

**FIRST-TIME PREGNANCY: A JOURNEY INTO THE PSYCHOLOGICAL
EXPERIENCES OF THE FIRST 12 WEEKS**

A narrative inquiry

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DECLARATION STATEMENT

I hereby declare that this thesis is my own work and that to the best of my knowledge does not contain any material previously submitted by another person. Nor does this thesis contain any material previously submitted for the qualification of another degree or diploma of a University or other institute of higher learning whereby due reference is not made in the text.

_____ Amanda Helen Smith.

ABSTRACT

Adjustment to pregnancy can vary significantly (Handley, 2006). Even when pregnancy is planned, the process of adapting to such a life-changing event is often difficult, and women may struggle to feel as though their pregnancy is legitimate (Handley, 2006). Previous local and international research related to first-time motherhood is largely quantitative with a focus on the postnatal period, with little attention paid to the experiences of the first 12 weeks of pregnancy (Swallow, Lindow, Masson & Hay, 2004, Barnett, 2010).

This study explores the experiences of the first 12 weeks of pregnancy for first-time mothers, through the use of narrative interviews. Transcripts were analysed for themes that emerged from the data. The analytical process was approached using an inductive stance of not knowing, and was guided by Crossley's (2000) six step method to analyzing personal narratives.

The findings from this study indicated that the pregnancy journey can begin prior to conception, and that first-time mothers may require psychological support throughout the process of trying to conceive. During the first 12 weeks, they may also benefit from the opportunity to experience tangible appraisals as well as support around identity change. The opportunity to ask questions and obtain pregnancy-related information from healthcare professionals might also support a more positive pregnancy experience and address some of the difficulties associated with such change. Furthermore, psychological screening tools are not being used throughout antenatal care, which seems to be the ideal opportunity for screening and prevention as most pregnant women are in regular contact with health care professionals (Dennis & Ross, 2006). Even if a first-time mother does not meet the criteria for anxiety or depression during pregnancy, the screening process may provide an

opportunity to discuss less distressing pregnancy related concerns, which may prevent psychological issues from developing and lead to a more positive pregnancy experience.

Future study recommendations include: the investigation of a larger scale study with wider demographics, the exploration of the psychological experiences of men/partners involved, and the outlook and experiences of healthcare professionals working in the field of pregnancy. As more research is conducted, it is hoped that an increased understanding of the first-12 weeks of pregnancy will promote a more positive psychological adaptation into the pregnancy journey.

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CHAPTER ONE: INTRODUCTION

Pregnancy and the transition to parenthood is a major developmental period (Deave, Johnson & Ingram, 2008). Research has suggested that it is often a stressful event that brings about more profound changes than any other developmental stage of the family life-cycle.

According to Lederman and Weis (2009), the developmental and adaptive process to pregnancy can be viewed as a period of transition between two states of being: the women-without-child and the women-with-child. Throughout the 9 month gestation period a transition is made between the two lifestyles. This can be understood as a period of preparation for the emergence of the new paradigm, with the newborn infant as an integral and crucial part. How women adjust to pregnancy however, can vary significantly and according to Handley (2006), some women struggle to believe that their pregnancy is a reality. Even when pregnancy is planned, the process of adapting to such a life changing event is often difficult (Handley, 2006). Pregnancy is not only a time of complex physical change, but may also be a time of emotional change, identity adjustment and a realisation of new responsibilities.

Some local and international researchers (e.g. Ammaniti, Baumgartner, Candelori, Perucchini, Pola, Tambelli & Zampino, 1992, Barnett, 2010) have suggested that women experience the first 12 weeks as living in an 'unreality.' This period has also been experienced as a time of 'secrecy' or an episode of 'being in limbo' (Barnett, 2010).

According to Lumley (1982), women report that these responses to early pregnancy did not appear to resolve until the more 'realistic' and 'safe' stage of pregnancy, for example the 13th week or the second trimester, had arrived. One of the primary reasons for this is because the risk of miscarriage after the twelfth week is lower (Barnett, 2010).

The purpose of this narrative inquiry is to gather and analyse the stories of five first-time mothers to explore some of the psychological experiences of the first 12 weeks of pregnancy. The primary aim is to develop a richer understanding and gain insight into how the first-time mothers adjusted to pregnancy. Research to date has focused on the postnatal experience with little attention paid to the prenatal experience (Swallow, Lindow, Masson & Hay, 2004) and the experiences of women who are pregnant for the first time. It is therefore hoped that the story-telling nature of the in-depth interviews will provide insight and further appreciation into the experiences and challenges of this time period. In addition, this information may assist with future research regarding the prevention of psychological issues, leading to more positive pregnancy experiences.

The focus is on first-time mothers who have experienced no complications leading up to conception (e.g. no previous miscarriage, conception occurred within 1 year of trying to get pregnant, no infertility treatment), with no diagnosis of postnatal depression. The participants' children were aged three months or less, participants were recruited from the Auckland region and competent in English. There were no restrictions with regards to ethnicity or socio-economic status; however participants were required to be between 25 and 35 years of age. This age distinction aimed to reveal the challenges surrounding first-time pregnancy, which is now, on average, 30 years of age (Statistics New Zealand, 2010).

The literature review highlights research regarding the psychological adaptation to pregnancy, which includes, the motivation to become pregnant, the role of pregnancy related cues, antenatal screening, ambivalence in relation to somatic complaints and professional and personal conflicts, and elements that attribute to psychological distress during pregnancy. The methods chapter explains the use of Crossley's (2000) six step method to conducting narrative interviews and analyzing personal narratives. This chapter also illustrates the recruitment process, together with the ethical and cultural considerations that took place in

the development of this study. Throughout the findings chapter, the participants' individual narratives are presented. The discussion chapter then presents the message from the story of each individual narrative and then links the commonalities and overlapping themes with the literature provided in chapter two. The implications of the study are then discussed, together with recommendations for future research.

CHAPTER TWO: LITERATURE REVIEW

Motivation to become pregnant

Research suggests that a woman's appraisal of her current life circumstances majorly influences her childbearing motivation (Lederman & Weis, 2009). It has also been revealed, however, that the multiplicity of diverse meanings that motivate women or influence reluctance to child-bearing may be difficult to determine. Diverse meanings have been identified in one's values, dreams, expectations, hopes, and fantasies relating to pregnancy, childbirth and motherhood. Further motivations may include confirmation of femininity, happy family life fulfilment, ones' liking for children, and a desire to nurture, love and emit affection (Lederman & Weis, 2009). A women's appraisal of her own competence, however, may affect her motivational stance, together with a fear of boredom, economic decline and loss of freedom. Bernardi, Kiem and von der Lippe (2007) also mentioned that partnership stability/instabilities, level of demands from a woman's career, and perceived age pressure (e.g. the biological clock) may also impact a woman's motivational stance.

Haedt and Keel (2007) indicate that the motivation to become pregnant may be altered by previous pregnancy, whereas in first-time pregnancy, women may more abstractly relate to the experimental accounts of relatives and friends as well as to their own mothering experiences in childhood. It is also possible that the social construction of meanings about family and fertility may generate from the parental and grandparental experiences, which may influence what is considered a 'normal' way of forming a family (Bernardi, Keim & von der Lippe, 2007, Haedt and Keel, 2007).

Researchers have also suggested that social interactions (or friendships) may affect the motivation for family formation and parenthood (Bernardi, Keim & von der Lippe, 2007).

Firstly, interactions with friends may encourage or speed up their family formation motivation due to observation or conversation. Bernardi, Keim and von der Lippe (2007) also suggested that the similarity of the family status of two friends may also bring about further desire or realisation. Alternatively, the effect can be the opposite, for instance, friends can encourage each other to postpone or decelerate the motivation of starting a family. Additionally, the influence of social interaction with friends may neither encourage nor discourage. Or childless friends may observe how their friends with children perform and from this draw positive or negative conclusions for their own intentions (Bernardi, Keim & von der Lippe, 2007).

Researchers have also suggested that during this transition, a process of separation-individuation towards one's own mother takes place. The motivation to become pregnant therefore relates to the acquisition of a definitive female and maternal identity (Ammaniti, Baumgartner, Candelori, Perucchini, Pola, Tambelli & Zampino, 1992). During pregnancy, maternal identity formation, and a woman's ability to withstand what may seem like a difficult pregnancy may also depend on the approval and confirmation of the pregnancy from her own mother (Weis, Lederman, Lilly & Schaffer, 2008). Furthermore, support from family and friends provides information and validation for the changes the pregnant women experiences during pregnancy. Researchers suggested that supportive sharing and balanced aspirations from the woman's family encourages successful maternal-foetal attachment and acceptance of pregnancy (Laxton-Kane & Slade, 2002; Weis, Lederman, Lilly & Schaffer, 2008).

Wayland and Tate (1993) investigated the relationship between prenatal attachment and the perceived relationship between adolescent pregnant women and the baby's father, together with the relationship between the adolescent pregnant woman and their own mothers.

Findings suggested that perceived closeness with own mother better predicted prenatal attachment than perceived closeness with the baby's father. In non-adolescent women, researchers discovered that the intensity of prenatal attachment was associated with increased levels of social support (Laxton-Kane & Slade, 2002). It was argued however that the mother may naturally become close to others during pregnancy; this may not therefore be representative of normal attachment.

The relationship between mother and child

The importance of the relationship between mother and infant, as conceptualized by attachment theory (Bowlby, 1969), is well documented (Laxton-Kane, 2002). Over the past few decades however, researchers have recognised that this relationship begins prior to the postnatal period, whilst the mother is pregnant and the child is still a foetus. According to Caccia, Johnson, Robinson and Barna (1991), women undergoing prenatal diagnosis have the ability to develop an attachment to the foetus as early as 10 weeks gestation. Several elements however can delay the prenatal attachment process creating significant amounts of ambivalence, and in turn prolonging the conceptualisation of the growing foetus as reality (Laxton-Kane, 2002). Researchers discovered that only 30 percent of women considered the foetus a person during the first trimester, compared to 63 percent during the second trimester and 92 percent by the 36th week of pregnancy (Lumley, 1982). Handley (2006) explains that one of the reasons that women may struggle to believe that their pregnancy is a reality during the first 12 weeks is because of the role of pregnancy related cues.

The role of cues:

According to Weis, Lederman, Lilly and Schaffer (2008), women generally have certain expectations of pregnancy. However when expectations do not materialize, women may

experience destabilizing dissonance and self-doubt. These feelings that occur in response to the acceptance of pregnancy have been reported to be the greatest in the first 12 weeks (Weis, Lederman, Lilly & Schaffer, 2008). Typical concerns during the first 12 weeks of pregnancy may involve thoughts around whether or not symptoms are expected ones or doubts around being pregnant (Swallow, Lindow, Masson & Hay, 2004). Handley (2006) relates these thoughts to the role of cues. This may be associated with a cognitive process of justification, for example, 'I am pregnant, and so I should expect to feel much worse' (Swallow, Lindow, Masson & Hay, 2004). It is also possible that a woman may expect to feel different; or she may have anticipated more obvious symptoms, even if these are not unpleasant ones.

Several researchers (Handley, 2006; Weiss, Saks & Haris, 2001) have associated the role of cues during pregnancy with Mishel's uncertainty in illness theory which is a model for understanding the way in which individuals create meaning (within the limits of his or her cognitive capacity) from illness-related stimuli. It has been suggested that uncertainty is particularly present when cues are ambiguous, complex, or if the outcome of the pregnancy cannot be predicted (Handley, 2006). One explanation for this phenomenon is that elements of the stimuli frame (e.g. symptom pattern or cues) as well as input from available structure providers (e.g. credible authority, education level, and social support) may not be sufficient enough to construct an appraisal or to interpret the event (Weiss, Saks & Haris, 2001). This can bring about uncertainty because the individual is unable to form a cognitive schema. According to Galotti (2004), cognitive schemas organise knowledge, and from a social constructionist point of view, cognitive schemas derive from the knowledge base and expectations derived from the social context. Furthermore, uncertainty may be foundational to both anxiety and depression as the women may be unable to accurately determine the meaning of the symptoms or changes in her life because the situation may not be adequately structured or categorized because sufficient cues are lacking. Appraisal of the event therefore

highlights the individuals coping strategies to resolve uncertainty, which may be conceptualised as effective or ineffective adaptation (Weiss, Saks & Haris, 2001, Handley, 2006).

Several researchers have suggested that the actual presence and realization that the growing fetus was an integral part of oneself had not become apparent until after the first 12 weeks of pregnancy, once foetal movements were felt (Ammaniti, Baumgartner, Candelori, Perucchini, Pola, Tambelli & Zampino, 1992). During the first 12 weeks, the relationship between mother and child may therefore only exist on an imaginary level, until more obvious and consistent signs, such as ultra sound images and foetal movements are detected. In first-time pregnancy, foetal movements known as ‘quickening’ are not typically reached until 18 to 22 weeks (Barnett, 2010). Second-time mothers or individuals who are hyper-vigilant might recognise foetal flutters earlier or at approximately 16 weeks. However researchers have not established whether or not foetal movements contribute to prenatal attachment or whether women who were already highly attached were more likely to be vigilant of any sensations and therefore more easily able to detect foetal movements (Laxton-Kane & Slade, 2002).

Langer, Ringer and Reinold (1988) also suggest that ultrasound images reduce the range of fantasies concerning the unborn child. They also mentioned that ultrasound scanning can foster more pleasant and relaxed perceptions, they may also make a woman feel stronger and experience less fear. These findings harmonise with the theory of prenatal attachment, for example, prenatal attachment would require the recognition of another to be attached to (Laxton-Kane & Slade, 2002). Foetal movements and ultrasounds scans may therefore reduce uncertainty and influence the maternal bond as the unborn child becomes more of a reality (Laxton-Kane & Slade, 2002).

Interestingly, research has suggested that fathers, too, experience a feeling of unreality during pregnancy, predominately during the first 12 weeks (Finnbogadottir, Svalenius & Persson, 2003). Researchers (Finnbogadottir, Svalenius & Persson, 2003) reported that the most common experience of unreality occurred when the father was informed that the pregnancy test was positive. The experience of unreality appeared to decrease following the observation of their unborn child in an ultra-sound image (Finnbogadottir, Svalenius & Persson, 2003).

When reviewing the literature on the role of cues, it seems that the appraisal or interpretation of the pregnancy as a reality may require something tangible. As mentioned previously however, physical sensations are not typically experienced until 18 to 22 weeks (Barnett, 2010). Additionally, in New Zealand ultrasound scans are not generally conducted until after the first 12 weeks of pregnancy (National Screening Unit, 2009). Occasionally, an ultrasound examination will be conducted earlier than 12 weeks gestation to establish the gestational age of the pregnancy (Pullon & Benn, 2008). Dating scans are generally recommended when a woman has irregular periods, has just stopped the oral contraceptive pill, has recently had a miscarriage, is breast feeding, or needs confirmation of implantation bleeding versus menstruation. This examination may also reveal the presence of a heart beat, the location of the pregnancy, the number of foetuses and gestation sacs, and unusual features (e.g. shape, or the presence of fibroids) within the uterus (Pullon & Benn, 2008).

In practical terms, ultrasound scanning allows many women to 'see' their unborn baby for the first time (Laxton-Kane & Slade, 2002). It could be argued that this would increase prenatal attachment and a sense that the baby is real. In one study, Dykes and Stjernquist (2001) found a shift in the mothers' awareness of the foetus after the ultrasound scan. For example, mothers expressed thoughts about the health of the foetus and the ultrasound making the baby seem more real. It could be hypothesised however that ultrasound scans

may also exacerbate uncertainty. For example, the maturity of the baby's heart beat may be questioned, and the pregnancy may be less advanced than expected (Pullon & Benn, 2008, National Screening Unit, 2009).

Antenatal Screening

During the first trimester, it is natural for women to have concerns about the development of their baby (Barnett, 2010). The wait during the first 12 weeks may be anxiety provoking, particularly if the woman or partner involved has a family history of a genetic condition whereby significant learning or physical difficulties are apparent (Ministry of Health, 2009, Hodgson, Gillam, Sahhar & Metcalfe, 2010). In addition, raised maternal age is associated with an increased risk of abnormalities and complications during pregnancy (for example, Down syndrome and miscarriage) (Berryman & Windridge, 1996). Therefore older women (particularly women over 35 years-of-age) may be more anxious and tentative of admitting feelings of attachment towards the baby until later pregnancy arrives.

Laxton-Kane and Slade (2002) explain that foetal detachment can protect older women, particularly against the possibility of foetal abnormalities or loss, together with those who have a high risk pregnancy, history of miscarriage, or fertility problems. Researchers hypothesised that women receiving assisted conception via fertility treatment (e.g. in-vitro fertilisation) would show higher levels of prenatal attachment because of longer periods of infertility and higher investment in the pregnancy (Laxton-Kane & Slade, 2002). It was also hypothesised however that higher associated risks may encourage mothers to distance themselves from the fact that the foetus is a reality to protect against the possibility of loss. Interestingly, in three studies no significant differences were found between the two hypotheses or between women who had conceived with or without assistance (Stanton &

Golombok, 1993, Bernstein, Lewis, & Seibel, 1994, McMahon, Ungerer, Beaurepaire, Tennant & Saunders, 1997).

Furthermore, for the last three decades, antenatal blood testing and nuchal translucency scans have been an integral part of routine prenatal screening (Fuchs & Peipert, 2005). Testing is generally non-invasive and screen for the probability of Down syndrome and other conditions affecting the development of the baby (Ministry of Health, 2009). Down syndrome screening tests identify chromosomal abnormalities where the replication of chromosomes is faulty. Screening can also identify structural abnormalities, such as heart defects and spinal bifida, whereby major organs fail to develop properly (Pullon & Benn, 2008). Different tests are used to detect different types of problems, but no test is perfect and some have significant associated risks. For instance, an amniocentesis involves taking a sample of amniotic fluid from the pregnancy sac to more accurately detect chromosomal abnormalities (Pullon & Benn, 2008). The chromosomal test however carries a 1 in 200 risk of miscarriage. Consequently, it may put a normal pregnancy at risk, or detect problems for which there is no treatment. It may also raise the question of possible termination if a major abnormality is found. Screening in New Zealand is optional and women need to make a decision that is right for them (Barnett, 2010). In addition, for some, continuing with the pregnancy regardless of a chromosomal abnormality is a positive choice; having these tests simply allows women and their families to prepare for having a baby with a disability.

According to Payne (2002) the socially constructed discourse surrounding the development of technology and possible detection of foetal genetic abnormalities suggests that becoming a mother is conditional on the status of the foetus. The pressure to undergo such antenatal tests may therefore impact on a women's pregnancy experience. Payne (2002) suggested that the socially constructed view of antenatal testing seems to disregard women who wanted to become mothers regardless of the kind of child they might have. The medical genetic

discourse associated with raised maternal age and increased risk of abnormalities and complications may also segregate older women and negatively impact their pregnancy journey. It has been suggested that the pressure to undergo antenatal testing may also have implications (e.g. choosing between partner and unborn child) on future relationships with the partner, and with other family members (Payne, 2002). Langer, Ringer and Reinold (1988) also explain that after having seen the evident proof of the baby's existence, the woman is deprived of coping mechanisms (e.g. denial and regression), which sometimes may be helpful for the adaptation process in early pregnancy.

