

**The Lived Experience and Meaning of Pregnancy In Women With Mild To Moderate
Depression**

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Abstract

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

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Dedication

To Jenny, who let me in on the best and worst parts of life.

Table of Contents

Permission to Use: University of Saskatchewan.....	i
Abstract.....	ii
Acknowledgements.....	iii
Dedication.....	iv
Table of Contents.....	v
CHAPTER 1: Introduction.....	1
Introduction.....	1
My Interest.....	2
Purpose.....	3
Organization of Thesis.....	3
CHAPTER 2: Literature Review.....	5
Diagnostic Issues of Antenatal Depression.....	5
Edinburgh Postnatal Depression Scale.....	6
Prevalence.....	7
Associated Risk Factors.....	8
Pregnancy and Motherhood.....	8
Experiences of Pregnancy.....	9
Social Construction of Motherhood.....	12
Summary.....	13
CHAPTER 3: Methodology.....	15
Qualitative Inquiry.....	15
Feminist Research.....	17
Hermeneutic Phenomenology.....	19
Lived Experience.....	20
Spatiality.....	20
Corporeality.....	20
Temporality.....	21
Relationality.....	21
Population and Participants.....	22
Purposeful Sampling.....	22
Gaining Access.....	23
Criteria.....	23
Obstacles in Participant Recruitment.....	24

Generating Data.....	25
Interviews.....	25
The Lifeworld Existentials.....	26
Data Analysis.....	28
Data Representation.....	30
Trustworthiness.....	30
Ethical Considerations.....	32
CHAPTER 4: Results.....	33
Participants.....	33
Alison.....	34
Beth.....	36
Chloe.....	37
Daphne.....	39
Eve.....	42
Fallon.....	44
Shared Meaning: Ambivalence.....	46
Theme 1: Disconnection Versus New Connection/Reconnection.....	47
Disconnection.....	47
Friends.....	47
Partner.....	50
Family.....	51
Unborn Baby.....	53
Connection.....	54
Friends.....	54
Partner.....	55
Mothers.....	56
Unborn Baby.....	57
Nature.....	58
Theme 2: Loss of Identity Versus Newfound Identity.....	58
Loss of Identity.....	58
Career Women.....	59
Loss of Individuality.....	59
Newfound Identity.....	60
The Fantasy.....	60
Choosing a Path of Motherhood.....	61
Identity in Subsequent Pregnancies.....	62
Theme 3: Fatigue and Illness Versus Vitality and Wellness.....	63
Fatigue and Illness.....	63
Nausea and Fatigue.....	63
Complications.....	64
Vitality and Wellness.....	65
New Vitality.....	65
Changes Symbolic of	
Wellness.....	65

Ensuring Wellness.....	66
Theme 4: Anxiety and Insecurity Versus Confidence and Security.....	66
Anxiety and Insecurity.....	66
Body Image.....	67
Relationship.....	67
Anxiety about the Baby.....	68
Intensified Anxiety.....	68
Confidence and Security.....	69
Beautiful Body.....	70
Purposeful Body.....	70
Assertiveness in Relationships.....	71
Theme 5: Sadness and Hopelessness Versus Joy and Expectation.....	72
Sadness and Hopelessness.....	72
Joy and Expectation.....	74
The Belly.....	74
Anticipation of Giving Birth.....	75
Dreams Fulfilled.....	75
Completion of Family.....	76
Summary.....	77
Chapter 5: Discussion.....	78
Summary of Findings.....	78
Integration of Findings.....	82
Popular Notions of Pregnancy and Depression.....	82
Existing Qualitative Literature.....	83
Strengths of the Study.....	87
Limitations of the Study.....	88
Distinct Findings.....	88
Lack of Diversity.....	88
Constraints of the Larger Study.....	89
Future Research.....	90
Implications for Counselling Practice.....	90
Conclusion.....	93
Post Script: My Process.....	94
References.....	96
Appendix A: Criteria for Participation.....	100
Appendix B: Consent Form.....	101
Appendix C: Interview Guide.....	105
Appendix D: Ethics Application.....	106

CHAPTER 1: Introduction

Pregnancy is often thought of as a joyous time, and for many women it is. Only recently has attention turned to the fact that for some women, pregnancy and motherhood are filled with unhappiness, hopelessness, and depression. Recent media attention has captured the most sensational cases of depression during pregnancy and postpartum. In the United States, media frenzy occurred when Andrea Yates drowned her five children in the bathtub (Jury Finds, 2006). In Canada, Suzanne Killinger-Johnson threw herself and her baby in front of a moving subway train (Mahar-Sylvestre, 2001). Both cases may have brought some awareness to postpartum depression; however, far more attention was paid to the sensationalized aspects of these cases than to the women's experiences leading up to these incidents.

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

Most women who are depressed during pregnancy and/or postpartum are not in the news. Instead, they face depression in their everyday lives, often without treatment (Marcus, Flynn, Boyle, and Barry, 2003), or even the awareness of what they are experiencing. However, researchers and clinicians have now begun to pay attention to antenatal depression with regards to diagnostic issues, prevalence, and factors associated with the condition (e.g., Bennett, Einarson,

Taddio, Koren, & Einarson, 2004; Marcus et. al., 2003). Still, the lived experiences of these women have very rarely been studied, leaving their voices unheard.

My Interest

The culmination of both personal and professional factors has brought my attention to this area. First, as a woman in my twenties, I have recently become introduced to the world of pregnancy and babies. Through conversations with friends and family members who are pregnant or new mothers, I have gained invaluable knowledge about their experiences. Many of our conversations were akin to the joy, promise, and wonderings of an expectant mother portrayed in books and movies. However, other conversations of worry, uncertainty, and feelings of sadness and loss were surprising to me and left me with questions. I became interested in other women's experiences. Were these negative feelings a normal part of pregnancy? If so, when is it no longer normal, but deemed an illness? What does it feel like to be depressed during a time when everyone expects joy and happiness from you?

Second, my attention was drawn to a position with the Department of Community Health and Epidemiology. Dr. Nazeem Muhajarine and Dr. Angela Bowen were seeking a graduate student to work as a research assistant for a large quantitative study on feelings during pregnancy. The aim of their study was to increase understanding of depression during pregnancy, particularly regarding prevalence and course throughout pregnancy, and the contributing factors to the experience of antenatal depression. The study was carried out in the Saskatoon region with 648 participants. These women were followed throughout their pregnancy and into postpartum. Dr. Muhajarine and Dr. Bowen were seeking an additional qualitative piece to be done as a master's thesis project. I immediately thought of my questions regarding depression and pregnancy and was given the opportunity to explore this further.

Purpose

Antenatal depression has been understudied and therefore under-diagnosed and under-treated (Marcus, et.al., 2003). What little has been studied has focused on prevalence, effective treatment, and contributing or protective factors; the lived experiences of women who have had antenatal depression have been practically ignored in the research. Yet, an understanding of women's experiences is necessary for three reasons. First, this research could give a voice to the women who experience mild to moderate antenatal depression, or at the very least provide some women with the opportunity to share their experiences, thus addressing the human experience and meaning of the medical diagnosis of antenatal depression. Second, this research could expand professional knowledge to include the rich and thick descriptions of the experience of antenatal depression, thus informing programs and services delivered to women. Third, health care professionals could use this new knowledge to validate the feelings and experiences of women living with antenatal depression.

Questions

A qualitative inquiry will be used to answer the following questions: What is the lived experience of pregnancy for women with mild to moderate depression? What is the lived meaning of pregnancy for women with mild to moderate depression?

Organization of Thesis

The chapters are organized as follows. Chapter 2 is a review of the existing literature on antenatal depression, diagnostic issues, prevalence, and associated risk factors, as well as the existing qualitative literature on the experience of pregnancy and the social construction of motherhood. Chapter 3 focuses on method, the hermeneutic phenomenological research method is described and the processes of gathering and analyzing data, ethical considerations, and criteria for

establishing quality are discussed. Descriptions of the participants and their circumstances along with the research findings are described in Chapter 4. Chapter 5 includes a discussion of the findings, limitations of the research, implications for counselling practice and suggestion for future research.

CHAPTER 2: Literature Review

In this chapter, I provide a review of the literature on antenatal depression, pregnancy, and motherhood. Research on antenatal depression has been predominantly quantitative in method and focused on definition, diagnostic issues, prevalence, and associated risk factors. Little qualitative research has been done with regards to women's experiences of antenatal depression, therefore qualitative literature investigating various aspects of pregnancy and motherhood is examined.

Diagnostic Issues of Antenatal Depression

Antenatal depression can be defined as major depressive disorder occurring during pregnancy. According to the American Psychiatric Association (1994), major depressive disorder is diagnosed when an individual experiences five or more of the following symptoms during the same two-week period, with at least one of the five being a) depressed mood or b) loss of interest in pleasure:

- a) depressed mood most of the day;
- b) anhedonia (severely diminished interest or pleasure in activities);
- c) weight changes secondary to appetite changes;
- d) insomnia or hypersomnia;
- e) psychomotor changes (restless, agitated, or slowed);
- f) fatigue or diminished energy level;
- g) feelings of worthlessness or excessive or inappropriate guilt;
- h) decreased concentration and increased indecisiveness;
- i) recurrent thoughts of death or suicide

Thus, if the criteria for the diagnosis of major depressive disorder are met, and the woman is pregnant, her condition would be described as antenatal depression to reflect both the disorder and the context.

Antenatal depression often continues undiagnosed for many women. Some of the reasons for this include the widespread belief that pregnancy acts as a protective factor for depression (Beck, 2003). Another reason why antenatal depression often goes undiagnosed is because of similar somatic symptoms expressed in depression and during pregnancy. Depressed pregnant women visiting the doctor with complaints of nausea and stomachaches are less likely to be assessed for depression because these are also symptoms associated with pregnancy (Kelly, Russo, & Katon, 2001). Thus, the standard assessments for depression in a clinical setting can be inappropriate to diagnose depression in pregnant women.

Edinburgh Postnatal Depression Scale

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

Prevalence

Bennett, Einarson, Taddio, Koren, and Einarson's (2004) systematic review of antenatal depression provided the most comprehensive information to date regarding prevalence. They identified 714 articles related to the prevalence of antenatal depression. Bennett and associates limited their review to studies that fit the following criteria:

- a) outcomes had to be reported as a percentage of depressed women of the total women assessed;
- b) information regarding gestational weeks or trimester had to be included;
- c) demographics of patients had to be included;
- d) all patients had to be over 17 years of age;
- e) no selected subgroups were to be used, thus all women had to be selected from general obstetric or prenatal units, or population surveys;
- f) patients from low socioeconomic backgrounds were analyzed separately.

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

Marcus and associates (2003) screened 3,472 women for antenatal depression using the Center for Epidemiological Studies Depression Scale. They reported 20% of the participants scored above the cutoff score, indicating antenatal depression. They also found that only 13% of the women who had antenatal depression were receiving care for their depression. These rates suggest that many women have experienced depression during pregnancy without receiving intervention.

Associated Risk Factors

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

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

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

Pregnancy and Motherhood

A few studies of pregnancy have been designed to include the pregnant woman's perspective. These studies, though not about antenatal depression, provided a backdrop for this project. The phenomenological approach used in these studies provided themes, some of which emerged in this project and thus, they can offer deeper knowledge of the experience of pregnancy. These

qualitative inquiries provided rich descriptions of the lived experience of “normal pregnancy” (e.g., Armstrong & Pooley, 2005), pregnancy in adolescence (e.g., Belgaumkar, 2001), as well as the lived experience of a pregnancy with complications (e.g., Leichtentritt, Blumenthal, Elyassi, & Rotmensch, 2005). Other qualitative inquiries that contribute to the research, examine women’s experiences of pregnancy and childbirth in contrast to dominant notions of these experiences (e.g., Houvouras, 2006 and Rudolfsdottir, 2000). Finally, feminist critique of the social construction of motherhood provides a context in which these experiences can be explored.

Experiences of Pregnancy

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

Belgaumkar (2001) examined adolescent women’s perceptions of social support during pregnancy and post partum. Belgaumkar interviewed six women from Saskatchewan, ranging in age from 15-21 in a phenomenological qualitative inquiry. Analysis revealed an overarching theme of the importance of ‘not being alone’. Five interrelated constructs contributed to their feelings of not being alone: (1) social networks; (2) social and personal identities; (3) experiences of support as a give and take process of exchange; (4) conflict as part of social interaction; and, (5)

the importance of valuing and feeling valued within their relationships. The findings of the study provided a definition of social support as ‘not being alone’, and suggested that engaging in a mutual exchange process is an important component of feelings of ‘not being alone.’ Belgaumkar’s study also acknowledged the importance of the women’s own appraisals of social support, rather than relying on a standardized measure of a predetermined definition of social support. This acknowledgement values the participants’ distinct needs within a relationship.

Leichtentritt, Blumenthal, Elyassi, and Rotmensch (2005) conducted 10 focus groups with Israeli women who were hospitalized due to high-risk pregnancy. The intent of their study was to understand the lived experience of hospitalization due to high-risk pregnancy. Phenomenological analysis yielded five themes: (1) the desire and social pressure to nurture; (2) the personal and social meaning of family; (3) the loss of experiences of childbearing and of normal life activities; (4) the conflict between a woman’s needs and the well-being of the fetus; and (5) her sources of strength and sources of stress. An overarching theme of ambivalence was also found in the analysis. This ambivalence and conflict was found between the feelings and experiences of the women and their perception of social norms and expectations. Though the women had fears, anxieties, anger, and frustrations about their high-risk pregnancy, they were also living in the context of Israeli society where normative proof of a woman’s femininity is still in giving birth, thus making motherhood the ultimate goal for women. The researcher suggested that the negative emotions the women felt, along with the expected attainment of the ultimate goal of motherhood created a sense of ambivalence. This research included the context in which the women lived in, recognizing how the influence of culture, religion, and gendered norms impact a women’s experience of pregnancy. The inclusion of context provides a more critical analysis of the everyday

experience of pregnancy because it acknowledges the role societal norms and expectations play in an individual's human experience.

Houvouras (2006) suggested that dominant notions of reproduction view pregnancy and childbirth as physical processes that take place in women's bodies. These notions are limited because they ignore the non-physical components of these processes. Houvouras used social constructionism to explore the various locations that women describe pregnancy and birth taking place. Houvouras interviewed 15 women about their conceptualizations of childbearing. The central research question was: "In what sphere of human experience do women conceptually locate pregnancy and childbirth when describing their own and their partners' childbearing experiences?" Houvouras found that the participants constructed their childbearing experiences as taking place in multiple locations: (1) within the female body; (2) within both the female body and a non-physical realm (e.g., emotional realm) of one or both partners; (3) detached from any particular location; and (4) within both partners bodies. Houvouras's research acknowledged that notions of pregnancy are socially constructed. The study noted how dominant constructions of pregnancy and childbirth are located in a physical realm and have ignored women's own constructions of these experiences. It also illustrated how the participants' own constructions of childbearing included realms other than their physical bodies, such as their own and their partners' emotions and cognitions.

