The Effects of Early Adversity on Women's Fertility Intentions: An Intuitive Inquiry

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Selena M. Doyle

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Abstract

In this thesis I use intuitive inquiry as a framework for investigating the relation between women's mental health and reproductive health. Specifically, the possible role that early adversity has on fertility intentions. Prior to presenting my understandings of these topics (in the form of preliminary lenses), I offer a description of theories that have been used to understand reproductive attitudes and behavior. I argue that these theories have an assumption of "healthy" or "typical" development, and that they may not be as effective for predicting outcomes for women with above-average levels of early adversity. I highlight the small amount of research that has investigated fertility intentions within women who have experiences of early adversity. I argue that knowledge and theory from contemporary areas in mental health (neurobiological theory) should be integrated with reproductive research. I analyzed interview transcripts of young, childfree women, with histories of early adversity: by consulting these transcripts, I suggest that fear and anxiety may be significant factors which should be considered when understanding the fertility intentions of women who have experienced early adversity. From the perspective of a neurobiological framework, I suggest reasons why women's experiences of early adversity may impact their fertility intentions. Lastly, I argue that identifying and intervening with this population during the sensitive perinatal time is important to improve outcomes for mothers and children.

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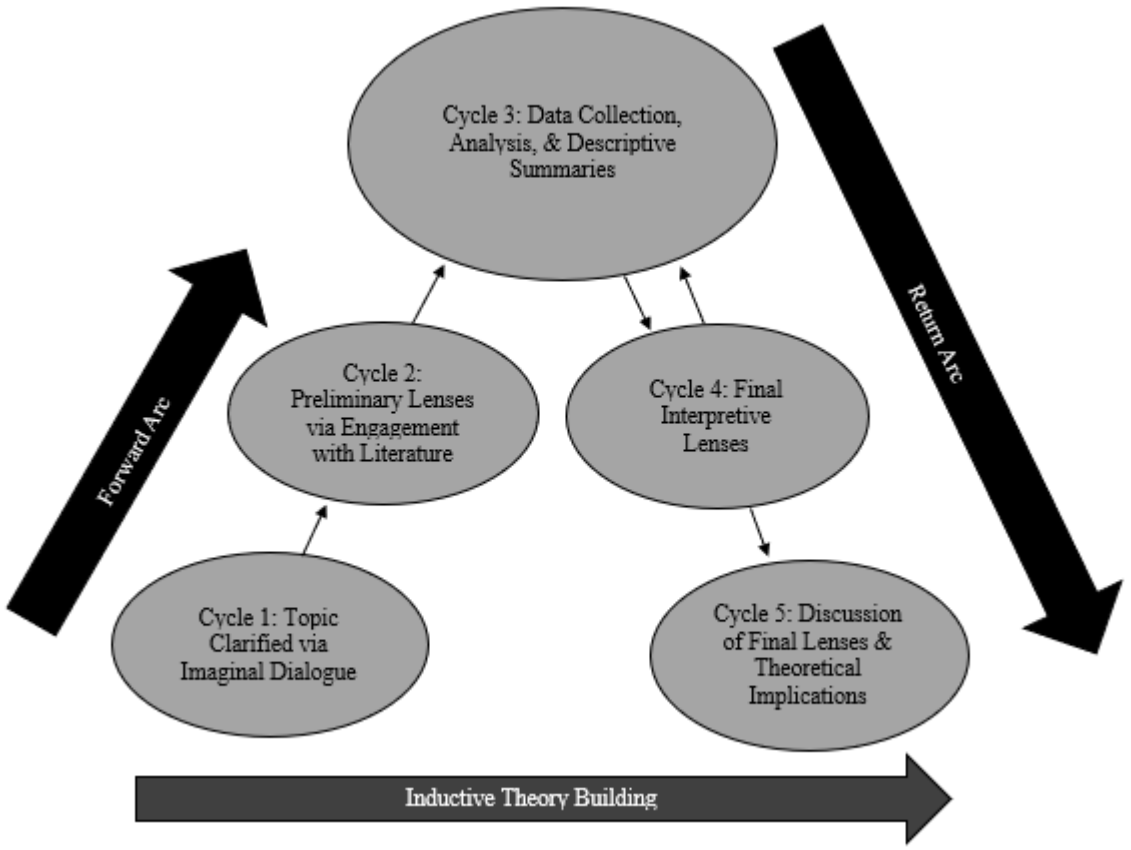
Introduction

Methodology

In this thesis I have used intuitive inquiry (Anderson 2004; Anderson 2019) as a methodology to understand the relation between women's mental health and reproductive health. "Intuitive inquiry is a search of new understandings through the focused attention of one researcher's passion and compassion for themselves, others, and the world" (Anderson, 2004. pp. 308-309). Anderson asserts that intuitive inquiry is a post-modern epistemology (2004) as it is "an epistemology of the heart" (p. 308) and a transformative research method (2018). She states that it is a hermeneutical (interpretive) process which involves both intuitive and intellectual precision (2004). A variety of methods and data sources may be used, depending on what is best fitting for the topic and researcher. Anderson (2019) states that intuitive inquiry is ultimately an inductive theory building process. It has undergone multiple changes throughout its development and refinement from 1995–2005, such as the addition of specific cycles to include during the hermeneutic process (Anderson, 2018). Anderson's (2000) hermeneutic structure is based on the biblical hermeneutics of Friedrich Schleiermacher (1998) and the philosophic hermeneutics of Hans-Georg Gadamer (1986). According to Gadamer (1986), the success of our interpreted understandings is based on our education on the matter. Specifically, the acquisition of knowledge on something, and equally, on the extent to which we have learned about ourselves, the world, and others through the process. Throughout this document, I have followed Anderson's (2019) suggestion and have organized each major section according to each of the hermeneutic cycles. (See figure 0.1). In doing so, I hope to more clearly narrate the process that I engaged in. In addition, I have included Anderson's (2004) suggested content in each cycle.

Figure 0.1 *Intuitive Inquiry: Dynamic Structure for the Five Cycles of Interpretation*



Note. Adapted from *Intuitive Inquiry: Inviting Transformation and Breakthrough Insights in Qualitative Research* (Anderson, 2019)

On the forward arc of the hermeneutic process, I have presented my initial understandings on my topic, in the form of preliminary lenses. On the backwards arc, I engage with, and interpret, the experiences of others, and subsequently have refined or nuanced these perspectives. By engaging in a forward and backward process, I have iteratively engaged with the topic and adopted different levels of analysis; that is, I perceived the individual components, and compared, contrasted, and integrated them with a more holistic perspective (Anderson, 2019). In addition, by structuring it in this manner, I have aimed to be as explicit about my perspectives as consciously possible and have identified how these perspectives may have changed through consultation with external data. This contrasts with other methodologies in which researchers may attempt to remove or bracket their values and assumptions, and which Anderson (2000) argues often results in simply circling back to one's original perspectives. Through this process, I

have experienced new insights from being to the experiences of others and from being reflective throughout the process.

Research Topics

I have always been interested in understanding the factors that contribute to an individual's and a community's health and well-being. Over the past few years, I have grown increasingly interested in topics in mental health, and in reproductive and sexual health. When I reflect on my relation to these topics, I have considered that I am a 30-year-old queer cisgender woman who has grown up in rural Alberta. Furthermore, I have had various fertility intentions throughout my life: Specifically, I have transitioned from wanting multiple biological children, to wanting to adopt children, to questioning whether I even want any children at all. Of note, I have experienced early and later adversity and I believe that these have played a role in my reproductive and sexual intentions and outcomes. Therefore, according to Anderson, (2000) I likely have a unique vantage point to investigate these topics since I have experienced adversity and have had, and do have, fertility intentions. As a result, I am likely more adept at identifying nuances in the data. Furthermore, I have primarily relied upon the intuitive style of "through our wounds" wherein researchers explore "fault lines of [their] personality [which] invite change and transformation" (Anderson, 2004. pg. 313).

Project Scope

Intuitive inquiry has allowed me to direct my investigation in whatever manner I feel is most appropriate to understand these topics. Initially, I sought to understand the possible relation between women's mental health and reproductive health. During this time, I identified having a feminist perspective on the social construction of women's mental health and reproductive health. Specifically, my epistemology was in line with Richman and colleagues (2000) who provided a critique of the medical research on women's experiences with chronic fatigue syndrome. Richman et al. highlighted previous research from this perspective, which identified the issue of unequal power in patient–provider relations (Andrist, 1997) and an unbalanced allocation of medical resources for men and women (Wallis, 1994). At this point, I had familiarized myself with Goldscheider et al.'s (2017) gender revolution framework and was considering the ways in which gendered and economic power imbalances impact women's sexual and reproductive intentions and outcomes. As I refined the scope of my project, eventually these power imbalances were no longer a significant lens for analysis. Specifically, I grew increasingly interested in

identifying the mechanisms involved in the relation between women's experiences with early adversity and their fertility intentions.

Therefore, I based my final inquiry around the following research question: "To what extent, and in what ways, do experiences of early adversity impact women's fertility intentions?" I approached this investigation with a post-positivist epistemology, wherein I focused on understanding the underlying mechanisms involved in this relation and accounting for significant contextual factors (Reed, 2010). At this point, my previous understanding of historical and contemporary attachment theory (Ainsworth & Bell, 1970; Fonagy & Allison, 2014) informed how I approached the relation between early adversity and fertility intentions. For example, contemporary attachment style theory is viewed from an evolutionary perspective (Howe, 2011) wherein a child's experiences of fear, comfort, and degree of predictability (Fonagy & Allison, 2014) inform the way in which they interact with—and interpret—interpersonal relations. Although I accepted this as one possible framework to understand early adversity, I was compelled to further understand the mechanisms that underly this theory. Therefore, I eventually discovered neurobiological explanations for understanding how trauma reactions from early adversity occur, and what the resulting impacts are. As a result, throughout this paper, I have predominantly relied on neurobiological theory to describe and offer explanations between the relation between women's early adversity experiences and their fertility intentions.

