainstorming sort of atmosphere where it's very non-judgemental." This finding is consistent with the previous research of Harrison et al., (1995) and Bondas and Erikkson (2001) showing that women prefer support to come from others with similar experiences, especially other pregnant women and new mothers. Pregnant women also feel supported when they have opportunities to focus on, and talk about, their experience of being pregnant. Yeh, cos everything is about the baby ... It's like ARRRRGHHHH!!! (No-one says) How are your hormones today? Can you poke your head out of the hole today? Yeh, I'm doing well. Or they say it as in ... how's your tummy going? It's not about YOU! And how's your BRAIN getting around it? I think ... you did ... you asked, 'What's it like for you to be pregnant?' and I was like Oh, God!!!' (relief). Previously, findings have indicated that women experience support when someone listens

while they explore issues (Harrison et al., 1995). Pregnant women feel well supported when they experience multiple sources of support: . . . I've just had so much fun and support because for 3 of us it's our 1st but one of the girls, it's her 3rd. She's been there done that . . . and I know the last person in my church to have a child . . . lots of people in my church were making meals for them and those kind of practical support things ... so that's a big support. And my family are very close. Experiencing multiple sources of support has been previously associated with improved pregnancy outcomes (Feldman et al., 2000). Supportive care is experienced by pregnant women when it is provided by female health-care professionals: "I prefer to talk to the midwives not the Dr. The female . . . it's good, you can talk like we are now . . . like conversation. It's better with the midwife. Even the female Dr is not . . . no, the midwife is GOOD!" Whilst previous research has shown that support provided by women is advantageous (Schaffer &Lia-Hoagberg, 1997), pregnant womens' experience of differences between health-care provided by males as compared to females has not been noted. However, pregnant women have been shown to have a preference for choosing a midwife or an obstetrician, and this preference has been related to the pregnant women's childbirth definition (Howell-White, 1997). The pregnant woman feels supported when health-care professionals are able to provide care in the pregnant woman's home: Also, they come to me, and I don't have to go to them. They visit me at home. That is all a happy thing. Not a hospital or not clinical. Nothing like that, it's all like a happy, more personal thing as well. She doesn't give her hand, she's just 'Oh' (gestures a hug) to give you a hug, and that's such a difference. Previous research conducted by Howell-White (1997) has demonstrated that pregnant women who perceive birth as being a natural and normal life event, prefer a more personalized approach from a midwife, however, location of care-provision was not indicated. An important source of support can come from pregnant women themselves when they take opportunities to engage in self-care: "And pregnancy was a surprise . . . and I thought what do I have to do to try and . . . I'm going to have three kids under three . . . I better start preparing myself. I thought . . . one thing I'm going to have to do is to have time-out . . . and that was yoga." Pregnant women have been shown to engage in positive health behaviours when they are in receipt of social support (Schaffer &Lia-Hoagberg, 1997). Lack of Support. The sub-theme of lack of support reflects women's experiences during pregnancy that are not helpful to them. Pregnant women experience a lack of support when their pregnancy is not affirmed by significant others, including family: "It was crazy cos the most shocking thing for us ... was the lack of support from the family."; and health-care professionals: "I spose I came out of there thinking, 'Well, why isn't she excited? Why doesn't she do a test to make sure I was actually pregnant?'" During pregnancy, a woman experiences a lack of support when others emphasize negative aspects of the childbearing experience: I've got this friend who's got children and she doesn't enjoy having children that much ... and it upsets me and drives me crazy whenever she comes and talks to me and she says in this condescending attitude, 'Oh, you'll find out ... it's horrible.' And it's the last thing you want to hear ... I'm mean, I'm not that naïve ... I know it's going to be difficult. You don't want your dreams shattered before you even get there. Women experience a lack of support when their health-care professional does not; offer guidance: "There was a bit of an assumption that I'd know what the process was. I didn't know what my options were."; address pregnancy-related concerns: "... that's another big gap, I think ... there's no-one to talk to if you've got those little concerns."; offer support during a crisis: "I went to the Dr ... and he was quite rude ... it was just sort of like What are you here for today?' I was like 'Oh, I'm pregnant and I've had a bit of trouble' and he was like "Well I can't really help you in that' ... sort of sense ... 