Rudolfsdottir (2000) investigated how healthcare discourses affect the experiences of pregnant women. Rudolfsdottir analyzed medical discourses in handouts and booklets readily available to pregnant women, as well as young women's own accounts of pregnancy and motherhood. Analysis of the healthcare literature revealed four themes which Rudolfsdottir called strategies used for minimizing the agency of pregnant women: (1) the detached body; (2) emphasis on emotional instability; (3) pregnant women and new mothers infantilized; and (4) the fetus as subject. Further

description of these strategies indicated that a pregnant woman is not always treated as a fully responsible agent. Pregnant women were described in the literature as childlike and emotional or simply as empty vessels for the process of reproduction. She found a contrast in the women's experiences of pregnancy and childbirth as well as criticism of the literature to which they were exposed. An overarching theme found in her analysis was that the women who had positive pregnancy and birthing experiences placed themselves centrally in their experience, rather than their bodies, the interventions done, or the fetus as separate from themselves, thus recognizing their own agency. Women who had negative experiences attributed the experience to not being seen as autonomous agents. They felt that they had been treated as patients or children or, simply as physical bodies without awareness of what was happening. Rudolfsdottir's research suggested that popular pregnancy and birthing literature removes women's autonomy and agency from the experience. It also suggested that this removal of agency had a negative impact on women's experiences of pregnancy and childbirth. This illustrates how social discourses can have a negative impact on a seemingly natural experience.

Social construction of motherhood

As the above inquiries noted, though pregnancy and childbirth are naturally occurring phenomena, they occur within a social context that creates expectations and parameters that are not inherently found in the experience. These expectations and parameters are the socially constructed elements of an experience. In addition to social constructions of pregnancy and birth, there are constructions of motherhood. Woollett and Boyle (2000) described a social construction of motherhood in their editorial introduction to a special issue on motherhood:

“Motherhood is constituted as compulsory, normal and natural for women, for their adult identities and personal development, and is regulated through binary oppositions in which

the warm, caring and `good` mother is contrasted with `bad` mothers, selfish, childless, and career women, and empty and deficient infertile women.” (p. 309).

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

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

Summary

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

CHAPTER 3: Methodology

In this chapter, I provide a description and rationale for conducting qualitative research within a feminist framework. I continue with a rationale for using the hermeneutic phenomenology method, present information on the population and participants, and the process of gathering data. This chapter also includes information on how data analysis was conducted and represented. Quality concerns such as trustworthiness and ethical considerations are also addressed.

Qualitative Inquiry

Qualitative inquiry is both a philosophy and a method of research. In part, it is born out of a reaction to quantitative inquiry's lack of ability to account for context in the social world. Creswell (1999) described qualitative inquiry as a "process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (p. 15). This definition includes the researcher's role as an instrument of the project, thus recognizing that the researcher brings values, attitudes, and assumptions to the research.

Creswell's definition also illustrates the natural setting in which research is conducted. Though the environment in which data is collected is often staged, the research allows for the context of the participant to be acknowledged. For example, although an interview setting is a contrived environment, the interviewer encourages the participant's subjective interpretation of their circumstances and does not manipulate variables to elicit results. Subjective interpretations are considered valuable data in qualitative research because of an acknowledgement of the multiple realities of the participants.

The questions posed in this project are best answered using qualitative inquiry for multiple reasons. First, and most importantly, qualitative inquiry acknowledges the women participants as experts on their own experiences. Though quantitative methods can offer generalized ‘facts’ about what pregnancy and antenatal depression might feel like, they do so at only one level. The information extracted from those types of inquiry is gained within the constraints of predetermined checklists rather than the rich descriptions provided by women reflecting upon their experience. By including the participants’ expertise, researchers give participants a voice to tell their experience in their own words.

Second, qualitative inquiry allows for the existence of multiple realities. The accounts of experiences with pregnancy and antenatal depression came from women who have lived those experiences. The accounts are from their own perspectives; their own realities. Though their stories have common themes, they are also very different. Qualitative inquiry allows for these different realities; it does not deny them in favor of one truth. Simply put, experience is a “reality” solely for the fact that it is experienced.

Finally, qualitative inquiry allows for the exploration of meanings attached to the experience. The women participants not only discussed their experiences of antenatal depression, but explored the meanings associated with those experiences. A grasp of the overall landscape of antenatal depression, with the women’s rich description of the experiences and meanings, were attained through qualitative inquiry.

Feminist Research

The primary focus of feminist research is exploring women's diverse experiences and the institutions that shape those experiences (Denzin & Lincoln, 2000; Kvale, 1996). Kvale (1996) suggested that feminist research strives to explore the everyday experiences of women and uses methods appropriate to gain insight into those experiences. Kvale also suggests that through this insight, changes can be made to the situations being studied. A literature review examined the common characteristics of feminist research. Feminist research is characterized by:

- a) a valuing of women and attaching validity to their experiences, ideas, and needs;
- b) a recognition of the conditions that oppress women;
- c) a desire to bring about social change through criticisms and political action;
- d) women and issues of gender are the central concern;
- e) research questions and answers are for the benefit of some groups of women rather than simply about women;
- f) women's current and historical context relevant to the research variables (e.g., reproduction, political implications) are recognized;
- g) there is an emphasis on subjectivity and women's context of experiences;
- h) there is a collegiality and mutual dialogue between different levels of the research team and between the researchers and the participant women;
- i) interactions are non-hierarchical in nature and structure;
- j) reflexivity, the self-questioning of the researchers' assumptions and biases, is ongoing;
- k) flexible open boundaries are honoured;
- l) there is a recognition that bias is impossible to eliminate completely. (McCormick & Bunting, 2002, p. 822).

This study is positioned in a qualitative feminist framework. The intention of this inquiry is to bring validity to women's experiences of being pregnant with depression. Though pregnancy is a natural physical state, rather than an oppressive plight women face, it occurs in a social context and is impacted by societal norms and expectations. These norms and expectations create a construct of what it means to be a mother and thus, create social parameters and constraints that go beyond the physical constraints of pregnancy and motherhood. Therefore, pregnancy as a physical phenomenon is not oppressive in itself, but socially constructed expectations, such as intensive mothering, can create a climate of gendered oppression.

An intention of this research is to create knowledge and awareness about the lived experience and meaning of pregnancy in women with mild to moderate depression. This awareness will hopefully benefit women's experiences in three ways. First, it could promote a greater understanding of these experiences among other women who may be having a similar experience. This can validate their experience and negate feelings of isolation that they may be experiencing. Second, a greater awareness of women's experiences could promote knowledge among health professionals and counsellors. Using phenomenological methods brings women's voices to this experience, providing a human side to issues surrounding pregnancy and depression, rather than simply treating a diagnosis. Finally, I hope that this inquiry encourages further research on the experience of pregnancy with depression and invites the development of practical implications grounded in this and other phenomenological studies.

I attempted to follow the characteristics of feminist research in gathering data for this project. The participants' subjectivity was encouraged and valued in their stories. I wanted to acknowledge the women's expertise in their own experience and did so by creating a non-hierarchical method of gathering data. Interviews were conducted in a conversational semi-

structured style. I also asked the participants to choose an interview location where they would feel most comfortable. I wanted to ensure that participants would not feel intruded upon by me entering their home, but also could choose to conduct the interview at home to ease issues of childcare, encourage comfort, and provide them with the opportunity to tell me about their experiences on their own turf. As such, two participants chose to meet in the research office, while the remaining four chose to meet in their home. Another strategy for maintaining a non-hierarchical structure was to engage in unrelated conversation before, after, and sometimes during the interview. Some of the participants wanted to know more about me in terms of my personal and professional life. I believe I was able to tell them enough about myself to make them feel comfortable with me, without overwhelming them with personal information or having the conversation become more about myself than their experiences.

I attempted to engage in reflexivity about my assumptions and biases throughout the research process. I needed to acknowledge my own position in a greater social context. I am a married, middle-class, and educated white woman with no children. Because the participants in the study had a similar background to me, I focussed on our one obvious difference: children. Not having my own children and my reluctance to discuss that aspect of my life, made me keenly aware of the private nature of the topics I would be discussing with the participants. I believe that this awareness prevented me from seeming intrusive; however, at times I had to push myself to ask them to expand on their ideas and tell me more.

Hermeneutic Phenomenology

The project used a hermeneutic phenomenological method. Phenomenology can be described as a research method used to examine the essence and structure of phenomena, which are seemingly insignificant experiences of everyday life (Merriam, 2002). Hermeneutics can be

described as “the art, theory, and philosophy of the interpretation of meaning of an object” (Schwandt, 1997, p. 62). Van Manen (1990) described hermeneutic phenomenology as trying

to be attentive to both terms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena (p. 180).

Thus, hermeneutic phenomenology attempts to be simultaneously descriptive and interpretive of a phenomenon.

Lived experience

The aim of hermeneutic phenomenology is to describe and interpret lived experience, which is how the world of everyday life is immediately experienced. This is referred to as lifeworld; the experienced and “taken-for-granted” everyday life (van Manen, 1990). Lifeworld is made up of themes called existentials. These include, but may not be limited to: spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived other).

Spatiality. Spatiality refers to lived space. This refers to the felt space of the experience. Lived space can refer to simply literal space such as length, width, and depth of a space; however, it can also refer to more abstract concepts of space. Space can be understood by how it feels. For example, the space of home has feeling attached to it (van Manen, 1990). These feelings may be of security and warmth. Conversely, a warehouse can create feelings of emptiness and coolness. Human activity occurs in a space and that lived space can affect how we experience the activity. Consequently, people may seek specific space to create specific feelings.

Corporeality. Corporeality refers to lived body. Individuals are always bodily in the world. The lived body refers to how it feels in that body in different situations. The physical body is the outward representation of the self. It can both conceal and reveal the self. This representation can change depending on the situation and the individuals present (Van Manen, 1990). For example, the lived body may feel uncomfortable and awkward in a pressured situation such as a job interview. Conversely, the lived body may feel comfortable and sensual in the arms of a romantic partner.

Temporality. Temporality refers to lived time. Lived time is subjective when compared to clock time. Lived time is felt time. Time can feel quick or slow, depending on the surroundings. The saying “time flies when you’re having fun” illustrates the subjectivity of lived time. Equally, time can feel as though it slows down when one is bored. Lived time can also refer to our overall orientation to time. A young person may only see time in terms of future, while an elderly person may feel time in terms of their past. The felt sense of past, present, and future are also subjective and can shape each other (van Manen, 1990). For example, as one grows, one’s views of the past may change that causes a reinterpretation of self, based on new knowledge.

Relationality. Relationality refers to lived other, which is the lived relationship one has with other people and with other non-human entities. An individual maintains relationships with others both in a bodily way and in more indirect ways. The relationship one has with others allows them to transcend themselves (van Manen, 1990). It is through these relationships with other humans and non-human entities that a person gains knowledge about themselves in relation to others.

These four lifeworld existentials, spatiality, corporeality, temporality and relationality, can be used to analyze the experiences of research participants to gain a richer and fuller account of

lived experiences and meanings. Each of these existentials can be examined separately; however, one must be mindful of the interconnectedness between these elements making up lifeworld.

The four lifeworld existentials can be used to reflect on lived experience and lived meaning of antenatal depression. Examining antenatal depression through the lens of these existentials reveals two ways of viewing this condition. First, there is the notion that antenatal depression is made of two separate experiences: pregnancy and depression, each with its own possible experiences and meanings. The lived body of pregnancy could be quite different and therefore separate from the lived body of depression. The second way of viewing antenatal depression is a more holistic view of the phenomena including both the experience of pregnancy with the experience of depression. The lived body of depression during pregnancy may carry with it both the separate experiences as well as a whole new set of experiences that can not be teased apart into two differentiated categories.

Population and Participants

Purposeful sampling

Qualitative inquiry relies on purposeful sampling. Patton (2002) described purposeful sampling as selecting “information-rich cases strategically and purposefully” (p. 243). Criterion sampling, which was used in this project, assures the quality of information given by participants is relevant to what is being studied, by ensuring that the participants selected are those best able to provide rich descriptions of the phenomenon being studied. Therefore, participants were selected on the basis of specific criteria, which increased their ability to reflect on and discuss the experience and meaning of antenatal depression.

Gaining access

Six women were recruited for participation in the study. Access to participants was gained through the larger quantitative study “Feelings in Pregnancy”, being conducted through the Department of Community Health and Epidemiology at the University of Saskatchewan. Interviewers for that study determined if their participants fit the listed criteria (Appendix A). The project was briefly described to eligible participants and they were asked if they might be interested in participating. Interested participants were then contacted by phone by the researcher. At that time, the study was described in more detail, with regards to the purpose of the study and the participation requirements, and any questions prospective participants had were answered. The met criteria were verified at this time as well. Consent was reviewed and signed at the time of the first meeting (Appendix B).

Criteria

The criteria used in selection of participants were to ensure that the information provided was rich and full in description and free from circumstances, which may cause unnecessary distress to the participant. Participants met the following criteria:

- a) Must currently be pregnant.
- b) Must self-identify as having never lost a child.
- c) Must currently score 10, 11, or 12 on the Edinburgh Postnatal Depression Scale.

The second criterion, self-identification of losing a child, is intentionally subjective in nature. Losing a child could change the meaning and experience of pregnancy as well as cause the participant distress. However, objectively labeling the criteria to include all miscarriages/abortions or neglecting to include miscarriages/abortions could unnecessarily affect eligibility of some participants, by rejecting a woman who feels that her miscarriage/abortion would not affect her

ability to participate or by accepting a woman who is still deeply grieving the loss of an unborn child.

The third criterion, a score of 10, 11, or 12 on the EPDS, was chosen out of the constraints of the larger study from which participants were recruited. Participants who scored lower than 10 were not considered to have antenatal depression, while women who score 13 or greater in the “Feelings in Pregnancy” study were referred to their doctors for further assessment and possible intervention, thus they may no longer be symptomatic. Another reason for excluding participants who scored 13 or greater on the EPDS was to avoid imposing a long interview on women with severe depression.

Obstacles in Participant Recruitment

Recruiting participants was more difficult than I expected. Though I only sought six participants for the study, recruitment took ten months. Because of this extended recruitment period, I was able to interview a participant and complete the interview transcription before an interview was scheduled with another participant. There were benefits to this extended time. It prevented a deluge of interviews to transcribe and provided me with time to reflect on individual interviews; however, I was concerned that the time between interviews may have changed my own interviewing process. I was conscious of the fact that my interviewing skills and the way I approached each participant improved over time. That being said, upon reading the interview transcripts, I realized that the quality of the interview was more dependent on the participant’s ability to reflect on and express her own experience, than on my interviewing skills and approach.

One possible reason for the difficulties in recruitment could have been the criteria used for selection. The interviewers from the ‘Feelings in Pregnancy’ study found very few participants who scored 10, 11, or 12 on the EPDS during the time period I was recruiting for this study.

Willingness to participate in the study did not seem to be an obstacle in recruitment. Very few women who met the criteria declined to participate and all of the participants who showed an initial interest in study followed through with participation.

Generating Data

Data, which comes from the word datum, means “that which is given” (van Manen, 1990). This suggests that the data used, particularly in qualitative inquiry, is given to the researcher by the participant and, therefore, is valuable. Schwandt (1997) commented on the nature of generating data in qualitative inquiry:

It is a common mistake to think that data are somehow discovered and collected (i.e., gathered), like picking berries from the vine. On the contrary, what constitutes data depends on one’s inquiry purposes and the questions one seeks to answer (p. 60).

This statement suggests that making data is a process, which includes both the participant, who gives the data, and the researcher, who determines importance and relevance of the data. Within this study, data was generated through a conversational semi-structured interview.