Cycle 1: Being Drawn to and Clarifying the Research Topic

In the first cycle, the researcher clarifies their topic ". . .via a creative process which involves (a) selecting a text or image that repeatedly claims their attention as related to the research interest, (b) engaging in an imaginal dialogue with that text or image, and (c) recording insights" (Anderson, 2019. p. 214). Therefore, my journey with this project formally began when I had the opportunity to read four transcripts from interviews that had previously been conducted. Generally, participants had been asked to reflect on how and when they made decisions regarding motherhood, and the personal and social factors that might have played a role in these decisions. Specifically, they were asked about their motherhood ideals; that is, in a perfect world, what would their family look like? (Would they have children?). In addition, they were asked why they wanted or did not want to be a mother. In these discussions, they were prompted to consider what factored into these decisions (e.g., personal and contextual factors such as issues related to relationships, sexual identities, career, SES, ethnicity, education, etc. underlying such differentials.) Despite not being directly prompted to consider their previous or current mental health, this factor was mentioned by three of the four participants. Below are the quotes from the three participants who indicated that mental health experiences were indeed a factor that had been significant when considering their fertility intentions:

> Participant 1: "'…We should have a baby.' And [inaudible, 0:53:46, Maury's] like. . . 'I'm not really sure.' And... 'I'm super depressed.' I'm like, 'No, honey, I, kind of, think I want one.' And he's, like. . . 'Does it make you happy if you're pregnant?' I'm, like. . . 'Yeah.' He's like. . . 'Fine.'"
>
> Participant 2: "I've also seen moms struggle a lot with postpartum depression, and I had a lot of anxiety when I was in university. So, that also freaks me out that I might be a risk for postpartum depression, and just what that's going to mean for me, and my partner. . .Just because, I'm not sure. . .We've discussed

> mental health and stuff before, but postpartum depression is pretty different from any. . .It's a mental illness on its own."
>
> Participant 3: "When I was 12 years old my best friend passed away and I remember, we were talking, she was talking about what names she wanted to name her kids. So, in my, kind of. . .That aspect of grief, it translated to. . . 'Shoot. I need to have children so she can get those names that she always wanted.'"

As mentioned, despite not being prompted to consider their mental health, these participants alluded to how their mental health had impacted their reproductive goals. At this point, I reflected upon my own experiences with mental health and how this had also impacted my own reproductive goals. Therefore, I considered that mental health experiences might impact women's fertility intentions, and that this may be an area which warranted further investigation.

After many months of reflecting on these excerpts, I decided on the initial topic of "exploring the ways in which women's mental health experiences impact their fertility intentions." In preparation for this investigation, I explored research from topics in mental health and reproductive health. At this time, I did not have any theories that guided my learning. Therefore, I approached these topics simply with curiosity and open-mindedness. In the remaining sections, I offer select literature that was important in informing the progression of this project and in my perspectives on these topics.

1.1 Introduction to Mental Health Topics and Issues

Over the past 20 years, there has been a shift in how we understand the factors that impact a person's mental health. Life-threatening adversities, or "big T traumas" such as active combat, natural disasters, rape, and physical assault are no longer considered to be necessary to experience severe negative mental health outcomes. Exposure to on-going adversity, or multiple "little t traumas," can also increase one's risk of severe mental health issues, such as complex post-traumatic stress disorder (Karatzias & Levendosky, 2019). Furthermore, childhood adversity, such as familial violence or poor attachment with one's caregiver, is especially damaging (Spinazzola, et al., 2018). Therefore, research has finally begun to conceptualize an individual's current mental health as being the product of biopsychosocial factors which have occurred across (and before) their lifespan.

1.1.1 Early adversity. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur before age eighteen (Centers for Disease Control and Prevention, 2021). Although not every adverse childhood experience is considered to be traumatic, profound or chronic early adversity is more likely to lead to a trauma response with significant consequences. Childhood trauma has been called the "single most important public health challenge in the United States. . ." (van der Kolk, 2005). Researchers at the Department of Preventative Medicine at Kaiser Permanente (Felitti et al., 1998) first used the Adverse Childhood Experience questionnaire (Appendix A) to investigate experiences of adverse childhood experiences and their cumulative relation to measures of risky behavior, health status, and disease. Specifically, they investigated experiences of 1) familial emotional and/or physical abuse; 2) emotional and/or physical neglect; 3) witnessing familial violence; 4) living with someone who had a substance abuse problem, mental health problem, and/or was incarcerated; and 5) experiencing sexual abuse. (I encourage my readers to reflect upon this questionnaire and consider how your experiences may have impacted your own reproductive behaviors and attitudes.[1])

Contemporary research using the ACE questionnaire continues to find a similar prevalence and degree of impact on participants who have experienced such adversities (Tough & McDonald, 2013; Zarse et al., 2019). Specifically, research with Albertan populations indicate that degree of adverse childhood experience is positively associated with adult mental health diagnosis, substance dependence, and is negatively associated with perception of physical health, emotional health, and social support (Tough & McDonald, 2013). These associations are strong even when covariate risk factors, such as poverty, are controlled for. Despite decades of research which highlight the significant role that ACEs play in people's lives, research has remained relatively siloed, and has not accounted for how early adversity likely impacts reproductive intentions and outcomes.

1.2 Introduction to Reproductive Topics and Issues

Researchers who have sought to understand and predict reproductive behaviors and outcomes have often consulted theories from demography. Contemporary demography is

[1] Intuitive inquiry encourages the researcher to express their research "in a personal and embodied manner, inviting readers to resonate to the full sense-scape of the experiences portrayed." (Anderson, 2000. pg. 39). Therefore, I aim to encourage readers to have a deeper and more relevant connection to the relation between adverse childhood experiences, reproductive health, and fertility intentions.

considered an interdisciplinary field with many theories that continue to be refined. In order to understand reproductive behavior over time and place, and at the individual and aggregate level, diverse perspectives have been used. Historically, researchers in the field of demography used quantitative data of a country's rate of fertility, mortality, and migration to describe and predict a population (Debruijn, 2006). To further understand and interpret these statistics, they incorporated qualitative elements from perspectives in history, anthropology, and biology. Thus, a slightly improved understanding of aggregate and individual fertility changes was introduced by way of the model of proximate determinants (Bongaarts, 2015). Specifically, the five interacting factors (e.g., marriage) which make up the model are thought to underly the mechanisms which account for fertility outcomes. The disciplines of micro and macro-economics and sociology were also incorporated to investigate the social structures that hindered or facilitated fertility. For example, Caldwell's (2005) net intergenerational wealth flow is a helpful macro-economic theory which weighs the costs of having children with the predicted economic benefits. In addition, in order to understand the complex interactions that are involved in fertility outcomes, contemporary research has incorporated multiple levels of factors. For example, the Easterlin Synthesis (Easterlin, 1975) consists of a model which integrates biological, social, and economic variables to attempt to predict fertility outcomes. Moving forward, with the increased availability of birth control methods, and improved access to medical interventions, researchers have become aware of the impact that an individual's choice has on their fertility outcomes. Of the many variables that have been studied to predict fertility outcome (e.g., marital status, length of relationship, education level, income, religion) an individual's fertility intentions accounts for the most variance and is thus our best-known predictor (Testa & Toulemon, 2006). With that in mind, although fertility intentions[2] may be effective for predicting fertility outcomes for those with minimal histories of early adversity, I argue that this relationship is more complex for women with histories of significant early adversity.

[2] I define *fertility intentions* as "women's plans regarding engaging in childbearing via the biological methods of vaginal and/or cesarian delivery and with the intentions to keep the child."

As mentioned, research is increasingly concerned about understanding the concept of fertility intentions and how they are formed[3] and expressed.[4] Of note, a woman's fertility intentions are a smaller component of her larger reproductive goals.[5] Therefore, psychological theories were incorporated in order to understand the factors that contributed to the expression and formation of women's fertility intentions: The theory of planned behavior (Azjen, 1991) has been used to explain the role that an individual's attitudes, behaviors, and degree of control, play in their fertility intentions. As mentioned, to the bewilderment of researchers, although many contraception methods are available, roughly half of pregnancies in the United States are unintended (Finer & Zolna, 2011) and this has increased about ten percent from trends observed over the past 30 years (Mosher et al., 2012). I argue that to understand this unintended fertility rate, and to develop a more holistic understanding of reproductive research, we must integrate contemporary understandings of trauma. Unfortunately, the reproductive research that has been integrated with women's mental health research has primarily focused on the prevalence of unintended pregnancies within women who have experienced early adversity (Testa et al., 2021) and research that attempts to understand this relationship is scare (Shreffler et al., 2021) and, commonly, theoretical in nature (Shreffler & Gallus, 2017). Therefore, I argue that, although the causal mechanisms are unclear, it is apparent that early adversity impacts reproductive outcomes, and it is therefore useful to investigate the possible role that it may have on women's' fertility intentions. Of note, although formation and expression of fertility intentions may be examined together, I have limited my investigation to understanding, and offering my explanations, to how and why early adversity is related with women's expressions of their fertility intentions.

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[3] I define the *formation* of fertility intentions as being "the process of development or refinement of fertility intentions." It involves explaining the mechanisms involved and identifying possible factors that trigger this decision-making process.

[4] I define *expressions* of fertility intentions as being "woman's claims of wanting to birth a child, not wanting to birth a child, or being ambivalent about birthing a child."

[5] I define *reproductive goals* as "the number of dependents that an individual would like to be responsible for; the qualities of these dependents (e.g., sex); the methods of conception and childbearing of these dependents; and the particular timeframe that they would like to engage in childbearing (and the closely related concept of the spacing of their births)."

Cycle 2: Developing the Preliminary Lenses

In the second cycle, the researcher consults "theoretical or empirical literature about the topic and prepares a list of preliminary interpretative lenses" (Anderson, 2019).

2.1 The Relation Between Early Adversity and Negative Health Outcomes

Growing research is examining the unique and profound ways that childhood adversity impacts short-term and long-term health outcomes (Karatzias & Levendosky, 2019). In fact, childhood adversity has been called the most significant root cause of negative health outcomes, with economic and social costs higher than any other root causes combined (Zarse et al., 2019). Childhood adversity has been continually shown to be associated with poor physical and psychological health. Unfortunately, less is known about its relation to reproductive health due, in part, to ethical challenges of researching this population (Pawluski & Dickens, 2019).

2.1.1 Physical health. Contemporary research continues to demonstrate the strong relation between early adversity and negative health outcomes. Zarse et al. (2019) reviewed the studies which involved the Adverse Childhood Experience questionnaire—the 44 articles generated from Dr. Kaiser's (Felitti et al., 1998) original data and 90 articles on new data—and concluded that exposure to early adversity has a dose-dependent effect on health outcomes: Specifically, there is an increased risk of indicators of negative general health, such as migraines, chronic pain, obesity, disordered sleep, and premature death (<65 years of age). Despite controlling for the covariates of smoking and obesity, participants showed a higher likelihood of experiencing specific areas of poor functioning and diseases such as autoimmune, pulmonary, cardiovascular, and cancers.

2.1.2 Psychological health. Similarly, early adversity continues to show a dose-dependent effect on psychological outcomes (Zarse et al., 2019). Specifically, it is positively associated with negative mental health outcomes (e.g., depression, PTSD, psychosis, and suicidality) and addictions (e.g., nicotine, alcohol, and illicit drugs).