'I'm not a counsellor' ..."; and provide continuity of care: "I feel like a sheep ... I just think cos it was public system you just see whoever is next ... which is kind of hard and sad in a way cos it's like ... you want to just see the same person all the time but you can't." Woman experience a lack of support during pregnancy when others primarily focus on the baby: "Yeh, and I think just people and books go on like nutrition ... YOU should eat this for baby, YOU should do that for the baby, YOU should try and ... not you can eat so you can keep yourself healthy, exercise so you can feel good about yourself ... What about me for a change?" Pregnant women experience a lack of support when they have no connections with similar others: "I've met some nice

people but they're all career women ... and have no interest in having a family. So, although we connect a little bit, it's not the kind of connection I really need right now." These findings, reflecting pregnant women's experiences with lack of support, reinforce the proposition of Bondas and Erikkson (2001) that women's negative experiences during pregnancy can intensify when support is inadequate. Barriers to Support. The third sub-theme of support during pregnancy is barriers to support. Support may be available during pregnancy, however there can be barriers that interfere with women obtaining support. Difficulties associated with asking for support can stop pregnant women from reaching out for the support they need: "7 think the hardest thing to do is ask for something and especially when you're not used to it ..." Pregnant women may not obtain available support due to the need to reciprocate support at a later time: "... 7 know where she's going (daycare) and not so much that you're paying for it but I don't feel that pressure that I'm putting someone out or asking ... or doing the I'll do it for you and you do it for me - payback." In other instances, pregnant women may be reluctant to obtain available support as they don't want to feel like a burden to others: "I'd left her with a couple of girls from mother's group ... but you'd drop her off ... I'd feel hugely guilty that you were inconveniencing them ... even if you'd had their children the day before ..." Research, conducted to explore barriers to support, has revealed that barriers to support are feeling like a burden, an inability to reciprocate support, and not wanting to appear inadequate (Harrison et al., 1995). These previous findings have also been highlighted through the current analysis. Unknown future obligations may also be a barrier for pregnant women in obtaining available support: I've got my mother-in-law but I don't like calling on her too much. She's really a bit of a hypocrit ... lady ... she's alright, she's really helpful, she's very practical with her help. She's good with the kids and she'll come over ... she, more than anyone will do my dishes for me or help with the ironing or laundry. But there's like a tie attached. Support services may be available, however, if the service does not appeal to the pregnant woman, the service will not be utilized even when utilizing support may be helpful: "To be honest, I actually got on the web and started looking up information and none of it jumped out as being quite what I was looking for ... it may have been ... it just wasn't portrayed that way." Financial barriers may also exist that stop pregnant women from utilising available support: "That's why I don't go to the Drs half the time ... I have to have the money then and there." The model of care a pregnant woman chooses may be a barrier to obtaining support that caters to her individual needs: "From where I come from ... it's like well, I'm lucky I've got private cover and an obstetrician. I thought that was the best that I could do. I didn't realize it was going to restrict me. " In other instances, not knowing where to obtain support can prevent pregnant women from receiving support: "... but this time I have been craving it and have been looking for it and I still never came across anything ..." Finally, there may be aspects of the pregnant experience that women tend not to talk about, creating a barrier to support: "It's strange that not all people find that it's normal to talk about this (the spiritual aspects of pregnancy) ... they think, 'Oh, it's witchy stuff.'" The preceding examples of barriers to support have not been indicated in the literature pertaining to social support during pregnancy. The qualitative design of this study allowed for a deep exploration of barriers to support for pregnant women, and may account for the emergence of such varied examples of the ways in which women acknowledge barriers to obtaining support during pregnancy. Ideal Support. The sub-theme of ideal support reflects the ideas of pregnant women about ways they