Interviews. According to Van Manen (1990), the phenomenological interview has two purposes. First, the interview may be used to explore and obtain experiential narrative that could later be used to develop a richer and deeper understanding of the phenomenon. Second, the interview may be used as a means of developing a conversational relationship with the participant about the meaning of the experience. These purposes reflect the nature of hermeneutic phenomenology by attending to both the experiential aspect of phenomenology and the interpretive aspect of hermeneutics.

Interviewing methods can vary along a continuum based on the structure involved. This continuum begins with an informal conversation interview where the intention is truly inductive

and grassroots to the closed, fixed interview that is predetermined and intends to compare and generalize (Patton, 2002).

This project used an interview guide approach. This type of interview has predetermined topics and issues to discuss in the process; however, the interviewer determines the sequence and wording of the questions during the interview (Patton, 2002). This approach allows the interview to remain conversational, with some direction being determined by the participants. By approaching the participants as experts in their own lives, it is necessary to allow them flexibility in their discussion as unforeseen experiences will come up. It also allows for the researcher to guide the interview toward general topics to discuss, thus increasing the comprehensiveness of the data.

One interview was conducted for each woman. Interviews ranged in time from 45 minutes to 90 minutes. Interviews followed an outline (Appendix C); however, participants were free to deviate somewhat from the outline. Interviews were audio recorded for purposes of transcription and analysis.

The Lifeworld Existentials

Though van Manen's lifeworld existentials are generally used as an analytical framework (van Manen, 1990), I chose to use them as an exploratory tool. The guided interview intentionally asked about the four lifeworld existentials as a way of encouraging the participants to reflect on and express all aspects of their experience. Reflecting on their experience through the lenses of corporeality, relationality, temporality, and spatiality provided a more complete or holistic account.

I chose to use the lifeworld existentials as an exploratory tool because lived body, relation, time, and space seemed to fit both the experiences of depression and pregnancy as well as the

whole experience of antenatal depression. In the following paragraphs, I outline my rationale for this.

Corporeality, or lived body, can be applied to the experience of antenatal depression. A pregnant body can be seen as an outward reflection of both a physical state and a change in the inward self. The analysis of the lived body can shed light on what it feels like to be in a pregnant body both physically and psychologically. Similarly, examination of the lived body of depression can create a description of the experience and feelings associated with being in a depressed body.

Relationality, or lived other, can be applied to both the preexisting relationships and created relationships antenatal depression. In pregnancy, a woman can have a relationship with her partner, her other children, her fetus, and more abstractly, herself as a mother or mother-to-be, and herself as a woman. Some of these relationships could be experienced uniquely in the context of pregnancy. This can also apply to how depression affects these relationships.

Spatiality, or lived space, can be applied to the experience of pregnancy and antenatal depression in several ways. First, the metaphorical spaces of pregnancy could be present. Pregnancy may hold space that is different from professional space literally because of the different physical places that they take place in (home vs. workplace) and more abstractly because of the roles and expectations of the different spaces. Secondly, the space of depression is arguably different than the space of mental wellness. Different space may be occupied when a person is depressed, and space may feel differently when depressed.

Temporality, or lived time, can be applied to the experience of antenatal depression. Pregnancy is a physical state of a very specific amount of time. This time may be felt subjectively. For example, a woman who is a week past her due date may feel time is passing slowly. Lived time can also be applied to pregnancy with regards to its momentous nature. Giving birth may be a

milestone from which a woman refers to her past, present, and future (i.e., before the baby was born, after I became a mother, etc.). Temporality can also be used to analyze the felt time of antenatal depression. Depression may make time feel as though it drags, or it may make time go by quickly as though the person felt unaware of time.

Participants were asked about each of these lifeworld existentials. The questions resonated with the participants and they were able to reflect on and describe their experiences within this framework. The questions about space and time were more abstract and some of the participants needed clarification; however, once an unrelated example was given, they easily spoke about their experiences.

Data Analysis

Phenomenological themes can be described as the structures of experience (van Manen, 1990). Therefore, theme analysis in a hermeneutic phenomenological study consists of determining the experiential structures of the phenomena. This process involves finding something telling and meaningful about the experience; discovering the point and making sense of the experience. Van Manen (1990) refers to it as mining meaning. Another way to describe theme analysis is discovering the essence of the phenomenon (van Manen, 1990). This means that there is something broad and foundational underneath the specific experience.

Van Manen (1990) outlined three approaches to theme analysis of text. First is the holistic or sententious approach. This approach involves reading larger sections of a text and determining broad, overarching themes of the text. The second approach is called the selective or highlighting approach. This approach involves the researcher attending to pieces of text which stand out, or pieces of text, which seem to be repeated, and determining the themes of these important sections of the text. The third approach is called the detailed or line-by-line approach. In this approach the

researcher attends to each individual line of the text and pulls specific themes from each line. All three of these approaches were used to create a comprehensive theme analysis.

I began data analysis by reading the transcripts over and over again. I attempted to avoid thinking about the lifeworld existentials as separate categories to avoid a tautological analysis. That is, I avoided looking for themes of lived body, relation, space, and time because the interview questions were specifically about those categories. Thus, I would be looking for themes that already existed in the research design. Instead, I attempted to ignore these separate categories and look for connections between them.

After reading the transcripts several times, I stepped back from them and thought about what themes or categories emerged from the reading. I intentionally did not look at the transcripts at this time, hoping that only the most important, prevalent, and striking themes were recalled. An overarching shared meaning emerged as well as three sub-themes. Once again I re-read the transcripts several times to determine if these themes emerged organically from the words of the participants or if this was a lens that I was imposing on the data. I initiated this process of re-reading the transcripts and stepping back several times using what van Manen (1990) described as the selective approach and the line-by-line approach. Two more sub-themes emerged during this process of checking and re-checking.

Once I determined a shared meaning, with five sub-themes, I examined them integrating the lifeworld existentials. I found that the themes encapsulated some or all of the lifeworld existentials and assumed that these themes are a holistic view of the participants' experiences. I discussed the themes with women from my personal life who self-identified as having antenatal and/or postpartum depression. They found these themes to resonate with their own experiences. Though this informal method of 'member checking' is unconventional, their input was incredibly

valuable and validating to the data analysis process. Finally, I returned to the limited literature about women's experiences of pregnancy and high-risk pregnancies and found that these themes were congruent with research.

Data Representation

The representation of data largely depends on the intended audience. Because this project is a Master's thesis, the standards set by the Department of Educational Psychology and Special Education must be followed. The formal designative text contains both the overarching shared theme as well as the five explicit sub-themes of the interviews. It also contains excerpts of anecdotes from the actual texts. These excerpts were used to personalize the information, give voice to the participants, and act as a "concrete counterweight to abstract theoretical thought" (van Manen, 1990, p. 116). Van Manen (1990) outlines the significance of anecdotal information suggesting it has the power: (a) to compel; (b) to lead us to reflect; (c) to involve us personally; (d) to transform; and (e) to measure one's interpretive sense.

Trustworthiness

Traditional notions of validity and reliability in the natural sciences and quantitative research are not applicable to qualitative research (Morse & Richards, 2002). In positivist science, validity requires that the results are an accurate reflection of the phenomenon and reliability requires that the results could be replicated if the same study was done. This notion of validity is problematic in qualitative inquiry as the realities are assumed to be multiple and interpretation is subjective; thus, determining the truth or accuracy of a phenomenon is impossible. The notion of reliability is also problematic. The rich description of qualitative inquiry would be difficult to replicate with a different population or even the same one as there may be points of awakening where the participant learns something about their experience in the process of telling it.

Lincoln and Guba (1985) offered an alternative view on rigor in qualitative research called trustworthiness. Trustworthiness refers to whether the findings of a study are worth paying attention to. Lincoln and Guba (1985) suggested four criteria be applied to determine trustworthiness:

- a) Credibility: establishing confidence in the ‘truth’ of the findings of the inquiry;
- b) Transferability: determining if the extent to which the findings can be applied to other similar contexts;
- c) Dependability: determining if the findings would be similar if the participants were the same and the inquiry was held in the same context; and
- d) Objectivity: establishing confidence in the findings being based on the participants and the context rather than the biases, motivations, interests, or perspectives of the inquirer. (p. 290)

Though some of these issues of trustworthiness can be difficult to address, strategies and methods can be used to ensure findings are as trustworthy as is possible. First, member checks were done. Member checks involved taking the data to participants to ensure that they felt that they have said has been accurately examined and written about. One problem with this method is that interviews and interpretations of experiences are snapshots of a specific time and place. The participants may not feel the account illustrates how they currently think and feel; however, it is important that they feel the account has captured their thoughts and feelings at the time of the data generation. Participants felt that the data accurately represented what they had said in the interviews.

Another way to ensure trustworthiness, particularly with the objectivity, is for the researcher to position oneself in the research. This means acknowledging biases and motivations

and keeping mindful of those biases throughout the research process. This acknowledgement not only allows the researcher to become aware, but informs the reader of the position of the researcher. Throughout the process of interviewing and analyzing the data, I asked myself how being an educated, middle-class, white, childless woman affected my interpretations. Because most of the participants were like me in terms of race, educational attainment, age, and socioeconomic status, I had to be conscious of over-identifying with the participants.

Ethical Considerations

Ethical considerations were addressed in the Behavioural Research Ethics Board Application (Appendix D). Ethical approval was granted by the University of Saskatchewan Advisory Committee on Ethics in Behavioral Science Research. This project was considered a low-risk study as participants were not considered a vulnerable population and were able to give informed consent and there was no deception used in this project. The sensitive nature of the topics discussed involved minimal risk as participants were informed that they could discontinue the interview at any time. I prepared a list of available counselling services in the event participants deemed them necessary, however this issue never arose.

CHAPTER 4: Results

In this chapter, I start with an account of the six women who participated in this project, including their family life, support network, careers, and other descriptions necessary to the context of their pregnancies. I have chosen pseudonyms for the women and their spouses and have changed any other identifying information to protect the confidentiality of the women. I follow by detailing the shared meaning and five sub-themes that emerged from their experiences. Quotations from the participants are used to illustrate these themes and to give voice to the women. Rather than presenting the participants as one voice or archetypes, participants are represented in their individual voices. This decision was made to value their individual experiences and retain the context of those experiences. Quotations are represented in italics and are edited for confidentiality and to simplify reading. Filler words such as, uh, umm, like, you know, have been deleted. Words added for clarification are in square parentheses.

Participants

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

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

Four of the participants were living with their partners (and children) full-time. One of the participants lived with her fiancé part-time as her fiancé worked away from home. One participant was living alone while her partner was in another province in the Armed Forces. Four of the participants owned their own home.

Alison

Alison is a soft-spoken, shy, 24 year-old woman with fair hair. She recently graduated with a Bachelor's degree. Alison was working as a server in a restaurant when she found out she was pregnant. She quit her serving job and moved into her parents' rural home and later moved into her own apartment when she found part-time employment in her chosen field.

Alison and her fiancé, Alex, have been together for two and a half years and became engaged after Alison became pregnant. Alex is an officer in the Armed Forces and is currently based elsewhere in Canada. Because of his occupation, they are only able to speak on the phone once a week. They are currently planning their wedding and hoping to be married before the baby is born. Alison plans to have the baby in the province and is not sure if Alex will be able to attend the birth. She is hoping to join him on base once the baby is able to travel.

Alison was 34 weeks gestation at the time of the interview. This is her first pregnancy. It was unplanned. Alison felt very nauseous in her first trimester and found it difficult to do everyday tasks because of this. At the time of our interview, she was feeling better physically, but found that her low mood had continued on after the nausea. Alison scored 12 on the EPDS.

Alison has struggled with depression since she was 12 years old. She has been prescribed medication in the past, but found that it made her feel lethargic. She has coped with her depression through counselling for the past five years and has found that to be helpful. Alison told me that

though she's been depressed for a number of years, she feels that her depression has been mild and has never had thoughts of hurting herself.

Alison reported a lack of a support network. Though she feels happy with her relationship with Alex and feels that he is supportive when he can be, the geographical distance and his lack of availability has made his support feel inconsistent. Alison has found her family, particularly her mother, to be generally unsupportive and judgmental. She has found it difficult to tell her extended family about the pregnancy and wedding and often mentioned feeling like she was a pregnant teenager because of the shame caused by others' reactions. Alison has found her future in-laws to be supportive most of the time, but struggles to keep her independence of them intact. Though she needs and enjoys Alex's family's support, she is leery of being '*swallowed up*' by them.

Alison was the first participant that I interviewed. I felt nervous about this initial interview because of the abstract nature of the questions I would ask, getting all of the paperwork signed, and the recording equipment working properly. I admitted to Alison that this was my first interview and I felt nervous and she calmed my nerves by telling me that she was nervous as well. We completed the interview in the research office in the hospital, which was an uncomfortable setting and felt very formal. Though our introductions to each other and the first couple of minutes of the interview were uncomfortable, we quickly found a smooth conversation-like interview rhythm. Alison was very forthcoming in her answers and elaborated on her experiences with very little probing. She easily understood and was able to speak to some of the more abstract questions about felt time and felt space. I enjoyed getting to know Alison through the interview process and was struck by her strength and resiliency through some of the difficulties she was facing in her pregnancy.

Beth

Beth is a tall, dark haired 33 year-old woman with an assertive, 'no-nonsense' look on her face. Beth owns and operates her own business and manages over 70 employees. She is also a full time student in a Masters program and is to be finished her program five weeks from the time of the interview. Though Beth can do some of her work from home, she still works 40 to 60 hours per week in addition to her studies.

Beth is married and has three children: an eight year-old daughter, a four year-old son, and a one year-old daughter. Her husband, Blake, co-owns and operates the business with Beth. Working and raising a family together is extremely busy for them, but Beth says that they have learned to take it in stride and have accepted this phase of their lives. They feel like old pros in terms of managing the housework and busy life of the children and share the work fairly equally. Because Beth has been pregnant before, Blake has recognized what she can and can't do and compensates for this.

Beth was 19 weeks pregnant at the time of the interview. This fourth pregnancy was planned and she and Blake decided that it would be their last child. Beth described being very nauseous from the beginning of the pregnancy and continued to be until the time of the interview. She was nauseous throughout her three previous pregnancies as well. Beth describes pregnancy as being difficult in terms of her energy levels, mood, and feeling ill, but because she has had three children, seems to fully recognize the temporary nature of pregnancy and is looking forward to completing her family with this fourth child. Beth scored 12 on the EPDS. Beth believes that she experienced depression during her second pregnancy, though was never treated. She attributed her depressed mood to the illness experienced during that pregnancy.

Beth had a strong support network. Her husband was supportive both emotionally and practically in the home and at work. Beth had recently lost her childcare provider, but was managing successfully with her work hour flexibility, working from home, and has found her parents very helpful with childcare. Beth also describes a strong network of friends who are mothers as well and understand the demands of working, raising a family, and being pregnant.

I interviewed Beth at her home. All of her children were home, which was distracting at times, but created a relaxed, comfortable, and informal interview setting. We sat at her kitchen table, drinking coffee, and enjoying the children as we completed the interview. Beth was brief and direct in answering the questions. She did not answer in long descriptive narratives and when asked to elaborate, I felt she expressed no more than required. Though her answers were brief and lacked some detail, I did not get the impression that she misunderstood the questions or my encouragement to go further, but that she was very matter-of-fact and saw no reason to go into much detail. After reflecting on our interview, I realized that the children in the room could have caused her to be less talkative, either for reasons of privacy or distraction. Another possible reason could be because this was her fourth pregnancy and her experience may feel very ordinary, expected, and perhaps mundane, thus not warranting deep reflection and insight. Beth was my second interview participant and perhaps a more experienced interviewer would have been more adept at guiding the interview. Beth appeared to be a very capable and competent person and I left our interview in awe of her ability to manage her busy life.