2.1.3 Reproductive health. As mentioned, there is significantly less research that examines reproductive health and outcomes from a trauma-informed perspective. Specifically,

there is a lack of research which views sexual and reproductive behavior and outcomes from a life-course perspective and accounting for the neurobiological and interpersonal effects of early adversity. Pawluski and Dickens (2019) have argued that the integrated area of perinatal health, significantly lags behind the more siloed areas of reproductive and mental health research. They claim that the lack of research in this area is due, in part, to the classification of pregnant women as special human subjects due to their "vulnerability to coercion" (p. 831) and the added complication of protecting the fetus. Therefore, I argue that by not engaging with a trauma-informed lens, mainstream reproductive research contains significant assumptions of "healthy" or "typical" biopsychosocial development and is not representative or predictive for women with an above average level of early adversity. Furthermore, I argue that in order to prioritize this neglected population, creative research methods are likely needed in order to understand and improve outcomes, while being sensitive to ethical difficulties.

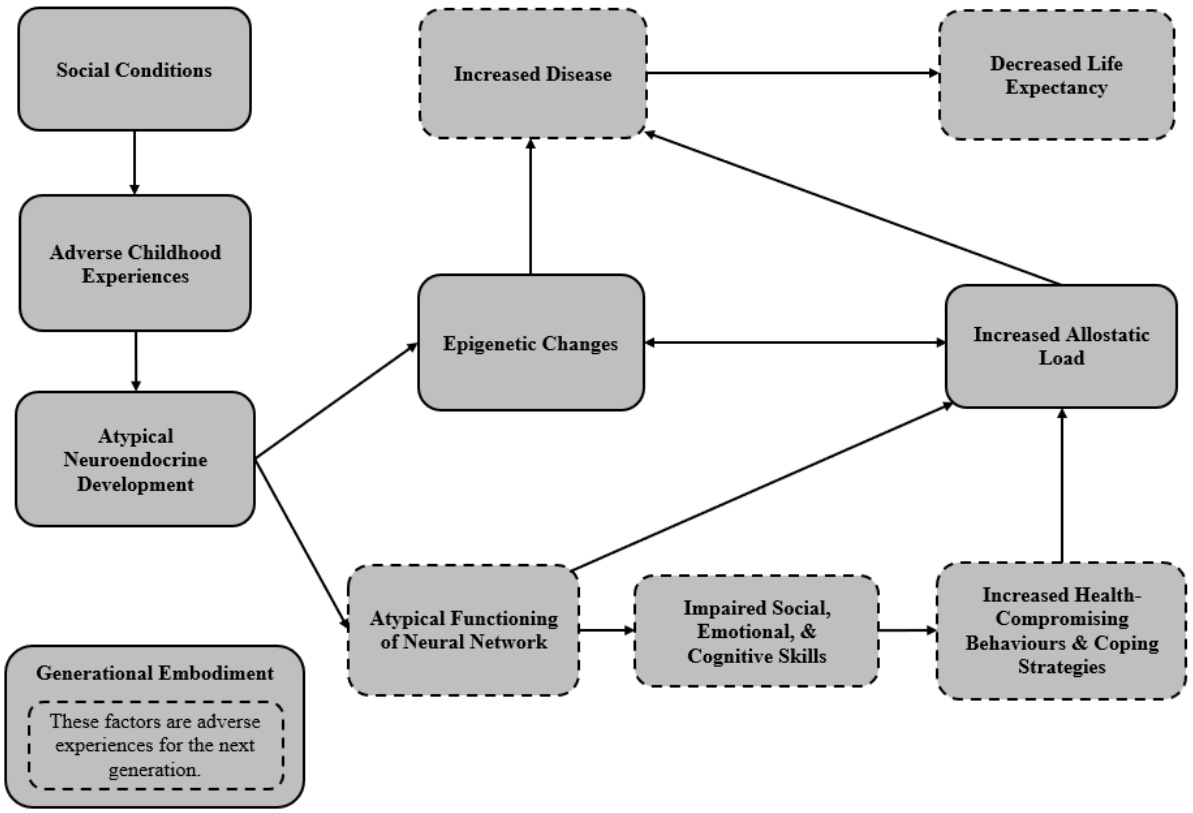
2.2 The Relation Between Early Adversity and Fertility Intentions

The relation between early adversity and fertility intentions has not been widely explored. As mentioned, the research that has been conducted has mostly established the connection between early adversity and unintended pregnancies. For example, current research suggests that three or more experiences of early adversity roughly double the risk of unintended pregnancies in adolescents (Flaviano & Harville, 2021) and in adult women (Testa et al., 2021). Gallus and Shreffler (2017) theorized that early adversity increases the likelihood that women will have ambivalent fertility intentions. To explore this theorized relation, Shreffler and colleagues (2021) assessed the impact that early interpersonal trauma had on fertility intentions. In doing so, they found that interpersonal trauma was indeed positively associated with an ambivalent child rearing attitude ("a baby would make no difference in my life") but found an even stronger association with positive attitudes ("a baby would make things better"). Of note, participants were female and male adolescents; researchers only investigated early interpersonal adversities; and childbearing attitudes were used as a proxy for fertility intentions. Therefore, more research is needed to understand the possible relation between early adversity and women's fertility intentions and the mechanisms of this possible relation.

2.3 The Mechanisms of Early Adversity and Intergenerational Trauma

I argue that to understand the underlying mechanisms involved in the relation between early adversity and fertility intentions, it is necessary to understand the neurobiological effects of early adversity (Meyer et al., 2013). The Department of Preventative Medicine at Kaiser Permanente has depicted the processes by which early childhood adversity leads to subsequent negative outcomes and eventual premature death (Felitti et al., 1998). The original pyramid structure has since been reconceptualized to highlight the role that social conditions and generational adversity play in these processes (Centers for Disease Control and Prevention, 2021). Contemporary research suggests that chronic or profound childhood stress disrupts neurobiological development; specifically, how the hypothalamic-pituitary-adrenal (HPA) axis develops and functions (Li et al., 2014). Thus, I have further re-conceptualized the adversity pyramid into a web shape (figure 2.1) to further delineate the neurobiological mechanisms of early adversity and highlight the areas of intergenerational transmission from mother to child.

Figure 2.1 *Health Effects of Adverse Childhood Experiences and Process of Intergenerational Trauma*



Note. Adapted from *Centers for Disease Control and Prevention* (2021, April 6).

Ultimately, this revised framework served as the lens through which I understood the relation between early adversity and fertility intentions. Therefore, I will elaborate on key areas in the sections below.

2.3.1 Atypical functioning of neural networks. As a result of an atypical functioning HPA axis, a child ends up with neuroendocrine systems in their body that are atypically functioning; that is, under-functioning or over-functioning. Lammertink et al. (2021) highlighted the resulting atypically functioning neural networks that are involved in the stress response: a) The *salience network* is responsible for filtering out, or alerting us to, relevant stimuli which requires our thoughtful attention; b) the *default mode network* is involved with automatic processing of social cognition (Li et al., 2014); c) the *executive control network* is responsible for higher-order functions which require conscious and intentional thoughts (Lammertink et al., 2021). Although a child's neural network may have initially developed to mitigate early adversity and to predict future experiences, eventually this manner of functioning is no longer helpful. For example, adults may experience a hypersensitive response to future stressors (Clayton et al., 2020) that is no longer adaptative for the current environment.

2.3.2 Impaired social, emotional, and cognitive skills. Furthermore, dysregulation in these networks results in social, emotional, and cognitive impairments and makes people more likely to struggle with the emotional regulation, problem-solving skills, and interpersonal skills that are necessary to handle stressors that may be experienced as an adult (Liu & Nusslock, 2018). These difficulties increase the likelihood that people will engage in health-compromising behavior and coping strategies which contribute to their higher risks for negative physical, mental, reproductive, and social outcomes. For example, researchers in Bosnia and Herzegovina indicated that childhood emotional neglect affected approximately a quarter of participants (26%) and that these experiences were significantly associated with increased likelihood of engaging in health-compromising behavior and experiences across all measurements of risk: specifically, drug abuse (3.4); early sexual initiation (3.3); victimization in dating violence (2.6); and alcohol use (2.2) Musa, et al., (2018).

2.3.3 Increased allostatic load. In addition, previously mentioned health compromising behavior and coping strategies exert stress on the body. When the body is experiencing a lot of stress, or inflammation, it is said to be in a state of allostatic load. Such increased "wear and tear" on the body causes more rapid epigenetic aging (Parade et al., 2021; Zannas et al., 2015).

Epigenome research has shown accelerated molecular aging among individuals who have experienced maltreatment. Specifically, Houtepen et al. (2018) examined the extent to which adverse childhood experiences led to changes in DNA methylation (an indicator of premature epigenetic aging) for women in their fifties. In the two–cohorts of 780 and 552 women, researchers found nine differentially methylated genomic regions associated with adverse childhood experiences. Therefore, the chronic accumulation of stress hormones increases the likelihood that an individual will experience disease and ultimately a reduced lifespan.

2.3.4 Epigenetic changes. Of note, the second pathway through which early adversity contributes to negative health outcomes is through epigenetic changes. As previously mentioned, the hypothalamic-pituitary-adrenal (HPA) axis is indirectly responsible for the body's stress response as well as "turning on/off" the expression of particular genes. As a result, atypical HPA axis development leads to the over- and under-transcription of genes. Although the processes and impact of this pathway are less relevant to the current study, it is worthwhile to highlight these processes so that readers are aware that early adversity can contribute to chronic disease and premature aging even if the adult does not engage in health compromising behavior or coping strategies.

2.4 Preliminary Lenses

My preliminary lenses are my observations of my topic and the perspectives that I have taken while viewing them (Anderson, 2004). There has been considerable range in the number of lenses that have been generated with intuitive inquiry research—ranging from 4 (Kelly, 2019) to 51 (Wasson, 2014). These initial lenses illustrate my understandings of my topic prior to consulting external data. Comparison of the preliminary lenses with my final lenses assists readers with assessing the degree of transformation that I experienced during this process.

Table 1: Preliminary Lenses

Investigating the Relation between Early Adversity and Fertility Intentions

- Reproductive health is composed of interacting intergenerational and lateral factors.
- Current theories used to understand and predict fertility have an unstated assumption of "healthy" development.
- Experiences throughout a woman's life impact her fertility intentions.
- Early adversity impacts one's cognitive, emotional, and social skills which are important to meet goals that precede fertility intentions
- Early adversity leads to a heightened stress response which makes some women not want to have children.
- Many context-specific factors, with complex interactions, impact a woman's fertility intentions and so it is difficult to predict fertility intentions at the individual level.