When reviewing the literature, there appears to be some controversy surrounding the benefits and limitations of antenatal testing. For instance, although antenatal testing does appear to enhance the sense that the baby is real; it also seems to have the potential to de-normalise the pregnancy journey for some women. Testing may bring about further uncertainty and could also raise questions around acceptance of the pregnancy by other family members (including the mother) if an abnormality is detected.

Ambivalence

During the first 12 weeks of pregnancy, it has been suggested that women come to accept the idea of being pregnant (Weis, Lederman, Lilly & Schaffer, 2008). During this process however it is not uncommon for women to experience some degree of ambivalence and emotional conflict regarding the pregnancy (Medina & Magnuson, 2009). Researchers have defined ambivalence as spontaneous and contradictory attitudes or feelings (as attraction and repulsion) towards an object, person or action (Kjelsvik & Gjengedal, 2010). In pregnancy, this can generate tension between the woman's own body and the developing foetus (e.g. due

to somatic complaints), as well as between her body and the surrounding environment (e.g. due to professional and personal conflicts).

Ambivalence in relation to somatic complaints:

Attachment to the pregnancy and the growing foetus may begin early in the first trimester. Somatic complaints however such as tiredness, change in body image, and nausea and vomiting (including hyperemesis gravidarum (HG), which is severe nausea and vomiting during pregnancy) can easily lead to ambivalence, and occasionally psychiatric morbidity (Fox & Yamaguchi, 1997; Thorstensen, 2000, Swallow, Lindow, Masson & Hay, 2004).

Historically, an ambivalent attitude during pregnancy indicated a conflict of attitude between wanting and rejecting the baby, or a rejection of femininity, psychological immaturity or sexual frigidity (Menninger, 1939, Chertok, 1972). These psychological theories also regarded vomiting during pregnancy as an intrapsychic conflict, which was symbolic of an unconscious rejection, or an oral attempt to abort the growing foetus (Munch, 2002).

According to Munch (2002), severe somatic complaints, such as HG, can have serious effects on mother and baby, including malnutrition, premature labour and low birth weight. Pregnant women with this condition however are usually minimized by health care professionals or ignored because of the psychologization in which female illness is socially constructed and because the actual pathophysiology and cure is unknown. Interestingly, in one study researchers discovered that women with significant somatic complaints changed greatly from their 'sick role' conceptualization to a more 'healthy' outlook following an ultrasound examination (Langer, Ringler & Reinold, 1988).

A change in body image has also been referred to as a somatic complaint during pregnancy. Body image generally refers to the feelings and beliefs that people have about their bodies (Fox & Yamaguchi, 1997). The pressure to be slim (particularly in Western cultures) has

been identified in pregnant women who often worry about becoming bigger. Such negative attitudes toward weight gain can adversely affect maternal as well as infant weight gain. Similarly, disruptions to pre-pregnancy body image can generate feeling of ambivalence and emotional conflict towards the pregnancy. For instance, Fox and Yamaguchi (1997) discovered that during pregnancy, some women with a normal weight prior to conception felt conflicted towards the pregnancy because their body weight was no longer under control. This generated feelings of doubt regarding their physical and sexual attractiveness. Overweight women prior to conception however, in general, expressed positive changes in body image, for instance, pregnancy offered freedom from the stigma of being overweight, and a decrease in the pressure to diet (Fox & Yamaguchi, 1997). A woman's weight and perception of body image prior to pregnancy may therefore contribute to a more positive or negative pregnancy experience.

Ambivalence in relation to professional and personal conflict:

During the first 12 weeks of pregnancy, women may experience a perceived sense of new responsibilities. Concerns may centre around societal expectations and worries about fulfilling the role of motherhood in a changing society (Medina and Magnuson, 2009). Professional and personal crises are much more prominent in first-time pregnancy than subsequent ones and issues related to self-image and identity may be prominent (Baum, 2010). Statistics reveal an increased trend towards later-in-life pregnancy, with the current age of first-time parenthood for women in New Zealand being thirty years of age (Statistics New Zealand, 2010). Elloy and Smith (2004) suggest that this trend correlates with the fact that women are now establishing careers before pursuing motherhood. Women may thus experience role conflict between first-time parenthood and professional obligations (Baum, 2010).

During the last few decades, the Western world has illustrated a change in the patterns of taking care of the newborn baby (Finnbogadottir, Svalenius & Persson, 2003). This appeared to be the result of increasing awareness for the need for equality between genders. In general, women have become a more established part of the workforce and men are more interested in actively taking part in the care of their children (Finnbogadottir, Svalenius & Persson, 2003). Medina and Magnuson (2009) argue however that although fathers are more involved in today's society, women still assume primary responsibility for home centred tasks. The socially constructed standards for women in today's society therefore seem to be escalating.

It has been suggested that the pressure to uphold these standards may contribute to role conflict between first-time parenthood and professional obligations (Baum, 2010). For instance, competing cognitive schemas may result in a devotion to work as well as a devotion to family, and when one is unable to blend or balance the two, it can generate cognitive dissonance (Medina & Magnuson, 2009). For example, 90 percent of women who chose to stay at home reported ambivalence about their decision. Their previous identification with their career dropped, leading to unhappiness and feelings of inadequacy. Additionally, mothers who considered employment after birth became concerned with critical social attitudes and felt guilty or undervalued (Medina & Magnuson, 2009).

Interestingly, one study discovered that an aspiration towards a successful male breadwinner; a positive evaluation of the 'housewife' model/or the part-time working model for women; and a strong preference for strict sequencing of events (e.g. completion of education, marriage, family; or for males starting work before thinking of having a child), contribute to more positive child-bearing motivation (Bernardi, Kiem & von der Lippe, 2007). These attitudes were also strongly associated with the idea that the mother is the best person to care for the young child.

According to Barnett (2010), there are some common worries about working in early pregnancy. Many women choose to keep the news of their pregnancy quiet in case of miscarriage, or because they may lose out on work opportunities. In addition, women may have concerns regarding parental leave and employment protection eligibility. Pullon and Benn (2008) point out however that a woman's relationship with her employer may be much better if she shares the news earlier, particularly if the working environment is putting their unborn baby and their own health at risk and/or if somatic complaints are interfering with work productivity.

Psychological distress during pregnancy

Pregnancy has traditionally been conceptualized as a period of increased wellbeing and emotional stability (Bloch, Rotenberg, Koren & Klien, 2006). The process of adapting to pregnancy however varies significantly (Handley, 2006). Even when pregnancy is planned, the process of adapting to such a life changing event is often difficult. One of these variations includes psychological distress, which is often associated with measurements of anxiety, depression and uncertainty (Handley, 2006). Researchers have suggested that these psychological responses can be influenced by a number of factors, for instance, psychiatric episodes prior to pregnancy, relationship status, marital problems, living arrangements, isolation, and geographical classification of residence (Johnson, Chapman, Murray, Johnson & Cox, 2000, Handley, 2006). The threat of miscarriage, fertility experience, hormonal changes, life style changes, and professional support (as well as the factors mentioned previously, such as, the role of cues, antenatal screening, and ambivalence) have also demonstrated the potential to contribute to psychological distress.

Anxiety and depression:

Major depression is a widespread health problem affecting approximately twice as many women than men (Andersson, Sundstrom-Poromaa, Wulff, Astom & Bixo, 2006). The majority of women have their first onset in reproductive age; they have longer periods of depression, and more frequently a co-morbid anxiety disorder. Approximately 30% of women are reported to experience anxiety and depression during pregnancy (Bastani, Hidarnia, Montgomery, Aguilar-Vafaei & Kazemnejad, 2006). Recent studies also suggest that these disorders are at least as common during pregnancy as otherwise (Andersson, et al, 2006).

It is well known that women are at increased risk of developing affective disorders after delivery (Anderson, Sundstrom-Poromaa, Wulff, Astom & Bixo, 2006). Postnatal depression (PND) is a serious and debilitating psychiatric disorder equivalent to a diagnosis of major or minor depression as defined by the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases (Boath, Bradley & Henshaw, 2005). It has been found that around 10-15% of women experience an episode of depression during the first two-three months after delivery (Josefsson, Berg, Nordin & Sydsjo, 2001). Recently, however studies have suggested that only half of women with postnatal depression were new onsets and researchers suggest that there may be an association between antenatal and postnatal depression (Anderson, et al, 2006).

Researchers from the United Kingdom utilized the Edinburgh Postnatal Depression Scale (which has been validated for antenatal use) in a prospective study of pregnancy-associated depression (Johnson, Chapman, Murray, Johnson & Cox, 2000). They discovered that there was a significant population in the antenatal period suffering from depression, which continued post-natally for some. The researcher's main concern appeared to be the fact that

antenatal depression has more recently been highlighted by a number of antenatal suicides and that only a small number of depressed mothers-to-be are being identified by general practitioners (Johnson, Chapman, Murray, Johnson & Cox, 2000). In addition, although most women visit health professionals regularly during pregnancy, the expectation that a mental health questionnaire will be administered to every woman seen ante-natally may be unrealistic (Dennis & Ross, 2006). Researchers have suggested that screening may seem unrealistic because of time-restrictions, as well as the difficulty of incorporating standardized psychiatric interviews into everyday obstetric practice (Johanson, Chapman, Murray, Johnson & Cox, 2000). As mentioned previously however, the Edinburgh Postnatal Depression Scale, which is a ten-item screening questionnaire, has been validated for antenatal use (Johnson, et al, 2000). It could be questioned therefore why health care professionals are not utilizing this ideal opportunity for screening and prevention as most women are in regular contact with health care professionals. According to research, antenatal education also fails to address the needs in relation to the reality of new parenthood and fails to address the emotional needs of new parents, particularly throughout the early stages of pregnancy (Deave, Johnson & Ingram, 2008). Instead there is a focus on labour and birth.

Furthermore, previous psychiatric episodes before pregnancy appear to increase the prevalence of psychiatric disorder during pregnancy (Johanson, Chapman, Murray, Johnson & Cox, 2000). Researchers have also suggested that single status and living with parents during pregnancy were associated with postnatal depression. Postnatal depression was also significantly associated with co-existing marital problems. (Johnson, et al, 2000). Weis, Lederman, Lilly and Schaffer (2008) found that women with supportive husbands or partners however had lower trait anxiety throughout pregnancy. Whereas women who confided emotionally with another (e.g. a relative or friend) instead of their husband or partner only showed lower trait anxiety after the first 12 weeks of pregnancy.

Interestingly, the role of the partner/husband has been shown to be the most important predictor in reducing anxiety and contributing to greater satisfaction and confidence with regards to the maternal identity (Weis, Lederman, Lilly & Schaffer, 2008). Women who may have to experience isolation during periods of pregnancy (e.g. due to single status, marital problems, military separation and so forth) may therefore experience more psychological distress, vulnerability surrounding the acceptance of the baby, and the maternal identity process may be compounded by the additional responsibilities (and stressors) associated with such separations (Weis, Lederman, Lilly & Schaffer, 2008). In addition, Handley (2006) suggested that pregnant women living in rural districts may be more vulnerable to anxiety and depression because of the possibility of additional stressors (in comparison to pregnant women living in urban districts). Additional stressors may include lower socio-economic status, less education, fewer social supports, and greater distances to healthcare facilities.

In some pregnancies, there may be a risk (or perceived risk) of foetal loss. Laxton-Kane and Slade (2002) suggested that this may affect pre-natal attachment. This may also make women particularly vulnerable to anxiety and depression in the first trimester as this time generally involves greater threat of loss (Thorstensen, 2000) with 1 in 5 pregnancies ending in miscarriage (Barnett, 2010). Bleeding in pregnancy can hence be distressing, and women may be uncertain about whether to remain hopeful or to grieve, which can bring about further anxiety and distress (Thorstensen, 2000). Subsequently, the impact of perinatal loss can be devastating for some and may affect the experience of the next pregnancy (Laxton-Kane & Slade, 2002). Furthermore, Blagdon, Dixon and Scott (2002) explain that 25 percent of couples experience infertility in their reproductive lives, which is defined as the inability to conceive after trying to get pregnant after one year. In order to cope with this news, men usually distract themselves with work, whilst women tend to 'put life on hold' in order to find a solution (Blagdon, Dixon & Scott, 2002).

Psychologically, the ability to have a child may signify a ritual crossing to adulthood life; it is an essential part of the gender identity, the consolidation of the couple, the main objective of marriage, and the constitution of a family (Mohammadi & Khalajabadi, 2001). Researchers argue that the logical conclusion that we derive from this association is 'I am because of my reproductive capacity and everything it implies.' Consequently, several researchers have indicated that 'obsessing' over becoming pregnant or attempting to 'control' conception can become psychologically exhausting (Mohammadi & Khalajabadi, 2001, Snow, 2002). The implications tend to lower wellbeing, decrease quality of marriage, disrupt work, disrupt social networks, and daily routines (Stenber & Soloman, 2008).

According to Handley (2006), the varying hormone levels and stressors during pregnancy may also precipitate the occurrence of psychological distress during pregnancy. Pregnancy has an enormous physiological and endocrine effect on a woman's body (Steiner, Dunn & Born, 2003). These changes may trigger off pathological mechanisms and neurotransmitter or receptor levels in the brain (Steiner, Dunn & Born, 2003). And since these profound changes related to pregnancy coincide with mood, a causal link has been supposed to be probable (Steiner, Dunn & Born, 2003). During pregnancy biological variables (such as hormones) may also alter sensitivity to psychological stressors, for instance lack of social support in an indirect manner, which may determine the threshold for developing depression (Ross, Sellers, Gilbert-Evans & Romach, 2004). Consequently, depression during pregnancy often goes undetected because people often associate and normalise mood change with hormonal changes (Handley, 2006).

One study suggested that women who are more vulnerable to hormonal changes during menstruation (e.g. premenstrual mood changes such as irritability) may be more susceptible to psychological distress during and after pregnancy due to the similar physiological underpinnings (Sugawara, Toda, Shimas, Mukai, Sakakura & Kitamura, 1997). Subsequently,

researchers discovered that women with irritability (premenstrual mood changes) before pregnancy had significantly higher scores of depression during pregnancy than those without irritability. This was not only during pregnancy, but also postpartum. These women also displayed greater anxiety about the pregnancy (including delivery); were more reluctant to accept the maternal role, and conceptualized their baby's as being vulnerable (Sugawara, et al, 1997). Premenstrual mood changes may therefore be an important risk factor for maternal mental health.

Medical illness may also have an influence on pregnancy. For instance, women with a diagnosis of epilepsy between the ages of 25 and 29 have a lower fertility rate, the foetus can be harmed by anti-epilepsy drugs, they have a two to threefold increase in congenital malformations, and seizures also increase the risk of difficulties (Crawford & Hudson, 2003). Crohne's disease is another medical illness that commonly affects women of childbearing age (Mottet, Juillerat, Gonvers, Froehlich, Burnand, Vader, Michetti & Felley, 2005). Available data on Crohne's disease and pregnancy indicates that women with Crohne's disease can expect to conceive successfully, carry to term and deliver a healthy baby. Control of disease activity before conception and during pregnancy however is critical, to optimize both maternal and foetal health (Mottet, et al, 2005).

It has been suggested (e.g. Bastani, Hidarnia, Montgomery, Aguilar-Vafaei & Kazemnejad, 2006) that anxiety and depression may be related to low birth weight and prematurity, and as mentioned earlier, it can be associated with the development of post natal depression. In addition, becoming pregnant can often re-activate previous life conflicts, and in some instances evoke vulnerability to psychological difficulties (Hildingsson & Haggstrom, 1999). In addition, the first 12 weeks may generate anxiety due to uncertainty around diet, physical activity and other lifestyle commitments known to have an impact on the developing foetus. For instance, in preparation for a healthy pregnancy, women are

encouraged to eat a healthy diet, exercise regularly, review their folic acid intake, medication use, and additional lifestyle choices, such as alcohol consumption and tobacco use (Tough, Tofflemire, Clarke & Newburn-Cook, 2006). When women are asked to describe their lifestyle habits during pregnancy however the beginning of pregnancy is often poorly defined (Inskip, Crozier, Godfrey, Borland, Cooper & Robinson, 2008).

Most women reduce their alcohol intake when they realize that they are pregnant. This may not occur however until well into the first trimester (Tough, Tofflemire, Clarke & Newburn-Cook, 2006). The exactness of alcohol consumption measurements during the early stages of pregnancy depends largely on the individual interpretation of when pregnancy began. Whilst some women report on time of conception, others may refer to the time in which they discovered that they were pregnant. As a result, it may be difficult to determine the impact of alcohol consumption during the early period of embryonic development. This may contribute to anxiety and foetal attachment difficulties during the later phase of the first trimester (Tough, Tofflemire, Clarke & Newburn-Cook, 2006).

In a Canadian study, 1042 women who had recently delivered a baby were interviewed (Tough, Tofflemire, Clarke & Newburn-Cook, 2006). Findings suggested that 80 percent reported alcohol consumption pre-conceptually, 50 percent pre-pregnancy recognition (period between conception and pregnancy confirmation) and 18 percent post-pregnancy recognition. Interestingly, women who continued to drink alcohol after pregnancy recognition were more likely to be 30 to 39 years of age. In addition, researchers discovered that binge drinking was higher among women with an unplanned pregnancy (Tough, et al).

Exposure to alcohol during pregnancy increases the risk of a range of conditions known as foetal alcohol spectrum disorder (FASD) (Pullon & Benn, 2008). In general, the higher the dose of alcohol, the more pronounced the effects. There is no known low dose that appears to

be safe for every pregnancy (Barr & Steissguth, 2001). Barnett (2010) stresses that when a woman drinks alcohol, so does her baby. Alcohol is carried through the placenta via the blood stream causing long lasting and debilitating effects on the baby's brain and central nervous system. As a consequence individuals with FASD often demonstrate deficits in general intellectual functioning, difficulties with learning, memory, attention, and problem solving. Difficulties may also transpire in mental health and social interactions (Barr & Steissguth, 2001).

Though no research has confirmed the prevalence in New Zealand, FASD is estimated to occur in at least one out of every 100 live births (Fetal Alcohol Network New Zealand, 2010). FASD is considered the most common nonhereditary, preventable cause of mental retardation in the developed world. The earlier in pregnancy a woman can stop drinking, the better the outcome; and the younger the age at which an affected baby is identified, the lower the frequency of secondary disability (Barr & Steissguth, 2001).