Chloe

Chloe is a tall, spiky-haired, 23 year-old woman with a wide smile and a bohemian look. Chloe graduated from high school and has worked various jobs since. She moved to the Prairies from Ontario three years ago. She currently works two part-time jobs, one in food services and the

other in a rural library. Chloe is not very interested in her jobs; however, she is trying to work as much as she can, so that she can receive maternity leave benefits.

Chloe and Charlie have been married for two years and together for five. Charlie works as an Emergency Medical Technician full-time and has been considering going back to school. Chloe describes her relationship with Charlie as being very loving, respectful, and considerate. Chloe feels very supported by Charlie during the pregnancy and is happy to see that he has been as excited as her about all of the changes she's gone through and about becoming a father.

Chloe was 23 weeks pregnant at the time of our interview. This was her first pregnancy and she and Charlie planned it. She described feeling very sick and tired throughout the beginning of the pregnancy. She found going to work difficult and often was unable to get out of bed in the mornings. At the time of our interview, Chloe was feeling better, both physically and emotionally, and attributed her emotional wellness to being able to work and be active. Chloe scored 12 on the EPDS.

Chloe was originally diagnosed with depression when she was eleven years old. She has tried a variety of treatments for the depression over her adult years including medication, acupuncture, and counselling. She discontinued her antidepressant medication during the first trimester of her pregnancy, but continued to see a counsellor. Her mother was diagnosed with postpartum depression after giving birth to Chloe. Chloe says that the possibility of herself having postpartum depression is in the back of her mind.

Chloe has mixed feelings about her levels and sources of support. Her greatest sources of support are her husband and her older stepbrother. She has also received support online and through telephone calls from old friends back east. Her source of ambivalence about support comes from getting support from individuals whom she does not like or respect, while not receiving

support from those she had expected it from. Chloe has had a difficult relationship with her in-laws in the past. They have become friendly and supportive upon hearing the news of the pregnancy and Chloe is hesitant to accept this as she does not trust them. Her own family, except for her stepbrother, has been far less enthusiastic about her pregnancy than she had hoped and has found them to be very self-involved in their own circumstances. Chloe is hurt by this and feels that she is tolerant of her in-laws' behaviour because of her need for some sort of family involvement.

I interviewed Chloe at her house in a rural community. Her home was very eclectic and offered a comfortable and cozy atmosphere. We very quickly began chatting like friends and I had to consciously remind myself of my role as an interviewer. Upon listening to the tape of our interview, I realized that we maintained a very professional relationship throughout the interview and that perhaps our friendliness was more felt than expressed. I was incredibly impressed by Chloe's insight and her ability to express herself. She took her time answering the questions and had obviously done a lot of reflection throughout her pregnancy. I left the interview feeling moved by her eloquence and excited on a professional level, knowing that she had provided a great amount of data both in quantity and quality. I enjoyed meeting Chloe and feel that if we had met in a different capacity, I would have enjoyed spending more time with her.

Daphne

Daphne is a tall, dark haired 27 year-old, with an athletic build. Daphne is finishing up her Master's degree and working full time in her field. Daphne enjoys her job and finds her co-workers very supportive of her pregnancy; however, she finds her new career stressful at times and often works long hours to keep up with her responsibilities.

Daphne and her fiancé, Dylan, have been together for ten years. They began dating in high school and have been engaged for eight months. Daphne feels some anxiety about how having a

baby will affect their relationship. She feels that because they have been together for ten years, they have had a lot of time alone, which on one hand has strengthened their relationship. On the other hand, they have become accustomed to only taking each other into consideration and the baby will change this dynamic. Dylan works out of the province. He is away from home for two weeks and home for one week. Daphne and Dylan have decided that she and the baby will move around with him, rather than be at home alone for two weeks at a time.

Daphne was nineteen weeks pregnant at the time of our interview. This is her first pregnancy. Though Daphne and Dylan planned to get pregnant, she felt shocked and sad at times that her life was about to change so drastically. Daphne was very nauseous for the first 17 weeks of pregnancy and links her low mood to that period of time. She is still finding it difficult to sleep, but her energy levels have increased in the second trimester. Daphne scored 10 on the EPDS.

Daphne was diagnosed with depression and anxiety in her early twenties. She has tried several treatments including medication, counselling, and Eye Movement Desensitization and Reprocessing. Daphne found that these treatments reduced her symptoms of anxiety and depression. She worries that the depression and anxiety may come back and has found that being pregnant has intensified this worry in terms of the effects on her child of having a depressed mother as well as hereditary components. Daphne's mother was diagnosed with depression when Daphne was a child. Reflecting back on her childhood, Daphne realized how her mother's depression might have affected her in terms of not always being present in her life. Daphne also expressed minor concerns about the possibility of postpartum depression. Though she has these concerns, she feels armed with education, knowledge, and first hand experience and believes that though this will not prevent depression, it could aid her in recognizing symptoms and seeking early treatment.

Daphne feels very supported in her pregnancy and expects a similar amount of support once the baby is born. Many of her friends are pregnant or already mothers. She relies on these women for information, encouragement, and a sense of connection. Daphne's mother is also a strong support. She has been a labor and delivery nurse for 25 years and has recently become a doula. Daphne receives a lot of information from her mother and although she feels a sense of comfort in having her mother's education and qualifications supporting her, she sometimes wishes that her mother supported her simply as a mother, rather than in a professional capacity. Because of her mother's experience, Daphne has found it difficult to make her own choices about pregnancy and delivery without her mother's influence.

I interviewed Daphne in the "Feelings in Pregnancy" research office. Though the office adds a formal feeling, Daphne's upbeat and enthusiastic personality filled the room and quickly turned the stuffy office into a comfortable space. She spoke very quickly and in a loud, clear voice. Daphne easily recalled past experiences and was able to reflect on new ideas quickly and articulately. We connected very quickly as we had so many things in common: our age, marrying high school sweethearts, and the frustrations of completing a Master's degree. I also found myself agreeing with her in many of her fears of becoming a mother, though I kept this agreement to myself. I enjoyed meeting and interviewing Daphne and left the interview feeling energized by her enthusiastic personality.

Eve

Eve is a petite 30 year-old woman with fiery red hair and a husky voice. She completed some post secondary education and works part time as a medical assistant. She spends the rest of her time at home with her one year-old son and has a 12 year-old stepdaughter who lives with her

and her husband full time. Eve recently moved to Saskatchewan from Alberta. She has found being away from her family and friends difficult.

Eve and her husband, Eric, have been married for a year. She describes their relationship as a whirlwind. They began dating three years ago, became pregnant five months later, and engaged three months after that. Eve also had to adjust to becoming a stepmother to Eric's preteen daughter during this time. Though she admits that this has been trying for her at times, she enjoys spending time with her and feels very supported by Eric.

Eve was 16 weeks pregnant at the time of our interview. This is her third pregnancy including her son and an abortion she had at eight weeks gestation over a decade ago. Eve and Eric tried to become pregnant very quickly after her son was born. They had some difficulty and began to consider fertility drugs before becoming pregnant on their own. Eve has found this pregnancy very difficult. She has felt exhausted and had nausea and vomiting. She has also had a sinus infection for several months that has been difficult to treat. Eve has also been diagnosed with rheumatoid arthritis. She has had to discontinue some of the medications she was taking to treat the arthritis and has found her that symptoms have increased because of this. Eve also has felt an increase in symptoms of anxiety and depression during her pregnancy. She scored 12 on the EPDS.

Eve was diagnosed with depression and anxiety during the last trimester of her pregnancy with her son. She received counselling and took medication for one year postpartum. She describes this time as being filled with anxiety, panic, and low mood and believes that some of these symptoms were caused by some health concerns in her newborn son. Because of her past experience with anxiety and depression, she describes her and Eric as being on high alert with this pregnancy. She is beginning to feel some of the same symptoms and has been addressing this with her doctor throughout the pregnancy. Though she feels nervous about the possibility of going

through the experience again, she thinks that she is more self-aware and better prepared to seek treatment and to cope.

Eve is ambivalent in her feelings about support. On one hand, she feels isolated and far from family. She misses being able to go for coffee with her sister, or have a quick visit with a friend. She has also missed her support network in terms of practical support such as babysitting so she and Eric can spend the evening together. On the other hand, being away from some family member has reduced stress for her and Eric. Some of their family members have been critical and judgmental of their relationship and their parenting and being away has removed this stressor. She has also found that her sister and mother are still very supportive through the telephone and states that she and Eric are able to lean on each other for emotional support.

I interviewed Eve at her home. She stated that she was not feeling well during the interview and this was noticeable by her demeanor, voice, and body language. Eve spoke slowly and in a monotone voice. She often had to shift her position as she was uncomfortable sitting for the interview. However, she was welcoming and friendly and offered coffee when I arrived. Eve's infant son was home, which was both distracting and entertaining as he was often demanding our attention. While transcribing our interview, her statements were often difficult to decipher because of her son chattering in the background. There were also several instances where we turned our attention to him and enjoyed watching him play. Eve was able to speak to the questions asked and elaborated freely. Though I left the interview feeling somewhat depleted, I was happy with Eve's interview and felt empathy for her situation.

Fallon

Fallon is a tall, curly haired 31 year old woman with big doe-like eyes. She earned her Bachelor's degree and is currently working full-time in her field. Fallon describes her job

supervising several employees and often working 75 hours per week as very stressful. Fallon moved to Saskatchewan from a neighboring province one and a half years ago and moved into a new home in a rural community just outside Saskatoon one year later.

Fallon and her husband, Frank, were married for five months at the time of our interview. Frank's job requires him to be out of town and often called out with only hours notice. Fallon states that they can go for days without seeing each other, but feels they manage to stay connected and spend a lot of time together on their days off. She does feel concerned about maintaining this connection once the baby is born, but thinks they will adjust.

Fallon was 21 weeks pregnant when I interviewed her. This is her first pregnancy. Though Fallon easily became pregnant only two weeks after her wedding, her pregnancy has been difficult. At seven weeks gestation, her doctor found a fibroid on her cervix, which was taking up much of the blood supply that should have been going to the baby. Later, she hemorrhaged on the other side of her uterus, but has since stopped bleeding. This led to her being on bed rest for six weeks. Though her employer was sympathetic, Fallon could not help but feel stressed and worried during this time. During this time, Fallon also experienced a lot of nausea and fatigue. Fallon felt isolated and sad as a result of being on bed rest and away from family and friends. Though she is physically feeling much better she continues to worry about the possibility of the baby being born prematurely. Fallon believes that she has been mildly depressed since she moved to Saskatchewan, though this has not been medically diagnosed. She attributes this to some of the isolation she has experienced as well as the stress of her job and adjusting to a new city, friends, and home. Fallon scored 11 on the EPDS.

Fallon has found a lack of support to be one of her biggest struggles during her pregnancy. Though Frank has been supportive in a practical sense, she feels that she cannot discuss her

worries with him. She states that Frank has dealt with the high-risk nature of her pregnancy by believing that everything will be fine, and becomes upset when she tries to discuss the possibility of prematurity. Fallon recognizes that her and Frank have different styles of coping with stress and this sometimes causes some friction in their relationship.

Being away from family and friends has also been difficult. She wishes she was able to stop at a girlfriend's house for a quick chat, or go for coffee, but instead stays connected through the telephone and Facebook. Fallon has found her Aunt and Uncle to be very supportive. She is estranged from her mother and father and says that her Aunt and Uncle will be the baby's grandparents. Her Aunt's enthusiasm and excitement about the pregnancy help her stay positive through the difficult times she has experienced.

I interviewed Fallon in her home. She was kind and welcoming, but also very professional. I left the interview feeling that we had thoroughly covered the topic without visiting or becoming overly friendly. This encounter was very indicative of Fallon's self-description as being task and detail oriented. I found her account to be honest and forthright. And though she stated that talking about her doubts and fears was difficult, she was able to articulate her feelings with eloquence.

Shared Meaning: Ambivalence

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

The participants described experiences that seemed dissonant. Upon reflection after each interview, I was struck by how each participant would describe positive experiences and negative experiences. Of course, human experiences are complex and therefore are rarely completely positive or negative, but this seemed more significant than the usual good and bad parts of life.

Instead, the positive and negative experiences were connected to each other and became one whole dissonant experience resulting in ambivalence about their experiences.

Further analysis uncovered sub-themes of dissonant experiences. The five themes are distinct enough to stand as categories; however, they are very strongly interconnected with each other and with the shared meaning of ambivalence. The discovery of these themes occurred through a deconstruction and reconstruction of the data. As stated above, after each of the interviews and the initial readings of the transcripts, I felt there was a broad sense of ambivalence among the women's experiences. I began to re-read the transcripts searching for evidence of this broad sense and saw patterns and similarities among the participants' experiences. These patterns and similarities became the five sub-themes. I teased apart the data within the five sub-themes and noted how they were interconnected with each other. Throughout this deconstructive process, I continuously stepped back to ensure that the sub-themes were connected to the larger theme of dissonance and shared meaning of ambivalence. I liken this process to looking at the brush strokes in a painting and then stepping back to see the whole picture.

The following five interconnected sub-themes emerged:

- a) Disconnection versus New Connection and/or Reconnection
- b) Loss of Identity versus Newfound Identity
- c) Fatigue and Illness versus Vitality and Wellness
- d) Anxiety and Insecurity versus Confidence and Security
- e) Sadness and Hopelessness versus Joy and Expectation

I describe these dissonant sub-themes as a conflict structure (i.e., versus). I do this because these experiences appeared to have a push-pull affect on the participants. The words dissonance and ambivalence, rather than dichotomous or contradictory, are used because the relationship is not

only one of conflict, but rather mutual in that the push-pull creates a transformative experience. Thus the experiences of two seemingly separate phenomena become one complex experience. Though the dissonant experience and resulting ambivalence is a whole experience in itself, I chose to deconstruct the experiences as two dissonant parts in their description, just as I had in the analysis and interpretive phases of this study. I did this for simplicity and to better illustrate each of the individual experiences.

Theme 1 – Disconnection Versus New Connection and/or Reconnection

All of the participants experienced a sense of disconnection and new connection or renewed connection during their pregnancy. The participants varied in who they experienced disconnection or new connection with, but this was a theme among all of them.

Disconnection

The women experienced a sense of disconnection with important people in their lives. Disconnection was experienced with friends, their partners, family members, and their unborn babies.

Friends. Some of the participants experienced disconnection with their single or childless girlfriends. They felt as though their pregnancy had created a space in the relationship that had previously been filled with closeness and shared experience. Alison attributed this distance to her and her friends being in different stages of life. She said:

Their focus was on parties and what they were doing that night and how much they could drink or how much...their focus was that partying phase still and so I was really impatient with it and I didn't really care and they wanted me to listen to that and I just like... You know? I can't, I just really can't care about the fact that you know, so and so did this, and I really didn't care about those little things.