would like to be supported to enhance their experience of pregnancy. The premise that pregnant women need to exist in a caring culture, be seen as unique, and have opportunities to grieve the losses associated with being pregnant has been emphasised in past research (Bondas &Erikkson, 2001), reinforcing the current findings related to the ways women want to be supported during pregnancy. It is important to pregnant women to get together with other pregnant women and new mothers to provide support for each other: "I think it would be wonderful ... especially for 1st time mums that you would be able to have like you do with mother's group ... but you're all pregnant and you just hook up and you start ... talking about it... cos that's all I wanted to talk about was being pregnant ..." Having early access to support from other pregnant women is important: "Just like those support groups would have been good cos you can go straight off ... it doesn't matter whether you're 2 weeks pregnant or 38 weeks,

you're gonna go through the same things and it's actually real people ... not just in a book ..." Beginning in early pregnancy, women want a guide, someone who will positively affirm their pregnancy and will inform them of their options: "Some positive affirmation ... 'How exciting! And how do you feel about it? And how do you and your partner feel?' I spose a bit more information ... like where do I go from here?" Pregnant women want more informational and emotional support from their health-care professionals, especially when the pregnant woman is experiencing a crisis: But that was just... an extremely bad experience and no support at all ... really in shock ... I think I never felt so bad in my life until that day. Losing your baby even though it's never been fully developed, it just feels like a loss. But they didn't even ask that, 'Do you need to make a phone call for a friend or your partner to come?' Pregnant women want opportunities to focus on relationship issues during their antenatal classes: ... if they were to not make it generalized just on baby but make it generalized on what you and your partner will go through ... and what could happen to you or what could happen to your partner in the sense of like he knows what you're going through ... Having access to support that caters to the uniqueness of a woman's pregnancy experience would be helpful: I think discussion groups ... maybe get togethers for people who've done that or are going through it. You can sit and compare experiences. I think that's really important ... Oh, I'm sorry you're having such a rough time but I'm glad it's not just me.' That makes a big difference. A 24-hour pregnancy-specific phone-line may facilitate access to support for pregnant women: ... you know the health department have got that you can call a nurse 24-hrs a day. If there was one of those for pregnancy questions because sometimes you feel really stupid asking the questions and you might not want to ask your own Dr. Experience of Pregnancy Experience of pregnancy was the second theme to emerge from the data. Five sub-themes emerged relating to women's experience of pregnancy: positive experiences, negative experiences, mixed feelings, unique experiences, and spiritual experiences. Positive Experiences. The sub-theme of positive experiences reflects women's experiences during pregnancy that were associated with positive affect. Simply being pregnant can be a positive experience for women: ... your taste is better, your smell ... your senses are more open I think, and it's more emotional but I think in a good way. Some say, they tend to cry quicker at things but I think that's only good cos you're more aware of what is going on in this world. You're bringing a child in so it's good. You have to know about what's going on. Be aware ... I like that actually ... to be more aware ... sensitive not only physically but emotionally and it's beautiful.

Table 1

Themes of Pregnancy Experience

Theme	*Sub-theme*
Support during pregnancy	Experience of support
	Lack of support
	Barriers to support
	Ideal support
Experience of pregnancy	Positive experiences
	Negative experiences
	Mixed feelings
	Unique experiences
	Spiritual experiences
Finding information	
Changing values	
Model of care	
Being responsible	

Previous research has demonstrated that women have experiences of deep joy during their pregnancies (Bondas &Erikkson, 2001). Receiving support from family and friends is a positive experience for pregnant women: "I was glowing from day one and loved every second of it . . . and it was because I had the support of my friends and family." Pregnant women experience positive affect when their partners adjust to the experience