Cycle 3: Incorporating External Data

In the third cycle, the researcher "(a) identifies the best source(s) of data for the identified research topic, (b) develops criteria for the selection of data from among these sources, (c) collects data, and (d) presents a descriptive data analysis" (Anderson, 2019). Therefore, following my decision to use intuitive inquiry as a methodology, I had to determine which method and source of data would be most appropriate. I considered multiple and sometimes competing factors to make this decision. I believed that a thematic analysis of the 52 interview transcripts was the best method and source of data, on account of ethical and practical considerations. Specifically, 1) ethical concerns, regarding the difficulty of researching the sensitive topic of early adversity, and 2) practical concerns, regarding the timely access to participants who had experienced both early adversity and who had developed, or were developing, their fertility intentions. Following my initial orientation with the data, I chose to further refine the external data to ensure that I had the most valid source of data to answer my research question. In the sections below, I delineate how I ultimately ended up focusing on the 10 interview transcripts and why they were the basis for my in-depth analysis.

3.1 External Data

As mentioned, I consulted previously collected transcripts from 52 women aged 19-48 who were interviewed. The current study was part of a larger interview study which had been reviewed by, and received approval from, the University of Saskatchewan Behavioural Research Ethics Board. Participants were recruited via a Facebook advertisement. Participants provided consent prior to the interview and were provided a $25 honorarium. (See Appendix B for a copy of the participant consent form.) Recruitment was primarily directed at Saskatchewan residents but, due to the nature of recruiting via social media, some participants from Alberta were also included. The 52 women who were ultimately interviewed, resided in Alberta or Saskatchewan. Interviews were conducted either in-person or virtually and lasted approximately an hour. The purpose of these interviews was to try and understand their reproductive goals, the timing of these goals, and the factors that impacted them. Specifically, (a) personal factors: such as attitudes and mental frameworks, (b) interpersonal factors: including pressures and supports, and

(c) structural factors: such as life context and facilitators and obstacles to achieving their reproductive goals. (See Appendix C for a copy of the interview schedule.) Audio-recordings were transcribed, and participants had the opportunity to revise their transcripts.

3.2 Data Analysis

The ultimate goal of my coding procedure was to assess and refine the accuracy of my initial lenses. In preparation for this, I familiarized myself with a variety of types of codes and coding procedures (Saldaña, 2016). On my first coding cycle, I examined the 52 transcripts and coded all for experiences of adversity (i.e., early, later, adversity-NA) and expressions of fertility intentions. (i.e., want children, do not want children, uncertain). [6] At this point, I reflected on my earlier assumption about the strong relationship between early adversity and later adversity and decided only to include participants with indications of early adversity. I then separated transcripts into document groups (fertility intentions and early adversity) for further analyses[7] During this process, I primarily used a deductive approach to code for the semantic and latent content of early adversity and fertility intentions. I deductively coded participants as experiencing an early adversity if they indicated experiencing one or more of the items in the ACE questionnaire such as parental separation, living with a family member with a mental illness, feeling unloved or unsupported, etc. (See Appendix D for an exhaustive list of the coding criteria.) In addition, I inductively coded for early adversity-not previously specified, if they indicated experiencing something which likely produced prolonged emotional, physical, or psychological stress. (e.g., a queer sexual orientation.)

When looking at the entire data set, it proved difficult to code for expressions of fertility intentions. Women with children were asked about their plans prior to having their children and as well as their plans for future children. Therefore, I found it difficult to parse out the intentions when women had multiple children. In addition, I was less confident relying on retroactive fertility intentions. Therefore, I chose to limit my analyses to the 26 women who currently did not have children. In addition, when analyzing the transcripts of interviews with these 26 women, it

[6] I also inductively coded other factors that captured my attention (e.g., social support, spiritual connectedness) but ultimately decided these were outside the scope of my project. Of note, just under half of all participants currently had at least one child (25/52, 48%) and more than half of these pregnancies were intended (15/25, 60%).

[7] Although I present the numerical breakdowns for descriptive purposes, it is not appropriate to draw inferences from these small groups.

became apparent that age significantly affected fertility intentions: Women who had initially wanted children would often change their intentions around ages 35–40. Therefore, I chose to divide these women into an older and younger group to attempt to remove some of the effect of age. Thus, my new target group consisted of women 35 years and younger and who currently did not have children.

I then further examined the remaining 16 transcripts to determine a possible relation between fertility intentions and experiences of early adversity: fertility intentions were coded for certainty of no children (4); certainty of children (5); and uncertainty of children (7). It should be noted that participants were not explicitly asked about experiences of early adversity. Therefore, I often identified these semantic or latent codes when participants discussed interpersonal relationships and what had influenced their fertility intentions. After reflecting on these transcripts, I was not comfortable assuming that participants who did not indicate signs of early adversity had indeed not experienced any. Therefore, instead of analyzing both between and within groups for all sixteen participants, I chose to limit my target group to the remaining ten women (A-J) who I was comfortable believing had likely experienced at least one form of early adversity.

In subsequent coding cycles, I developed a summary matrix (appendix E) to summarize the deductive factors of interest and to compare and contrast participants based on their particular fertility intention group. In this second cycle, I used an inductive approach to identify additional factors of interest that I had not anticipated (e.g., fear) and documented them in the summary matrix.

Overall, although I had approached this process with an openness to latent and manifest codes in an inductive and deductive manner, it was an iterative process, and I revised my procedure when I encountered information that prompted me to do so. (e.g., such as only analyzing younger women when I realized that participant's actual or perceived fecundity altered their fertility intentions.) When I reflected on this process, I realized that I had gone through multiple steps in order to test my hypotheses or preliminary lenses, and had essentially conducted a content analysis (White, & Marsh, 2006).

3.3 Descriptive Summaries

In addition, as per Anderson's (2004; 2019) recommendations, I have included a summary of the participants' experiences in order to encourage the reader to develop their own

perspectives before I present my interpreted data in the fourth cycle. Anderson has identified descriptive data analysis as commonly presented in the form of ". . .participant portraits, edited interview transcripts, and thematic content analysis," (2019. p. 315) and ". . .summary findings of videotapes, each woman's story, a report of brainstorming sessions, photographs, and creative expressions" (2004 p. 321). Ultimately, whichever form the researcher deems as being the most effective for the topic and researcher is considered appropriate. Therefore, due to the broad-scope of questions that were included in the initial interviews, I have provided summarized descriptions of the main content that was relevant to my analysis.

3.3.1 Certain about abstaining from childbirth. Less than half (4/10, 40%) of my target group met my coding criteria for being certain that they *did not want* to engage in childbirth.

I classified Participant 1 as experiencing early adversity since she indicated having a queer sexual orientation. She did not elaborate on how this affected her, other than suggesting difficulties in interpersonal relation. She had considered adoption but decided against this due to the permanence of children. Another factor that she identified has being a deterrent to having biological children was her extreme fear of childbirth.

Participant 2 was bullied as a youth. She indicated having a "wonderful mother" and currently having positive relations with her. Despite this, she indicated that she did not want to have children because she could not live up to her mothering standard since she was "selfish" and had high work ambitions that would make these life choices incompatible. In addition, she also did not want to have children because she did not want them to be bullied like she had been.

Participant 3 grew up with divorced parents and did not have strong relations with her father. She was diagnosed with major depressive disorder at age 13. She used to be angry when thinking about mothers and motherhood—although she was unsure why this was the case—but has since come to appreciate that although she does not want to be a mother, it is likely a good role for others who do want this. She indicated that her previous mental health challenges posed a barrier to having biological children since she viewed it as irresponsible to affect her hormones so much. She valued children and therefore has considered fostering them.

Participant 4 grew up with a family history of disease and disability and was afraid of having a child with a disease or disability. Finding a partner who was happy being child-free and supported her decision further solidified her decision to abstain from having (biological) children. Despite this, she was open to the idea of adoption.

3.3.2 Ambivalent about engaging in childbirth. Over half (6/10, 60%) of my target group met my coding criteria for being *ambivalent about childbirth.*

Participant 5 grew up with divorced parents and never had a relationship with her father. Instead, her mother co-parented along with other single moms. Therefore, she felt that a romantic partner was not required to raise a child, although it would certainly make things easier. She highlighted the strong support system that her mom had established where they lived, and that similar community supports would be necessary if she did have children. Throughout her childhood and adulthood, she experienced positive and supportive relations with her mother and brother. She had not thought too much of motherhood and claimed she "wasn't someone who planned things and it would likely just happen at some point." With that being said, because of her mother's occupation as a midwife, she had often been around babies and women giving birth. As a result, she was very interested in experiencing childbirth but was uncertain beyond that.

Participant 6 had been an outcast from her peers; grew up in poverty; had divorced parents; and experienced frequent chaos and turmoil in her family. In addition, autism was prevalent in her family, which contributed to her fear of having biological children. Furthermore, a general fear of passing on her genes was a deterrent to having biological children since she did not want her children to suffer because of difficulties that she might pass on to them. When she had contemplated having children, she was drawn to them due to the perceived stability that this lifestyle would bring. In addition, she had considered having children when she thought that this might make her partner happy and thus bring them closer. At the same time, she struggled with the fear that her partner might regret having children with her when he "could have had better children with someone else."

Participant 7 recalled having an "unpleasant childhood" due to her parents' frequent fighting: She believed that these arguments were caused from work and childcare stressors. In addition, she witnessed the aftereffects of her mother's multiple traumatic miscarriages. She stated that one benefit of having children would be knowing that there would be people around her when she was older. She has avoided thinking and talking about pregnancy—despite stopping contraception while still being sexually active.

Participant 8 grew up in a divorced home where she often felt resented. Her mother had often been working and so they were not close. She had positive relations with her late grandmother and viewed her as the role model for the mother that she wanted to be. Earlier in her

life, she did not want to have children, although she did not elaborate why. More recently, she wanted to have one or two children since it would provide a source of fulfillment and a way to "fill a void" in herself; she was eager to give them the happy home that she never had. While trying to become pregnant, she avoided thinking about a life without children since imagining infertility induced panic attacks. Similarly, during her current pregnancy, she had disconnected from her emotions and often used humor to deflect difficult emotions. She did not appear to have positive and supportive relations with her partner.

Participant 9 grew up in a low–income family that frequently moved. Her father was absent, and she witnessed a lot of fighting between her mom and stepdad. In addition, she witnessed the aftereffects of her mother's multiple miscarriages which were supposedly a secret and were not discussed. These miscarriages prompted her to decide that she did not want to go through similar experiences. In addition, she also felt guilty for having been born to a mother who had been in university. As a result, initially she felt that she did not want children and her main focus was on establishing a career: this would ensure that neither herself nor her children would experience the hardships that her mother and she had. She appeared to have friends which provided her with social support.