Alison felt that she had passed the stage that her friends were in. She no longer cared about parties and drinking and gossip. These activities seemed trivial to the kinds of circumstances and choices she was facing. Being in a different phase of life disconnected her from her friends with whom she formerly had a shared experience.

Chloe experienced this disconnection in a much more abrupt fashion and attributed it to jealousy:

I had one friend, quote unquote that said to me when I was trying to get pregnant, she said, 'well you can think of it this way, you can either be friends with me or you can get pregnant. So if you don't get pregnant, it's not a big deal.' And I was blown away by that. Wow. I really have to choose. And she was right because as soon as I told her I was pregnant, I haven't seen her since... Honestly I do think it's kind of a jealousy thing. Where she is a really needy kind of friend and so then if my attention is going to be devoted somewhere else then she can't handle that because she needs all or nothing.

Beth felt that the disconnection she experienced was in part due to the demands of her current families in combination with feeling too tired to socialize. Beth saw this disconnection as temporary in nature, having experienced a brief disconnection with friends in her previous pregnancies:

One of my best friends is pregnant with the same due date. And it's her second child. And they live right by us too. We don't see each other that much because with my last, or when I was pregnant with my son, I was pregnant at the same time as another friend of mine. We both know that we're bitchy and emotional and we should just stay away, to save the friendship. And they are long-term friendships, like I have known her since I was a toddler.

Although we might do lunch once in a while, we kind of naturally avoid each other... the friendships will pick up right after [the baby is born.]

Beth, Chloe, and Fallon all experienced distance with friends who were having difficulty becoming pregnant or had a history of miscarriage. Chloe described two of these kinds of friendships:

One is 38, just got out of a long term relationship and is now dating and trying... And she wants more than anything to have a baby and she hears her clock ticking away and then there's me at 23 already having a baby and so I can't help but feel the tension from her and I know that it's painful for her to see that. And then my other friend too, she has been trying to have a baby for the past 7 years and it just hasn't worked for her. She's lost babies and just hasn't been able to get pregnant again. So, with both of them, I find it stressful to be around them, because I don't even want to be happy around them about my baby because I don't want to be like rubbing it in. That's made those relationships harder.

Beth, Chloe, and Fallon saw the disconnection as reciprocal with their friends feeling upset or jealous of their pregnancies and themselves having feelings of guilt for their own happiness.

Partner. Some of the participants experienced physical and emotional disconnection from their partner or spouse during their pregnancy. This disconnection left them feeling unheard and uncertain about their partner's role in their pregnancy and later into parenthood.

Alison experienced this disconnection in a very literal way with her husband being out of town for work. Alison found it difficult to share her experiences of pregnancy with her partner, as he has not been present for most of her pregnancy. Though they speak on the phone regularly, it is a scheduled phone call and she wishes that he were there to support her on an ongoing basis. She

has found coping with his military position difficult because there is a lot of uncertainty around his availability to support her:

Like I can't depend on him to be here for the baby even though they gave him 2 weeks of holidays... it just happens to land around my due date. Hopefully he'll be here. I hope it will happen then, but I've had to plan for other people to be there with me. And then also we have to move out there to be with him. I'm going to go out there probably 8 weeks after the baby is born, once the baby can handle the travel. Other than that, the military is just hard to plan around. And it's hard to explain that to other people.

Fallon also experienced disconnection in an abstract sense. Frank is reluctant to acknowledge any future complications resulting in Fallon feeling uncomfortable talking to him about her fears:

We were so excited and all the help in the world and then as soon as there was problems, and even still now, he doesn't want to hear it. He doesn't want to think of the reality that we could have a preemie child and it could be born in 12 weeks time. Like he's just no, we'll be full term. We'll be fine. We'll be great... That was trying on us and because again he wouldn't, couldn't understand what I was feeling and what I was going through with the sickness and everything else. It just seemed like everything that you could possible have go wrong in a pregnancy. Like, being so sick and being so tired and being on bed rest. He's like, 'is there anything else that you can get?'

Family. Disconnection from family members was experienced by some of the participants. Lack of excitement expressed by family members resulted in feelings of disconnection and a lack of support. Chloe was surprised by her parents' lack of excitement about her pregnancy:

So with my parents I feel a lot more alienated from them. I feel like they don't, like I don't have their approval or acceptance for it. So that's kind of a barrier, like when I told them, they both just stood there like a deer in the headlights and then we didn't talk about it again for days. And you know, they live in Ontario and I was there visiting for a week. Like we went just to tell them and it just got kind of dropped and ignored, so that kind of made me feel ashamed about the whole thing. I started questioning myself. So that's kind of made me feel a bit of a separation from them. Mostly because I wasn't expecting their reaction to be like that.

Alison felt disconnected from her siblings because their excitement about the pregnancy was in stark contrast to her feelings of unhappiness and uncertainty:

You know, my sister was the first person that I told I was pregnant. She was on the phone with me when I was taking my pregnancy test and she wasn't that helpful. Like I was really... I expected more from her as a sister because she's 31, or she's 32 now, and so I thought that she would be more mature about it. I was going through all of these scary feelings and I didn't even... I couldn't even look at a picture of a fetus, like it would just make me ill. And she was going on and on about how she couldn't wait to be a favorite aunt and like she was going baby shopping the next day and like that's not really helpful.

These experiences of disconnection occurred within relationships that the participants felt were healthy and positive. Thus, the experiences were surprising and created feelings of loss for the women. In contrast, some of the women had experiences of further disconnection with individuals with whom they already had negative or difficult relationships. They discussed how the experience of pregnancy seemed to intensify the negative feelings and encounters that they had with these individuals.

Strained relationships with in-laws were already experienced by some of the participants. Chloe felt that her mother-in-law believed that she was not good enough to be married to her son. Her mother-in-law's excitement and newfound positive attitude toward Chloe felt insincere and exaggerated resulting in Chloe feeling more disconnected with her mother-in-law:

We've never had a good relationship and his mother has never approved of me, or really wanted anything to do with me, but all of a sudden, I'm the porthole for her grandchild and I'm the most amazing person in the world.

Alison had a difficult relationship with her father-in-law. She described them as having very different personalities and was uncomfortable with his abrupt and grumpy attitude. She also felt as though he had failed as a father to her partner and was upset with how his family had so easily forgiven him for his mistakes:

And so, they think that this baby is going to be his dad's second chance, like they said that. Like his wife said 'I just really want [Alison's father-in-law] to have a second chance with the baby.' Ugh, like no, I don't want this baby to be his second chance. I don't even want him around the baby.

Alison did not want her child to be “*the family experiment*” to determine if her father-in-law could rectify his role in the family by being a better grandfather than father.

Fallon found the disconnection with her mother intensified with pregnancy. Fallon had been periodically estranged from her parents since she was a teenager. She lived with other relatives as she finished high school and considers her Aunt and Uncle to be the parental figures in her life. Fallon and Frank decided that very limited contact with her parents would be the healthiest decision for their new family. Though Fallon continued to believe that this was a healthy choice

for her, Frank, and the new baby, she felt a sense of loss being disconnected from her own mother when she was about to become a mother:

So that's been difficult while I'm pregnant because I know that my mom went through all of the same fibroid problems and complications. And I feel like calling her and asking her 'what happened and how did you feel? How much weight did you gain?' Because I don't know any of that stuff...so that's been kind of difficult not having her to talk to and I sent her the ultrasound picture, just to try to keep her in the loop and make her feel... because I know that she's hurting, missing out on this. So that's been kind of difficult. Most days are good and some days aren't, but I try to not let those days get to me because I know that was the right decision.

Unborn baby. Some of the women described a disconnection they felt from the baby growing inside of them. Though they felt connected in the physical sense, they found that they lacked some of the positive emotional feelings normally attributed to connection. Chloe and Daphne both experienced feelings of resentment towards their baby as they experienced negative physical symptoms. When I asked Chloe how she felt during pregnancy, she responded:

Rather invaded. (Laughs). Like for the first couple months I was actually feeling pretty resentful. Like, just towards this little tiny being that was just taking up residency and taking control of everything and because of it I couldn't do anything and I felt so useless and I wasn't cleaning, I wasn't cooking, I was just... I wasn't doing anything and I was feeling totally invaded and kind of angry towards it for doing this to me, even though I wanted it. You know?

Daphne described a similar experience, which led to feelings of guilt:

I was feeling like my body was being invaded. And I mean it sounds... now that I look back, I'm almost embarrassed and feel guilty that I felt that way because it seems ridiculous, but you know I guess it's normal.

While all of the participants experienced disconnection with various individuals in their lives and because of different circumstances, they each felt that this profoundly affected their feelings of support and encouragement. This sense of disconnection was largely felt in a negative way; however, these negative feelings seemed to be tempered by their simultaneous experiences of new or renewed connection.

Connection

While feeling disconnected from some of the important people in their lives, the women also experienced new or renewed connection with others, and in some cases with those they were feeling some disconnection from. They experienced a sense of new or renewed connection with friends, their partner, mothers as a group, their unborn baby, and in a more abstract sense, nature.

Friends. Many of the participants found new and renewed connections with friends from their past. All of these connections were with girlfriends who were either pregnant or had children of their own. The women attributed this newfound connection to their shared and common experience with their friends.

Chloe described making contact with old elementary school friends that she had not spoken to in years. Though all of her communication with them has been on the phone or through the Internet, she has found their experience as pregnant women and knowledge of motherhood to be incredibly helpful and reassuring:

There are two girls, in particular that I hadn't talked to in years, I just came across them on the Internet and we started chatting online and we've gotten really good friendships

back again even though we haven't be friends since public school. And that was because well they both just had babies and one is pregnant again. So it's kind of a string that ties you together. And that's been really helpful because... especially with one because every time I have a concern, I call her up and say, do you remember this when you were pregnant? Did this happen? And so that's so nice to have.

Fallon's experience had been with current, but found the connection deepened within their shared experience of pregnancy. They have been able to connect on a new level. She too, has found her girlfriend's experience and knowledge to be helpful and reassuring:

So to have my one friend who's had a baby and she's pregnant again and we're going through it again together and it's just been awesome because we can talk about stuff and we're feeling the same things and we're feeling the same frustrations and so it's easy to vent with her... you know ask any type of question, gross or not, talk about any feeling because she might be going through it too or has before, so that's really good.

Partner. All of the participants described a deeper connection with their partners upon becoming pregnant. Beth discussed how having children deepened the connection between her and her husband in the past and how she believes that it will be the same with the birth of their last child.

He's really understanding. He's been through it too, so he knows that it's not forever... I mean it definitely makes it stronger... it's a strengthening thing for the relationship. It's a strengthening aspect to the relationship to know that you're creating an extra person in your family.

Eve felt that she and her husband have become closer during this pregnancy and in her previous pregnancy. Eve feels that Eric has been her greatest support both practically and

emotionally. She has particularly found his practical support helpful as she copes with some of the physical illness and exhaustion:

He was at one point... like last week he worked 18 hours a day, but he would still come home around supper time and help make supper and then go back to work, just because he knew I couldn't...

Eric's willingness to help with daily chores gave Eve a feeling that her experience was acknowledged and valued.

Mother. Some of the participants described feeling connected to a larger and more abstract group of mothers. Alison, Chloe, Daphne, and Fallon, all of whom would be first time mothers, felt a sense that they were already connected or about to become connected to all mothers. Daphne describes this connection as joining a secret club:

I think there's kind of that whole club out there of people that have this common thing. So I'm anticipating sort of that feeling when I have a child... I think there will be more of a change then. Especially with co-workers and things that have babies, or women that are in my life that are maybe middle aged, I'm anticipating this kind of underlying being closer, just because we have that in common.

Chloe described the deeper connection and understanding she has with her own mother:

I know it gives me a better understanding of why my mom treated me the way she treated me my whole life. And that was very good. And she was very overprotective and just always really worried about me and I used to get so annoyed by that because I was like stop worrying about me. I'm going to be fine. It's me. I know how to take care of myself. And I'm fine. But now that I have a daughter, it's terrifying. Like every time I feel a little bit of a twinge or a cramp, I immediately go into that mother mode, where I'm like, oh my

god, call the hospital. Something's wrong. And so now I understand and I don't think I ever understood that capacity to love another person, so I appreciate how much my Mom loves me now because I know how much I love my child and it's not even born yet. So it's frightening actually... It's a pretty big emotion. So that made me appreciate my mom more in my life.

Unborn baby. All of the participants felt connection to their babies. Some of them experienced this connection to the fetus growing inside them. Daphne found that once she heard her baby's heartbeat and her belly began to swell, she felt connected: "*you're starting to show and it makes you connect with the baby a bit more.*" Beth feels that knowing the sex of the baby intensifies the connection:

We don't pick names until we know if it's a boy or girl and then also how life is going to change for the kids and you know, if I'll be doing hair everyday and ballet classes vs. hockey and cars and so on. And it definitely makes a bigger connection to know if you're having a boy or a girl...it just that it changes. It's still the same strength. It just changes.

Nature. Chloe described how she felt more of a connection with nature. She attributed this connection to her body participating in the natural act of growing a human being:

I like being outside a lot. And just relaxing in the sun. Feeling that connection with the earth and being at ease and just within nature and stuff. I think that goes along with just feeling more natural. Like I feel more comfortable in nature. I feel more natural as a person... I'm not going to fight against nature because I'm kind of dependent on nature right now... just feeling connected to it because it's such a natural event.

All of the participants experienced disconnection and connection with various individuals in their lives. Experiences of disconnection often resulted in feelings of loss, lack of support,

isolation, and guilt. Connection and reconnection created feelings of support, love, intimacy, and solidarity. Though the new and renewed connections may have created some balance for the negative feelings associated with disconnection, we can not assume that either of these experiences was dominant in all or any of the participants. The simple fact that each of the participants described both phenomena suggests that disconnection and connection were important experiences in their pregnancies.

Theme 2 – Loss of Identity Versus Newfound Identity

The four participants who were to be mothers for the first time experienced a loss of identity and a newfound identity. The two participants who were already mothers did not talk about this experience and I did not ask them about it as this theme emerged after data was collected.

Loss of Identity

The four participants who were expecting their first child experienced a loss of identity. They had some understanding of how their life was changing with pregnancy and how it was about to change with the birth of their first child. For some, it was the loss of their roles in their career. For others, the sense of loss was regarding their individuality.

Career Women. Daphne and Fallon experienced this loss of identity in terms of their careers. For both of these women, their careers had taken precedence over other aspects of their lives, dedicating most of their time to education and subsequently their careers. They felt a sense of loss about their transition from career women into motherhood. Daphne described this realization:

All of a sudden it was like, ok it's never going to be just about me anymore. And now I am completely fine with that, but just for that first stage I think. And then starting to wonder career-wise and things that I haven't done yet. Ok, I haven't traveled as much as I wanted

to maybe. And a promotion came up at work that's going to involve a lot of national travel and I started to think about maybe not... maybe holding off on trying to get pregnant to explore this job for a year or two and see how that went. Then I found out I was pregnant and went, oh ok I guess... and now I'm still going to interview for the job and can still do it, but obviously it is going to change things because I'll only be able to do it for maybe a year instead of two if I'm on mat leave. So I think that too, that was part of me being selfish... because all of a sudden it's real.

Daphne realized that becoming a mother meant having to make decisions regarding her child and not just herself. Furthermore, many of the choices she would make for the benefit of her child, would mean sacrifices for her. This recognition resulted in feelings of selfishness and consequently guilt, as well as an overwhelming sense of responsibility.