of pregnancy and fatherhood: ... I think he was quite proud of himself then the fact that I noticed ... that he actually took the reins ... he took (1st baby) for walks, he put (let baby) in the tub while I cooked dinner. It was like 'Hello ... (sexy voice) ... I like this husband!' Having a supportive partner and receiving support from family and friends has been shown to positively influence women's pregnancy experience (Schaffer &Lia-Hoagberg, 1997). During pregnancy, being pampered and receiving attention can be a positive experience: "I've felt fantastic ... and I love the attention ... cos everyone was like Oh, you're pregnant, you're pregnant!"' Feeling creative is also a positive experience during pregnancy: I've been taking pottery classes as well. I don't know what's happened but my creative side has just exploded since I've been pregnant so I've been going to pottery every week. I've just bought a whole lot of gemstones to start making my own jewellery. Yeh, the creative juices are just flowing. Research has indicated that some women reveal an attachment to their unborn baby by displaying nurturing, comforting and preparatory behaviours toward their developing baby, especially once fetal movement has been felt (Salisbury et al., 2003). The current findings suggest that feeling emotionally attached to the baby is a positive experience: Well I guess it was an immediate attachment because all I wanted to do was grow up and have children ... all my life and ... I guess it was more as soon as I started feeling it move, it was like, oh it's a real thing, it's part of me ... I can't even describe the feeling ... this amazing sense of ... I don't know ... love ... and it's not even someone you've met yet. It's incredible! I'm just absolutely dying to meet it... and see what it looks like and what sort of personality it's going to have and ... just excited ... I feel like a mum already... I know people see it as a fetus but to me it's not ... it's my child. At times, being distracted from pregnancy can be a positive experience: Getting back to pregnancy being enjoyable ... some distractions cos you do focus all your time and energy on being pregnant and talking ... we call it 'Placenta Brain." So the distraction for those two hours when you're not thinking about it. I think that's really important. Negative Experiences. The second sub-theme, negative experiences, reflects pregnant women's experiences during pregnancy that were associated with negative affect. When experiencing an unplanned pregnancy, a woman can find herself in unknown territory: "I didn't know what to do ... we just arrived (from overseas) and I wasn't expecting to be pregnant... and I was really worried about it." Hearing about others' negative experience is a negative experience for pregnant women: "As soon as people hear you're pregnant they start to talk horror stories ... like 3rd degree tears ..." Having unmet expectations is also a negative pregnancy experience: The first three months were absolutely horrible. I was really, really naïve before I fell pregnant. I thought you just fell pregnant then got up in the morning and threw up and then felt fine for the rest of the day. I thought that was it. Being unwell can be a distressing experience for women during pregnancy: ... this time I was really, really sick for the first sixteen weeks. Sicker than the rest (1st two pregnancies) ... and I probably felt quite alone then. I used to stick the kids in the car while I was so sick so I knew where they were. I didn't realise how hard it was until after ... These findings are characteristic of previous research results suggestive of women's suffering during pregnancy (Bondas &Erikkson, 2001). Negative experiences can begin early in pregnancy in the form of worries. Worries associated with pregnancy have been previously reported as being related to the pregnant woman's own health, her baby's health, and the impending birth, supporting current research findings (Roesch et al., 2004). Worries can be present throughout pregnancy although the content of the worries can vary: "The first thing I started worrying about was miscarriage ... especially considering another girlfriend had a miscarriage about 6 weeks before that. And once I got over that it was ... (more worries)." Women's past negative experiences of pregnancy and birth can be a source of worry in subsequent pregnancies: Even now my fear is having it at home cos I'm really quick. I dilate really quick. I was much more emotional after James (2nd haby) cos it was so quick. I didn't have a chance to go, 'Oh, I'm in labour!' Nine months pregnant and 90 minutes in labour! It's so quick! It's such a small event compared with the rest that goes on. Past negative experiences can impact on women's current pregnancy experience when the care they previously received during a negative experience was inadequate: "I had a miscarriage last year. On the internet I found all the information but the experience with Doctors ... that was horrible." When pregnant women do not resolve difficulties, negative