The endangered foetus:

For some mothers, pregnancy may be a difficult time resulting in either active or passive harm to the unborn child (Laxton-Kane & Slade, 2002). This can include a range of behaviours, such as physically hitting one's stomach (active), through to failing to access appropriate antenatal care or recreational drug abuse (passive). For some pregnant women lifestyle change in order to benefit the developing foetus may be difficult due to addiction (Barnett, 2010). It is also possible that addictive substances may alter the woman's sense of reality; for instance, they may not even be aware of the consequences, or of the fact that they are even pregnant. Researchers (Nulman, Rovet, Stewart, Wolpin, Pace-Asciak, Shuhaiber & Koren, 2002) have also reported that some women may struggle with the decision to continue taking prescribed medications. For example, women who utilise anti-depressant drug therapy

for depression may resist taking their medications due to the lack of information about their safety. Discontinuation of anti-depressant drug therapy in women with medication-responsive illness carries a high risk of relapse and suicide attempts. Yet, it is also known that the fetal brain develops throughout gestation, and injury may occur at various critical times of exposure to these drugs (Nulman, Rovet, Stewart, Wolpin, Pace-Asciak, Shuhaiber & Koren, 2002).

The relationship between abusive behaviours towards the foetus, personality and prenatal attachment was investigated (Pullock & Percy, 1999). Quality of prenatal attachment was regarded as either positive or negative and intensity of attachment was categorised as preoccupied or disinterested. Researchers discovered that 38 out of 40 participants represented either negative-disinterested or negative-preoccupied. Women who represented negative-disinterested scored significantly higher in passive aggressive, sadistic, antisocial and narcissistic personality measures. Women who represented negative-preoccupied however scored significantly higher on scales measuring paranoid, borderline and histrionic personality. Of the later group, 38 percent reported that they could potentially harm the foetus, 14 percent reported feelings of irritation toward the foetus, and 42 percent indicated that they may lose control in the future (Pullock & Percy, 1999). Pullock and Percy (1999) concluded that women measuring significantly high in a negative-preoccupied stance (which is seen in borderline personality traits) may have greater hostility towards the foetus.

Previous research has revealed relatively little success when attempting to demonstrate the relationship between personality, fertility desires and actual fertility experience (Miller, 1992). It has been discovered however that early pregnancy can instigate emotions and behaviours that often mimic mental illness. Vizziello, Antonioli, Cocci and Invernizzi (1993) state however that they do not necessarily become pathological. For instance, researchers

have discovered that ambivalence towards the growing foetus due to nausea and vomiting in early pregnancy could imitate psychiatric morbidity (Swallow, Lindow, Masson & Hay, 2004). In one case study, nausea and vomiting lead the pregnant woman to feel unhappy about her pregnancy. Later however she felt guilty about having such negative thoughts and became very angry at herself (Lub-Moss & Eurelings-Bontekoe, 1997). Interestingly, researchers related this presentation to features of borderline personality disorder.

Another study discovered that individuals who strive for perfectionism may become distressed when pregnant because their over-controlled life is disturbed (Lub-Moss & Eurelings-Bontekoe, 1997). This can instigate anxiety and an increase in obsessive and compulsive behaviour. In addition, for individuals with present or past eating disorders, episodes of ‘normal’ vomiting throughout early pregnancy may cause distress because the vomiting is not under voluntary control (Lub-Moss & Eurelings-Bontekoe, 1997).

Keeping, terminating and adoption:

Throughout pregnancy women may grapple with issues concerning their ability to be a good mother; they may question their financial position, level of support and who they should confide in, together with the ambivalence of completing or terminating a pregnancy (Kjelsvik & Gjengedal, 2010). Despite the widespread use of contraception in New Zealand, unplanned pregnancy is still quite common (Pullon & Benn, 2008). Today, New Zealand women who find themselves unexpectedly pregnant have three main options (1) Continuing the unplanned pregnancy, (2) Terminating the pregnancy, or (3) Adoption.

Sable and Libbus (2000) investigated the relationship between pregnancy intention and pregnancy happiness. The study’s findings suggested that uncertainty about the future of a pregnancy and consideration of adoption or abortion was reported more frequently by women with perceived ‘mistimed’ pregnancies who were also unhappy compared to women who

were happy (Sable & Libbus, 2000). This study also found that ambivalence toward pregnancy is manifested in contraceptive risk-taking. For instance, among women who stated that they had no plans to become pregnant, almost half were poor or inconsistent users of birth control.

In an unplanned pregnancy, it may be more likely that the pregnancy is unwanted, contributing to lower rates of prenatal attachment (Laxton-Kane & Slade, 2002). However there has been no systematic research carried out to indicate the relationship between the perceived sense of reality and connection with the unplanned child. Researchers do however hypothesise that if a woman will not be continuing in the role of mother, that attachment avoidance would be a common coping mechanism in preparation for the subsequent separation (Fischer & Gillman, 1991). Researchers have also pointed out that many studies treat pregnancy intendedness (for example, wanted versus unwanted pregnancies) as a fixed attitude, one that women have before, during, and after her pregnancy. It was argued however, that intendedness status is not fixed during pregnancy (Poole, Flowers, Goldernberg, Cliver & McNeal, 2000). It was also suggested that a shift from a more positive feeling to a more negative one might also be a sign of problems in a woman's life that require attention.

New Zealand women have had the right to choose abortion since 1977 (Abortion Services in New Zealand, 2006). This law gives women the right (in certain circumstances) to abort with a gestational limit of 12 weeks at a certified clinic or to a specialist operating in a licensed hospital if beyond 12 weeks. This can instigate feelings of guilt and insecurity (Abortion Services in New Zealand, 2006). In addition, issues with coping and being in control when other responsibilities are present alongside pregnancy can transpire, possibly leading to anxiety and obsessive compulsive behaviour (Lub-Moss & Eurelings-Bontekoe, 1997). Should a woman wish to request the termination of pregnancy, she must obtain approval from

two certified consultants. In addition, counselling services must be available to ensure an informed decision is being made. The grounds for abortion are documented in the Crimes Act 1991 (Abortion Services in New Zealand, 2006).

Adoption services in New Zealand are managed by Child Youth and Family (2011), which is a service of the Ministry of Social Development. Child Youth and Family (2011) acknowledge that adoption is a big decision to make and allow birth parents the right to choose the adoptive family. This is a process that requires consent. A birth mother however, may not sign consent until her baby is at least 12 days old. This 12 day rule does not apply to birthfathers.

Many birthparents take longer than 12 days to come to a decision. However once the consent form has been signed, it is almost impossible to have the decision reversed. Simone (1996) mentioned that birth mothers may experience higher levels of grief if they are coerced into adoption. Higher levels of grief were also associated with feelings of guilt or shame regarding the decision to adopt. Most current adoptions in New Zealand are 'open' adoptions, meaning that both sets of parents are known to one another. In general, both sets of parents meet together before consent and make a contact agreement in order to maintain an on-going relationship. Nevertheless, however carefully the decision is made, most birth parents who place their child for adoption experience feelings of grief and loss (Child Youth and Family, 2011).

To conclude

This literature review highlighted that several elements can delay the prenatal attachment process creating significant amounts of ambivalence, and in turn prolong the conceptualization of the growing foetus as reality (laxton-Kane & Slade, 2002). One factor

that seemed to influence this notion included the expectations around pregnancy related cues and whether or not anticipated pregnancy symptoms materialised (Swallow, Lindow, Masson & Hay, 2004). It was also mentioned that the appraisal or interpretation of the pregnancy as a reality may require something tangible, such as, physical sensations (for example, foetal movements) and/or visual evidence (for example, ultrasound scans) (Laxton-Kane & Slade, 2002). Women with higher associated risk (for example, women over 35 year-of-age and/or women with family history of genetic abnormalities) may also distance themselves from the fact that the foetus is a reality to protect against possibility of loss. The threat of miscarriage, fertility experience, hormonal changes, life style changes, and professional support also constituted factors with psychological distress during the early stages of pregnancy. Furthermore, it seems that ambivalence in relation to somatic complaints, body image, as well as professional and personal conflicts may also impact adjustment to pregnancy.

To conclude, adjustment to pregnancy can vary significantly (Handley, 2006). Even when pregnancy is planned, the process of adapting to such a life-changing event is often difficult. Research to date has focused on the postnatal experience with little attention paid to the prenatal experience in pregnant women (Swallow, Lindow, Masson & Hay, 2004). In addition, with the exception of the vast amount of literature concerning the pregnant adolescent, little attention has been paid to exploring the experiences of women who are pregnant for the first time. In addition, literature on the prenatal experience is more greatly sourced internationally, making a local study even more important.

This research seeks to explore and develop a richer understanding of the first 12 weeks of pregnancy for first-time mothers in New Zealand. It is hoped that the story-telling nature of the in-depth interviews will provide insight and further appreciation into the experiences and challenges of this time period. Furthermore, from a clinical perspective, a woman's sense of perceived reality and prenatal attachment with her unborn child could aide clinicians in

understanding and providing psychological support throughout early pregnancy. This knowledge may assist in the prevention of psychological disorders and influence a more positive adaptation into pregnancy.

CHAPTER THREE: METHODS

Introduction

The purpose of this narrative inquiry is to gather and analyse the stories of five first-time mothers to explore some of the psychological experiences of the first 12 weeks of pregnancy. The primary aim is to develop a richer understanding and gain insight into how the first-time mothers adjusted to pregnancy. Research to date has focused on the postnatal experience with little attention paid to the prenatal experience (Swallow, Lindow, Masson & Hay, 2004) and the experiences of women who are pregnant for the first time. It is therefore hoped that the story-telling nature of the in-depth interviews will provide insight and further appreciation into the experiences and challenges of this time period.

The purpose of this chapter is to outline the methodological processes that took place in order to uncover the stories and themes that derived from the participants' narratives.

Theoretical framework

Narrative Inquiry:

Narrative inquiry falls into the general paradigm of qualitative research methodology (Polkinghorne, 1995). Within that framework, there are many stances that influence the study's design (Clandinin, 2007). This narrative inquiry has been approached from a social constructionist viewpoint, which explores how various versions of relationships, events and memories are created and told in different social contexts and in distinctive relationships (Clandinin, 2007). This stance assumes that the world is constructed when people talk to each other, therefore language is a necessary pre-condition for thought as we know it (Burr,

1995). It stands in opposition to the assumptions made by logical positivists who advocate that they can predict and control the social world and that there is a single reality that can be discovered (DePoy & Gitlin, 2005). Instead, social constructionists assume that it is impossible to capture a single reality or a single truth.

Social constructionism argues that the world is dynamic, ongoing and ever changing because of peoples' interpretations and experiences (Burr, 1995). Narrative researchers that sit under this umbrella are aiming to capture subjective realities as well as knowledge and understanding through the participants' eyes (DePoy & Gitlin, 2005). Throughout this process the narrative researcher however becomes an integral part of the research. Therefore findings are presented not only from a particular socio-historical context, but also from the researchers' own point of view (Steier, 1991).

Polkinghorne (1995) describes narrative inquiry as a qualitative method that elicits storied accounts in order to describe human phenomena. These accounts capture meanings; they contribute to our identities and explain how we uniquely exist in our socio-cultural world (McAdams, Josselson & Lieblich, 2001). Narrative inquiry is generally conducted in an interview setting; it purposefully engages and reveals descriptive human experience (Hatch & Wisniewski, 1995). For instance, when broad open-ended questions are asked, a broad storied answer is generally provided. Polkinghorne (1995) explains that participants do not have to be taught how to tell stories, it is a common technique whereby people make sense of and communicate life experiences.

Narrative inquiry has been used for clinical purposes, such as therapeutic use of autobiography and biography. DePoy and Gitlin (2005) explain that the power of story in healing has been highlighted in numerous scholarly works. For instance, it is a technique that can give a voice to vulnerable or marginalized populations. By giving people a voice, they can come to be heard, which may lead to empowerment (Clandinin, 2007). In addition,

although some claim that narrative inquiry can generate theory, this is not typically viewed as its primary purpose (DePoy & Gitlin, 2005). We are simply exploring how one individual experienced the world at one particular time, like a snap shot photograph along a continuum in the story teller's life (Thomas & Schwarzbaum, 2006).

According to Bruner (1990), narrative-type inquiry refers to the collection of events and happenings in the linguistic form to produce raw data. Narrative data is analysed to produce storied accounts which are then used to create meaning. In addition, transcripts are generally read with an inductive, 'not knowing' stance that is congruent with the theory of social constructionism (Burr, 1995). Throughout these accounts, the plot is the narrative structure. For example, the plot marks the beginning and the end of story and it determines which messages need to be included to produce a coherent account. Subsequently, the plot includes the ordering of events and the unfolding of the story's significance as a whole (Bruner, 1990, Hatch & Wisniewski, 1995).

Crossley (2000) explains that people's expressions can be analyzed in order to reveal narrative tones, themes and images, which then merge together to produce a coherent storied account, leading to knowledge and understanding. "Through narratives we define who we are, who we were and who we may become in the future" (Crossley, pp. 67, 2000).

Participants

Selecting the participants and recruitment:

First-time mothers were recruited through ante-natal class coffee group organizations within the Auckland region. Information sheets regarding the study were given to the host of each coffee group to distribute to interested first-time mothers during coffee group time. Interested mothers were able to decide within a two week time period, if they wanted to be considered

for participation, and were invited to make contact with the researcher via email or telephone. OHbaby www.OHbaby.co.nz and Parents Centre www.parentscentre.org.nz were the first point of contact. These centers were all situated within the Auckland region, for example, North Harbor, The Hibiscus Coast, Onewa, Waitemata and West Auckland.

Participant selection criteria included first-time mothers who had experienced no complications leading up to conception (e.g. no previous miscarriage, conception occurred within one year of trying to get pregnant, no infertility treatment), with no diagnosis of postnatal depression. The participants' children were aged three months or less to facilitate recall of the first trimester and for practical reasons, the participants were recruited from the Auckland region and were competent in English. There were no restrictions with regards to ethnicity or socio-economic status; however participants were required to be between 25 and 35 years of age. This age distinction aimed to reveal the challenges surrounding first-time pregnancy, which is now on average, 30 years of age (Statistics New Zealand, 2010).

The first five participants who volunteered to share their stories and fitted the required criteria were selected. The reason behind this number of participants was because narrative inquiries typically employ small numbers of informants which allows for in-depth and thorough exploration of the area under study (DePoy & Gitlin, 2005). In addition, any more participants could potentially lead to data saturation whereby themes become repetitive and contain no new ideas. Five participants is also number appropriate for the requirements of a practice research project.

Data collection

In-depth interviews: The mothers' stories:

The in-depth interview was chosen for several reasons. Firstly, interviewing and recording (audio or video) are the most frequently used information-gathering strategies for narrative data in health and human services (DePoy & Gitlin, 2005). This method appeared to be straightforward and provided a forum that effectively captured the voices of the participants. The use of open-ended questions seemed to allow for more freedom of speech and seemed less likely to distract from the participants' true authentic story (Hill, 2009). In addition, this approach, as opposed to structured or fixed interviews, appeared to encourage more detailed accounts rather than brief answers or general statements (Kohler-Riessman, 2008). This method also encouraged me, as the interviewer to give up control, which generated the potential for more possibilities. For instance, the freedom of the in-depth interview necessitated that I follow the participants down *their* pathways (Kohler-Riessman, 2008). It was anticipated that this would lead to greater equality in conversation and also bring about richer discoveries.

The data collection process began early July 2011. Data were collected via face-to-face in-depth interviews and were audio-taped with participant consent (Consent Form: See appendix 1). Each interview took approximately 60-90 minutes and was conducted in the participant's home. The beginning of the interview process was guided by the Interview Protocol (See Appendix 3). This acknowledged that each participant had the opportunity for a support person to be present throughout the entire interview, and it prompted discussion regarding my background, including a reminder of the purpose of the study. This also included reminders such as the availability of counselling services at AUT University and confidentiality in the use of narrative inquiry. The aim of this process was to attempt to create a sense of

connectedness and rapport with each participant, which then progressed into the in-depth interview. I attempted to encourage participants to direct the interview; however prompts were expressed in a broad, open-ended manner if I felt that participants were struggling with the direction of the story. The Interview Guide (See Appendix 5) was developed from current literature, with particular reference to Medina and Magnuson (2009). Once the Interview Guide had been developed, a member of the target population was consulted to determine the relevance of the questions (See Appendix 8).

At the end of the interview, participants were invited to complete the demographic information sheet (See appendix 4). This information was then transferred to a chart (See appendix 9), which was used when introducing the participants narratives in chapter four. An audio-tape recorder was used during the interview process so that the researcher could actively listen to the stories. Each interview was transcribed. The transcription process allowed the researcher time to reflect upon the interview process, and to ensure accuracy, transcriptions were checked several times and amended accordingly.

Ethical considerations

Ethical approval was granted by the Auckland University of Technology Ethics Committee on the 14th of June 2011 (AUTEC Reference number 11/107). Once approval had been granted, the recruitment process began.

An invitation:

Interested mothers received a written invitation stating the purpose of the study, the procedures, how confidentiality was maintained, participant rights, the risks and benefits, and expected commitment timeframe. This invitation was free of deception and written in lay person terms (See Appendix 2). These information sheets were given to the host of each

coffee group to distribute in a setting away from the researcher in order to minimise the risk of what DePoy and Gitlin (2005) term researcher bias or manipulation. For instance, the researcher wanted to ensure that first-time mothers did not feel pressured to take part in the study. Additionally, the researcher did not want to come into contact with ‘possible’ acquaintances as this may have pressured individuals not only to take part, but to tell the ‘right’ story when being interviewed. Mothers wanting to participate were advised that the study was limited to five; therefore a response was required via email to the researcher within two weeks following invitation to secure a placement. Five women who met the selection criteria responded and were invited to participate.

The consent process:

The consent process took place prior to the interview. During this time, participants were informed that unstructured interviews can initiate unanticipated or upsetting issues and that consent could be a process of negotiation as the interview progressed. Participants were also assured that the voluntary nature of this study indicated that they could withdraw at any time following the interview, up until the final transcript had been sighted and confirmed by the participant. This confirmation of transcript process was conducted via email. According to Clandinin (2007), the right to withdraw can be frightening for researchers however there is no ethical way around it. If a participant no longer wishes to be a part of a study, that person must be free to withdraw his or her material.

When the researcher was satisfied that each participant understood the consent process, informed consent was obtained in writing and signed by both participant and researcher. According to Marshall and Rossman (2006), informed consent is unique to Western practice and has the potential to generate cultural challenges. It assumes literacy and individualism, and in Non-Western cultures, signing ones name may seem dangerous or unusual if not

understood. It was expected that some participants may find this concept challenging, therefore I ensured that participants were fully informed and comfortable with the consent process prior to signing.