Loss of Individuality. Some of the women felt a sense of loss about their own individuality and autonomy. Chloe felt this loss with regards to her body:

Yeah I don't feel like my body is my body at all anymore. But I think that definitely comes across with the way... I don't know. There's my attitude, but then other people's attitudes too. Like I know that when people look at me now, they don't look at me as me, they look at me as pregnant me. And people think that they can just come up to you and start talking to you about really personal things or touching you, which they would never do otherwise... And even one of the doctors I went to was like, get used to it. It's not your body anymore. It's your baby's body now. That is different to get used to.

The participants expressed this loss of identity and role in terms of a transition to something new. Thus, losing part of their identity did not leave emptiness, but rather new identities and roles to navigate.

Newfound Identity

The four women experiencing their first pregnancy sensed new identities and roles for themselves. The expected new role of mother brought mixed feelings in terms of excitement and overwhelm. Some of the participants described this new role in terms of a fantasy. Some recognized the overwhelming sense of responsibility. Others thought about the kind of mother they would like to be. The two participants who already had children did not experience a loss of identity, nor a newfound identity, but reflected on their first pregnancies and discussed the ease of the transition in their subsequent pregnancies.

The fantasy. Some of the women expressed their excitement with fantasies of what motherhood would be like. Fallon described her fantasy:

This is the home that we are going to be raising our baby in and every time I go into the nursery... like it's not a nursery yet. It's just a mess, but I can visualize it and I can daydream about that rocking chair sitting there and me breastfeeding the baby. I can see that.

Choosing a path of motherhood. The newfound identity of mother brought an overwhelming feeling of responsibility to Alison and Fallon. They described how they had not only recognized the importance of being a parent, but had reflected further on what kind of mother they wanted to be. Alison described this reflection in terms of her goals for herself as a parent and her goals for the child she was carrying:

Well, the project that we have, we have a goal. You know, like, to raise a healthy independent adult...you don't know what the outcome is going to be, but you are testing your own theories. Like we pick a parenting strategy. We pick feeding strategies. How we are going to handle our relatives? What we're going to... How we're going to discipline

him? These are the things that have an outcome, but we don't really know what the outcome is yet, and we're just... Like the project is us testing these theories, and I mean, because we believe in them. And we'll evaluate it later too.

Fallon described her reflection of the kind of mother she wanted to be in terms of what she would not be. She was somewhat unsure of the positive characteristics she would bring to motherhood, however, she felt resolved to not allow the negative characteristics she had seen in her own parents play a role in her parenting:

To a point I felt like my mom was a good mom, until I really looked deep down and said you know what? No, she wasn't. And I want to be that much better and have that much better of a life for my kids, so that my child never goes through what I went through... everyone says that the apple doesn't fall far from the tree. So, and sometimes I worry about that and think am I going to turn out like her? Am I going to put a blind eye to things and not stand up for myself? Be verbally and physically abused? And I know that wouldn't happen with Frank, but deep down am I truly like that, or am I as strong as I think I am? Or is it just a front that I put on? So it makes me question my own being and my own values and my own way of how I think that I am going to do things. So that's kind of difficult and I keep thinking, no, I'm going to be fine. I have Frank. I'm not in that situation. I'm not her.

Identity in subsequent pregnancies. Beth and Eve did not express any feelings of loss of identity or newfound identity. Both of them had children and were comfortable in their role as mother. They expressed the ease they felt in their current pregnancy compared to their first pregnancies with regards to a transition in identity and role. Beth said:

I guess for myself, I just kind of realized that I have to get through all of the uncomfortableness and sickness and things like that. And I'm kind of on hold. And the first couple of pregnancies I was a little selfish, like... I want to go do this and I wish I could go on a bike ride or a camping trip or something like that. And it just wasn't feasible. So now, I know that my life is on hold for baby and no kind of feelings like... oh I wish I didn't do this or anything like that. Like I absolutely hate the feeling of being pregnant, for the sickness and exhaustion, but with baby... now I feel the baby kicking now even... it's a really good feeling to know this is... I know exactly what's going to happen and know how much life is going to change.

Neither Beth nor Eve expressed any identity loss or transition from being a mother of one, to a mother of more than one.

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

Theme 3 – Fatigue and Illness Versus Vitality and Wellness

All of the participants described feeling fatigue and illness, but also a sense of vitality and wellness during their pregnancy.

Fatigue and Illness

All of the participants experienced exhaustion, fatigue, nausea, and vomiting in their pregnancy. These experiences played a large role in how the women felt physically and emotionally during their pregnancies. The sheer volume of data gathered regarding these experiences speaks to their significance. Two of the participants had conditions that further complicated their pregnancies.

Nausea and Fatigue. All of the participants described experiences of nausea and vomiting within the first five minutes of our interview and described these experiences at length. Chloe said she felt:

Really, really rotten and just constantly felt like I was sick and felt like I had stomach flu for three solid months and didn't want get off the couch and didn't want to go outside. I quit a couple of my jobs. I was doing a couple of part-time jobs and I quit them just because I couldn't be around anything. Like smells just everything made me so sick and if there was one candle burning in the house I could smell it and I'd have to go outside and it was pretty awful. And I think that when you feel that way, like your body is really sick then it makes your mind... it's really hard on your emotional state too.

Complications. Eve's exhaustion and nausea were further complicated by having rheumatoid arthritis. Eve had been unable to take some of her prescribed medications and worried about the medications she was taking for the pain:

This pregnancy has been... I refer to it as hell. A horrible thing to say but I know the end result is a great thing. Like since I found out I was fine for the first couple of weeks and then I started getting really bad morning sickness, or all day sickness. I was sick from the moment I'd get up, even sometimes I'd wake up sick in the middle of the night. I also have

rheumatoid arthritis, so my body has been trying to adjust to my hormones kind of kicking in for all of the medication that I am not on. So I'm still taking my painkillers.

In addition to fatigue and nausea, Fallon has had serious complications to cope with during her pregnancy:

I have a fibroid that is quite large and it's sitting on my cervix. So they were worried about that and with the a baby not getting enough blood supply because it's taking quite a bit of the blood supply right now. And then I had a hemorrhage on the other side of my uterus that they weren't sure what was going on with it, but it has kind of stopped now and it's clotted and it's done. So they basically put me on bed rest to get me through my twelfth week and to make sure that things were going ok and not putting any stress like lifting and basically doing nothing.

Being on bed rest for six weeks was very difficult for Fallon. She described herself as an energetic person and so she found it frustrating to rest all day. Fallon also found the six weeks to be very isolating because her close friends all live in another province and Frank's work required him to be out of town.

Vitality and Wellness

Some of the participants described experiences of wellness and vitality even within their periods of fatigue and illness. For some, this was felt as a newfound energy. Others noticed changes in their bodies that they felt were symbolic of wellness. Taking better care of their bodies during pregnancy seemed to account for this vitality and wellness.

New Vitality. Chloe described this experience as something new, something that she had not experienced previous to becoming pregnant and therefore attributed the experience to pregnancy:

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

Changes symbolic of wellness. Fallon also experienced changes in her body that signified wellness and vitality:

Your body just completely changes and like my fingernails are growing like crazy and my hair is growing like crazy. So just that kind of stuff is just neat to watch and see... it's great because I feel pregnant and I feel great and I feel energy.

Fallon felt that these were physical signs of wellness and combined with the excitement of watching and feeling her body change this created an energy within her.

Ensuring wellness. Chloe felt a heightened sense of awareness of her body and mind as well. She attributed this to taking better care of her body ensuring that she got enough sleep and was eating properly:

I think that I am just a lot more alert and a lot more receptive and more involved in my environment, just more tuned in. And I do think that I have more energy now than I did even before and maybe that's because I'm taking specific measures to eat better and to sleep. Like I am sleeping like 11 hours every night because I know I need the rest. And I don't feel guilty about it. Whereas before, I would try to shove so much into one day, but now I feel like, oh I'm just going to relax a little and even if I just work 4 hours I'll come home and have a nap and I always feel really well rested, which I never felt before.

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

Theme 4 – Anxiety and Insecurity Versus Confidence and Security

The participants described feelings of anxiety and insecurity that they attributed to pregnancy; however, they also found that pregnancy brought a new sense of confidence and security.

Anxiety and Insecurity

All of the participants experienced anxiety and insecurity during their pregnancy. Some of these experiences were about their changing bodies and the resulting insecurities about their relationships. Uncertainty about their own health and the health of their babies also caused anxiety for some of the women. One participant found that the anxiety she experienced when she was not pregnant intensified with pregnancy.

Body image. Fallon struggled with her weight in the past. She spent a lot of time and energy losing weight and began feeling better about her body. When she began to gain weight during her pregnancy, she felt very insecure about her body:

I just felt fat and I knew I was pregnant, but because of my past worries about how I looked and how people perceived me, I was worried that people were like, oh you know, look at her. She's got a nice tire around her waist. And even with friends, they were like oh you know, you're gaining some weight and that was really hard for me to take because you spend so many years not gaining and maintaining.

Relationship. Chloe found that her insecurities about her changing body affected her confidence in her relationship with her husband:

I started putting a little of the weight on and I started just feeling conscious of the fact that I'm going to get really huge. You know? And my husband married me as a very skinny person. And I know that he was attracted to me then. Is he still going to be attracted to me when I put on 30 pounds? And I started having a really hard emotional time with really bad jealousy and just panic. And even if I saw him talking to a female co-worker, I would start sweating and shaking because I was thinking, well she's not going to get fat. She's skinny. She's not gaining all of this weight. She's still attractive to him, but I'm not going to be attractive to him anymore.

When Chloe thought about the actuality of her husband leaving her for another woman, she realized that she was being irrational; however, she continued to question how her husband could find her attractive when her body no longer looked the same.

Anxiety about the baby. Each of the participants experienced some anxiety about the health of the baby. For Fallon, this was because of the complications due to the fibroid, but for the others this anxiety was related to the possibility of miscarriage in the first trimester. Daphne described how this anxiety affected how she felt about the baby:

Most of my feelings were due to not wanting to get too attached or knowing that there was a chance of miscarriage. I just had this... again back to I'm usually optimistic, but I had this pessimistic feeling that something was wrong. That something wasn't right. That something wasn't... I had this deep down intuition.

Daphne also found herself feeling detached from the baby to protect her feelings in case of miscarriage. This led to feelings of guilt for not having an attachment to the baby inside her.

Chloe also experienced anxiety about miscarriage:

I think that most people are really worried in their first 12 weeks of pregnancy that anything could go wrong at any moment and you're constantly going to the bathroom to make sure you're not bleeding or anything because you just feel so insecure being pregnant. Being pregnant is a really insecure feeling.

Intensified anxiety. Eve struggled with anxiety in her previous pregnancy and throughout various other times in her life. She found her anxiety to be manageable when she was not pregnant and find that pregnancy intensifies her anxiety. She also described how even though she is more anxious during pregnancy, her fears are not necessarily pregnancy related:

Emotionally, I'm exhausted. Because I can't think anymore. I constantly have thoughts racing, racing, racing. And it's the anxiety level of something happening to either the kids or to T. Or to my parents and I'm not there. And I can't do anything to help. That's my main anxiety. I have things just rushing through my head, and I can't stop. Like I try my best to keep the thoughts. I try to focus on something, or try to do something different and try to get the thoughts out of my head, but it gets to the point where I'm just wiped out.

Even though Eve's anxiety was very distressing to her, she described how attributing the heightened anxiety to pregnancy gives her some understanding of her experience. Because she knows that pregnancy is temporary situation, she hopes that the heightened anxiety is temporary as well:

Like if I had no understanding and just all of a sudden this was the way I turned into and I wasn't pregnant or anything like the, I'd be more worried because that's just not my regular self. And I'm hoping that's... That's my main hope, that it is just the hormones and I will be back to normal again.

Confidence and Security

Some of the participants experienced a sense of confidence and security in their pregnancy. They experienced this about their bodies in two ways. First, by seeing their pregnant bodies as beautiful and sexy. Secondly, they recognized the purpose and strength of a pregnant body. Another way they experienced confidence and security was within their relationships. They found their pregnancy to be a catalyst to assertiveness in their relationships.

Beautiful body. Alison appreciated the changes in her body, particularly getting larger breasts. When she first said, “*I felt really excited about getting bigger boobs,*” we laughed, but when I asked her to elaborate on what that meant to her she explained:

Because I have never had boobs. And so I was really excited about that. I always thought that I might get big boobs when I was pregnant because I was a really petite and skinny girl and I wasn't really sexy or anything, I was just very, like almost prepubescent. Like I was just, like not, I should rephrase that. Like there were teenagers that looked older than me and I didn't really have a lot to offer physically, like sexually. So, I was always like when I get pregnant I'll probably get big boobs. You know, so there was always that potential. So the fact that I had actually got big boobs was like yes, I reached that potential.

Although Alison brought this up in a light-hearted manner, after discussing it further we uncovered a deeper meaning. Pregnancy and her changing body signified the confidence, beauty, and sensuality that she had longed for.

Purposeful body. Some of the participants described their bodies as having purpose. Growing a baby brought a sense of function to their bodies and this resulted in a sense of responsibility, purpose, and confidence in their ability to do so. Beth said, “*I guess it's quite a*

change where you feel like you're doing a job 24 hours a day. You're growing someone. It's a satisfying thing." Chloe described a similar sense of purpose and direction that she had not experienced before:

I feel like I do have a really specific purpose right now. So that's really nice and in the past things just trudge along, but now I have got direction and I've got purpose and that's really nice. And I've got a plan and it's to have a baby.

Assertiveness in relationships. The participants noticed that they became more assertive during their pregnancies. This assertiveness seemed to have grown out of two themes. First, there was a new appreciation for themselves. Having a purpose and experiencing the power of their bodies while growing a human being helped them to value their bodies and themselves, and thus, recognize and assert their worth. Secondly, the new responsibility for the baby inside them and the future responsibility for a child after giving birth, created a protective and demanding attitude. The participants who had difficulty being assertive for their own needs in the past, were now able to assert their needs in relation to their baby. Chloe was able to express this experience eloquently:

I love myself so much more now than I have ever in my whole life. And I appreciate myself so much more and I'm so much more willing to stand up and say what I believe and stand up for myself and defend myself. And I can get quite hostile at times now. Whereas for 22 years I was your typical doormat who would just kind of lay down and let everyone walk all over me and would never really voice my opinion or my needs at all. I just felt that my needs weren't important, but now I am so much more willing to voice my opinion and to portray to people that I am a valuable person and I feel good about my self. My confidence is a lot higher and I'm just much more vocal. And I haven't quite wrapped my mind around where that comes from, but I think that part of it is feeling a responsibility for somebody

that is important to me. Like I feel a responsibility to the baby that I need to stand up for us.

Alison also expressed this new assertiveness when describing an ongoing conflict she has had with her parents about her fiancé being in the army. When I asked her if being pregnant changed the dynamic between her and her parents, she replied:

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

She described pregnancy as a truth. Her pregnancy was the catalyst for asserting herself about her choices.