Participant 10 viewed children as being a source of fulfillment and a way to carry on traditions and her legacy. With that being said, she grew up with a sibling with a disability and this impacted her fertility intentions: she was afraid of passing on unhealthy genes and possibly struggling to raise a child with a disability. In addition, she viewed social support as being a crucial prerequisite to having a child: Specifically, a partner where her child would be exposed to positive things—as opposed to the heavy drinking and dysfunction in her previous partner's family.

3.3.3 Certain about engaging in childbirth. Out of all the participants who were child-free, under 36 years of age, and who indicated an experience of early adversity, there were none that met my coding criteria for being *certain about engaging in childbirth.*

Cycle 4: Presentation of Final Lenses and Conclusions

In the fourth cycle, the researcher refines their preliminary lenses in light of their current, and perhaps, transformed perspectives on their topics (Anderson, 2019). Preliminary lenses are ". . .modified, removed, rewritten, expanded, and so on, reflecting the researcher's more developed and nuanced understanding of the topic at the conclusion of the study" (p. 315). In addition, I have identified the degree of transformation in each lens according to categorization proposed by Esbjor (2003, pp. 210-211). "New" lenses refer to perspectives that I did not previously identify until cycle three and beyond. "Seed" lenses refer to perspectives which retain an element of the preliminary lens, but which have been expanded upon or are more nuanced. "Change" lenses refer to perspectives that have undergone a significant change which is incongruent with the meaning in the preliminary lens. Lastly, I have added the categorization of "unchanged" for preliminary lenses which have maintained their original meaning.

4.1 Presentation of Final Lenses

I followed Esbjor's (2003 p. 209) advice of identifying my changed perspectives with the guiding question of "To what degree does my present understanding of the topic differ from, expand and elaborate upon, or challenge my earlier lenses?" Consulting the interviews contributed to four seed lenses, three change lenses, and one unchanged lens.

Table 2 Final Lenses

Investigating the Relation between Early Adversity and Fertility Intentions

- SEED-Reproductive health is composed of dynamic interactions of intergenerational and lateral factors.
- UNCHANGED-Current theories used to understand and predict fertility appear to have an unstated assumption of "healthy" development.
- SEED-Experiences throughout a woman's life, and her partner's life, likely impact her fertility intentions.
- CHANGE-Early adversity may impact the long-term goals that precede fertility intentions.
- CHANGE-On average, early adversity likely leads to a dysregulated stress response which may make women not want to have children.
- CHANGE-Contextual factors must always be considered to understand how early adversity has influenced an individual woman's fertility intentions.
- SEED-Different categories of early adversity may have different effects on health outcomes.
- SEED-Early adversity may result in a range of self-protective behaviors.

4.2 Conclusions

Anderson (2019 p. 315) states that "challenging and refining one's understanding of a topic is the purpose of intuitive inquiry" and therefore it is important to describe this process and possible areas of transformation. Therefore, in the following section, I have listed my new perspective, the degree to which it has changed from the initial perspective and provide a quote to illustrate an example of the data that informed this new perspective.

4.2.1 SEED-Reproductive health is composed of dynamic interactions of intergenerational and lateral factors. Through reviewing literature, I learned that we must look across at least two generations to understand a person's current health. Unresolved trauma from early adversity transfers and impacts peer and romantic relations as well as future generations. Therefore, my preliminary lens stated that "reproductive health is composed of interacting intergenerational and lateral factors." By consulting the interview transcripts, I further nuanced this lens by adding that this is a dynamic and multi-directional process. Specifically, reproductive

attitudes and behaviors may change over time, as women process and integrate adverse experiences.

> Participant 3: "I had a fairly good childhood, good growing-up here, relatively speaking. . .In my early-twenties, I definitely felt like 'I don't need a mom.' And 'I don't wanna be a mom.' And 'Being a mom is a stupid choice.' And 'This is not for anyone. Why would anyone want this?' Which has shifted into an appreciation for moms while still knowing that I am not one and I don't want to be one.

4.2.2 UNCHANGED-Current theories used to understand and predict fertility appear to have an unstated assumption of "healthy" development. Through reading the fertility literature and through personal reflections, I initially believed that our current understandings of fertility have an unstated assumption of "healthy" development. Consulting the interview transcripts did not change my perspectives on this and therefore I still believe that current fertility theories are likely descriptive of—and predictive for—women who have experienced "typical development." Although the interviews do not contain enough information to fully examine this claim, I do not believe that current models fully account for the effects of disrupted hypothalamic-pituitary-adrenal (HPA) axis functioning and subsequent dysregulated neural network. More research is needed to reflect upon our current fertility theories and to identify any assumptions that they may contain, which may make them more or less suitable to use with particular populations.

4.2.3 SEED-Experiences throughout a woman's life, and her partner's life, likely impact her fertility intentions. By learning about the factors that impact health, I had anticipated that experiences throughout a woman's life would impact her fertility intentions. Therefore, it was unsurprising to learn of the range of factors that woman indicated had impacted their fertility intentions: perceived and actual fecundity, economic security, romantic relationship stability, and health. On the other hand, I had not anticipated the degree to which their romantic partner's experiences with early adversity would be significant factors.

> Participant 10: ". . . I would also have to know that [my partner was] a good influence. Because, realistically looking back on it, like, my ex-mother-in-law is kind of a functional alcoholic, and he had a really rough childhood. . ."

4.2.4. CHANGE- Early adversity may impact the long-term goals that precede fertility intentions. While developing my cycle two lenses, I became aware of research that highlighted how early adversity impacts neural networks responsible for cognitive, emotional, and social skills (Lammertink et al., 2021; Li et al., 2014). Women who have experiences of early adversity often struggle with decision-making, impulse control, and learning and, as a result, often struggle with finances (Greene, & Green, 2012.) My preliminary lens asserted that "early adversity impacts one's cognitive, emotional, and social skills which are important to meet goals that precede fertility intentions." Furthermore, I believed that these impairments would interfere with women's ability to plan and accomplish goals that were prerequisites to establishing fertility intentions. Specifically, I believed that women with histories of early adversity would struggle to obtain and maintain supportive and stable romantic relations, a stable career, and adequate housing. By consulting the interview transcripts, I did not identify a strong relationship between experiences of early adversity and difficulties in these domains and so have since revised my initial perspective.

With that being said, the interviews suggested that experiences of early adversity possibly impact the degree of importance of which certain long-term goals are necessary prerequisites prior to establishing fertility intentions. For example, many women who grew up in poverty often placed high importance on achieving financial independence. Therefore, the women who also wanted children indicated that personally achieving financial stability was a significant precursor to actualizing their fertility intentions.

> Participant 9: ". . . that I knew I didn't want them until I was done schooling. My mom had me during college and I, sort of. . .Not like guilty. . . She did well for herself, and stuff like that, but I, kinda, feel guilty that she had to be the, sort of, young mom, and stuff like that. And she would push for me. . . "Oh, have kids after school." . . . "We don't want to have kids until we're in a position where we can afford a house, and then, because both of us, kind of, grew up in rented situations. . .there's a lot of things that I didn't get to do as a kid, like paint my own room, or something like that, because we moved around a lot. That's, I think, something we both, kind of, agree on. That we want that structure. We want the neighborhood and the friends and, sort of, that suburban bullshit life [laughter]."

4.2.5 CHANGE-On average, early adversity likely leads to a heightened stress response which may make women not want to have children. By reading the literature on the impacts of early adversity, I learned that early adversity causes atypical neuroendocrine development which results in dysregulated neurobiological systems; including those involved in the stress response (Lammertink et al., 2021). As a result, in my preliminary lenses I asserted that "early adversity leads to a heightened stress response which makes some women not want to have children." I based this lens on my understanding of the neurobiological effects of early adversity and my personal experiences of thinking about how being more prone and sensitive to stress could impact women's fertility intentions. Through analyzing the interviews, I have learned that, although women who I coded as experiencing early adversity often reported extreme fears of pregnancy and childbirth, this did not always result in them wanting to be childfree. In fact, the interviews suggest that the relation between early adversity and fertility intentions is likely affected by other interacting factors: for example, factors related to their views of themselves (self-esteem, self-efficacy, and coping strategies.) In some cases, low self-worth and self-efficacy appeared to serve as both a motivator and deterrent from childbirth. For example, participant 6 had considered having a child when she considered that it might make her partner love her more, yet also had considerable uncertainty:

> Participant 6: ". . . and it might've been my own. . .Just being self-conscious about, like… Feeling inadequate. Not good enough. Or, like. . . 'Oh, what if I waste your time and you could've had a better kid with someone else?'

Therefore, although it may be the case that, on average, the heightened stress response may result in more fear and anxiety which makes women more apprehensive to have children, at the individual level, this relation is likely less direct.

4.2.6 CHANGE-Contextual factors should be considered to understand how early adversity has influenced an individual woman's fertility intentions. In my preliminary lenses, I believed that "many context-specific factors, with complex interactions, impact a woman's fertility intentions and so it is difficult to predict fertility intentions at the individual level." I have revised this preliminary perspective and also used key features to develop two new lenses.

Through consultation with the interview data, I now believe that it is likely that contextual information regarding the early adversity (e.g., type, duration) and factors throughout her life (e.g., reactions of others, adult adversity) impact how adversity affects a woman. Each experience

is unique. Different types of early adversity appear to impact fertility intentions in different ways, depending on contextual factors regarding the adversity, and contextual factors throughout a woman's life. These contextual factors appeared to buffer or exacerbat the influence that the adversity had on fertility intentions, as well as the way that fertility intentions were expressed. For example, women who grew up with a sibling with a disability were often more likely to indicate a desire for no biological children, because they were afraid of passing on their genes to their children. Similarly, women were afraid of their future children suffering from the mental health issues that they had experienced.

> Participant 6: ". . . maybe my genes aren't good enough to pass on. Maybe I should keep those to myself. . .is it fair for me to bring someone into the world who might suffer because of things I knew I was going to give them?"

Furthermore, growing up in a family with a lot of fighting and chaos led some women to want to have children and others to not have children. Specifically, some women stated that they wanted to create the positive and happy home for their children that they never had. They also wanted the stability that they thought this lifestyle would bring. Conversely, some women did not want to have children because they "saw how much work" babies were and how they felt that children negatively impacted romantic relations. Resentment was a common theme. Specifically, participants feeling resented by their parents, watching their parents resent their siblings, and participants resenting their parents. In addition, having a close connection (e.g., mother, sister) who experienced a miscarriage made some women less likely to want to have children.

4.2.7 SEED-Different categories of early adversity may have different effects on health outcomes. As mentioned, through familiarizing myself with the literature, I became aware that the relation between early adversity and fertility intentions appears to have many interacting factors. Therefore, in my cycle two lenses I believed that it was difficult to make predictions on how a type of adversity would affect an individual woman's fertility intentions. With that being said, I believe that it is worthwhile to try and understand two features which affect these relations. These factors are highlighted in the remaining lenses.