Privacy and confidentiality:

The interviews were conducted in a private setting convenient to the participants. This turned out to be the participants' homes. Participants expressed that they felt comfortable being interviewed at home because they were less likely to be identified by the public and because the interview could be conducted whilst their babies were asleep. The nature of interviewing participants in the home however raised concern for researcher and participant safety, therefore a safety protocol was developed (See Appendix 7). This protocol outlined the procedures that were followed to ensure that my whereabouts were known by a colleague and what actions were to be taken if safety was suspected to be compromised. In addition, the safety protocol highlighted that each participant was to be approached with respect for cultural and social sensitivity. The latter is an ethical consideration which highlights the need for sensitivity and responsiveness to diversity because people live and develop within particular social, cultural and community settings that may be very different from our own (Evans, Rucklidge & O'Driscoll, 2007).

In addition, any information provided by the participants has been protected so that there are no links to their identity, for instance, the participants are unidentifiable in this thesis due to the use of pseudonyms. All computerized documentation had password protection and was conducted in private; audio-tapes and written documents were and still are under strict lock and key and unwanted information was shredded and discarded accordingly. The only people entitled to access participant information are the researcher and the primary and secondary supervisor.

Further ethical principles in narrative inquiry:

Each interview was approached with a genuine interest in the participants' lives; through cultural respect, and through interpersonal skills such as building rapport, trustworthiness, and empathy (Hill, 2009). In addition, to honour justice and fairness, I was constantly aware of my biases and strived to ensure that this thesis reflected a genuine representation of each participant's experience. Each participant was given an opportunity to view the transcriptions and feedback amendment requests were respected and amended with utmost integrity. The participants have played a crucial role in this study and their active contribution has been highly and anonymously acknowledged.

Ethical dilemmas:

One issue was whether or not to interview participants during or after their pregnancy. One option was therefore to conduct a study in the midst of pregnancy and the other was to conduct a retrospective study (after pregnancy). When assessing the potential harm and benefits involved, it was decided that participants should not be interviewed during pregnancy as the researcher considered this period a more vulnerable time than post pregnancy. This decision making process was guided by the ethical principles of beneficence and non-maleficence. Beneficence relates to an action that benefits the welfare of others, such as the prevention or removal of harm (Evans, Rucklidge & O'Driscoll, 2007), whereas non-maleficence means 'to do no harm.'

Cultural considerations

When conducting research in New Zealand, it is possible that participants will be from different ethnic/cultural backgrounds than the researcher, therefore it is important to

acknowledge diversity of worldviews (Evans, Rucklidge & O'Driscoll, 2007). In addition, when conducting health research in New Zealand, it is important to acknowledge the meaning and implications of the Treaty of Waitangi in research (Evans, Rucklidge & O'Driscoll, 2007). Subsequently, throughout this research the principles of 'Partnership,' 'Participation,' and 'Protection' has been honoured in order to show respect for both Maori and non-Maori participants (Durie, 2004).

Throughout this research project, I actively attempted to protect participants from harm. They have been granted all information necessary, free from deception, indicating the purpose of the study along with the procedures, timeframe and expected commitment from each participant. Informed consent was obtained and participants were aware that they had the right to partake only in ways that they felt comfortable. In addition, the researcher was contactable via email or in person to assist with any further questions that may have transpired throughout the duration of the research project. In order to protect the participants' privacy, stories were transcribed with honesty and cared for in a confidential manner. Furthermore, I attempted to minimise any power imbalances in the professional relationship with my genuine interest in the participants' lives and through professional interpersonal skills, such as, rapport building and empathy. In addition, I did my best to ensure that participants' specific cultural practices were respected. And as mentioned earlier, the participants have been invited to view the transcriptions. Any feedback and amendment requests have been respected and amended in partnership and good faith as the outcomes of this study have been designed to potentially benefit this group.

Bolstad (2004) stated that an awareness of cultural understanding can initiate good communication. Culturally competent practice can also help promote richness and cultural diversity in the data. Consequently, participants were viewed as having unique experiences to share and have been approached with sensitivity, respect and a willingness to learn more

about their particular culture and social group. Interestingly, it became apparent that all five participants identified as New Zealand European, which harmonises with the cultural group that I identify with.

Narrative Interpretation

The process of narrative interpretation involved a procedure whereby elements of the interview transcripts were organized and synthesized in order to present coherent storied accounts (Polkinghorne, 1995). This process was guided by Crossley's (2000) six step method to analyzing personal narratives and began when transcribing and transforming the orally generated stories from each interview into a textualized form.

The following illustrates Crossley's (2000) step by step approach that was adhered to in order to conduct narrative interpretation.

1. The transcripts were read several times (usually 5 to 6 times), whilst documenting any notable patterns or threads, in order to become familiar and make sense of the data.

During this step, the documentation of notable patterns or threads were hand written in the right hand margin of each transcript. Highlighter pens were also utilized to illuminate themes of significance. Crossley (2002) defines a theme as any dominating or repeated patterns of motivation, which can include, any identifiable needs, subjects of importance, together with any patterns of inconsistencies. As the themes are identified, significant elements become apparent. This process has been defined as the development of a 'rough map' or 'picture' of the emerging interview (Richmond, 2002).

The following is an extract from Stacy's interview (One of the participants in this study) to illustrate the highlighting process:

“... I also found that I didn't let myself get attached because I was afraid that I would lose the baby. So even though I was over the moon and felt some kind of love, I suppose initially I didn't let myself feel much until probably when she was about 2 weeks old. That was when I actually believed that I had a baby and that everything was going to be okay” [Stacy].

2. Step two involved the identification of important elements within each transcript, such as narrative tone as well as common themes.

During this step, the above notable patterns, threads, and illuminated themes were examined. The common themes and tones were then transferred to a sheet of paper (each participant had their own sheet of paper) in a mind map format.

3. In step three Crossley (2000) examines the narrative tone in the content as well as the manner in which the narrative is told.

For instance, during analysis I examined and recorded on the mind map whether the experiences of the first 12 weeks of pregnancy presented with an optimistic or pessimistic tone.

4. Step four involved the analysis of imagery together with themes, because Crossley (2000) indicates that these elements tend to overlap.

Throughout this step, attention was focused upon concepts such as, the use of cultural symbols, language, and repeated patterns of motivation.

5. In step five, the narrative tones, themes and images were then presented.

During this process, Richmond's (2002) 'storymap' approach to organizing narrative themes was utilised. The story map is a 'grid like' illustration that helps the researcher to visually

organise and make sense of the overarching themes and sub-themes. The storymap is a useful tool for information reduction, it is a useful way of introducing a narrative, and it is a useful technique for summarising events. The storymap also assisted with identifying the voice of the story, which Polkinghorne (1995) terms, the plot. The storymap for each participant is located at the beginning of each narrative in chapter four.

6. In step six the research report was constructed and given a title, which was referred to as the plot (Crossley, 2000).

During this step, the identified themes from each participant's story map were utilised to construct each storied account. Each story was then given a title which emerged from the employment of a thematic thread which drew together and integrated themes into a coherent whole to create meaning (Polkinghorne, 1995).

The development of the plot (or title) followed an inductive approach to research, taking a 'not knowing' stance, in the search for meaning and social significance. As each plot transpired, key elements and experiences were highlighted enabling the researcher to determine which items should be included in the final storied account. This process has been defined by Spence (1986) as *narrative smoothing*, suggesting that not all data is needed for the telling of story. Throughout this process, the researcher also unfolded dimensions of human experience and arranged data along a temporal continuum (Polkinghorne, 1995). For instance, each storied account was listened to carefully to ensure that themes were placed in a sequential order. Furthermore, I attempted to ensure that the final storied accounts were configured in a way that was not strikingly obvious when simply glancing at the raw data (Polkinghorne, 1995).

Rigour

Kohler-Riessman (2008), has accentuated that trustworthiness is the key element of success in the professional relationship when interviewing. It contributes to rigor by strengthening the honesty of expression; leading to a greater depiction of one's lived experience. Throughout this study, it was anticipated that trust emerged naturally due to my genuine interest and ethical approach to research. In addition, audio-taped interviews can enhance rigor by capturing the details that would otherwise be impossible to memorize, such as narrative tone, overlaps and pauses (Silverman, 2005). Not only did replay assist with accurate transcription, it also enabled familiarization and future clarification (Silverman, 2005).

Throughout the findings chapter, the study's rigour has been enhanced with the presentation of direct quotes from each participant's transcript (Clandinin, 2007). Additionally, the identified themes have been graphically presented in a table form, which was guided by Richmond's (2002) storymap technique. To further strengthen the rigour and trustworthiness of this research, the entirety of each transcript was regarded, and quotations were used in a manner that best illustrated the participants' experiences. Furthermore, to overcome the excitement of jumping to easy conclusions, I have ensured adequate time for comprehensively analyzing each story.

During the development of this inquiry I also embarked upon a reflective process. According to Kohler-Riessman (2008), being reflexive means exploring how one's own personal experiences shape how understandings and how viewing issues from multiple viewpoints affects one's understanding of a phenomenon under study. It is hoped that this practice has contributed to the studies rigour.

Limitations

It is impossible to interpret a narrative in a singular way because of the creations through shifting social discourses, producing a multiplicity of possible meanings (Clandinin, 2007). The danger in this arises when the researcher's perspective takes centre stage, which could potentially abandon the voice of the narrator. In addition, narratives help people make sense of experiences by giving shape, organization and cohesion; however this assumes that we need literacy to understand ourselves and to create meaning, which can be deemed a limitation (Crossley, 2000). In narratives it may also be difficult to interpret or grasp the presence of the unsayable, for example, the time spent between words and between sentences (Clandinin, 2007). As a consequence, the rendering of every elaboration of 'meaning' in the interpretation of text may be inadequate.

Most narrative inquiries discuss the ethnographic nature of their studies, for example, staying together as participant-observers long enough to develop trust and intimacy to get the 'real stories.' In this study however only a short amount of time (approximately 10 minutes) was spent developing a relationship with each participant prior to beginning the in-depth interview. As a result, one could become sceptical about the power relations between the researcher and researched. For instance, Connelly and Clandinin (1990) warn about the 'scared story' or participants feeling as though they have to produce the 'right' story. This study is also retrospective, which indicates that each client has looked back on an experience and shared a story from the past. As a consequence, this may limit the richness of each storied account due to the possible lack of recall (Kohler-Reissman, 2008).

Reflexivity

If my epistemological viewpoint as a researcher is that knowledge is socially constructed, then I must apply the principle of reflexivity to myself and my work. This is because I am ‘co-producing’ rather than simply ‘discovering’ the phenomenon under study (Steier, 1991). As mentioned earlier, Kohler-Riessman (2008) explained that being reflexive means exploring how one’s own personal experiences shape how understandings and how viewing issues from multiple viewpoints affects one’s understanding of a phenomenon under study. As a result, being reflexive means that my own assumptions and experiences as a researcher must become an integral part of the research. In other words, the researcher becomes a part of a process that explicitly engages in the complexities of multiple realities (Steier, 1991). Traditionally researchers have wanted to say something about the ‘subjects’ that they are studying, that then become the ‘objects’ of their study. They may now realise however that in doing so they are saying something about themselves (Steier, 1991).

In order to be reflective, I conducted a purposeful self-examination in order to reveal my personal biases, assumptions and perspectives in relation to the subject under investigation (DePoy & Gitlin, 2005). Self-reflection assists with clarifying what aspects of what is ‘observed’ stem from the researcher, what from the object under observation (the participant), and what from the interaction between them (Steier, 1991). This process was important because it allowed me to explore the ways in which my involvement influenced the direction and findings of the study (Webster & Mertova, 2007).

My interest in the area of psychology and pregnancy, particularly the first 12 weeks of pregnancy, derived from one of my own personal experiences. The news that I had fallen pregnant in 2010 came as a surprise, and although my husband and I were delighted, I always seemed to be missing that sense of reality, for example, that the pregnancy was legitimate. When reflecting back, the feelings of unreality began at my first doctor’s appointment where

I had requested to confirm my pregnancy with a blood test. The doctor however declined my request, and stated that a home pregnancy test was sufficient. The support and information that I had received from the doctor that day was disappointing. I walked away with a website address which would guide me through the next 9 months as well as a deep feeling of invalidation.

Throughout this period I also began to struggle with what I felt was incongruence with regards to my professional identity and my identity which involved the emergence of motherhood. The pressure that I felt to up-hold both positions simultaneously at times felt exhausting.

In my opinion, first-time pregnancy can be a time of great joy together with great confusion. And although after connecting with a Lead Maternity Carer I was supported with regards to information concerning the physical changes, dietary requirements, antenatal testing and so forth, it became apparent to me that support options seemed limited with regards to the psychological adjustment that I was experiencing.

When I met my participants' I felt that being pregnant was a nice way of breaking the ice and developing a feeling of relatedness with each client. I did refrain however from revealing too much information about my experience until the interview was complete due to concerns that I may influence the participants' stories.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this narrative inquiry is to gather and analyse the stories of five first-time mothers to explore some of the psychological experiences of the first 12 weeks of pregnancy. The primary aim is to gain insight into how the first-time mothers adjusted to pregnancy.

The purpose of this chapter is firstly to present each of the five participants' narratives. The commonalities and overlapping themes among the participants' narratives will then be discussed. Each narrative does refer to the literature; however chapter five will link the findings to the literature that was presented in chapter two in more depth.

Participant's individual narratives

The purpose of this segment is to present each of the five participants' narratives separately. The structure of this presentation is outlined in the table below:

Participant's Names	Presentation of findings
Rose	Introduction
Stacy	Map of Participant's story
Verity	Participant's narrative
Ruth	
Brooke	

Table 1: Summary of the narratives

Each segment will begin with a brief introduction, which entails the demographic information about each participant. A picture of the emerging narrative will then be presented in a table format (mapping the story), followed by the participants' narrative.

The results section has been presented in this manner to guide the reader through the development of each of the emerging narratives. This process has been guided by Crossley's six step method to analysing personal narratives, which is outlined in chapter three.

Throughout this chapter, the plot of each narrative has also been considered. This is the employment of a thematic thread which draws together and integrates themes into a coherent whole to create meaning (Polkinghorne, 1995). The plot will be regarded as an overall message that the story bestows, which will be evident in each story's title.

Each of the participants narratives have been written from my own understanding. Therefore direct quotes from each participants' transcripts have been provided to maintain the richness of each storied account and to differentiate the participants' voices from my own (Clandinin, 2007). Furthermore, as mentioned in chapter three, pseudonyms have been used to protect the participants' identities and the telling of story has been presented in the past tense, because these narratives are constructs of the past.

Rose

Introduction

Rose is a 29-year-old, married woman who identifies as New Zealand European. She lives with her husband, her three month old daughter, and her older brother in the Auckland region. Rose is employed at a law firm and is currently on one year maternity leave, and her husband works full-time in the automotive industry.

Map of Rose's Story

Over arching themes		Sub-themes
Phase of life	⇒	Motivations
	⇒	Ambivalence
Getting pregnant and finding out	⇒	Expectations
	⇒	Wonderment
A sense of reality	⇒	Tangible appraisals
	⇒	The role of cues
Bonding	⇒	Competence
	⇒	Maternal identity
	⇒	Ultrasound
Sharing the news	⇒	Excitement
	⇒	Guilt

Table 2: Map of Rose's Story

Rose's narrative- The emerging maternal identity

Throughout Rose's narrative, the emergence of her maternal identity appeared to illustrate one perception of her pregnancy journey, which became the thematic plot for this story. The over arching themes interwoven throughout Rose's narrative to create the plot included the timing around becoming pregnant, her experience of getting pregnant and finding out, when her pregnancy felt real, the difficulties surrounding her bonding experience, and her experience of sharing the news with others.

Phase of life:

Rose's motivation to start a family was constructed with reference to her parents' experiences. What Rose had conceptualised as an appropriate age for conception seemed to be the dominant sub-theme and appeared to influence what she considered a 'normal' time for family formation. Rose explained:

"I always planned to get pregnant at about the age that I'm at now because my mum got pregnant when she was... And I just thought that it was a nice age gap between her age and our age, and just sometimes you just copy your parents with that sort of thing... And so I always imagined myself pregnant when I was about 28-29" [Rose].

Rose also seemed to attribute her motivation to the time spent in her current employment. This may have been partly because she had concerns regarding parental leave and employment protection eligibility. However, later in her narrative it seems that she has concern for her reputation and does not want to let her firm down. She also mentioned the influence of social interactions which seemed to provide confirmation around the timing of family formation. For instance:

"Well we started talking about it for a least a year before I got pregnant. But at the time I'd just swapped jobs so I didn't want to get pregnant as soon as I'd changed jobs. I wanted to work there for a least a year first. And um so we talked about it a lot and friends who were starting to talk about it at that stage as well... oh and um start to have babies so it was kind of the right time for us" [Rose].

As Rose continued, she appeared to express some indicators of ambivalence and emotional conflict with regards to her construction of first-time parenthood and professional obligations. She appeared to express what researchers (Medina & Magnuson, 2009) have identified as worry about inadequacy and critical social attitudes when taking time away from work. Rose

also appeared to show what researchers (Bernardi, Kiem & von der Lippe, 2007) have defined as a strong preference for strict sequencing of events, and it is possible that becoming pregnant may have conflicted with the sequence that she had previously constructed. Rose's apprehension was captured in the following:

“Just the worry of taking a year off work and how that would... like what they would think of me and how that would affect my sort of career and going back to work and that sort of thing... well I suppose that's how I felt during the first 12 weeks... Most people do have their career established and then they have babies when they are lawyers, whereas I'm sort of midway I haven't quite got my profile sort of out there like I'm not really known in the community yet ... and I haven't sort of ticked all the boxes I thought I would have done by the time I got pregnant and took time off work...” [Rose].

Getting pregnant and finding out:

It has been suggested that women generally have certain expectations of pregnancy (Weis, Lederman, Lilly & Schaffer, 2008), and for Rose, these expectations included conception.

“We went away to Germany for a month in February and then came back and started trying and got pregnant straight away! ...and um my husband was quite pleased with himself, he always thought that it would happen straight away and I didn't think it would.

It seemed that Rose had constructed an expectation around the physiological functioning of the female body with regards to conception. Yet she also held the idea that becoming pregnant may take time, which could have been a protective mechanism against the possibility of disappointment. Rose's lack of difficulty in conceiving appeared to initiate a sense of confidence regarding the viability of her pregnancy. Her narrative did however suggest that she still maintained an element of uncertainty. This may be associated with the constructions that Rose had created from structure providers, for instance, credible authority

and social supports, reducing her ability to experience absolute certainty about the viability of her pregnancy (Weiss, Saks & Haris, 2001, Handley, 2006).

“It was fun trying cause we were just trying for the first time and we didn’t have to go through the disappointment of having a test and having it negative when we were ready to get pregnant. So by the time I did the test um well when I did the test it was just... well it felt really good... I was just really happy that we could get pregnant. Cause I always wondered if one of us might be infertile or something... we have been together for years... So I just enjoyed knowing my body was working the way it should... We were so excited and I just wanted to share the news with people and I did feel quite confident that everything would be alright... but in the back of my mind I thought, should I be telling people?” [Rose].