experiences can intensify as pregnancy progresses: "I think I'd pushed a lot of things off in the first trimester ... then it's just come back and got me even worse. Some of the problems I should have dealt with then and there I just kept pushing them away ... then they just come through the back door and hit me harder." This finding is supported by the previous work of Melender (2002) who found that women may hide their difficulties, and suffer silently. Pregnant women can have difficulty in adjusting to bodily changes: "You see all these changes to your body and you think, "Oh, what's happening to me?" Although, engaging in self-care can also be a negative experience for pregnant women, "You feel guilty if you sit on the couch and do nothing .. .I don't like to milk the pregnancy thing. I don't like them to think I'm not pulling my weight. I don't give myself permission enough." Adjusting to being at home can also be a negative experience: "The hard bit about staying at home is the consistency of it. OK, it's not rocket science and you're not doing mega-deals, and it's not flashy and exciting ... but the hard bit of it is the consistency of it." A partner's difficulty in becoming a parent can be a negative pregnancy experience for women: ". . . I think, he was kind of choking a bit... especially in the last three months ...he would spend a lot of time at the pub." Mixed Feelings. The third sub-theme, mixed feelings, reflects pregnant women's experiences of simultaneously feeling positive and negative affect. During pregnancy, a woman can experience occasions when she is challenged by feeling a range of emotional states within a short period of time: "One minute you're fine and euphoric then the next minute ... you're crying ... and that's really hard to deal with ..." Pregnancy has previously been revealed as being a time when joy and suffering can exist simultaneously (Bondas &Erikkson, 2001). Unique Experiences. The fourth sub-theme, unique experiences, reflects the varied experiences of women during pregnancy: From my point of view I was, 'How can this woman not even want to see ..." She's gonna be in the thick of it whether she likes it or not. What's she gonna do on the day? But then from her point of view, well she didn't want to see, she didn't want to know about it... we got talking and she just wanted an exact date an exact time ... everything diarised ... and that was her. There's such a range of normal. The diversity of pregnancy experience has not been noted in the literature. It is possible to gain further insight into the range of pregnancy experiences through qualitative explorations of women's experience. Spiritual Experiences. The fifth sub-theme, spiritual experiences, reflects women's ideas that pregnancy is more than a physical and emotional event. During pregnancy, women can have experiences of a spiritual nature: ... I feel really strong ... you never know whether this is true or not but it (the baby) has a strong feeling how he feels ... and how he thinks a bit... how he is ... I tried to find some books about more spiritual side of it ... It was hard to find information on the internet or even the bookshops cos most of the things were really about the physical, and a bit about the emotional but not the spiritual side. Research conducted by Chamberlain (2003) has recently documented research findings on fetal consciousness. Finding Information The third major theme to emerge from the data was finding information. During pregnancy, women's experiences of finding information are varied. Women find information relating to pregnancy and birth on the internet, and in books: "I'd hop on the Internet ... it's just an easy way of typing in something ... or I'd buy a pregnancy book ..." Other women are also a source of information: "Talking to my friends who've already done it. From my experience, I've not got that much information from medical people. It's all been my friends." However, pregnancy-specific information can be difficult to find: "There could be resources out there and they're not finding me or I'm not finding them, and that in itself is a problem." Changing Values Changing values was the fourth major theme to emerge. Pregnancy is a time when the principles that are important to a woman can change: "In general, the importance of the job ... where I was very career (focused) ... people are in shock and they think I've had a major sea change but in saying that I haven't lost my brains ... I'm not stupid." Park et al., (1997) proposed that the use of constructive thinking may assist in the process of psychological and behavioural adjustment in pregnancy (Park et al., 1997), and this proposition may explain the current findings. Model of Care The fifth theme of model of care reflects women's experiences of health-care management during pregnancy. Choosing a medical model of care can influence a woman's experience: "It's like they try and get you set up all neat and nice and have the light set up so when the Dr gets in ... he just comes in Oh, yes,' delivers this baby then out he