I believe that it is possible and worthwhile to identify how categories of early adversity (e.g., environmental, interpersonal, familial) will likely impact women's general mental, physical, and reproductive health outcomes. These health outcomes, in turn, provide a more direct relationship to predicting fertility intentions. Having "a negative childhood" appears to be both a

motivator and a deterrent to having children. Information regarding how the person experienced the "negative childhood" is likely necessary to predict the outcome at the individual level. A negative childhood, due to family fighting and dysfunction (familial adversity), motivated some women to want to create a happy childhood that they never had. A negative childhood, due to bullying (e.g., interpersonal adversity), made some women not want to have children. A negative childhood, due to poverty (e.g., environmental), motivated some women to become financially dependent, and this increased the importance of meeting this goal before establishing fertility intentions.

> Participant 8: "Well, I grew up with a very, for a lack of a better word, a broken home. My parents divorced when I was three. . .Two. . . Three. So, I was very young, and I never really got to experience what it was like to have a traditional household. A traditional home. So, that was very much something stuck in my head that that's what I wanted for my future, and I wanted to be able to create that for my future family."

Therefore, it may be possible to predict how different types of early adversity impact women's health at the aggregate level, but contextual factors likely reduce our ability to predict this relation at the individual level.

4.2.8 SEED-Early adversity may result in a range of self-protective behaviors. As mentioned, this lens is a new insight that was developed when reflecting on my initial assertion that "many context-specific factors, with complex interactions, impact a woman's fertility intentions and so it is difficult to predict fertility intentions at the individual level." Through consulting the interview data, I now believe that, although it may be difficult to predict the relation at the individual level, it is likely worthwhile and helpful to try and understand the relation between 1) *categories* of early adversity, as well as 2) *variables that interact* with the relation between early adversity and fertility intentions.

The interviews highlighted the difficulties of establishing a direct relation between early adversity and fertility intentions because of interacting factors: for example, an individual's self-protective behaviors and coping strategies. Often women coped with their anxious feelings through denial and avoidance. For example, avoidance and denial of pregnancy and childbirth was present in women who were trying to become pregnant and in those that were currently pregnant.

Participant 7: “So, this exercise is probably, like, the most I've talked [about] this subject and probably the most I've talked about it. . .Which is probably why I signed up because I thought it would be good to force myself to think about it.”

Cycle 5: Reflections on Project and Implications

In the fifth cycle, the researcher "discusses the final interpretative lenses in light of the empirical and theoretical literature on the topic and explores the implications of the findings as is conventional in all research reports" (Anderson, 2019. p. 315). In addition, I have highlighted areas that I believe warrant future investigation since ". . .intuitive inquiry focuses not only on the present but also on the future, seeking to inspire, invite change, and reveal what the present reveals of future possibilities" (Anderson, 2004 p. 308).

5.1 Implications and Future Research

As a result of familiarizing myself with the academic literature, reflecting on personal experiences, and consulting the transcripts of women who discussed their fertility intentions, I believe that experiences of early adversity likely impact women's fertility intentions in important ways. Although I am reluctant to assert that early adversity has a direct impact on fertility intentions, the interview transcripts of 10 childfree women 35 years and younger and with indications of early adversity suggest that early adversity may increase the likelihood that women will be certain about abstaining from childbirth or will be ambivalent about childbirth. These findings both coincide and conflict with Gallus and Shreffler's (2021) findings that interpersonal trauma increases the likelihood that youth will have ambivalent and positive emotions regarding having a baby in their life. Further research at the aggregate level could clarify if it is possible to establish the relation between early adversity and expressions of fertility intentions.

With that being said, it is likely that early adversity has the general effect of increasing a woman's baseline level of fear and anxiety, which—in turn—may affect their fertility intentions. Experiences of high levels of fear and anxiety were commonly used to explain women's decisions to abstain from childbirth or contributed to their ambivalence. Interestingly, the theme of fear was present for women who had different fertility intentions (e.g., did not want a child or were ambivalent about having a child.) In addition, the theme of fear also differed in its expression. For example, some women were fearful of the birthing process. Some were fearful about their "unhealthy genes" (which were viewed as potentially detrimental to their child as well

as themselves). And some were fearful of their children having other negative life experiences. Therefore, it is important that researchers and health practitioners understand the factors that may increase women's fear surrounding childbirth, since it is important for improving perinatal outcomes: Women who experience higher levels of fear of childbirth have longer labors, due—in part— to their heightened stress response which slows down contractions (Dwiarini et al., 2022).

In addition, it appears that an individual factor which may interact with the relation between early adversity and women's fertility intentions is coping strategies. For example, denial and avoidance were common self-protective strategies that women used to cope with difficult feelings surrounding childbirth. These findings are consistent with the neurobiological literature which demonstrates that early adversity sensitizes people to future stressors and also impairs their social, emotional, and cognitive skills which are important to handle the stress-response in effective ways. Therefore, future researchers who are interested in examining fertility intentions, at the individual level would likely benefit from accounting for individual differences in coping strategies.

As mentioned, women with histories of early adversity are more likely to have unintended pregnancies (Testa et al., 2021). Since mothers with early adversity histories are particularly sensitive to stress, the perinatal period is an important time to provide support for these mothers, in order to try and reduce the intergenerational transmission of adversity. For example, women with histories of childhood sexual abuse and poorer perceived family functioning have increased cortisol levels during pregnancy (Bublitz et al., 2014). This heightened stress response is more likely to pass on to the fetus due to its presence in utero (Suarez, et al., 2020). Therefore, I argue that it is essential that we include screening for early adversity, alongside routine prenatal care, in order to identify and support this population during this particularly vulnerable time.

Lastly, although ACE (Adverse Childhood Experiences) scores have been shown to be positively associated with antepartum health risks, this effect is fully moderated by the presence of prenatal social support (Racine et al., 2018). Similarly, Shreffler et al. (2021) demonstrated that the ACE scores of pregnant women were positively associated with greater pandemic-related stress but social connectedness fully mediated this relation. Therefore, future research may benefit by continuing to focus on strategies which improve women's access to, and connection with, social supports as this is likely a significant area of intervention in order to improve perinatal outcomes for mother and child.

5.2 Reliability and Validity of Project

Anderson (2000) has suggested the requirements for assessing the quality of research conducted with intuitive inquiry. Key aspects include rigorous awareness of one's processes and perspectives, telling the truth, writing in one's own voice, risking personal transformation, as well as evoking "sympathetic resonance" with the audience (pp. 32-33).

5.2.1 Reflexive practice. Intuitive inquiry highlights the importance of recording seemingly unimportant or even contradictory or disconnected pieces of data because these will often lead to major areas of learning (Anderson, 2000). Therefore, to aid in the development and refinement of my lenses, I scheduled regular meditation and journaling throughout cycles two through four. Of note, meditation has been a regular part of the data analysis process for researchers in intuitive inquiry studies (Unthanks, 2019; Watson, 2014). Although I initially attempted to engage in a standardized procedure (e.g., day 1 = body scan, day 2 = breath, day 3 = loving-kindness) with strict documentation, this proved to be a barrier: during cycle two, I struggled to maintain a regular meditation practice. With that being said, I was successful with writing in my journal every day. As a result, many of the insights that contributed to my initial lenses were recorded in this journal. These thoughts or, "potential insights" as I called them, would occur in a variety of situations. These moments of clarity would occur passively: when I was cleaning, dancing to music, or lying in bed; or more actively or consciously: when I was looking at a meme, listening to friends talk, or reading a newspaper article. Eventually, during cycle four, I adopted a more relaxed procedure: I briefly meditated before working on my project; I also regularly took meditation breaks to rest and reflect. At this point, I experienced success in terms of regularly meditating. With that being said, I struggled to maintain a consistent journal practice: scribbling my "insights" onto scraps of paper. Therefore, I had to scavenge these notes from different sources when I was formalizing my final lenses.

5.2.2 Internal awareness. As mentioned, a high level of awareness of one's perspectives is integral to successfully conducting intuitive inquiry. Between cycles two and four, I changed my perspectives to varying degrees: four lenses were nuanced or expanded, three lenses were significantly changed, and one remained unchanged. Therefore, I believe that my understandings of these topics have been transformed. With that being said, my personal transformations could have been more adequately captured if I had established cycle one lenses. I learned a tremendous amount by consulting academic articles and non-academic sources during cycle one. Specifically,

my understandings of health significantly changed during this time. For example, initially, I did not view mental health as a concept that must be approached from a life course perspective. In addition, I initially viewed trauma from a more individualistic perspective instead of through family and social systems. Therefore, by only documenting my lenses in cycle two and four, which occurred after my literature review, I was unable to fully capture the magnitude of my different perspectives throughout this project.

5.2.3 Risking personal transformation. In addition, being a receptive and vulnerable participant in personal transformation is a component of conducting intuitive inquiry. At the start of this project, I had a basic understanding of early adversity and virtually no understanding of fertility intentions. Therefore, it was easy to be open to changing my perspectives in these areas. With that being said, prior to conducting this project, I had a narrower understanding of research which dramatically changed throughout this project. For example, I now see the value of examining a phenomenon from the perspective of different disciplines and being open to revisiting historical theories. Furthermore, by being open to insights from the disciplines of philosophy and physics, and the content areas of trauma and resiliency, I consider myself to now be a spiritual person instead of having my original agnostic perspective.

5.2.4 Sympathetic resonance. Importantly, the validity of my research is also determined by the experiences that my audience has while reading my perspectives. Sympathetic resonance (Anderson, 2000) is determined by reading my claims and comparing them to the reader's own perspectives and experiences. The extent to which my arguments and analyses resonate with their experiences ultimately determines how valid my research is. If my perspectives are perceived as being plausible, based on my arguments, and if they align with the overall experiences of my readers, then my research is considered to have sympathetic resonance.

5.2.5 Delimitations. There are multiple caveats that must be noted when considering the many assertions that I have made throughout this paper. Firstly, Phillipov and Bernardi (2011) highlight that there are different types of uncertainty or ambivalence about engaging in childbirth according to what is motivating this feeling and how the uncertainty is expressed. Due to my limited sample of participants that met my inclusion criteria (younger than 36 years of age, child-free, indication of early adversity), I grouped all of these subtypes into the larger category of uncertainty. With that being said, when I had enough data to understand what was informing their

uncertainty (e.g., fear of birthing process, desire for financial stability, lack of conscious thought on the idea), I did consider and comment on these nuances.