Rose’s memory of the beginning of pregnancy seemed particularly special because the realisation of her pregnancy coincided with father’s day. Her narrative also suggested that her husband experienced a feeling of wonderment when he discovered that she was pregnant.

“It was father’s day and so appropriate. When he woke up he went to the bathroom and he said “you did the test”, and I said “yup” and he goes “so are you pregnant?” And I said “what do you think?” And then there was silence for about a minute, while he read the instructions and um and he said “I think you are pregnant” and I said “Yup” and he came out and gave me a kiss and the rest of the day he sort of just like watched me like everywhere I went like I was this sort of fairy or something, it was just an amazement that suddenly I was pregnant so it was really neat” [Rose].

A sense of reality and bonding:

Central to Rose’s narrative was also the notion of her pregnancy becoming a reality, together with an overarching theme around her bonding experience. It appeared that Rose required tangible appraisals or interpretations of her pregnancy in order to conceptualise her

developing foetus as something real during the first 12 weeks. In addition, it seemed that Rose had constructed expectations around the symptoms associated with pregnancy and when they failed to materialise, the opportunity for what researchers (Weis, Lederman, Lilly and Schaffer, 2008) term ‘dissonance or self-doubt’ to creep in appeared to be minimised by the opportunity to undergo an ultrasound examination.

“I first went there when I was 8 weeks they had a scanning machine in their offices so they put me on it straight away. So she was a little baby looking thing at that stage with a little heart beat and stuff so that was really cool... My husband came as well... So that made it seem all the more real because before that the only thing that really made it feel real was seeing the pregnancy test and then four weeks went by where ya know my belly wasn’t changing, I didn’t really have morning sickness...” [Rose].

During Rose’s narrative, one particular comment stood out. She expressed:

“I loved being pregnant... it was just that feeling of being connected to having a baby inside you like that I found difficult” [Rose].

The underlying reason for this comment may be associated with Rose’s social interaction. For instance, Haedt and Keel (2007) had pointed out that in first-time pregnancy women often abstractly relate to the experimental accounts of relatives and friends. It seemed that Rose’s narrative verified this idea as she attempted to associate and measure up her experience against that of her pregnant friend.

“We did some graph scans as well and I found those really useful because throughout my pregnancy I found it quite hard to bond with her in a way because it felt like, well I had a friend who was pregnant and she was sort of talking as though you know she was already in love with her little baby and they sort of had already bonded in a way” [Rose].

This association appeared to have an impact on Rose's perceived competence and seemed to make her question what researchers (Lederman and Weis, 2009) term her 'maternal identity'. The opportunity to undergo an additional ultrasound examination however seemed to foster Rose's experience of pre-natal attachment. Rose's need to experience something tangible fits with the theory of prenatal attachment, which suggests that prenatal attachment requires the recognition of another to be attached to (Laxton-Kane & Slade, 2002).

"...I like found it quite strange like I would try talk to her or I would um I don't know I just felt like maybe I wasn't feeling how I should be... so each time we saw her that kind of helped a bit..." [Rose].

Handley (2006) explains that one of the reasons that women may struggle during the first 12 weeks is because of the inconsistent role of pregnancy-related cues. Rose previously mentioned that she did not experience morning sickness and that her stomach did not change. The experience of yet another expectation that did not seem to transpire may have therefore contributed to the experience of further dissonance and self-doubt; or as she described it, not *"feeling how I should be..." [Rose].*

In addition, Rose's narrative fitted with the notion that even when pregnancy is planned, the process of adapting to such a life-changing event is often difficult (Handley, 2006). For instance, Rose had contemplated pregnancy for a year prior to conception, it seemed however that she had not anticipated the depth of emotions that she experienced. For instance, Rose spoke about her role in the family and how this had an impact on her emotions and maternal identity:

"I'm really not a baby person like I'm the baby of my whole extended family well I was for quite a while anyway until grandchildren arrived and that sort of thing so whenever people had babies around me I didn't really know what to do with them. So it was quite a big thing

for me to think I'm going to have a baby. It was kind of scary... I found that when I hit about 7 weeks I think it suddenly hit me and I can't remember exactly how I felt but I felt quite overwhelmed and scared about I'm going to become a parent like it hit me for a day or two. And I felt quite scared and teary and um that just passed and it's probably to do with the whole I don't know what to do with babies" [Rose].

Rose's ability to identify as a mother was then further influenced by a comment made by one of her friends, for instance:

"Like one of my best mates from high school was like I can't imagine you as a mum (laughs) it was quite mean" [Rose].

Sharing the news:

When Rose spoke about sharing her pregnancy news, it was clear that this event was very memorable for her. She sound excited to share her pregnancy journey with her best friend who was also pregnant, and as mentioned earlier, the news came about on Father's day which seemed like the perfect Father's day gift. Rose explained:

"I thought I would just tell close friends and family to begin with cause I was only four weeks pregnant at that stage... I told my best mate straight away...she was only five weeks ahead of me... and I got to ring my dad on father's day and say happy father's day. We got him on Skype and just showed him the test. And it's their first grandchild so they were really excited" [Rose].

Sharing her pregnancy news with work however appeared to bring about some anxiety.

According to literature, it is common for women to keep the news of their pregnancy quiet in the workplace in case of miscarriage, losing out on work opportunities, parental leave and employment protection (Barnett, 2010). In Rose's narrative however she seemed more

concerned about not wanting to let her firm down and telling her boss early seemed to alleviate some of her guilt. For instance:

“I thought I would tell my boss right now because they find it really hard to recruit people and I thought well if he needs a temp to replace me while I’m on parental leave or whatever the sooner he knows the better... And that’s the most nervous I can ever remember being because I had only worked there a year and I was the first person ever to be pregnant at this firm and I just felt a bit stink that they had just recruited me and there I was about to go for a year” [Rose].

Rose’s anxiety, and possible guilt, also seemed to be related to the fact that her boss had been struggling to ‘get pregnant’ with his wife. Her difficulty was captured in the following:

“At the same time him and his wife had been trying to get pregnant for a long time and so it was a bit difficult telling him for that reason as well. They are both late 30s and really want children” [Rose].

Conclusion:

Nevertheless, Rose explained that becoming pregnant encouraged her to let go of her worries and live more in the present moment. And in a way, her narrative suggested that she was coming to terms with the possible loss of her professional identity and learning to embrace the emergence of her newfound maternal identity. For instance, Rose explained:

“I think I just started living more in the present rather than worrying about the future you know...although I was enjoying my job and I loved the firm I was at and I intend to go back there, I was ready for the next thing... and the next thing for me was family and I just saw it as the next sort of adventure and I think your never really ready to have a baby and that sort of thing but I was ready to take the first step” [Rose].

This concludes Rose's narrative which will be discussed in the next segment of this chapter.

Stacy's narrative Follows in the next section

Stacy

Introduction

Stacy is a 29-year-old, married woman who identifies as New Zealand European. She lives with her husband and her 3 month old daughter in the Auckland region. Stacy worked full-time in the fashion industry, but since having her daughter, she works part-time. Her husband works full-time in the engineering industry.

Map of Stacy's story

Over arching themes		Sub-themes
Getting pregnant	⇒	Giving up control
	⇒	Accepting loss of professional identity
Finding out	⇒	Disbelief
	⇒	Secrecy
Somatic complaint	⇒	Isolation
	⇒	Relating to sister's experience
	⇒	Avoidance of attachment
	⇒	Reassurance from health professionals
Hyper-vigilance	⇒	Tangible appraisals
	⇒	Crohn's disease

Table 3: Map of Stacy's Story

Stacy's narrative- The test of character

Stacy's narrative seemed to predominately involve the testing of her character. For instance, her pregnancy journey seemed to reflect the endurance and triumph over a really bad illness. The over arching themes interwoven throughout Stacy's narrative that contributed to the plot included her experience of getting pregnant, finding out that she was pregnant, her experience of a severe somatic complaint, and the justification behind her hyper-vigilance.

Getting pregnant:

Stacy spent an entire year obsessing over 'getting pregnant.' According to Stacy however, the moment she let go of this obsession she conceived. This experience appeared to challenge an element of Stacy's character, which surrounded the notion of control. For instance, Stacy said:

"We had actually stopped trying that month. We were like, let's just have a month off, because the next month we were going to be seen by the fertility specialist... so we were like... let's just not even try... you know, not even think about it... and that's when it happened. It's like it's not natural to be so obsessed about it" [Stacy].

There appeared to be an element of exhaustion that accompanied Stacy's obsession around 'getting pregnant.' It seemed that the disappointment that Stacy endured each month may have drained her from the resources that she had to maintain control, which resulted in her ability to let go. As a result, losing control seemed to bring about an experience of meaningfulness into Stacy's life and allowed her notice the calm that accompanies release. Interestingly, researchers (Lub-Moss, Eurelings-Bontekoe, 1997) discovered that individuals who strive for perfectionism may become distressed when trying to get pregnant because their over-controlled life is disturbed. This notion may fit with Stacy's experience, which was captured in the following:

“And look... it’s so up and down as well emotionally I found it really hard to kinda cope with the sadness every month when it wasn’t happening. I think I had to learn that I couldn’t control it and it was just nature and I got to that point when she was actually conceived and I felt like it was meant to be... felt a lot calmer... even though I was still pretty stressed (laughs) for the first two weeks. But yeah, it was quite a lead up... to actually getting pregnant” [Stacy].

It seemed that Stacy also associated her high stress job with her difficulty to conceive. It sounded as though Stacy was devoted to work, yet she also had the desire to start a family. Her desire to start a family took precedence and subsequently led to her decision to leave her current job. Medina and Magnuson (2009) pointed out that when one is unable to blend or balance work and family, it can generate cognitive dissonance. It seemed that Stacy did experience a degree of cognitive dissonance when coming to terms with change. After time however, this change seemed to bring a sense of harmony into her life and settle her somewhat ‘highly strung’ character. For instance, Stacy said:

“So I’m just like a crazy manic kinda stress pot... it totally was a good thing to leave my high stress job. It totally changed who I was and as the time went on I became more accepting of it. I kinda made quite a few changes in my life... I’m much calmer. It kinda helped me become a better person I guess... life lesson. I was so really career orientated for like 10 years so... I worried that I’d lose my reputation in my job and wouldn’t get work again... But now I don’t care (laughs)” [Stacy].

Finding out:

It seemed that Stacy had constructed the expectation that she was going to require the assistance of fertility treatment to conceive. The discovery that she was pregnant therefore

seemed like a very unanticipated and overwhelming experience. For example, Stacy expressed:

“We just so didn’t believe it. It was so strange because we didn’t expect it. We’d been trying for so long... so I had a cry and I was like oh my god I’m so happy... it was cool. It was really really nice” [Stacy].

In addition, when Stacy spoke about reading the positive pregnancy test her tone contained an element of amazement and disbelief. It seemed that she had anticipated this experience to result in a negative reading, which seemed understandable considering that she had endured an entire year of disappointments. Her disbelief also seemed amplified by the fact that her reading was a ‘text book’ absolute positive. For instance, when clarifying that the positive reading showed up instantly she said:

“Like yeah, just straight away. Within about, I don’t know, as quick as it can come up. And it was really really dark as well and um, I wasn’t even four weeks... it hadn’t even been four weeks yet” [Stacy].

Stacy explained that she and her husband were not ‘technically’ trying for one month, which made me wonder why Stacy had taken a pregnancy test before her period was due. This was made clear when she explained:

“I took the test that morning because I wanted to drink lots of wine that night (Laughs) and I was like, I better do it just in case you know, because I don’t want to drink if...” [Stacy].

It seemed that Stacy was doing her best to ‘let her hair out’ and ‘let go’ for the month; yet she also seemed to display a notion of responsibility and toward her potential foetus. This was possibly because she was aware that exposure to alcohol during pregnancy increased the risk of a range of foetal conditions and a part of her may have simply been hopeful. This

pregnancy ‘check’ fits with the notions raised by Tough, Tofflemire, Clarke and Newburn-Cook (2006) who suggested that most women reduce their alcohol intake when they realize that they are pregnant.

Furthermore, Stacy aligned herself with the construct that pregnancy should be kept secret until the first trimester is complete because the earlier stages of pregnancy involve greater threat of loss. Keeping her news private however seemed to intensify the dreamlike reality that she was experiencing. For example, Stacy commented:

“I had to keep it a secret from everyone... It was kind of, quite surreal because I had to go and do hair and makeup for my friend’s wedding... and I was just so happy but I couldn’t say anything to anyone, and I also didn’t want to make it about me because it was my friend’s wedding day... so I was just like, ya know, just keep it to yourself. It’s not about you today (laughs)” [Stacy].

Stacy mentioned that she and her husband experienced ‘finding out’ together and that she had shared her news with certain family members. *“You want to just tell everybody because everyone knew that we were trying... I told my best friend that night, I showed her the picture (of the positive pregnancy test on her cell phone) when no one else was around, at the wedding, at the end. And then, she cried... like in the middle of the party (laughs)... like in the corner because she knew how much we wanted it” [Stacy].*

Somatic complaint:

Stacy spoke about her difficulty with vomiting throughout the early stages of pregnancy, which brought about a sense of isolation and loneliness into her narrative. For instance, the severity of her somatic complaint seemed to mirror that of a medical illness of which she had no choice but to hide from the outside world. Stacy explained:

“When I was 4 ½ weeks I started vomiting, once a day kinda thing... And by 6 weeks I was vomiting 7-8 times a day and that didn’t stop till the 14th week. So for 8 weeks I lay in my bed with a bucket, in the dark... I pretty much didn’t leave the house. I didn’t see any of my friends. I couldn’t talk to people... It was just like the worst hangover you’ve ever had for 8 weeks, with no break” [Stacy].

What seemed to exacerbate Stacy’s circumstance was the fact her sister had experienced vomiting throughout her pregnancy and Stacy seemed to relate to this experience.

Researchers (Haedt & Keel, 2007) indicate that it is common to relate to the experiences of relatives in first-time pregnancy, which may lead first-time mothers to believe that their pregnancy will be the same. As a result of this association Stacy appeared to take one day at a time and avoided focusing on the future. This could have restricted her ability to visualise the end of her pregnancy, with the newborn baby as an integral and crucial part. For instance, Stacy expressed:

“I didn’t eat... I lost weight and um, I just kept telling myself its gonna go away. And I didn’t know that it was... like, my sister vomited the whole way through... and I was just like, I just, I just can’t, like this is something I wanted sooo much and so I just got through every day...”[Stacy].

The extent of Stacy’s vomiting did not seem to generate feelings of ambivalence toward her developing foetus, which researchers (Fox & Yamaguchi, 1997, Thorstensen, 2000, Swallow, Lindow, Masson & Hay, 2004) have found to be common when women experience severe somatic complaints. It seemed to cause her to avoid attachment or feelings of closeness with her developing foetus because she never seemed convinced that she would end up with a baby. In addition, it seemed that Stacy’s priority throughout the early stages of pregnancy was simply getting past the un-wellness that she endured each day. Stacy explained:

“I didn’t resent the baby at all because it was something that I really really wanted, and so I would just try and remind myself... like all I could focus on was not throwing up, I didn’t even think about being pregnant really. It was just like, take it day by day get through it... I also found that I didn’t let myself get attached because I was afraid that I would lose the baby. So even though I was over the moon and felt some kind of love, I suppose initially I didn’t let myself feel much until probably when she was about 2 weeks old. That was when I actually believed that I had a baby and that everything was going to be okay” [Stacy].

The severity of Stacy’s vomiting also seemed to increase her worry and heighten her need to control what was happening to her and her baby. But Stacy could not control her vomiting which appeared to impact her ability to cope. It seemed that Stacy felt out of control and required the advice from healthcare professionals in order to restore her emotional strength and decrease her apprehension of losing the baby. Stacy spoke about her hospital visit:

“I just went for the day... and got IV fluids just to kind of make sure everything was okay because I was with an obstetrician but I didn’t see them until 10 weeks. So I just kind of wanted to make sure that everything was fine, and they reassured me that everything was fine. The baby was taking everything that it needed. But I was green...” [Stacy].

This notion made me wonder about the professional support that was made available to Stacy because her pregnancy journey thus far seemed very difficult and seemed to be something that she endured on her own. Stacy clarified my curiosity when she mentioned:

“I had an obstetrician and they actually were not that helpful, um... they were good nearer the end. But at the beginning, they were just like, oh yeah, the baby’s fine...” [Stacy].

Hearing that her baby was ‘fine’ did not seem sufficient to restore her sense of control. It seemed that Stacy required something tangible and constant which she was not getting. This

may have intensified Stacy's identification with the need to research. For example, Stacy said:

"I'm a big researcher... like I research everything, especially when I knew I was pregnant... I'd Google a lot, I read a lot of books. And so I pretty much knew everything that should have been happening on the week, each week" [Stacy].

When listening to Stacy's narrative it seemed that she had placed an expectation on her body to function like 'clock-work' or to coincide with the 'week by week' literature that she had been researching. Her need to monitor her pregnancy and her need for constant reassurance and control seemed to come to light in the following sub-theme, hyper-vigilance.

Hyper-vigilance:

Research suggests that in first-time pregnancy, foetal movements known as 'quickening' are not typically reached until 18 to 22 weeks (Barnett, 2010). Individuals who are hyper-vigilant however might recognise foetal flutters earlier or at approximately 16 weeks. Stacy experienced foetal flutters at 11 weeks, which seems to fit with the theory of hyper-vigilance. For example, *"I felt a first flutter at 11 weeks... I was lying on my tummy..." [Stacy]*. It is possible that Stacy's fear of loss contributed to her constant physiological monitoring and her ability to detect what she conceptualised as foetal flutters.

Interestingly, Stacy's hyper-vigilance appeared to stem from the medical illness, Crohn's Disease, which she has lived with for a number of years. As a result of this illness, Stacy has learnt to monitor the functioning of her body to remain well. When her body fails to function as she expects it to, she therefore experiences a loss of control. This seemed evident when she expressed her experience of trying to get pregnant and the vomiting that followed conception. Stacy explained her condition:

“Yeah, I’ve got Crohn’s disease so I’m really aware of my health and the way my body works because I monitor it with food, I don’t take medication for it. So I have always been like that. I think that’s probably part of the reason why I couldn’t mentally get past how sick I was because I was so aware of how I felt and I still am... And I think I don’t like my body to fail me... and I like to feel well” [Stacy].