All of the participants experienced forms of anxiety and insecurity related to their pregnancy. For some, it was the changes in their bodies, particularly gaining weight that made them feel insecure about themselves and in their relationships with their partners. For some, the possibility of complications and miscarriage and the uncertainty of what pregnancy would bring created vulnerability and anxiety. For Eve, pregnancy intensified her existing levels of anxiety. However, all of the participants gained a newfound confidence and security. A few of the participants expressed a satisfaction with their growing bodies. Some participants found purpose through being pregnant. An appreciation for their purpose and worth along with a protective feeling for their babies led to confidence and assertiveness in their relationships. Though they may not have experienced both confidence and anxiety about the same aspects of their lives, they did describe having both of these experiences simultaneously.

Theme 5 – Sadness and Hopelessness Versus Joy and Expectation

The women experienced feelings of sadness and hopelessness in their pregnancy. They also felt feelings of joy and expectation about their pregnancy and becoming a mother.

Sadness and Hopelessness

All of the participants experienced periods of sadness and hopelessness. All of them attributed some of this to the nausea and vomiting they were experiencing in the pregnancy. They were acutely aware of the connection between their emotions and the physical sensations in their bodies. They described how feeling nauseous caused feelings of sadness and low mood and how in turn their low mood intensified their feelings of exhaustion. Fallon illustrated this connection between her body and mood:

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

Alison also described this connection:

I'm feeling so sick that I can't make 3 meals a day for myself and I can't expect my fiancé to be here. Like we live separately so he would come over every once in a while and help me out but he just couldn't do that all of the time. And so I was like, I need help and as much as I feel sick I don't want to hurt this baby by being depressed and not eating.

Alison found that her physical illness, exhaustion, and low mood led to feeling unable to take care of herself. Fortunately, she moved in with her parents so they could help take care of her; however, her relationship with her mom was difficult and the conflict regarding her unplanned pregnancy led to Alison feeling even more depressed:

The beginning of it felt really bad. Because it was unplanned and because I'd just finished university even though most people when their 25 do have kids, or just in history that's the time to have kids. I felt like a teenage pregnancy because I think university extends adolescence... My family, I felt very uncomfortable with it and I had trouble telling them and I haven't told all of my relatives yet and I think it was because I felt shame and my parents wanted me to come home...so I hid. Like I basically hid for 3 or 4 months. Like because we live on the farm so it's easy. So it's like... And it's wintertime and so I could just kind of hide out there and that's essentially what I did. I put my head in the sand because I didn't know how to deal with the situation.

Feelings of sadness and hopelessness seemed to be strongly linked with physical symptoms like nausea and fatigue. The participants had a good understanding of this connection between body and mind and the connection helped them make sense and meaning of their emotions. Though Alison had a similar experience, hers was complicated by her own feelings and her family's feelings about her unplanned pregnancy. The shame and guilt that she felt were unique to her situation and seemed to intensify her experiences of sadness and hopelessness.

Joy and Expectation

All of the participants experienced joy and expectation in their pregnancies. All of them enjoyed their expanding belly and felt proud that they were about to become mothers. Beth and Fallon were excited about not being pregnant anymore and concentrated more on their anticipation for their babies. Chloe described being pregnant as a fulfillment of her dreams. Beth, knowing that this would be her last pregnancy, viewed this pregnancy as a completion of her family.

The Belly. All of the participants described the joy they felt when they saw their pregnant bellies swelling. Their expanding bellies signified that ``*there really is a baby in there.*`` This gave

them a feeling of joy and a sense of pride. Daphne described sharing this experience with her fiancé:

I mean I enjoy the feeling of it and I enjoy my partner. He'll rub and feel. It makes it more real too. You start to realize, Oh something is going on down there. I think that's one thing. I guess that it's probably too that you're proud that you're pregnant.

Anticipation for giving birth. Beth felt excitement about being done with pregnancy. She saw pregnancy as a difficult but temporary phase. The anticipation of giving birth was partly about meeting the baby, but also about no longer being pregnant. When I asked Beth to elaborate on her feelings about no longer being pregnant, she replied:

Relief. Relief that I'll get my body back, my life back. I'll have energy again. Because I knew we were going to do it, and now it's almost half way through the pregnancy and we can plan for things. Life will return to normal once baby is born. Even though we'll be having four kids around us, but that's what we would consider normal. The relationship will return to normal. My body will hopefully return to somewhat normal. And energy level especially. And work will return to normal.

Because Beth had gone through this experience before, she had insight into what her life will be like after she gives birth and looked forward to it.

Fallon also experienced anticipation about the baby being born. However, her anticipation was less about not being pregnant and more about meeting the baby:

I'm excited and I'm full of joy and I'm full of... the anticipation is killing me to know... We aren't finding out what the sex is but on the same token it's like, ok you're in there and I just saw you on the screen and I really want to know what you are. So that's really exciting, but also the suspense of it is exciting too. I've always wanted that where you see

the movies where they're in labor and going through wicked pain and then it's a boy or it's a girl at the end... I want to hear that.

Dreams fulfilled. Chloe views pregnancy and becoming a mother as the fulfillment of her dreams. She describes pregnancy as the beginning of a journey that she has always wanted to embark upon. Now that she has begun this journey, she is filled with joy and anticipation for what it will bring:

I'm not sure why, but my whole goal has always been to have a child and to shape this life and to help raise a good citizen. That's always been my career plan; to be a mother. I've been fanatical about it for the past six or seven years. Starting when I was about sixteen or seventeen, when everyone else was looking at their universities, all I was thinking about was when do I get to have my baby? When do I get to start this voyage? So before when I didn't know when that was going to be it frustrated me. And now that I know that I am going to have the baby, this feels like a lifelong thing for me.

Completion of family. Beth and her husband had decided that this pregnancy would be their last child. Beth viewed this pregnancy as the completion of her family:

Well I think we're going to think: after baby number four, our family is complete. I think that is how we are going to view it... Just because we are very happy to have everybody added in and after a month it is like... what was it like without this child?

Beth anticipated the new baby quickly becoming a part of their family and thus completing it.

All of the participants experienced both periods of sadness and hopelessness while experiencing other periods of joy and expectation. The periods of sadness and hopelessness were strongly connected to the experiences of physical illness and fatigue. Alison's sadness was intensified by feelings of guilt and shame about her unplanned pregnancy. The periods of joy and

expectation came from a variety of sources including, enjoying their belly; the anticipation of giving birth; the fulfillment of dreams; and the completion of family.

Summary

The rich descriptions expressed in this chapter illustrate Alison, Beth, Chloe, Daphne, Eve, and Fallon's lived experiences and lived meaning of antenatal depression. Listening to and reflecting on their experiences, I came to believe that they all had dissonant experiences in various aspects of their lives. They experienced both disconnection and new connections in their relationships with friends, family members, their partners, and their unborn babies. They experienced both lost and newfound identities as they transitioned from the role of childless woman to motherhood. They experienced illness and fatigue and yet had periods of vitality and wellness. They felt anxious and insecure while finding a new confidence and assertiveness. They found that periods of sadness and hopelessness were met with joy and expectation. These dissonant experiences resulted in a shared meaning: ambivalence. They felt ambivalent about their relationships, identities, physical bodies, beliefs about themselves, and moods.

Chapter 5: Discussion

In this chapter I will provide a brief summary of the findings. I position the findings within popular notions of depression and pregnancy and in the current research on pregnancy and motherhood. Strengths and limitations of the current study are addressed. Finally, I suggest possible future research and implications for counselling practice.

Summary of Findings

This hermeneutic phenomenological study was conducted to understand the lived experience and lived meaning of antenatal depression. The limited research about antenatal depression has focused on diagnostic issues, prevalence, and associated factors. There was a need to give voice to women who experience antenatal depression to gain a deeper understanding of their experience and the meaning they make of that experience. The aim of this study was to gather rich descriptions of that experience and meaning from six women with mild to moderate symptoms of depression during their pregnancies.

The shared meaning of the six participants' lived experience was ambivalence. This ambivalence grew out of various dissonant experiences. Ambivalence, the state of having simultaneous, conflicting feelings towards a person or thing (Wikipedia, 2009), can be a stressful position to be in. It can create a sense of uncertainty about the person or thing one is feeling ambivalent about, but also an uncertainty about one's ability to make sense of their world. In this study, the participants described many dissonant experiences resulting in ambivalence about their relationships, identities, bodies, beliefs about themselves, and moods. This is a lengthy list of important life experiences they felt ambivalent about, leaving one to wonder about their quality of life. I have no intentions of finding causal relationships between ambivalence and the diagnosis of depression; however, I am left to question the relationship between them. Are these women

assessed as having mild to moderate depression because of the stress and uncertainty they experience in making meaning of their world? Does having mild to moderate depression during pregnancy lead these women to perceive their experiences as dissonant, thus resulting in ambivalence? Are they separate entities? Is the relationship between them more complex than simply one causing the other? These questions, though rhetorical, stem naturally from interviewing women with a shared ambivalence who also have symptoms of mild to moderate depression.

Five interconnected sub-themes emerged from the data. These themes were of the dissonant experiences that led to ambivalence in the participants: (1) disconnection versus new connection and/or reconnection; (2) loss of identity versus newfound identity; (3) fatigue and illness versus vitality and wellness; (4) anxiety and insecurity versus confidence and security; and (5) sadness and hopelessness versus joy and expectation.

All of the participants experienced disconnection and new or renewed connections. Experiences of disconnection were difficult for the participants. Alison lost friendships due to no longer sharing experiences with their friends and Chloe perceived jealousy to be the reason for the loss of her friend. Beth found it difficult to maintain her friendships due to the demands of work, family and fatigue in her pregnancy. Fallon, Beth, and Chloe experienced a disconnection with friends who were having difficulty conceiving because of feelings of guilt. Alison and Fallon also experienced disconnection with their partners due to their physical or emotional availability to offer support. Chloe and Alison experienced disconnection with their family members because of a lack of support as well. Relationships that were difficult for Alison, Chloe and Fallon became even more strained resulting in further disconnection. Some of the participants also experienced disconnection with their unborn babies. Both Chloe and Daphne described feeling like their unborn children had invaded them.

All of the participants experienced new or renewed connections. Chloe and Fallon found themselves closer to friends who were pregnant or had children and found their shared experience and knowledge valuable. Beth and Eve found a renewed connection with their husbands resulting from the shared experience of parenthood and practical support. Alison, Daphne, and Fallon all felt a new connection with mothers in general and Chloe felt a deeper understanding and appreciation of her own mother. All of the participants described a connection they felt with their unborn baby. For some, this connection was deepened as they watched their bellies grow. Beth found this connection became stronger once she knew the sex of the baby. Finally, Chloe experienced a connection with nature, which she attributed to being dependent on nature and going through the natural process of pregnancy.

The four first time expectant moms experienced a loss of identity, while transitioning to a new identity. Alison, Daphne, and Fallon were concerned about their roles as career women and recognized that they needed to make some sacrifices in their careers to be mothers. Chloe felt that she lost her individuality by being pregnant. She felt that her body was no longer just her body, but also her baby's body while she was pregnant. The participants also described how new identities were being explored and found. Fallon described a fantasy of motherhood. Alison and Fallon discussed what kinds of mothers they wanted to become. Beth and Eve, who already had children, did not have this experience with this pregnancy, but reflected on having these feelings during their first pregnancies.

All of the participants described the dissonant experience of fatigue and illness alongside vitality and wellness. All of the participants described having nausea, vomiting, and fatigue. Fallon and Eve experienced further complications to their health. Alongside these experiences all of the participants having periods off energy. Chloe described this as feeling more alive during pregnancy

and attributed some of this to her taking better care of herself to ensure wellness. Fallon described physical changes in her body as symbols of her wellness.

The participants described having feelings of anxiety and insecurity, while also having a newfound confidence and assertiveness. Fallon experienced insecurity about her growing body. Chloe also had these insecurities, which led her to feel insecure about her relationship with her partner. Fallon, Chloe, and Daphne all experienced anxiety about the health of their babies and the possibility of miscarriage. Eve, who had struggled with anxiety throughout her life, found her experience of anxiety intensified with pregnancy. The participants also had experiences of confidence and assertiveness. All of the women appreciated the way their pregnant bellies looked. Beth and Chloe recognized purpose in the bodies leading to a recognition of their worth. Alison and Chloe also found confidence in the way they related to others. They became more assertive in relationships they had previously stepped back from.

The participants experienced periods of sadness and hopelessness, while also experiencing periods of joy and expectation. Fallon and Alison attributed their low moods mostly to the illness and fatigue they felt. Alison also experienced sadness, shame, and guilt about her unplanned pregnancy. Periods of joy and expectation were felt among all of the participants. They all felt joy when they looked at their bellies and described feeling proud about being pregnant. Beth and Fallon both described looking forward to giving birth. Fallon and Chloe described being pregnant and becoming mothers as a fulfillment of their dreams. Beth, knowing that this would be her last child, felt a sense of completion for her family.

In summary, the shared meaning of antenatal depression involved ambivalence about dissonant experiences. There were also five dissonant sub-themes I identified in the data: disconnection versus new connection and renewed connection; loss of identity versus newfound

identity, fatigue and illness versus vitality and wellness; anxiety and insecurity versus confidence and security; and sadness and hopelessness versus joy and expectation.

Integration of Findings

Popular Notions of Pregnancy and Depression

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

Existing Qualitative Literature

There is a very limited amount of literature about antenatal depression and I was unable to find any qualitative research about antenatal depression. However, two qualitative studies about high-risk pregnancy due to complications or adolescence were particularly relevant to the present

study. Though these studies were not about antenatal depression, they succeeded in giving voice to pregnant women's experiences. These were particularly relevant in confirming findings of ambivalence.

A qualitative inquiry conducted by Bender (2008) investigated child-bearing decision making in three adolescent women. The study explored the pregnant teens experiences of deciding to keep the baby, put the baby up for adoption, or abort the baby. The findings indicated a considerable amount of ambivalence in the girls' descriptions. This ambivalence was categorized into three themes: (1) ambivalence about pregnancy; (2) ambivalence about keeping the child; and (3) ambivalence about motherhood. Though the participants in the study were teens, Bender noted that the participant who experienced the greatest level of ambivalence was the oldest participant at 20 years of age.

Two of the themes in Bender's study paralleled findings in the present study: ambivalence about pregnancy and ambivalence about motherhood. Ambivalence about pregnancy in Bender's (2008) study were illustrated in one participant's comment: "One minute there was great joy . . . and everything extremely bright and happy; then the other minute, it was like everything collapsed." She went on to say: "This is too early for me, I am too young. I think I should have accomplished something more" (p.879). This parallels Daphne's experience of realizing that she had not completed everything in her career that she had intended to complete before becoming pregnant. Ambivalence about motherhood in Bender's (2008) study was expressed in terms about not being ready for the responsibility of motherhood and wanting to remain a teenager. This parallels Alison's experience of feeling like a pregnant teen. She doubted if she was ready for the responsibilities of motherhood. Fallon's worries about responsibility are similar as well. Though Fallon felt prepared to face the challenges of motherhood, she worried about what kind of mother

she would be. The themes of ambivalence in Bender's study are congruent with some of the themes found in the present study.

A phenomenological study conducted by Leichtentritt and associates (2005) explored the experiences of 57 pregnant women who were hospitalized for complications during their pregnancies. The essential theme of their experiences was one of ambivalence:

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

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

Because of the limited research on antenatal depression, qualitative inquiries about other difficult circumstances in pregnancy were used to confirm findings in the present study. Bender (2008), Leichtentritt and associates (2005), and the present study all found an overarching theme of ambivalence in the experiences of pregnant women with complicating circumstances.