goes. And I think O, god!'... you know, that's the model they work in ..." Women's experiences are also influenced by choosing a midwifery model of care: "You could do it standing on your head if you wanted to . ..it was very much up to you. I got in the bath and it was like ... You can stay there if you want to and have it (the baby) ... and so I did." Women's beliefs about pregnancy and childbirth can influence the model of care they choose: "It's a shame that women don't understand how powerful their bodies are and they don't trust themselves anymore ... A friend of mine, she's so scared of childbirth I reckon she'll book her caesarean at seven months as she's definitely pro not going into labour." Previous findings relating to women's choice of care-provider, demonstrates support for the current findings that women's experience of pregnancy can be influenced by their choice of model of care (Howell-White, 1997). Women can make uninformed decisions about their choice of model of care when they are not aware of the full range of options available to them: "I think a lot of women never realise it's possible ... cos it's the way it goes. It's a shame. Even be aware of the options even if you still choose a hospital birth." Being Responsible The final theme to emerge from the data was being responsible. It is important for a pregnant woman to do everything in her power to be an informed and involved member of the team of people guiding her through pregnancy: "I think that maybe that... you're responsible, and if you're gonna have a baby, you're responsible and you shouldn't be passing that on to the Dr or to the ... admittedly you go to these people for their advice and their expertise cos you don't want things to go wrong but you've got to come to the party as well." Research into women's pregnancy and childbirth beliefs and choices may reveal support for the current finding. Conclusion This qualitative study was conducted to explore women's experience of pregnancy, focusing on experience of support. A qualitative study design was chosen as the most appropriate design for exploring experiences of pregnancy from the pregnant woman's perspective. Thirteen themes emerged from the data, and were clustered into six major themes. The primary theme to emerge from the data was support during pregnancy. Women feel well supported when support is available from multiple sources. An important source of support can be found in connections with other pregnant women and new mothers. Connecting with others provides pregnant women with important opportunities to talk about their experiences of being pregnant. Pregnant women also value a more personal approach to prenatal care, provided by female health-care professionals, and where possible, provided in the pregnant woman's home. An essential source of support occurs when the pregnant woman develops and utilizes her personal resources. In contrast, pregnant women experience a lack of support when: the woman and her pregnancy is not affirmed; others focus on negative aspects of child-bearing; their health-care professional neglects to offer appropriate and individualised support; and when other pregnant women are inaccessible. In addition, pregnant women acknowledge numerous barriers that exist to obtaining needed support. Amongst these barriers are: difficulties in asking for support; needing to reciprocate support; feeling like a burden; feeling obligated to those who provide support; lack of appeal of available support services; inappropriate model of care-woman fit; not knowing how to access support; and concealing aspects of the pregnancy experience. Pregnant women also have insights into ways to enhance their experience of pregnancy. Primarily, women want to connect with other pregnant women and new mothers, have a guide from early in pregnancy to inform them of their options, and require more informational and emotional support from their health-care professional. Furthermore, women would like semi-structured opportunities to focus on relationship issues, and their unique experiences of pregnancy. Access to support for pregnant women may also be facilitated through the availability of a 24-hour pregnancy-specific phone-line. The second theme to emerge from this study was experience of pregnancy. Amongst the positive experiences of pregnancy are heightened sensitivity, being supported by family and friends, being pampered and receiving attention, feeling emotionally attached to the baby, and occasionally having distractions from the experience of pregnancy. However, negative pregnancy experiences can be linked to an unplanned pregnancy, hearing about others' negative experiences, having unmet expectations, and being unwell. Encountering worries is a negative experience that can begin in early pregnancy, and can continue throughout pregnancy in varying forms. Previous negative experiences of pregnancy and birth can also