Stacy went on to explain that her ability to detect foetal movements gave her back a sense of control, but this was soon shattered following an episode of bleeding. Researchers have suggested that bleeding in pregnancy can be distressing, and women may be uncertain about whether to remain hopeful or to grieve, which can bring about further anxiety and distress (Thorstensen, 2000). Stacy’s narrative seemed to resonate with this notion and in order to maintain hope she invested in a foetal doppler which appeared to provide her with immediate reassurance. For example:

“I had some bleeding at 16 weeks... so I, at that point I got a foetal Doppler, so I could hear her... I used it, pretty much every day. And most people were like don’t do it because you’ll get obsessed but I felt like it was reassuring... I needed it. It’s just, I like to be in control and I think it was quite hard for me to let go and just go with the flow... So I wanted to understand and embrace what I was going through, because I felt like this might be my only chance to have a baby, I might not get to have another one, I don’t really know. It’s not something that I can control...” [Stacy].

Although Stacy’s pregnancy was difficult, she kept this information private. It seemed that she had constructed the notion that being ungrateful or admitting the difficulty that she was experiencing may instigate a crisis in her pregnancy journey; possibly to the point of loss. As a result, she did not speak of her difficulties when in the company of friends. But putting her

needs aside only seemed to amplify the difficulties and isolation she was experiencing. Stacy explained:

“Looking back I hated being pregnant. I thought it was terrible. And I couldn’t say that at the time because it would be like I was being ungrateful... or that something would happen, so I was like, happy happy face for everyone, ya know... But the whole time I felt awful... and I’ve got a lot of friends who are waiting to do fertility treatment, like people who have been trying for like 3, 4 or 5 years and like... and I didn’t want to seem ungrateful . And I guess I never was ungrateful, it was just really hard” [Stacy].

Conclusion

Pregnancy seemed to be something of an achievement for Stacy; it challenged her character and reflected that of really bad illness. The devotion that she expressed for her baby however seemed to make her journey worth the while, for example, Stacy ended with:

“I’d do it all again in a heartbeat... I’d do it again tomorrow for her, I’d do anything. And it’s crazy like... it’s so worth it. All that vomiting... and all that, it was worth it” [Stacy].

This concludes Stacy’s narrative which will be discussed in the next segment of this chapter. Verity’s narrative follows in the next section.

Verity

Introduction

Verity is a 29-year-old married woman who identifies as New Zealand European. She lives with her husband and her 2 ½ month old daughter in the Auckland region. Verity works full-

time for the New Zealand Defence Force, and is currently on 6 months maternity leave. Her husband also works full-time for the New Zealand Defence Force.

Map of Verity's story

Over arching themes		Sub-themes
Becoming pregnant	⇒	Disappointment
	⇒	Change of attitude
Finding out	⇒	Husband's disbelief and need for tangibility
	⇒	Having a 'surprise' and impact on bonding
The secret time	⇒	Influence of the construct of loss
	⇒	Body image
Professional identity	⇒	Ambivalence
	⇒	Confronting normality

Table 4: Map of Verity's Story

Verity's story- The ordinary life.

Verity's narrative involved an element of letting go and coming to terms with her experience of living what she considers a more 'ordinary' life. The over arching themes interwoven throughout Verity's narrative to create the plot included her experience of becoming pregnant, finding out that she was pregnant, keeping the news of her pregnancy a secret and the influence that pregnancy had on her professional identity.

Becoming pregnant:

Verity and her husband had decided to start trying for a baby after their wedding, following their honeymoon. It took them approximately 6 months to conceive, which Verity conceptualised as "*not too long...*" Her recollection of this journey however seemed quite

emotional. It seemed that Verity had constructed the expectation that she would become pregnant relatively quickly. This is possibly because of the commitment she and her husband expressed to starting a family. However, Verity's expectations did not materialize each month, which seemed to decrease her ability to sustain hope. For instance, Verity expressed:

"You know, you might be late for a couple of days and you're like yes!...but no" [Verity].

The consistency of disappointment that Verity endured appeared to devastate her to the point of giving up and it seemed that adopting a 'whatever' attitude was Verity's way of managing her frustration and in a way dealing with the inability to experience success. Ironically, and much to Verity's surprise however, it seemed that her reaction to 'let go' of the commitment made conception possible. Verity found this notion amusing, almost to the point of seeming 'typical'. For instance, Verity commented:

"I was just like you know, whatever, it will happen when it happens... and as soon as I adopted that attitude, straight away we caught (Laughs)" [Verity].

It seemed that 'trying' to get pregnant had also encouraged Verity to submerge back into her former lifestyle because become it had become such a laborious task. In addition, although this lifestyle change allowed Verity to relax and conceive, it seemed that her husband had concerns about the impact of alcohol consumption during the early stages of pregnancy. Becoming pregnant therefore seemed to come with a compromise as Verity and her husband struggled to find the middle ground. Verity explained:

"My husband had said... do you think you should be going out drinking? And I was like, well... I can't stop drinking just because you know... because we are trying to have a baby. I can't stop my life... for the last 5 months I've like, you know... and then I went out on a big bender and I was 3 weeks pregnant... So yeah, I think maybe I just relaxed a little... And it

was a chore. My husband would be like... uhhh is it that time of the month again? You know, and that's not cool. And yeah, it is hard" [Verity].

Finding out:

When Verity experienced reading the positive pregnancy test it was clear that she was excited because as she spoke her tone was elevated. It became apparent however that her husband did not share the same level of excitement as he struggled to comprehend the legitimacy of the faint, but positive reading. This finding fits with the notion raised by researchers (Finnbogadottir, Svalenius & Persson, 2003) who argued that fathers commonly experience a feeling of unreality when they are informed of the positive pregnancy test reading. Verity's husband's disbelief was captured in the following:

"I came running out and I was like, two lines, two lines!!... And he's like, what's two lines? And I was like, pregnant! And he had a look and he was like...nope... one lines faded. So we went and did some blood tests, and he still wasn't one hundred percent sure we were pregnant" [Verity].

It seemed that Verity's husband required something more tangible, such as an ultra-sound image, in order to believe that his wife was pregnant with his child. Verity relates this to the fact that her husband was unable to encounter the pregnancy related cues that she was experiencing. For example:

"I think it's very hard for the men. You know I mean, I had a baby growing inside of me, you know, you feel it kicking, you're feeling the tiredness, if you have morning sickness your feeling that. The man doesn't actually experience it until the baby comes out... You know, my husband didn't believe that I was pregnant right until he saw that scan! Even after we had had the pregnancy test and the blood test that said that we were pregnant... he still didn't really like take it on until he saw that picture, you know that ultra sound" [Verity].

Verity sounded saddened as she talked about her husband's lack of excitement towards their developing foetus. What Verity may have not realised however is that her decision not to find out the sex of the baby, for example having a 'surprise,' could have further contributed to his remoteness and struggle with excitement. Verity's husband was already struggling with the reality of the pregnancy and it seemed that not knowing the baby's sex distanced him further. Researchers (Laxton-Kane & Slade, 2002) have found that several elements can delay the prenatal attachment process creating significant amounts of ambivalence, and in turn prolong the conceptualisation of the growing foetus as reality. Furthermore, although Verity's husband struggled throughout the early stages of pregnancy, she explained that he did eventually appreciate her persistence to have a surprise. For example, Verity explained:

"My husband wasn't excited... I mean he was excited but he wasn't as excited as what I was because he wanted to find out. But I just think it's such a great surprise... I think it's a great surprise for other people, not just yourself... I think it's quite traditional and old school as well... and I said to him... I'm the one that has to have it, it's my choice! (laughs). And I said to him, if the scan comes back that it's a girl, I've got to put up with you for six months being really annoyed... He has admitted that he is actually quite glad that he didn't know..."

[Verity].

The secret time:

During the first 12 weeks, Verity seemed to maintain an emotionally impartial stance towards her developing foetus. This seemed to occur because she associated the early stage of pregnancy with potential problems, which appeared to delay her experience of prenatal attachment as well as influence her decision to keep the news of her pregnancy a secret. It seemed that she had constructed the idea that it would be less complicated coping with a potential pregnancy problem in private, rather than in the public eye.

“I think it’s just so drilled into people that during the first 12 weeks there is such a high chance of problems (pause)... that I didn’t want to feel all happy, tell heaps of people and then have to go through, you know, if something happened...” [Verity].

Keeping the news of her pregnancy a secret appeared to be difficult. For example:

“It was quite hard because we weren’t telling anyone. So for the first 12 weeks it was just my husband and I really” [Verity].

This may have been influenced by the fact that her husband struggled to believe that their pregnancy was a reality. This appeared to generate a notion of loneliness during the early stage of Verity’s pregnancy journey as she had no-one to share her excitement with. Verity did mention however that she could not keep the pregnancy a secret from her mum. Verity explained that this decision was influenced by the fact that her mum lives so far away. For instance, Verity said:

“I think if she lived up here, I probably would have been able to... but because I hadn’t seen her for so long...” [Verity].

A part of me wondered however if she shared her pregnancy news with her mum because she did not want to experience this journey alone.

When discussing Verity’s social life, it seemed that she was easily able to disguise the fact that she was pregnant during the first 12 weeks. Her narrative suggested that this was because her friends were aware of the fact that she struggled with her body weight and quite frequently focused on improving her body image. For example, Verity said:

“So in the first 12 weeks when we hadn’t told anyone I kinda just told people I was still doing weight watchers and that I was trying to watch my weight and my friends were used to me

maybe not drinking because I was trying to exercise and trying to lose some weight...”

[Verity].

Although this explanation adequately maintained her secret from her friends, it seemed that Verity did have concerns about her body image. Verity appeared to struggle with what researchers (Fox & Yamaguchi, 1997) describe as a disruption to pre-pregnancy body image, which in Verity’s circumstance appeared to generate feelings of ambivalence and emotional conflict towards the pregnancy. These feelings may have transpired because her body weight was no longer under what researchers (Fox & Yamaguchi, 1997) have termed ‘voluntary control.’ For example, Verity made the comment:

“My main thing before I even got pregnant was that I was scared of putting on heaps of weight... just because I can put on weight easily as it is. And then, because I was so tired and I didn’t want to cook and my husband wanted takeaways I was like... oh man this is gonna kill me! What am I doing? Like, it was awful and I was just like... oh shoot and I kinda put on a certain amount of weight to start with and was like, if this is gonna be the carry on then I’m gonna be massive...” [Verity].

Professional identity:

It seemed that Verity struggled to inform her workplace of her pregnancy because they were going through a particularly busy period. Her struggle appeared to stem from the fact that she was extremely involved in this ‘busyness’ and found it difficult to imagine herself handing her workload over in an incomplete manner. For instance, Verity expressed:

“I was actually a bit gutted because I wanted to finish the job that I was doing because I’d worked so hard on doing it and there was only a couple more months left, you know and it wouldn’t have been a very nice position to hand over to someone. You know, I had so much stuff up in my own mind...” [Verity].

Verity's narrative appeared to capture an element of pride and responsibility in her work ethic and it seemed that the possibility of leaving her work unfinished, particularly during a time of staffing difficulties, caused her to experience guilt and a sense that she was disappointing her team mates. For example:

"I wanted to finish it... and I was so scared about telling work... you know, we had just lost another member of staff... I felt like I was going to let them down" [Verity].

Verity's narrative also contained an element of ambivalence towards her pregnancy because it restricted her from experiencing the excitement and honour associated with a potentially newfound work opportunity. Verity's ambivalence may have been amplified by the fact that she had worked so hard to prepare her workplace and therefore felt entitled to be a part of its functioning. In addition, it seemed that Verity had accepted the fact that she had not conceived and she appeared to be enjoying her break away from the disappointment of unsuccessful conception, to the point of possibly postponing her desires to start a family. Verity's ambivalence is captured in the following:

"It was hard! Because I was actually... the worst thing was because we had taken 5 or 6 months to get pregnant, and then I was like, you know, stuff it, it will happen when it happens... and I then started getting excited ... because it was potentially going to be this thing that we had never done before... And then I got pregnant straight away so... as much as I was absolutely ecstatic I had gotten pregnant... I was a little bit disappointed too because I'd worked myself up to thinking I was gonna do this..." [Verity].

When Verity mentioned that once she became a mother her role in the workplace would change, I felt an overwhelming sense of loss. Verity's construction of motherhood did not blend with the career choice that she had identified with for the last eight years.

Medina and Magnuson (2009) argue that 90 percent of women who chose to stay at home reported ambivalence about their decision. Their previous identification with their career dropped, potentially leading to unhappiness and feelings of inadequacy. This finding seemed to fit with Verity's experience; however the notion of unhappiness and inadequacy seemed to transpire before she left the workplace. For instance, Verity had become particularly attached to her role in the workplace and the professional identity that accompanied, and being transferred seemed to conflict with Verity's sense of who she was. It seemed that her newfound position did not offer a sense of pride or responsibility and it failed to stimulate Verity's identification with hard work. Consequently, the degree of tension associated with this change seemed difficult for her and appeared to bring about the desire to escape. Verity's loss is captured in the following:

"Then I went to a horrible boring office job, which I didn't like. I basically was really upset... I actually got a little stressed out about where I was going because I had been there before and didn't like it... I was actually even considering going on maternity leave straight away... because I didn't want to be there" [Verity].

It almost seemed that becoming what Verity considered 'ordinary' was frightening because she had spent so long living what she considered a life 'less' ordinary. However she did eventually indicate a notion of acceptance and took ownership of her newfound identity. For example, Verity explained:

"It's just the career that I'm in. You know, if I was just a normal person that just went to the same office everyday... you know if you got pregnant it doesn't matter but when you're in the navy it does matter and you know you have to swap jobs so... that's just part of the career choice as well" [Verity].

Conclusion:

When looking at Verity's narrative as whole, it became apparent that her overall perception of pregnancy was rather unremarkable. She had to endure months of disappointment, the first 12 weeks seemed to be a journey that she travelled alone, conception appeared to have a significant influence on her professional identity, which created a degree of ambivalence but eventually forced her to confront her concern for living what she considered an ordinary life and accept her maternal identity. The unremarkable nature of Verity's pregnancy was illustrated further in the following:

"I don't think that pregnancy is the best thing... you know, you hear women do the, pregnancy's the best thing in the world ra ra, and to be honest I really don't think it is. I mean, you're tired, I didn't have a bad pregnancy to be honest, I had a picture perfect pregnancy, but I still don't think it was the best thing in the world. You know you start putting on weight... I actually got bad skin. People go on about how you glow... I didn't glow when I was pregnant, I got bad skin and I was like how is this great? You have to watch what you eat, you can't drink... Your putting on weight, you can't wear the clothes you wanna wear..."
[Verity].

It seemed that one thing kept Verity going, which was that she would eventually have the family that she and her husband had set out to have. Verity finished with:

"I think the only enjoyment is the happiness you know that you're having a baby" [Verity].

This concludes Verity's narrative which will be discussed in the next segment of this chapter. Ruth's narrative follows.

Ruth

Introduction

Ruth is a 31-year-old married woman who identifies as New Zealand European. She lives with her husband and her three month old son in the Auckland region. Ruth works full-time as a primary school teacher, and is currently on six months maternity leave and her husband works full-time in the health industry.

Map of Ruth's story

Over arching themes		Sub-themes
Legitimacy of pregnancy	⇒	Impact of media
	⇒	Blood testing = reality and excitement
	⇒	Professional support = incongruence
Professional support	⇒	Conflicting advice
	⇒	Lack of support associated with miscarriage
	⇒	Being seen quite 'late'
Nutrition and fitness	⇒	Loosing part of self
	⇒	Impact of medical issue
Attachment difficulties	⇒	Stand in midwife = disappointment
	⇒	Sisters cancer = responsible

Table 5: Map of Ruth's Story

Ruth's story- No-one wanted to know me.

Ruth's narrative appeared to encompass an expectation for the level of support from health care professionals, which did not seem to transpire. The over arching themes interwoven throughout Ruth's narrative to create the plot included the legitimacy of her positive

pregnancy test and having it confirmed by her doctor, her problems with professional support, including concerns around the continuation of her nutrition and fitness, as well as factors that contributed to attachment difficulties.

Legitimacy of pregnancy:

Ruth's motivation to take a pregnancy test was influenced by her husband. This suggestion seemed to stem from the fact that Ruth was acting extremely out of character one evening. This particular incident involved Ruth phoning her husband late at work from the bathtub where she sat crying hysterically and complaining of sore breasts. It seemed probable that Ruth was experiencing very early pregnancy related cues because she did not mention a history of premenstrual complaints. Pregnancy also seemed a reasonable explanation because she and her husband had been 'trying' to get pregnant. Her ability to associate the probability of pregnancy with her current situation however seemed hindered, which was captured in the following:

"...but he was like, but there are two lines... if there's two lines then you're producing the hormones so you're definitely pregnant. And I'm like well you better go fetch it out of the bin then... (laughs). Then he had to take it out of the bin... and he's like woo hoo! And I'm like, nar... it's not right... nar it's not accurate (laughs)..." [Ruth].

In order to experience pregnancy related cues, Ruth had constructed the notion that a woman needed to be 'late.' In addition, Ruth seemed to associate a legitimate pregnancy with a pregnancy test reading that displayed an instant dark line. Ruth was unable to convince herself that she had legitimately conceived because these two constructs were not present. In addition, the fact that the realisation of her pregnancy was not 'movie like' seemed to amplify her uncertainty and bring about a sense of disappointment. For instance, Ruth explained:

“So anyway we sort of got... did another one. In fact we did about 5... and it was the next morning, the Monday morning when I actually got another line and it actually came up. It actually came up much much lighter... I think the movies are totally wrong on every account.... And of course I wasn't late...” [Ruth].

As Ruth continued, the uncertainty and scepticism around her pregnancy seemed to fade. This seemed to be influenced by the confirmation of a blood test, which appeared to challenge the construct that she had created and legitimised the reality of her pregnancy.

Ruth's memory of this experience however seemed to contain an element of incongruence. For instance, her narrative suggested that a part of her was attempting to embrace the excitement of her pregnancy; however another part of her was struggling to comprehend her doctor's lack of response. For instance, Ruth said:

“So then we went to the doctor and had it confirmed. Had the blood test and had it confirmed that yeah, I was pregnant, and it was sort of all very exciting. As soon as we had that blood confirmed for us it was like wow... I'm pregnant! ...But then they just leave you! Like no-one wanted to know me...” [Ruth].

The news of her pregnancy seemed to bring about a notion of shock and rejection. The level of professional support that Ruth had expected, which involved feeling guided and supported, did not transpire, which left her feeling a sense of abandonment. Consequently, the lack of professional support became a central component to Ruth's narrative, which will be presented in the following segment.

Professional support:

Ruth's first issue with regards to professional support appeared to surround the lack of direction and assistance from her doctor. It seemed that Ruth had expected to be supported through the 'next stage' which appeared to involve finding a suitable lead maternity carer.