In addition, because my external data consisted of interview transcripts that had been conducted by other members of my lab, the transcripts are akin to archival data. Although consulting archival data is considered an appropriate part of the method in intuitive inquiry, I feel that due to the static nature of the transcripts and the lack of inquiry into women's mental health, this was not the most direct approach to understand the relation between early adversity and fertility intentions. As previously mentioned, this method was the best choice, when considering ethical and practical limitations, but future research should continue to identify trauma-informed and appropriate ways to investigate these topics.

Furthermore, the necessity to further limit the scope of my project altered, and eventually impacted, how I approached this project. Initially I adopted a curious and open-minded approach to explore the ways in which women's mental health experiences may impact their fertility intentions. As I continued to learn about these topics, through academic literature and personal reflections, I grew increasingly interested in understanding the mechanisms of this relation and the interacting factors. Therefore, my final topic was potentially less ideally suited for intuitive inquiry than was originally anticipated since it was focused on explaining a phenomenon, rather than describing it (Anderson & Braud, 2011).

5.3 Reflections on Current Project

As mentioned by Anderson (2000), intuitive inquiry is not suitable for everyone nor every project. Intuitive inquiry is most useful for studying phenomena involving complex human emotion and experiences (Anderson, 2004). Topics that have been examined using intuitive inquiry include

- exploring how self-blame empowers and disempowers survivors of interpersonal trauma (Unthank, 2019);
- the nature of the therapeutic workspace in palliative care groups (Kelly, 2018);
- women's transformative experiences while running in nature (Ludwig, 2019);
- the intersubjective embodiment of prayer (Wasson, 2014); and
- the effects of mindfulness on adult women adoptees' adoption stories, relationships, and identities (Topfer, 2012).

Through this project, I have come to view intuitive inquiry as a useful methodology for advanced researchers. Its inclusive and flexible manner allows for researchers to dynamically navigate the research process in whatever way they deem as most effective. Furthermore, I believe that novice and seasoned researchers would benefit by incorporating aspects of intuitive inquiry into their research. Including: 1) Meditating and journalling; 2) engaging with the data in creative ways; 3) consulting diverse sources; and 4) recording one's perspectives before, during, and after your project. Despite many positive experiences with this method, I also encountered significant technical and personal difficulties which impacted my ability to carry out this project.

5.3.1 Technical difficulties. My most notable technical difficulty was the amount of time that it took for me to understand and feel competent enough to perform this methodology. To understand intuitive inquiry, one must understand its core philosophies and technical components, and then adapt this flexible methodology to the specific context of one's project. Although Anderson has provided literature on this process, amateur researchers are likely to struggle with understanding and applying it. I have discovered that it involves a vulnerability, openness, and acceptance of the unknown, that can be difficult to summon and maintain. In addition, I have learned that this methodology is particularly difficult for those who are unfamiliar with qualitative research methods and philosophies.

5.3.2 Personal difficulties. I also experienced personal difficulties during this project which proved to be considerable barriers. In order to be successful in intuitive inquiry, I had to strive to be flexible, creative, accepting of uncertainty, and engage in multiple ways of thinking (e.g., data analysis, synthesis, and interpretation). I had significant difficulty with accepting the uncertainty related to this project at the beginning, and to a lesser but a varying degree, throughout the project. Additionally, the sensitive nature of my topic proved to be a barrier. I had to take many breaks throughout this process since I would often because emotional and overwhelmed while learning about the prevalence and nature of adverse experiences and reflecting upon my own experiences.

5.4 Final Thoughts

Through this process, I have learned a great deal about the causes and impacts of adversity, early adversity, and intergenerational adversity. With that being said, I have also learned about areas of intervention and prevention. Furthermore, I have come to appreciate the number of factors that influence a woman's fertility intentions and the complexity of this process.

Therefore, when reflecting on my original research question—the extent to which, and in what ways, experiences of early adversity impact women's fertility intentions—I have come to several conclusions:

Overall, although it is not clear if there is a direct relation between early adversity and expression of fertility intentions, it is likely that experiencing significant early adversity impacts fertility intentions. Furthermore, certain categories of early adversity (interpersonal and familial) may have stronger effects. The transcripts highlight that one possible mechanism which contributes to the relation between early adversity and fertility intentions is the role of fear and anxiety. Specifically, early adversity has the general effect of increasing a woman's baseline level of fear and anxiety, which—in turn—likely affects their fertility intentions. With that being said, at the individual level, it is not as straightforward to predict how early adversity will affect a woman's fertility intentions. Interacting variables, such as an individual's self-protective strategies, and their degree of social support, likely play a role in the degree to which fear is experienced and in what way it is expressed. Overall, I believe that it is essential that we include screening for maternal early adversity, alongside routine prenatal care, in order to identify and support this population during this particularly vulnerable time. As a result, it will allow us to provide intervention supports for mothers and prevention supports to children and hopefully reduce the degree of intergenerational adversity that may be transmitted.

Appendices

Appendix A: Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:			
1.	**Did a parent or other adult in the household often. . .** • swear at you, insult you, put you down, or humiliate you? or • act in a way that made you afraid that you might be physically hurt?	**yes**	**no**
2.	**Did a parent or other adult in the household often. . .** • push, grab, slap, or throw something at you? or • ever hit you so hard that you had marks or were injured?	**yes**	**no**
3.	**Did an adult or person at least 5 years older than you ever. . .** • touch or fondle you or have you touch their body in a sexual way? or • try to, or actually have, oral, anal, or vaginal sex with you?	**yes**	**no**
4.	**Did you often feel that. . .** • no one in your family loved you or thought you were important or special? or • your family didn't look out for each other, feel close to each other, or support each other?	**yes**	**no**
5.	**Did you often feel that. . .** • you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or • your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	**yes**	**no**
6.	**Were your parents ever separated or divorced?**	**yes**	**no**
7.	**Was your mother or stepmother. . .** • often pushed, grabbed, slapped, or had something thrown at her? or • sometimes or often kicked, bitten, hit with a fist? or • hit with something hard? or • ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	**yes**	**no**
8.	**Did you live with anyone. . .**	**yes**	**no**

	• who was a problem drinker? or • who was an alcoholic? or • who used street drugs?		
9.	**Was a household member depressed or mentally ill?** or **Did a household member attempt suicide?**	**yes**	**no**
10.	**Did a household member go to prison?**	**yes**	**no**
	To determine your ACE score, add up your "yes" answers: _____		

Appendix B: Informed Consent Form

Interview Consent Form: Decisions Regarding Motherhood

Researchers: Karen Lawson, PhD, Department of Psychology, U of S
Email: Karen.lawson@usask.ca or Phone: (306) 966 2524

Pamela Downe, Department of Archeology and Anthropology, U of S
Email: Pamela.downe@usask.ca or Phone: (306) 966 1974

Purpose: You are invited to participate in a research study entitled "Decisions Regarding Motherhood" Please read this form carefully, and feel free to ask any questions you might have about the study.

The purpose of this research project is to gain greater understanding about how and when women make decisions regarding motherhood, and the personal and social factors that might play a role in these decisions.

Procedure: If you are interested in participating, the study will consist of an audio-recorded interview lasting approximately 60 minutes, conducted online using Zoom, a videoconferencing platform. With Zoom you can either participate using your computer, or by your phone. You will be asked to tell the story of your current reproductive status or your imagined reproductive future. Only answer questions that you feel comfortable responding to. At any time, you can request that the audio-recorder be turned off without giving a reason. At the end of the study, you will be given a change to ask any further questions that you might have.

A few weeks from now you will be provided with a transcript of the interview (by email). You can review the transcript and change any responses that you would rather not be included, or provide clarifying comments if you think something you said could be misunderstood. You will have two weeks to provide edits to the transcript, after which if we do not hear from you we will us the transcript in its original form.

Potential Risks: It is possible that our interview will make you think about life occurrences that have been or are distressing to you. Please feel comfortable asking the interviewer for help finding resources or contact any of the following organizations to seek help:

Immediate help: Mobile Crisis Saskatoon (306) 933-6200 or Regina (306) 757-0127

Saskatchewan 211: free, confidential information and referral system for community and social services available across the Saskatchewan: https://sk.211.ca/, or dial 2-1-1 on your phone.

Walk-in counselling at Family Services Regina https://familyserviceregina.com/thrive/ or Saskatoon Catholic Family Services https://www.cfssaskatoon.sk.ca/services/counselling/

Potential Benefits: It is anticipated that this research will add to the knowledge of reproductive decision-making and will increase our understanding of current fertility trends. Further, a better understanding of the factors which underlie intentions regarding motherhood will highlight

possible means (at both the personal and societal/policy level) of enhancing women's ability to meet their fertility aspirations.

Confidentiality: Your responses will be confidential. The interviews will be transcribed by the researchers, or research assistants. Although the researchers will use direct quotations from the interviews, quotes and data will be reported using a pseudonym and all personally identifying information will be removed. The data may be published in journal articles, conference presentations, and a summary for participants.

We will take every precaution to keep your information private, and while Zoom has implemented safeguards to protect privacy, the privacy of your data is not guaranteed. Please refer to Zoom's privacy statement: https://zoom.us/privacy. The audio-recording of your interview will be saved and stored on the researcher's computer and not on the cloud. In providing your consent to participate, you agree that you will not make any unauthorized recordings of the interview session.

Storage of Data: All the data from the interviews will be securely stored on the researcher's computer and the University of Saskatchewan data storage system for five years and then it will be destroyed beyond recovery. The data may be published in an academic journal and/or presented at a professional conference. When the data is no longer required, it will be destroyed beyond recovery. The data and consent forms will be stored separately and securely by the researchers at the University of Saskatchewan for a minimum of five years post-publication. After this point it will be destroyed beyond recovery.

Right to withdraw: You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort, and any data that you have contributed will be destroyed beyond recovery. Your right to withdraw data from the study will apply until April 30th 2019, at which time manuscripts will have been submitted for publication. After this point, your results may have already been combined with those of other participants and it may not be possible to withdraw your data.

Questions or Concerns: This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board on ID 334. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.To obtain results from the study, please feel free to contact us by phone (306 966-2524) or e-mail (karen.lawson@usask.ca).

Follow up: To obtain results from the study, please email (reproductive.pyschology@usask.ca). A summary of the results will also be available on our research website: https://research-groups.usask.ca/reproductivepsychology/index.php

Consent to Participate:

I, _____ **(print your name),** have read and understood the description of the research study provided above. I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I agree to participate in the study,

understanding that I may withdraw my consent to participate at any time without penalty.

_____	_____	_____
Name of Participant	*Signature*	*Date*

_____	_____
Researcher's Signature	*Date*

Appendix C: Interview Guide

Today I would like to talk to you about how you arrived at your current motherhood status (whether you have children or not) and how you envision your future in this area. There are many aspects of this that I would like to discuss with you, and rest assured there are no right or wrong answers. I am interested in your thoughts and your experiences.