Weigert's (1991) discussion of ambivalence is valuable and pertinent to the current study. He builds upon Merton's theories of how sociological ambivalence is the result of contradictory expectations. This theory accounts for the social constructs in which a person lives, rather than suggesting that ambivalence is simply a psychological phenomenon as Freud had suggested (Weigert, 1991). Furthermore, he suggests that ambivalence can result from contradictory

normative expectations within a role, role set, or status. As such, an individual feels ambivalence when the expectations of their role are not congruent with another role in which they occupy, or when the expectations of their role are not congruent with their emotions.

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

Weigert (1991) discussed how ambivalence is often experienced as an undesirable state. He suggested that ambivalence feels uncomfortable because in an individualistic and competitive society, ambivalence is seen as indecision, a sign of a weak ego, or as blurred values. In the current study, the participants made reference to this either in the interview process or after the interview, when I asked them about the process. They all made reference to how their uncertain feelings were

things they could not talk about with others. The expectation was that they were filled with joy when they were feeling well, or they were feeling negative when they were sick or had a difficult day. They perceived others' expectations to be black or white about their experiences. In reality they were feeling contradictory feelings most of the time and felt uncertain, or "wishy-washy" or "like I don't know how I'm feeling, so how can I describe it to you?" However, ambivalence could be seen as functional, rather than as weak or undesirable (Weigert, 1991). Ambivalence shows confidence to confront both sides of an issue and weigh further alternatives. Lichtentritt and associates (2005) also suggest a positive side to ambivalence. They suggest that ambivalence is a dialectical concept that can have a calming influence on an individual because of the possibility of positive outcomes. For example, the women in the current study had positive feelings which contradicted their negative feelings in each of the five themes.

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

Strengths of the Study

Four strengths of the current study exist. First, the research on antenatal depression is limited. This limitation is partly the result of the under-diagnosis of antenatal depression due to the widespread notion that pregnancy is a protective factor for depression (Beck, 2003) and diagnostic issues, such as physical symptoms, which are common to both depression and pregnancy. Thus, the current study adds to the growing literature on antenatal depression.

Second, the limited research on antenatal depression that has been completed has been quantitative in nature. By presenting a qualitative inquiry that provides rich descriptions of the lived experience and meaning of antenatal depression, women with antenatal depression have been given a voice. Hopefully, these descriptions provide professionals and other women with useful insight into this experience.

Third, this study explores issues of maternal mental health within a feminist framework. This study intended to adhere to Kvale's (1996) characteristics of feminist research and did so in position, purpose, and method. Though pregnancy and childbirth are not oppressive in themselves, the social context in which they take place have expectations and parameters that can limit women in their choices, thoughts and feelings around pregnancy and motherhood. Any choices, thoughts or feelings that go beyond those limits are deemed abnormal and wrong. This study, at the very least, recognizes the social context in which pregnancy and motherhood take place. And at most, question the role that the social construction of pregnancy and motherhood play in depression during pregnancy.

A final strength of the present study involves benefits to the participants themselves. The participants found the interview process beneficial for various reasons. Chloe found preparation for the interview to be helpful in sorting out her own thoughts about her pregnancy. She was confused and unable to verbalize her thoughts until she explored them using the four lifeworld existentials. Though the interviews were not intended as pseudo-counselling sessions, Alison and Eve found the interview beneficial in a therapeutic way. Both described feeling very isolated in their pregnancy and the opportunity to speak to an objective party left them feeling some relief. Fallon and Daphne appreciated being asked to talk about their pregnancies. They felt excited and consumed with thoughts about being pregnant and were concerned that they were

boring friends and families with the details of their pregnancies. Both happily shared their experiences in an informal and social manner.

All of the participants hoped that sharing their experiences would be beneficial to other women by perhaps validating others' experiences and creating awareness among helping professionals and the general public. They each felt proud of their anticipated contribution to women's wellness.

Limitations of the Study

Distinct Findings

The intention of this qualitative inquiry was to gain insight into the lived experience and meaning of depression during pregnancy. The generated data provided a snapshot of the six women interviewed. The intention is not to generalize the findings, but rather provide rich description of their experiences to add to the growing body of literature around antenatal depression. Therefore, these experiences cannot be deemed the truth for all women with symptoms of depression during pregnancy.

Lack of Diversity

Though the participants' life context and experiences differed, there was a lack of diversity among the participants. All of the participants were Canadian-born, Caucasian, middle-class and with the exception of Chloe, university educated. New Canadians and First Nations women are unrepresented in this study and would certainly add to the literature. Also, women of low socioeconomic status were not represented. There was larger diversity among the participants in the larger study, "Feelings in Pregnancy", which the participants were recruited from. Perhaps one explanation for the homogenous sample was a greater willingness among university educated women to participate.

Constraints of a Larger Study

The study was completed as a qualitative component to the larger quantitative inquiry, “Feelings in Pregnancy.” The “Feelings in Pregnancy” study involved three interviews: one early in the pregnancy, the second during the last stages of pregnancy, and the third occurring after delivery. The investigators purposely omitted any references to antenatal depression while collecting their data to prevent bias or stigma within the research project. Because participants for this study were recruited during the initial interview of the larger study and interviews were completed before their second interview, I was unable to reference antenatal depression in my queries as well. This created uncertainty with regards to my ability to capture their experiences specifically around antenatal depression given that I was unable to use the words depression.

Completing the study within the constraints of the larger study may have created too much specificity in the requirements of participation. Participants in the “Feelings in Pregnancy” study were screened for antenatal depression using the Edinburgh Postnatal Depression Scale. Those who scored 13 or over on the scale were advised by the researchers that their score may indicate depression and were referred to their physician for follow-up care. Participants had the opportunity to seek treatment for the depression through counselling or medications. The requirements for this study purposely excluded women who scored 13 or higher on the scale because they may have received treatment prior to the interview, or were too clinically depressed to be burdened by a long, qualitative interview. Thus, this study was limited to exploring the experiences of antenatal depression in women with mild to moderate symptoms.

Future Research

Limitations of the current study as well as findings of the current study indicate possible future research, which could be done with regards to antenatal depression. First, further qualitative

inquiry could investigate the lived experience and lived meaning of pregnancy in women with depression in other populations. The homogenous sample of the current study may limit our understanding of these experiences. Further research on these experiences among women of other ethnic groups, socioeconomic classes, and other age groups could bring a greater understanding of these experiences. Furthermore, qualitative research exploring these experiences in women with more severe symptoms of depression could give the research community deeper insight into the experience and the meanings women attach to their experiences. Completing a qualitative investigation with that population would create greater ethical implications as the population may be viewed as vulnerable.

The findings of the current study indicate that further research could be completed with a similar population in terms of postpartum reflections on their experiences. Because pregnancy is a transitional stage in a woman's life, reflection on that stage after moving through it may provide some insight into how the transition affected her as a woman and as a mother.

Implications for Counselling Practice

In examining the expectations of motherhood, the ambivalence felt by pregnant women in the literature, and the prevalence of antenatal depression, we can assume that pregnant women and mothers are a substantial group seeking counselling. I have found this to be true in my current position as a family therapist in a non-profit counselling agency. In light of this, counsellors need to adopt theories of practice that engage, accept, and are beneficial to pregnant women and mothers. Counsellors must be aware of their own biases and belief systems that could impede the counselling process. An awareness of the social construction of motherhood and the expectations created by the dominant ideology of intensive mothering could, at the very least, help counselors to acknowledge the expectations their clients carry and perhaps help the counsellor to be conscious of

their own adopted values. Medina and Magnuson (2009) suggest two useful theories to guide counsellors who work with pregnant women and mothers: social constructivist theory and feminist therapy.

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

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

The literature about ambivalence also indicates some therapeutic avenues for pregnant women. Weigert (1991) and Leichtentritt and associates (2005) suggested positive views of

ambivalence. Ambivalence can be viewed as functional and as a calming influence for individuals experiencing it. Using a strength-based approach, the therapist could plan interventions with the goal of acknowledging the ambivalence and determining the benefit the individual receives from feeling ambivalent. In the context of pregnancy and motherhood, the client could be encouraged to accept the ambivalence experienced during in a transitional stage in her life. The client could also view ambivalence as a process of keeping a balanced approach to their feelings and experiences.

The lifeworld existential were used as an exploratory tool in this study. The participants were able to provide rich descriptions about their experience when reflecting on the questions based on corporeality, relationality, spatiality, and temporality. These questions could be used as an informal assessment with clients in the counselling setting. Asking a client about how her body, relationships, space and time feel in this experience would provide her with the opportunity to reflect on her situation in a more holistic way. Her descriptions of those experiences could provide the counsellor with a greater understanding of the client's situation from her own perspective, thus creating a client-centered informal assessment.

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

Conclusion

In conclusion, this study explored the lived experience and lived meaning of pregnancy in women with mild to moderate depression. This study provided six women with the opportunity to bring their voices to this experience and begin to create and awareness among other women, and health care providers. Their experiences revealed a shared meaning of ambivalence, the best and

worst times with five related and interconnected sub-themes. This study contributes to existing qualitative literature about ambivalence in pregnancy and introduces a qualitative component to the existing literature on antenatal depression.

Post Script

My Process

Not having had the experience of being pregnant, it was difficult to relate to the experiences of the participants. However, needing to make meaning of my own experience in the process of research and writing this thesis, I could not help but draw parallels between the participants' experiences and my own. I feel that I have in a sense been pregnant with this research and given birth to this piece of writing. This is not to say that producing a Masters thesis is as significant as growing a human being and becoming a mother, but I moved through some very similar experiences: a life on hold; a recognition of the temporary nature of my circumstances; anxiety about the unknown; the anticipation of completion; and the gain and loss of fifteen pounds. All joking aside, this experience felt like gestation, labour and delivery. Like the participants in the study, I also experienced dissonant feelings during this process. One ongoing theme that I have experienced and reflected on was confidence and enthusiasm versus uncertainty and apathy. Each phase of the research process had moments of enthusiasm and excitement. During the interview process, I was amazed at the participants' abilities to reflect on their experiences and felt energized about the research. This led to feelings of confidence about the significance of the research. This amazement and confidence remained present through the process of analyzing, integrating, and writing. Alongside these positive experiences there was an underlying uncertainty and fear. What would this completed project look like? Would this be a quality piece of research? Is this significant? These doubts often led me to put the project aside and become apathetic about its completion. Support and encouragement from my advisor, friends, and family were somewhat helpful to me during those times; however, I came to realize that I was the only person who could "push through" this process and the only person who could complete this experience. And so, after

an incredibly long gestation, and an arduous labour and delivery, I can say that up to this point, this was the best and worst time of my life.

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Appendix A

Criteria for Participation and Script for Interviewer

- (1) Must currently be pregnant.
- (2) Must self-identify as having never lost a child.
- (3) Must currently score 10, 11, or 12 on the Edinburgh Postnatal Depression Scale.
- (4) Must be willing to discuss their experience.

If the following criteria are met you can ask them if they would be interested in participating in the study.

One of the research assistants for this project is completing another study about feelings in pregnancy. Her study is focused on your thoughts and feelings during pregnancy. Participating in her study would involve one telephone conversation and two meetings. The initial phone conversation would allow you to ask any question about the study and set up an appointment to meet for an interview. The interview would last approximately 45-90 minutes and require you to talk about your feelings and thoughts during pregnancy. The final meeting would be a chance for you to review what was said in the interview. Would you be interested in participating or learning more about this study?

If she is interested please gather the following information:

Name: _____

Phone Number: _____

Best Time to Contact: _____

APPENDIX B

CONSENT FORM

You are invited to participate in a study about your thoughts and feelings during pregnancy. Please read this form carefully, and feel free to ask questions you might have.

Researcher: Erin McKillop

Department of Educational Psychology and Special Education

University of Saskatchewan

373-0031

Supervisor: Dr. Stephanie Martin

Department of Educational Psychology and Special Education

University of Saskatchewan

966-5259

Purpose and Procedure: The purpose of this study is to gain an understanding of your experience and meaning of your thoughts and feelings during pregnancy. Participation will involve three points of contact: a brief phone call to answer any questions you may have regarding the study; a tape-recorded interview about your thoughts and feelings during pregnancy, which will last approximately 45-90 minutes; and a final meeting for you to review the transcription of our interview.

Potential Risks: Participation in this study has very few risks. Although the interview process may at times cause some emotional distress, you are free to stop discussing upsetting topics at anytime you wish, and you may turn off the tape recorder should you wish. If at anytime you feel like you would like to speak to a professional, the contact number of a counsellor working with the study will be provided. If at anytime during the study, you feel that you are unable to continue participating, you will be free to do so, and the information you have provided will be destroyed.

Potential Benefits: Participation in the study may be beneficial to you. Talking about your thoughts and feelings during pregnancy may help you to sort out feelings regarding these times of your life. Your participation may also help other women and healthcare professionals by creating awareness of women's experiences in pregnancy. The benefits are potential and can not be guaranteed.

A \$30.00 gift certificate for London Drugs will be presented to you to thank you for your participation.

Storage of Data: Audiotapes, transcripts, and signed consent forms will be stored in a locked filing cabinet and separated from identifying contact information. Only the researcher and supervisor will have access to these confidential items. All forms of data will be stored for five years in accordance with the University of Saskatchewan's Ethics Board. Data will be destroyed after this time period.

Confidentiality: Findings of this study will be written up in a thesis submitted for completion of a master's degree. These findings will be available to the public. Direct quotes from your interview may be used; however, all names and identifying information will be changed in the text. The researcher is aware that Saskatoon is a small community and will take steps to ensure that identifying information, such as area of residence, occupation, and information about family circumstances will be changed or not discussed in the text. After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit. Audiotapes will not be accessible to anyone, but the researcher and supervisor.

Right to Withdraw: Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort, including your participation in the larger study, "Feelings in Pregnancy". If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. Because the duration of this study is approximately six weeks, you will be asked upon each of our three points of contact, if you still feel that you would like to continue participating in the study.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researcher at the number provided above if you have questions at a later time. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect. A

summary of the results will be available by August of 2007 and you can contact the researcher to request a copy.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

(Signature of Participant)

(Date)

(Signature of Researcher)

(Date)

Appendix C

Interview Guide

Guiding Question:

Tell me about your thoughts and feelings during your pregnancy?

Probes (Lifeworld Existentials):

How does your body feel in this experience?

What do your relationships with others and yourself feel like in this experience
(partner, children, friends, co-workers, self)?

How does time feel during this experience? Does it feel the same/different from before
you were pregnant? What do you think you will feel after giving birth?

What do different spaces/ locations feel like for you in this experience (home, work,
etc.)?

Appendix D

Ethics Approval



Behavioural Research Ethics Board (Beh-REB)

18-Dec-2006

Certificate of Approval

PRINCIPAL INVESTIGATOR
Stephanie (Lin) L. Martin

DEPARTMENT
Educational Psychology and Special Education

BEH#
06-292

STUDENT RESEARCHERS
Erin McKillop

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED (STUDY SITE)
University of Saskatchewan

Saskatoon SK

SPONSOR

TITLE
The Lived Experience and Meaning of Pregnancy

CURRENT APPROVAL DATE
18-Dec-2006

EXPIRY DATE
17-Dec-2007

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: <http://www.usask.ca/research/ethical.shtml>

APPROVED

Dr. John Rigby, Chair
Behavioural Research Ethics Board
University of Saskatchewan