Finding the 'right' midwife seemed important to Ruth, which appeared to instigate her decision to seek the guidance of a midwifery consultant. The term midwifery consultant signified an element of expertise, which seemed to indicate to Ruth that she would be capable of finding someone to meet her maternity needs. Prior to meeting with the midwifery consultant however Ruth had already determined from the website of the company, which midwife she preferred. This notion suggested to me that Ruth was expecting to be 'let down' therefore to reduce the impact of disappointment she conducted the work herself. For example, Ruth said:

"I mean, I was quite on to it, so I went and hunted down a midwife and I saw a woman who does midwifery consultancy. Now to be honest, it's the biggest have... it's a load of crap... I chose the midwife actually... I mean she was lovely, and she wrote down a lot of information that I guess my LMC would have seen, but really we sort of covered it ourselves..." [Ruth].

Ruth found it difficult to comprehend the lack of professional support during the early stages of pregnancy. This frustration may have stemmed from Ruth's awareness around the risk of miscarriage, which seemed exacerbated by her friend's miscarriage experience. Ruth's narrative suggested that she had constructed the belief that her friend miscarried due to a lack of professional advice. This notion could therefore explain Ruth's sense of urgency to receive professional support and pregnancy related information, as this, in her mind would increase her chances of experiencing a successful pregnancy. Ruth explained:

“The biggest fear that you have... is the miscarrying thing. Particularly like looking back... my friend she miscarried at 13 weeks and I think you don’t have any real advice... A lot of my friends; their midwives didn’t want to see them until they were at least 12 weeks... I think I was seen quite late... but, it was before I was 12 weeks... but I still think I was seen quite late. It’s funny because me and mum were talking and they say that the chances of miscarriage is at its greatest up to the 13th week, and that is when your care is at its lowest” [Ruth].

Haedt and Keel (2007) pointed out that in first-time pregnancy, women may more abstractly relate to the experimental accounts of relatives and friends. And although this finding seemed to fit with Ruth’s experience, several other factors were also found to contribute to her difficulty with professional support.

Nutrition and fitness:

Ruth’s narrative was difficult to sequence. She kept bouncing back to prior happenings, and with each memory, her frustration towards the professional support that she received seemed to grow.

Ruth expressed early in her narrative that her doctor did not give her any pregnancy advice. During the later stages of her narrative however she recalled a piece of advice that her doctor had given her, which in retrospect seemed to cause her more harm than good. For instance, her doctor had advised her to ‘stop running’ which seemed to strip away at Ruth’s identity. It also seemed to have an impact on the feelings and beliefs that she had about her body. For example, Ruth explained:

“So straight away my doctors like don’t do any exercise, ya know, don’t run 16 km again... And so basically she pretty much encouraged me to give up running at that point, and I really wish now, as it’s so much harder to lose the weight after, I wish I had kept running. And, I

mean I was really tired, so it would have been hard, but I do still wish I had kept running... I don't think it's really talked about how much you can loose of yourself..." [Ruth].

When discussing her weight, Ruth also developed a sense of frustration towards her midwife, for example:

"My weight was never checked... I put on nearly 30 kilos during my pregnancy and I was never weighed once..." [Ruth].

This frustration seemed to stem from the fact that Ruth had worked hard prior to her pregnancy to maintain her body image. And consequently, when reflecting back, Ruth appeared to believe that the disruption to her pre-pregnancy body could have been avoided. Interestingly, Fox and Yamaguchi (1997) discovered that during pregnancy, some women with a normal weight prior to conception felt conflicted towards the pregnancy because their body weight was no longer under control. This generated feelings of doubt regarding their physical and sexual attractiveness. Ruth's narrative suggested that she did struggle with her image; however the tension that she experienced seemed more directed at the healthcare professionals rather than her baby. For instance:

"I think... because I had worked hard to lose a lot of weight before getting pregnant and in saying that I then had to put it on to get pregnant... If I had been given a more pregnancy diet, I think I could have stuck to that a bit better. Ya know rather than, don't eat this don't eat think... ya know what can I eat? ...It was really hard, like that's the hardest part, ya know like buying clothes, the figures all changed... its quite challenging" [Ruth].

The underlying reason for Ruth's persistence in needing greater professional support was then revealed... It became apparent that she suffered from epilepsy. As a result, she had constructed the idea that during pregnancy, health care professionals would provide her with additional support as she seemed to believe that this illness could potentially have an impact

on her developing foetus. Her epilepsy was not taken as seriously which seemed to invite feeling of rejection as well as a notion of disbelief regarding the care provided by the health care system. For instance, Ruth revealed:

“And the other thing too at the start was that they think I’ve got epilepsy. I’ve only ever had two seizures, so it’s not very bad at all, like totally minor, and those were triggered by... um that’s why I worked so hard to try to be fit and stuff... So that was hard too, because we had been to pre-pregnancy counselling over with the neurologist in the city, and like all of this stuff, you get pregnant, no one cares.... No one wants to know... So I think because of the epilepsy thing I had the idea that we would be sort of like cared for and given lots of information and things like that but we really weren’t” [Ruth].

Attachment difficulties:

Ruth explained that she had a stand-in midwife for her first two midwifery appointments. During one of these appointments the midwife suggested to Ruth that they listen for a foetal heartbeat with the doppler. Similarly to ultrasound scanning, it could be argued that hearing the baby’s heartbeat would encourage thoughts about the health of the foetus and increase prenatal attachment and a sense that the baby is real (Laxton-Kane & Slade, 2002). It has been argued however that ultrasound scans (and possibly foetal heartbeat monitoring) may also exacerbate uncertainty. For example, the maturity and health of the baby’s heart beat may be questioned (Pullon & Benn, 2008, National Screening Unit, 2009). In Ruth’s circumstance, the opportunity to possibly hear her baby’s heartbeat appeared to momentarily reignite her sense of excitement. After learning that it is generally impossible to detect a foetal heartbeat prior to the 12 week mark however, Ruth’s frustration returned. For example, Ruth said:

“You know how I said to you that I saw that woman twice... well one of them, she was like... well listen and we’ll see if we can hear a heart beat... and she was like, you can’t normally hear a heartbeat. And my husband was like, why did she even try? Because it’s just setting you all up for failure... It’s disappointing as well because you get your hopes up as well...”
[Ruth].

As a result, it is possible that this experience influenced Ruth’s attachment process with her developing foetus, and again amplified her frustration toward the lack of competency she saw in the health care system. Unfortunately, Ruth’s negative emotions were fuelled further at another appointment whereby her stand-in midwife asked about foetal movements. For example, Ruth continued:

“And the other thing she said to me one time was, have you felt baby move... and I said, oh well I think I did... and she goes, oh well you can’t possibly feel him move at this stage... and I was like, well why ask!! And I swear I actually, I did feel him move. But she was just, of course you can’t feel him move... My husband said after the second time... we are never seeing that woman ever again!” [Ruth].

In first-time pregnancy, foetal movements known as ‘quickening’ are not typically reached until 18 to 22 weeks (Barnett, 2010). Research suggests that second-time mothers or individuals who are hyper-vigilant however might recognise foetal flutters earlier. Due to Ruth’s medical history and constant monitoring and concern for her well-being it is very likely that she was able to detect foetal movements. Her hyper-vigilant nature however seemed minimised by her stand-in midwife, which seemed to result in the need to distance herself from the professional support she needed.

Consequently, it seemed that one day Ruth woke up and suddenly felt as though she had lost control. Her doctor took her fitness away from her, and her stand-in midwife only seemed

capable of disappointing and minimised Ruth's innate abilities. It is possible that these factors influenced Ruth's inability to experience excitement and a sense of closeness with her developing foetus, making her pregnancy journey more difficult as it progressed. In addition, what made Ruth's pregnancy journey even more difficult was that her sister was battling with cancer. Ruth expressed that she felt as though her sister's cancer diagnosis and unfortunate passing was her fault. For example, Ruth expressed:

"One morning when I was watching breakfast I remember them talking about how life and death are intertwined... and he said with death comes life in this whole cycle of life, so if you're carrying a baby its new life coming... And I just felt so bad, because my sister had cancer, and I just felt like I had signed her death warrant. I felt like I had signed it myself, because here I was pregnant... and knowing that I had that new life I was sort of worried because she was going to die and I felt that I had sort of done that... You know it's not even right that I thought that but... yeah, and then she did die... so I felt responsible..." [Ruth].

This unfortunate circumstance seemed to have an impact on Ruth's ability to feel a sense of closeness with her developing foetus, predominately because her baby was going to be a boy. The idea of having a baby girl seemed to signify to Ruth that her sister had returned to her, whereby she and her mother could continue their special triad relationship. But because her sister's spirit did not return as she had hoped or expected, she held herself accountable for the loss of her sister's spirit and ending of the unique relationship that they shared. Ruth explained:

"When I think about it, tied in with the fact that he was a boy, probably did make it harder again... I wonder if it's because my sister and I and my mum are all the same, were cut from the same fabric if you like... and then to find out that it was a boy... was really hard" [Ruth].

Conclusion:

To conclude, when Ruth's pregnancy journey came together, it seemed that she battled with the ability to experience excitement and a sense of closeness with her developing foetus. Her narrative also contained an overwhelming sense of abandonment, not only by the health care system, but because of her sister's death which seemed to spark a sense of ambivalence towards her pregnancy.

This concludes Ruth's narrative which will be discussed in the next segment of this chapter. Brooke's narrative follows.

Brooke

Introduction

Brooke is a 28-year-old married woman who identifies as New Zealand European. She lives with her husband and her one month old daughter in the Auckland region. Brooke is a full-time student and her husband works full-time for the New Zealand Defence Force.

Map of Brooke's story

Over arching themes		Sub-themes
The legitimacy of the pregnancy test	⇒	The meanings around fertility
	⇒	Influence of husband's disbelief
	⇒	Relatives influence on reality
Ultra-sound scanning opportunities	⇒	Disappointment
	⇒	Aloneness
	⇒	Reality

Bodily changes	⇒	Growing stomach = reality
	⇒	What is normal = influence of friends
Maternal identity	⇒	Sequence of events
	⇒	Competency
	⇒	Husbands interest
	⇒	Interaction with friends

Table 6: Map of Brooke's Story

Brooke's story- The anticipated sequence of events

Brooke's narrative involved the desire for strict sequencing of events, which appeared to transpire effortlessly. The over arching themes interwoven throughout Brooke's narrative to create the plot included the legitimacy of her positive pregnancy test reading, her experiences around ultra-sound scanning and bodily changes associated with pregnancy, and the ease of transition into her maternal identity.

The legitimacy of the pregnancy test:

Brooke's motivation to take a pregnancy test was influenced by an obvious change in her behaviour. It seemed that Brooke needed an explanation for acting 'out of character' and the most obvious rationalization in her mind, was that she could be pregnant. Firstly, Brooke mentioned a change in her mood. It seemed that she had constructed the notion that her uncontrollable moodiness may have been related to the influx of hormonal changes associated with early pregnancy. In addition, she appeared to conceptualise that the nature of her mood extended beyond the changes associated with premenstrual symptoms. Brooke also mentioned how she could not comprehend the fact that her body did not feel like running. Running appeared to be a part of her identity, therefore to experience this unfamiliar need to

stop seemed to further activate the suspicion that she may be pregnant. For instance, Brooke explained:

“I did the test because I was kinda like moody... and I felt like I wasn’t myself. Like, my husband had been saying to me that I was being rude to his mum (laughs)... I just couldn’t really control my feelings I guess. And then before that, we were in the Mount and I went for a run, and ya know, I love running... and I didn’t feel... like I had to stop running because I just didn’t feel like running. It was real weird” [Brooke].

Brooke explained that by the next morning she desperately needed an explanation, so she decided to take two pregnancy tests. This was the first time that Brooke and her husband had been ‘trying’ for a baby therefore the fact that they had conceived right away came as a surprise. The reason for Brooke’s surprise seemed influenced by the construction that she had around her own physiological functioning with regards to fertility. For instance, it seemed that she had associated her history of ‘unsafe sex’ and not yet conceiving with the probability of infertility. As a result, this construct appeared to generate some doubt in Brooke’s mind around the legitimacy of the positive pregnancy test reading. I found this notion interesting because of the way she described the strength of the pregnancy test lines. Brooke spoke about her reaction of ‘finding out’ in the following:

“ I had two and the second one came up and they were real strong lines... and then I was just like... oh my god... just pretty much lying there going, oh my god! I actually am... I kind of like, couldn’t believe that it happened straight away... because, you know when you kind of be not safe your whole life... you just kinda think that you can’t get pregnant. And then you’re like holy hell I am! And I was kinda thinking, do I need to do a blood test to make sure that I definitely am? So I was still doubting it kinda thing...” [Brooke].

Brooke's disbelief continued throughout the day and it seemed that she attempted to settle this feeling by conducting another pregnancy test, yet from another brand, at the non-recommended time. The test immediately indicated a positive reading, which under the un-recommended circumstance seemed to settle Brooke's doubt. However, the interaction with her husband appeared to reactivate her uncertainty towards the positive pregnancy test reading. Her husband seemed to be experiencing the most common experience of unreality which researchers (Finnbogadottir, Svalenius & Persson, 2003) have suggested occurs when the father was informed that the pregnancy test was positive. As a result, it seemed that the appraisal or interpretation of the pregnancy as a reality required something tangible, which in Brooke and her husband's case, involved the confirmation with a blood test. For instance, Brooke said:

"Later in the day I went and got one from the chemist, and I did it in the middle of the day... with a different test, and it came up straight away. And I was like, ohh, I must be... And then I told my husband and I was kinda like... so, I'll ring family planning and see if I can get a blood test or whatever... and, cause my husband was just like, oh my god, ya know, he didn't believe it either... So we both were thinking we needed to back it up with something else to make sure..." [Brooke].

Furthermore, Brooke mentioned that the moment she spoke to her older sisters about her 'possible' pregnancy, the sense that it was real returned. This seemed to be influenced by the fact that her older sister had four children. Therefore when her sister explained that positive pregnancy tests cannot lie, the explanation for her change in character and suspicion that she was pregnant was suddenly confirmed. Researchers (Haedt & Keel, 2007) have indicated that in first-time pregnancy, it is possible that the social construction of meanings about fertility may generate from the experiences of relatives (Bernardi, Keim & von der Lippe, 2007,

Haedt & Keel, 2007). Brooke's experience appeared to fit with this finding, which was captured in the following:

"And then next day I saw my sister and she said if it's positive, it's positive... if it shows up negative then it can lie, but... if it shows up positive, positive tests don't lie. So I was just like, well must be. Because she's had four children so for her to say that I was kinda like, oh yeah, that makes sense..." [Brooke].

Ultra-sound scanning opportunities:

Brooke spoke about her husband's career and how he was soon to go away. This seemed to encourage Brooke's motivation to seek a midwife early and request an ultra-sound scan because seeing her baby for the first time appeared to be something that she wanted to experience with her husband before he departed New Zealand. It seemed however that Brooke and her husband had expected to see a heartbeat, which was not possible because it was too early in the pregnancy. As a result, Brook and her husband experienced a significant amount of disappointment which had an impact on their ability to truly conceptualise their developing foetus as a reality. Researchers (Laxton-Kane & Slade, 2002) have explained that ultrasound scanning allows many parents to 'see' their unborn baby for the first time. It could be argued that this would increase prenatal attachment and a sense that the baby is real. It has also been hypothesised however that ultrasound scans may also exacerbate uncertainty. For example, the maturity of the baby's heart beat may be questioned, and the pregnancy may be less advanced than expected leading to disappointment (Pullon & Benn, 2008, National Screening Unit, 2009). This notion appeared to fit with the experience that Brooke described, for instance:

"My husband was due to go away ... so so we booked in to see a midwife and we asked for an early scan, so my husband could see the baby before he went away. So we went in and did

that but it was a bit early... all there was, was a sack. So I think it was real for him then, but not as real... yeah, we were kinda disappointed that that was all that you could see..."

[Brooke].

Fortunately, the next time that Brooke went for an ultra-sound scan, her baby's heartbeat was present. It was unfortunate however that she had to experience this special occasion on her own. During this part of Brooke's narrative I felt an overwhelming sense of incongruence. For instance, she seemed to be overwhelmed by a sense of relief and excitement; however she also seemed to be overwhelmed by a sense of aloneness. Brooke's emotions are captured in the following:

"... I went to that one by myself... I then like got in my car and had a little cry (laughs)... Yeah, so nar, it was cool because my husband told me to text him because he was in Australia... as soon as I had had it. And I was like, yeah, there's a heartbeat..." [Brooke].

Subsequently, it seemed great that she could communicate immediately after with her husband, however the physical sense of being alone appeared to dampen the beginning of her pregnancy journey.

The opportunity to see her baby's heart beating seemed to indicate to Brook that her baby was developing. Particularly when comparing with her previous scan. In addition, Brooke had also begun to notice physical changes in her bodily appearance which signified to her that the pregnancy was real. For example, Brooke mentioned:

"I think seeing the blob and the heart beat I was like yeah, there is a baby in there... and because my stomach was already starting to kinda grow, because it was quite flat before I was pregnant" [Brooke].

Bodily changes:

When listening to Brooke's narrative, it became apparent that she was quite self conscious about the physical changes that were happening to her stomach. This notion seemed interesting to me because Brooke had just started her first year at University where no-one particularly knew her. It is possible that her self-consciousness was influenced by the fact that in the Western culture there is a pressure to be slim, which researchers (Fox & Yamaguchi, 1997) have suggested can bring about worry. The disruption to Brooke's pre-pregnancy body image did not appear to generate feelings of ambivalence or emotional conflict towards the developing foetus. Instead, this notion seemed to capture more of an adaption or adjustment because due to her previous identification with exercise she simply was not used to 'having a stomach.' Brooke explained:

"I kinda hid my stomach. But then they never knew me before, so they wouldn't know if I was putting on weight or anything like that... I think because, I didn't want people looking at me. And because there's so many people at university ya know, young and old...even though I'm married, ya know, I just felt... It took me ages to get to terms with having a stomach. Even though I knew that it was a baby" [Brooke].

As mentioned previously, Brooke felt more secure when she was able to hide her growing stomach. Interestingly, Brooke mentioned that she also felt relief after each time that she went to the toilet and saw that she had 'no blood.' Brooke had no expectations of pregnancy and she had no idea what was normal therefore she seemed to abstractly relate to the pregnancy experiences of friends in order to determine the 'normality' of her pregnancy. Haedt and Keel (2007) indicate that such motivations may be altered by previous pregnancy, whereas in first-time pregnancy, women may more abstractly relate to the experimental accounts of relatives and friends

It seemed that because her friends had difficulties and that they had to take it easy that Brooke chose to do the same.

“I don’t think I ever thought what it would be like to be pregnant... I had no idea what was normal... My friend, she had a lot of bleeding when she was pregnant and um, even though her baby ended up being fine... I think, every time that I would go to the toilet I would be checking to see if there was blood or anything. And it would put my mind at ease knowing that I didn’t have any. I didn’t run or anything... when I knew I was pregnant... because I didn’t feel like it anyway, but yeah I didn’t also just in case something would happen...but yeah, I do remember always checking, no blood, oh good” [Brooke].