negatively impact a current pregnancy. Furthermore, negative experiences can be linked to unresolved difficulties, bodily changes, engaging in self-care, being at home, and a partner's transition to parenthood. During pregnancy, women can be challenged by rapidly changing emotional states, have unique experiences of pregnancy in relation to other pregnant women, and experience pregnancy in a spiritual way. Finding information was the third theme to emerge from the data. Women frequently find pregnancy-related information on the internet, in books, and from other women. However, there are women who are not able to find the information they are seeking. The fourth theme to emerge was changing values, reflecting pregnant women's decisions to alter their standards of living. Previous ways of living can become unacceptable to a woman once she is pregnant. The fifth theme to emerge was model of care. Women's experiences of pregnancy can be influenced by the way their health-care is managed, and a woman's beliefs about pregnancy can influence the model of care she chooses. However, women may not be aware of the full range of options available to them. The final theme to emerge was being responsible. Women have a responsibility to be an informed and active member of the team managing her prenatal-care. Implications Whilst the purpose of this study was to explore women's experience of pregnancy the results of this study indicate that their experience of pregnancy may be enhanced through receiving guidance in early pregnancy that enables women to access multiple sources of support, and importantly, is inclusive of connections with other pregnant women. Whilst health-care professionals have been noted as being well placed to offer guidance to pregnant women (Melender, 2002), it appears that women may not be receiving this type of support from their care-provider. When a pregnant woman is not able to access the support that she needs, there exists the potential for her to experience prenatal maternal stress, a negative psychosocial experience linked to adverse pregnancy outcomes (Stanton et al., 2002). Women in this study have also reported a preference for a more personal approach to their prenatal-care, provided by a female healthcare professional. Given this preference, the increased availability of one-to-one midwifery care throughout pregnancy may be a more appropriate model of care for many pregnant women. Through the longer consultations associated with one-to-one midwifery care, pregnant women may have increased opportunities to discuss their concerns, and with appropriate guidance, to develop personal resources that may enhance their pregnancy experience. Future Directions The findings of this study give cause to further exploration of the ways that women find out about the process of pregnancy. It appears that women expect to receive guidance from their general practitioner in early pregnancy; however, in many instances this may not be happening, leaving women feeling lost in the early stages of a transformative life experience. Research into the pregnancy-specific community level knowledge of the general practitioner, and the ways that the general practitioner is able to facilitate a woman's transition to pregnancy is justified. Further exploration of the process by which pregnant women connect with each other is also supported by the current findings. Knowing more about the ways women connect, and the barriers to connecting, may enable pregnant women to be more successfully facilitated in their efforts to gain support from each other. The findings of this qualitative study, designed to focus on the pregnant woman's perspective, indicate that women's experiences of pregnancy, and experience of support during pregnancy, are diverse. Whilst women's experiences during pregnancy are unique, not only to each woman but also for each pregnancy an individual woman experiences, women also share a range of common pregnancy experiences. According to the findings of this study, pregnant women know: the type of support that would be most helpful to them; when they are not receiving the support they want; and what prevents them from obtaining the support they want. To enhance women's experience of pregnancy, and to discover the type of support that will be most helpful to each pregnant woman and her developing baby, each pregnant woman needs to be asked about the type of care and support that will most appropriately meet her individual needs. References REFERENCES Aaronson, L.S. (1989). Perceived and received support: effects on health behavior during pregnancy. Nursing Research, 38(1), 4-9. Bondas, T., &Eriksson, K. (2001). Women's lived experiences of pregnancy: a tapestry of joy and suffering. Qualitative Health Research, 11(6), 824-840. Bost, K.K., Cox, M.J., Burchinal, M.R., &Payne, C. (2002). Structural and