1. Do you have children?
    - If so, how many children do you have? How old are they? Are they your children by birth, adoption, step-children? How old were you when you had your children?
    - If not, would you like to have children in the future?
    - How old are you now?

2. I would like you to tell me about your plans regarding motherhood. At any point in your life (including now) did you have a plan, – even a rough one – about becoming and being a mom? Can you tell me a bit about your plan?
    - Were these plans specific, or general, or somewhere in between?
    - What factored into your plans? (probe to illuminate personal and contextual factors such as issues related to relationships, sexual identities, career, SES, ethnicity, education, etc. underlying such differentials)
    - What information did you seek? Where did you seek information?
    - Who did you talk to? Who else was involved in helping you form these plans?
    - What feedback did you receive from others? How do you feel about that?
    - Have these plans changed over time? In what way? Why? (life transitions, career, relationship, education, etc.)
    - How do you feel about these changes in plans?
    - Are you in a relationship? If so, what do you think are your partner's plans around parenthood?
    - Have you ever felt external pressure that impacted your plans (from spouse/partner, family, friends, employer?)
    - What are the main things that might/did interfere with realizing your plans?
    - What are the main things that might/did help you to realize your plans?

3. Can you tell me about why you want/wanted to be a mother (or why you do not/did not want to be a mother?)

- How has this changed over time? How have your feeling/ beliefs/attitudes towards motherhood changed over time? What prompted these changes?

4. Tell me about your motherhood ideals; that is in a perfect world, what would your family look like - would you have children? How many? How old would you be when you had your first child? Your last child?

- Do your ideals differ from the plans we just talked about or from the family that you have now? If so, why do you think they differ? (probe to illuminate personal and contextual factors such as issues related to relationships, sexual identities, career, SES, ethnicity, education, etc. underlying such differentials). How do you feel about that?

5. Can you talk about times in your life that you viewed becoming a mother as more or less important to you?

- Did your motherhood plans change as the importance of becoming a mother changed? What else was happening in your life at these times (cohabitation, marriage, education career, etc.)? Do you think these issues had an influence on your views of motherhood, your motherhood goals? Who did you talk to about your views of motherhood at these different times? What sorts of things did they tell you? How did this influence you?

6. Can you talk about times in your life that you felt more or less certain about becoming a mother (or not)?

- Did your motherhood goals change as your certainty changed? What else was happening in your life at these times (cohabitation, marriage, education career, etc.)? Do you think these issues had an influence on your certainty and your motherhood goals? Who did you talk to about your mothering goals at these different times? What sort of things did they tell you? how did this influence you?

7. What comes to mind when you think about balancing motherhood, family and career? Do you have ideas or strong feelings about how a mom should balance these aspects of her life? Do you have ideas or strong feelings about how you want to balance these aspects of your life?

- How have these ideas influenced your reproductive goals/intentions?
- How did these ideas or feelings develop?
- What sorts of things might make it easier for you to balance motherhood, family, and career? (nanny/daycare/intergenerational care; workplace supports, etc.)
- Who have you talked to about these issues?

- What feedback have you received from others?
- Do you think that your partner experiences the same issues in balancing parenthood, family, and career?
- If their responses indicate they want a career - Why do you want a career?

8. Lastly I just have a couple of questions for you -
    - Where were you born? (if not in Canada, how long have you lived in Canada? Do you have close ties to your birth country?)
    - Where were your parents born? (if not in Canada, how long have they lived in Canada)
9. Those are all the questions that I have for you today. Thank you so much for sharing your experiences with me. Before we end, is there anything that I didn't ask you about that you would like to discuss? (remind them that they can contact you via email after the interview if something comes to mind that they want to tell you).

Appendix D: Analysis Coding Documents

Codes for Adverse Experiences	
ADVERSITY-EARLY	Occurred before age 19 AND Explicit (semantic) or implicit (latent) expression of at least one of the deductive codes from the ACE questionnaire: - emotional/psychological degradation or intimidation -sexual assault -feeling unloved or unsupported -physical or emotional neglect -caregiver separation -caregiver violence -caregiver substance abuse -family members with mental illness -family member incarcerated OR Explicit or implicit expressions of at least one inductive code based on my interpretation of an adverse experience: -an experience which likely produces prolonged emotional, physical, or psychological stress.
ADVERSITY-N/A	Absence of the above indicators.

Codes for Fertility Intentions	
AMBIVALENCE	Explicit or implicit expressions of one or more indicator: -Uncertainty of childbirth (Don't have their minds made up.) -Quick or multiple changes regarding childbirth (No children one year and then want children next year.) -Lack of conscious thought regarding childbirth.
CERTAIN-YES	No explicit or implicit indicator of ambivalence AND Explicitly reports intentions to birth a child in their lifetime.
CERTAIN-NO	No explicit or implicit indicator of ambivalence AND Reports intentions to not birth a child in their lifetime.

Appendix E: Summary Matrix

Participant Summaries		
-Women ≤ 35 without current children (16) -Women ≤ 35 without current children and with indication of early adversity (10) -Grouped by fertility intentions (YES/NO/UNCERTAIN) and indication of early adversity (Trauma/Trauma-NA) -Further analyzed for factors of interest		
Factors of Interest -Conscious vs. automatic FI -FI facilitators -FI constraints -Social support -Spirituality **-trauma experiences or symptoms**		
Certain of NO CHILD (4 people) 4 Trauma-YES & 0 Trauma-N/A *(removed)*	**Certain of YES CHILD (5 people)** 0 Trauma-YES & 5 Trauma-N/A *(removed)*	**UNCERTAIN of childbirth (7 people)** 6 Trauma-YES & 1 Trauma-NA *(removed)*
Participant: 1 -individual motherhood schema-Aware of structural motherhood schema and at that point she thought she might want to adopt (never remembers wanting		Participant: 8 -individually interpreted motherhood schema-now has fewer goals of how she wants her child to be and how she behaves.

to have biological children) but now realizes (in university) that children are with you forever so doesn't want children. **-avoidant attachment** -very afraid of the idea of childbirth **-has a diverse sexuality** Participant: 3 -initially was very angry at the concept of mothers and motherhood. Now appreciates mothers but does not want to be one. (Individual)-Thought of potentially fostering when seeing unhappy children in foster care. -**experienced ACES** **-mental health as FI** -experiences spirituality to others and greater good w/ job. -Still doesn't want her own kids but would foster. -Values children. **-is unaware of how ACEs affect her FI. Was going to do personal processing.** Participant: 2 -structural motherhood schema-she said she had a very good mom growing up and wouldn't be able to replicate that.		**-ACE-divorced home. Resentment. Wanted to create happy home for her family (unlike how she grew up.)** -Wanted to give them the love that she got from her non-related grandmother. **-it is a way of fulfilling a part of her that was missing**. -not great relationship with her mother (was working all the time) -humour as deflection/coping mechanism **-would deny the possibility of her not having children because it was a coping mechanism.** -questionable relationship w/ partner -remembering **her infertility would lead to panic attacks**. **-normally is an emotional person but she had to detach from her emotions when she got pregnant and during pregnancy.** -disenfranchised grief-she wanted 3-4 children and now has to accept she will have only 1-2. Finds it depressing. Participant: 6 -when she and her partner broke up she re-examined having children to see if she actually wanted that or she was just following the

-bullied as a child and doesn't want her child to experience that. **-partner was a bad parent and she saw a lot of resentment towards the child.** Doesn't want to resent her children (doesn't want child to resent her.) -positive relationship with her mother didn't buffer negative effects on her FI. **-Seemed unaware of how ACEs (bullying and friend w/ child) affected her FI**. Participant: 4 -Motherhood was "expected" but then critically thought about motherhood when had to renew her birth control.-Individualized **-Afraid of history of family illness** **-friend almost died in childbirth and she/her partner is afraid of her dying during labour.** **-afraid of having a child with a disability. (Would adopt though.)** -spirituality-views career as contributing to greater good.		structural schema. (Is currently conflicted between following the structural schema and what she actually wants to do.) **-ACE-difficulty making friends** **-ACE-chaos, turmoil, divorce, poverty** -adult control issues -**avoidant attachment** -bad anxiety **-was attracted to the perceived stability that having a family provides.** **-would occasionally want children to make her partner happy. (Poor self-worth.)** -external self-worth **-scared to create kids with autism (prevalent in her family) because it would be difficult.** **-poor self-efficacy. Scared her partner would regret having" better kids with someone else."** **-doesn't want to make future children suffer from her genes.** Participant: 10 **-lack of partner is impacting her FI (was divorced now single)** -used to view children as "just what you do" and now sees it as something that is fulfilling and a way to carry on yourself and your traditions.

		-might have fertility issue **-brother has developmental disability and is concerned about passing that on and how difficult it would be to raise a disabled child.** **-her former partner has drinking issues and was dysfunctional (rough childhood) and she didn't want to expose her child to that.** -very focused on family issues (brother w/ developmental issues, other brother w/ MS, father wi/ cognitive issues) -thinks motherhood and mental health support groups or one-on-one would be helpful for mothers. Participant: 7 -removed IUD because she realized she is getting older so now is the time. **(Lack of conscious thought. Has not thought about # of children she wants or really anything about it. Actively avoiding thinking about it.)** -having a supportive partner made her want to consider motherhood/new adventure. -getting closer to 35 made her think they should probably take the next "step"-structural view. Seems like she has some dissonance between this

		expectation and what she might want. Denial of thinking about it. **-ACE-fighting during childhood so thinks babies are a lot of work.** **-ACE-Her parents were often stressed due to work issues and so her childhood was crappy.** **-ACE-Mom and sister had numerous traumatic miscarriages (doesn't explicitly say this is why she put it off pregnancy.)** **-denial of pregnancy thinking even though currently "trying" to become pregnancy (signed up for study to get forced to think about it)** **-baggage of thinking she'd be a bad parent (past partner told her this)-low self-efficacy** Participant: 9 -Seems like she doesn't actually want children. -very traditional structural view of motherhood yet this conflicts with her current life experiences and what she wants. -Never initially wanted children. Structural schema of motherhood and timeline happened when we met her partner.

		ACE-moved around a lot, didn't have a lot of money, lots of fighting. . .-wants to wait until college/work/house to have children. **ACE-feels guilty by being born to her mother during college since her mom would tell her to have kids after college.** **-watched her mom experience multiple miscarriages and she didn't want to experience that.** -her mother pressured her to have children. Participant: 5 -no conscious decision-making. "Not much of a planner." **Raised by a single mom** so that was normalized. -claims she wants children but holds a structural view of motherhood. (e.g., 2 children, be financially secure, maybe want a partner.) -good support system while growing up (despite being raised by single mother.)

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