supportive changes in couples' family and friendship networks across the transition to parenthood. Journal of Marriage and Family, 64(2), 517. Chamberlain, D.B. (2003). Communicating with the mind of a prenate: guidelines for parents and birth professionals. Journal of Prenatal and Perinatal Psychology and Health, 18(2), 95-108. Collins, N.L., Dunkel-Schetter, C.I., Lobel, M., &Scrimshaw, S. (1993). Social support in pregnancy: psychosocial correlates of birth outcomes and postpartum depression. Journal of Personality and Social Psychology, 65(6), 1243-1258. DiPietro, J.A., Hilton, S.C., Hawkins, M., Costigan, K.A., &Pressman, E.K. (2002). Maternal stress and affect influence neurobehavioral development. Developmental Psychology, 38(5), 659-668. Epstein, S. &Meier, P. (1989). Constructive thinking: a broad coping variable with specific components. Journal of Personality and Social Psychology, 57, 332-350. Feldman, P.J., Dunkel-Schetter, C., Sandman, C.A., &Wadhwa, P.D. (2000). Maternal social support predicts birth weight and fetal growth in human pregnancy. Psychosomatic Medicine, 62, 715-725. Harrison, M.J., Neufield, A., &Kusner, K. (1995). Women in transition: access and barriers to social support. Journal of Advanced Nursing, 21(5), 858-864. Howell-White, S. (1997). Choosing a birth attendant: the influence of a woman's childbirth definition. Social Science Medicine, 45(6), 925-936. Huizink, A.C., Robles de Medina, P.O., Mulder, E.J.H., Visser, G.H.A., &Buitelaar, J.K. (2003). Stress during pregnancy is associated with developmental outcome in infancy. Journal of Child Psychology and Psychiatry, 44(6), 810-818. Hurdle, D.E. (2001). Social support: a critical factor in women's health and health promotion. Health and Social Work, 26, 72-79. Korenbrot, C.C., &Moss, N.B. (2000). Preconception, prenatal, perinatal, and postnatal influences on health, from http://www.nap.edu/openbook/0309071755/html/125.html Levy-Shiff, R., Dimitrovsky, L., Shulman, S., &Har-Evan, D. (1998). Cognitive appraisals, coping strategies, and support resources as correlates of parenting and infant development. Developmental Psychology, 34(6), 1417-1427. Lobel, M., DeVincent, C.J., Kaminer, A., &Meyer, B.A. (2000). The impact of prenatal maternal stress and optimistic disposition on birth outcomes in medically high-risk women. Health Psychology, 19(6), 544-553. Maykut, P., &Morehouse, R. (1994). Beginning Qualitative Research: A philosophic and practical guide. London: The Palmer Press. Melender, H. (2002). Experiences of fears associated with pregnancy and childbirth: a study of 329 pregnant women. Birth, 29(2), 101. O'Connor, T.G., Heron, J., &Glover, V. (2002). Antenatal anxiety predicts child behavioral/emotional problems independently of postnatal depression. Journal of the American Academy of Child and Adolescent Psychiatry, 41(12), 1470-1477. Park, C.L., Moore, P.J., Turner, R.A., &Adler, N.E. (1997). The roles of constructive thinking and optimism in psychological and behavioral adjustment during pregnancy. Journal of Personality and Social Psychology, 73(3), 584-592. Patton, M.Q. (2002). Qualitative Research and Evaluation Methods. 3rd Ed. Thousand Oaks, CA: Sage Publications Ltd. Rini, C.K., Dunkel-Schetter, C.I., Wadhwa, P.O., &Sandman, C.A. (1999). Psychological adaptation and birth outcomes: the role of personal resources, stress, and socioculturel context in pregnancy. Health Psychology, 18(4), 333-345. Roesch, S.C., Dunkel-Schetter, C., Woo, G., &Hobel, C.J. (2004). Modeling the types and timing of stress in pregnancy. Anxiety, Stress and Coping, 17(1), 87-102. Ryding, E.L., Wijma, B., Wijma, K., &Rydhstrom, H. (1998). Fear of childbirth during pregnancy may increase the risk of emergency cesarean section. Acta Obstetricia et Gynecologica Scandinavica, 77, 542-547. Salisbury, A., Law, K., LaGasse, L., &Lester, B. (2003). Maternal-fetal attachment. Journal of the American Medical Association, 289(13), 1701-1702. Salmero-Aro, K., Nurmi, J., Saisto, T., &Halmesmaki, E. (2001). Goal reconstruction and depressive symptoms during the transition to motherhood: evidence from two cross-lagged longitudinal studies. Journal of Personality and Social Psychology, 81(6), 1144-1159. Schaffer, M.A., &Lia-Hoagberg, B. (1997). Effects of social support on prenatal care and health behaviors of low-income women. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 26, 433-440. Seligman, M.E.P., &Csikszentmihalyi, M. (2000). Positive psychology: an introduction. American Psychologist, 55(1), 5-14. Stanton, A.L., Lobel, M., Sears, S., &DeLuca, R.S. (2002). Psychosocial aspects of selected issues in women's reproductive health: current status and future directions. Journal of Consulting and Clinical Psychology, 70(3), 751-770. Thompson, L.M., Murphy, P., O'Hara, J., &Wallymahmed, A. (1997). Levels of daily hassles and uplifts in employed and non-employed pregnant

women. Journal of Reproductive and Infant Psychology, 15, 271-280. Walker, L.O., &Grobe, S.J. (1999). The construct of thriving in pregnancy and postpartum. Nursing Science Quarterly, 12(2), 151. AuthorAffiliation Toni M. Armstrong and Julie Ann Pooley Edith Cowan University, Western Australia AuthorAffiliation Send correspondence to: Julie Ann Pooley, School of Psychology, Edith Cowan University, 100 Joondalup Dve, Joondalup, Perth, Western Australia, 6027. Phone 618 6304 5591; fax: 618 6304 5834; email: j.pooley@ecu.edu.au

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