Maternal identity:

Researchers (Weis, Lederman, Lilly & Schaffer, 2008) have argued that women who may have to experience isolation during periods of pregnancy (e.g. due to single status, marital problems, military separation and so forth) may experience more psychological distress, vulnerability surrounding the acceptance of the baby, and the maternal identity process may be compounded by the additional responsibilities (and stressors) associated with such separations. Brooke’s narrative suggested that her experience of separation from her husband did not have an impact on her feelings towards her developing baby or her maternal identity. However she did seem bothered that her husband was not there to assist with everyday responsibilities, such as preparing meals. As a result, this appeared to generate a notion of ambivalence towards her husband. For instance, even though she knew that he was working hard, it appeared that she perceived her position as a student, who also needed to study and endure the tiredness of carrying a baby, to be significantly harder. Brooke explained:

“I think I was okay with what it was doing to my body, but, just not having my husband there, because I would come home, go to sleep and then have to get up and cook tea, and that’s

what I hated. And then study, and then ya know, I was just annoyed that he wasn't there to help me" [Brooke].

Researchers (Weis, Lederman, Lilly & Schaffer, 2008) have also suggested that the role of the partner/husband has been shown to be the most important predictor in contributing to greater satisfaction and confidence with regards to the maternal identity. It seemed however that the absence of Brooke's husband did not interfere with the confidence that she had regarding her ability to transition into motherhood. Several reasons are mentioned below.

Firstly, Brooke's narrative appeared to contain what researchers (Bernardi, Kiem & von der Lippe, 2007) have defined as a strong preference for strict sequencing of events, and it seems that becoming pregnant immediately after her wedding installed a sense of confidence in the fact that her motherhood dreams, did have the potential to become reality.

"I think I've dreamt about being a mum for ages... It's like one of my dreams ya know. Like one of my dreams was to get married... and I did that. And then my next one was to have a family" [Brooke].

Brooke's ability to transition into motherhood was then further appraised by her perceived level of competence. This perception seemed to stem from the positive interaction with her older sisters children and from her university educational experiences. For instance, Brooke explained:

"With my older sister having kids and looking after them... it's kinda made me feel more prepared and given me the belief that I will be able to do it. And then with my study as well because we are learning all that kind of stuff. Because I did an infant and toddler paper so... it made me more like excited I think, that I will be able to know more. Yeah, I think my course has helped me come to terms with it..." [Brooke].

Furthermore, although Brooke and her husband were apart, it appeared that his continuation to show signs of participation in the pregnancy by indicating his desire to understand his role as a father made her even more excited about her role as a mother. In addition, Brooke's maternal identity also seemed to fit with the construct of her social world. Interestingly, researchers (Bernardi, Keim & von der Lippe, 2007) have suggested that interactions with friends may encourage or speed up an individual's family formation motivation due to observation or conversation. They suggested that the similarity of the family status of two friends may also bring about further desire or realisation. This notion appeared similar to that of Brooke's experience, which was captured in the following:

“And also I think with having my husband so eager to want to do and learn himself... And cause lots of my friends have just had babies...” [Brooke].

And finally, Brooke indicated that she had adjusted her lifestyle prior to conception, which appeared to contribute to her level of confidence and belief that she was going to be the mother of a healthy baby. Brooke explained:

“...And I was just happy that when I found out that I was pregnant that I hadn't drunk at all... and I had been taking folic acid like months before too. So I thought that in my mind that I had done it right... and hoping for a healthy baby” [Brooke].

Conclusion:

To conclude, Brooke's narrative seemed to start with the surprise and disbelief around the immediacy of her pregnancy. Her journey then encountered an element of aloneness and frustration concerning the distance between herself and her husband. These emotions however never appeared to impact how she felt about her developing foetus and did not interrupt the emergence of her maternal identity. Subsequently, the fact that her pregnancy journey seemed to adhere to the sequence of events that she had anticipated her entire life and

the fact that so many elements were nurturing her transition into motherhood seem central to Brooke's narrative, and provided her with strength throughout her pregnancy journey.

This concludes Brooke's narrative which will be discussed further in the next segment of this chapter.

Commonalities between participant's narratives

The purpose of this segment is to present the commonalities and overlapping themes among the participants' narratives. In order to make sense of what is being told or heard however, themes have firstly been presented in a 'grid like' format. This process was organized using Richmond's (2002) narrative 'storymap' technique, which is outlined in chapter three. The themes from the storymap will then be discussed.

How first-time mothers adjusted to pregnancy:

The storymap below presents the themes that transpired around (1) getting pregnant, (2) the elements that attributed to or hindered (n) the pregnancy becoming a reality, (3) professional identity, (4) additional themes that supported the psychological adaptation to pregnancy, and lastly (5) additional themes that made adaptation more difficult.

Participant	(1)	(2)	(3)	(4)	(5)
Rose	-Immediate conception	-Ultra-sound - See heartbeat -Lack of cues (n)	-Guilt -Loss of reputation	-Immediate conception -Fathers' day	-Maternal identity
Stacy	-Giving up control	-Baby 2 weeks old -Severity of cues (n) -Medical illness (n)	-Loss of reputation		-Hyper vigilance -Somatic complaint=

					Isolation
					-Relation to sisters experience
					-Not wanting to seem ungrateful
Verity	-Giving up control	-Seeing 2 lines -Husbands disbelief (n)	-Guilt -Loss of professional identity	-Easy to hide	-Loneliness -Loss of body image control
Ruth		-Blood test -Not late (n) -Faint line (n) -Not movie like (n)			-Lack of professional support -Loss of fitness and nutrition -Loss of body image control -Sisters cancer
Brooke	-Immediate conception	-Sisters advice -Ultra-sound too early (n) -Husbands disbelief	-Self appraisal of competency -Interaction with friends/family -Husbands interest	-Aloneness -Loss of body image control -Influence of friends experiences	

Table 7: Storymap of how first-time mothers adjusted to pregnancy

(1) Getting pregnant:

When exploring Rose and Brooke's narratives it became apparent that 'getting pregnant' straight away positively influenced the psychological adaptation into pregnancy. For instance, immediate conception appeared to prevent the experience of disappointment; it supported the

preference that they both had for strict sequencing of events, and quickly settled doubts around infertility. Both participants illustrated this by saying:

“It was fun trying cause we were just trying for the first time and we didn’t have to go through the disappointment of having a test and having it negative when we were ready to get pregnant... I was just really happy that we could get pregnant. Cause I always wondered if one of us might be infertile or something...” [Rose].

“I kind of like, couldn’t believe that it happened straight away... because, you know when you kind of be not safe your whole life... you just kinda think that you can’t get pregnant. And then you’re like holy hell I am!” [Brooke].

Stacy and Verity’s narratives indicated that ‘getting pregnant’ required giving up an element of control. Both participants illustrated this by expressing:

“We had actually stopped trying that month. We were like, let’s just have a month off... so we were like... let’s just not even try... you know, not even think about it... and that’s when it happened. It’s like it’s not natural to be so obsessed about it” [Stacy].

“I was just like you know, whatever, it will happen when it happens... and as soon as I adopted that attitude, straight away we caught (Laughs)” [Verity].

(2) The elements that attributed to or hindered the pregnancy becoming a reality:

Rose, Stacy, Verity and Ruth’s narratives shared an overlapping theme which involved the need for something tangible in order to perceive their pregnancy as a reality. It was interesting to observe however that each participant required a differing ‘level’ of tangibility to psychologically comprehend that they were actually pregnant. For instance, Verity indicated that ‘seeing two lines’ on the pregnancy test was sufficient enough to feel as though her pregnancy was real. This was indicated in the following:

“I came running out and I was like, two lines, two lines!!... And he’s like, what’s two lines? And I was like, pregnant!” [Verity].

In Ruth’s narrative however the faintness of the lines on the positive pregnancy test reading, the fact that she was not late for her period and the actuality that her experience of ‘finding out’ was not movie like seemed to bring about the need for something more tangible. Ruth did however believe that her pregnancy was real following the confirmation of a ‘blood test.’ For example:

“As soon as we had that blood confirmed for us it was like wow... I’m pregnant!” [Ruth].

Rose appeared to require an ‘ultra-sound examination to see her baby’s heartbeat’ in order to feel that her pregnancy was a reality. This was because Rose did not experience any pregnancy related cues, such as, a growing stomach or vomiting. This was indicated in the following:

“...they had a scanning machine in their offices so they put me on it straight away. So she was a little baby looking thing at that stage with a little heart beat... So that made it seem all the more real...four weeks went by where ya know my belly wasn’t changing, I didn’t really have morning sickness...” [Rose].

Whereas Stacy did not believe that her pregnancy was a reality until her baby was two weeks old. It seemed that she needed to ‘physically hold her baby’ in order to establish a sense that her baby was real. This was influenced by the fact that she suffered from severe vomiting and had a constant fear that she would lose her baby. For instance, Stacy expressed:

“All I could focus on was not throwing up...I didn’t let myself feel much until probably when she was about 2 weeks old. That was when I actually believed that I had a baby and that everything was going to be okay” [Stacy].

In Brooke and Ruth's circumstances it was interesting to observe the negative consequences associated with providing tangible appraisals too early. Both participants illustrated this by expressing:

"My husband was due to go away ... so we booked in to see a midwife and we asked for an early scan... So we went in and did that but it was a bit early... all there was, was a sack. So I think it was real for him then, but not as real... yeah, we were kinda disappointed that that was all that you could see..." [Brooke].

"You know how I said to you that I saw that woman twice... well one of them, she was like... well listen and we'll see if we can hear a heart beat... and she was like, you can't normally hear a heartbeat. And my husband was like, why did she even try? Because it's just setting you all up for failure... It's disappointing as well because you get your hopes up..." [Ruth].

(3) Professional identity

Rose and Verity shared a common theme around the feelings of guilt with regards to sharing the news of their pregnancy with their workplace. This seemed to bring about some difficulty during the early stages of their pregnancy. The following quotes illustrate this commonality:

"...that's the most nervous I can ever remember being because I had only worked there a year and I was the first person ever to be pregnant at this firm and I just felt a bit stink that they had just recruited me and there I was about to go for a year" [Rose].

"I was so scared about telling work... you know, we had just lost another member of staff... I felt like I was going to let them down" [Verity].

An overlapping theme with regards to professional identity also seemed to centre around the adaptive process that took place with regards to losing one's reputation or professional identity. For instance, Stacy, Rose and Verity expressed the following:

“I was so really career orientated for like 10 years so... I worried that I’d lose my reputation in my job and wouldn’t get work again... But now I don’t care (laughs)” [Stacy].

“Just the worry of taking a year off work and how that would... like what they would think of me and how that would affect my sort of career and going back to work and that sort of thing...” [Rose].

“Then I went to a horrible boring office job, which I didn’t like. I basically was really upset... I actually got a little stressed out about where I was going because I had been there before and didn’t like it...” [Verity].

(4) Themes that supported the psychological adaptation to pregnancy

The overlapping theme identified that seemed to support the psychological adaptation to pregnancy was the interaction and timing of pregnancy in relation to the participants’ friends and family members. For instance, Rose and Brooke mentioned how this positively influenced their pregnancy journey:

“...so we talked about it a lot and friends were starting to talk about it at that stage as well... oh and um start to have babies so it was kind of the right time for us” [Rose].

“With my older sister having kids and looking after them... it’s kinda made me feel more prepared and given me the belief that I will be able to do it... And cause lots of my friends have just had babies...” [Brooke].

(5) The themes that made adaptation more difficult.

Concern for change in body image was identified in Verity, Ruth and Brooke’s narratives, which appeared to negatively influence the transition into the pregnancy journey. For example, the participants expressed:

“My main thing before I even got pregnant was that I was scared of putting on heaps of weight... just because I can put on weight easily as it is. And then, because I was so tired and I didn’t want to cook and my husband wanted takeaways I was like... oh man this is gonna kill me! What am I doing? Like, it was awful and I was just like... oh shoot and I kinda put on a certain amount of weight to start with and was like, if this is gonna be the carry on then I’m gonna be massive...” [Verity].

“I put on nearly 30 kilos during my pregnancy and I was never weighed once... I think... because I had worked hard to lose a lot of weight before getting pregnant and in saying that I then had to put it on to get pregnant...It was really hard, like that’s the hardest part, ya know like buying clothes, the figures all changed... its quite challenging” [Ruth].

“I kinda hid my stomach... I think because, I didn’t want people looking at me...even though I’m married, ya know, I just felt... It took me ages to get to terms with having a stomach. Even though I knew that it was a baby” [Brooke].

The relation to friends or family members’ pregnancy experiences appeared to have a negative influence on Stacy and Brookes pregnancy journeys. This notion was captured in the following:

“...my sister vomited the whole way through... and I was just like, I just, I just can’t, like this is something I wanted sooo much and so I just got through every day...” [Stacy].

“I don’t think I ever thought what it would be like to be pregnant... I had no idea what was normal... My friend, she had a lot of bleeding when she was pregnant and um, even though her baby ended up being fine... I think, every time that I would go to the toilet I would be checking to see if there was blood or anything” [Brooke].

The common theme of loneliness also seemed to contribute to the difficult adaptation to pregnancy. This was illustrated in Stacy, Verity and Brooke's narratives:

"So for 8 weeks I lay in my bed with a bucket, in the dark... I pretty much didn't leave the house. I didn't see any of my friends. I couldn't talk to people..." [Stacy].

"I think it's just so drilled into people that during the first 12 weeks there is such a high chance of problems (pause)... that I didn't want to feel all happy, tell heaps of people and then have to go through, you know, if something happened...It was quite hard because we weren't telling anyone. So for the first 12 weeks it was just my husband and I really"
[Verity].

"... I went to that one by myself... I then like got in my car and had a little cry (laughs)..."
[Brooke].

And lastly, it seemed that Stacy and Ruth found the pregnancy journey more difficult because of an existing medical illness. This finding was illustrated in the following:

"... I've got Crohn's disease so I'm really aware of my health and the way my body works...I think that's probably part of the reason why I couldn't mentally get past how sick I was because I was so aware of how I felt and I still am... And I think I don't like my body to fail me... and I like to feel well" [Stacy].

"...they think I've got epilepsy. I've only ever had two seizures..._So that was hard too..."
[Ruth].

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this chapter is to firstly present the message from the story in each individual narrative. The commonalities and overlapping themes will then be critically analyzed and compared to the existing literature presented in chapter two. The aim of this process is to gain insight into how the first-time mothers adjusted to pregnancy. It is hoped that this discussion will provide insights for psychological practice and the prevention of psychological disorders, and lead to appropriate recommendations for future research.

Throughout the analytical process, each storied account appeared to contain a unique significance, which fitted with Handley's (2006) notion that the adjustment to pregnancy can vary considerably. They also resonated with the argument that, even when pregnancy is planned, the process of adapting to such a life changing event is often difficult (Handley, 2006). Furthermore, although each narrative was honoured as bearing a unique significance, the analysis of the commonalities and overlapping themes provided insight into some of the shared experiences that may be considered throughout the pregnancy journey.

The message from the story of each narrative

In chapter four, each individual narrative was given a title, which drew together and integrated themes into a coherent whole to create meaning (Polkinghorne, 1995). Each title presented with a very individual message. What can be gained from these messages is presented in the following.

The story from Rose's narrative resulted in the title... *The emerging maternal identity*. The message derived from Rose's narrative indicated that the pregnancy journey will be less difficult if an individual constructs the idea that she will never be absolutely ready to have a baby because the expectations and pressure to establish a maternal identity are lessened. This attitude appeared to encourage Rose to live more in the present moment; it enabled her to embrace the emergence of her newfound identity, and reduced her worry about the future.

Stacy's title reads... *The test of character*. Similar to Rose, Stacy learnt to live just one day at a time throughout the duration of her pregnancy journey. This appeared to make the psychological adaption to pregnancy more manageable when experiencing severe vomiting. Focusing on the future generated fear around foetal loss, however focusing on the present brought about a sense of achievement for getting through each day.

Verity's narrative was titled... *The ordinary life*. The message in Verity's narrative suggested that the adaptation to pregnancy can affect professional identity; particularly when a woman's career conflicts with a woman's construction of the ideal maternal identity. In order to experience a more positive psychological adaptation to pregnancy, the woman may therefore require an element of acceptance for identity change.

Ruth's narrative was titled... *No-one wanted to know me*. This narrative seemed to indicate that the adaptation to pregnancy may be more difficult when professional support is lacking. As a consequence of Ruth perceiving her needs to be unmet, she appeared to struggle with a sense of abandonment, which may have negatively influenced the bond with her developing foetus. An important consideration may be to express pregnancy-related needs more assertively in order to influence a more positive pregnancy journey.

And lastly, the story from Brooke's narrative resulted in the title... *The anticipated sequence of events*. Overall, Brooke appeared to have a positive pregnancy journey which seemed to

be reinforced by the preciseness of the sequence of events that she had anticipated. This phenomenon may nurture the transition into motherhood and provide a sense of confidence regarding the physiological functioning of the female body and the viability of the pregnancy.

Conclusion

The overall messages obtained from these narratives indicate that for these women, living in the present throughout the pregnancy journey may lead to more positive adaptive experiences. In addition, if the maternal identity is viewed as something that emerges gradually and over time, the first-time mother may find change more manageable. Lastly, if a first-time mother is more persistent about expressing her pregnancy-related needs to healthcare professionals or additional support systems, her journey may be a more positive one and the relationship with her developing foetus enriched.

The commonalities and overlapping themes will now be critically analyzed and compared to the existing literature presented in chapter two.

Discussion of identified themes

Getting pregnant

Rose and Brooke's experience of conception without difficulty appeared to positively influence the psychological adaptation to pregnancy, constituting what researchers (Lederman & Weis, 2009) have termed a 'confirmation of femininity.' Psychologically, researchers (Mohammadi & Khalajabadi, 2001) have argued that the ability to have a child is an essential part of gender identity and that the logical conclusion that we derive from this association is 'I am because of my reproductive capacity and everything it implies.'

Conversely, the experience of prolonged conception (or infertility) could potentially threaten personal identity and self definition. This is illustrated by Stacy and Verity's narratives. The difficulty that they experienced around 'trying to get pregnant' seemed to trigger a notion of invalidation regarding their experience of femininity, which over time invited 'control like' behaviour. 'Control like' behaviour has been defined by Sternber and Soloman (2008) as attempting to treat (or control) the delay in conception by, charting the reproductive cycle, temperature monitoring, and taking hormones. Infertility studies have identified similar reactions and highlighted that 'obsessing' over becoming pregnant or attempting to 'control' conception can become psychologically exhausting (Mohammadi & Khalajabadi, 2001, Snow, 2002). The theory of psychological exhaustion was evident in Stacy and Verity's narratives, which appeared to come about after a period of 'putting their lives on hold' in an attempt to conceive. Blagdon, Dixon and Scott (2002) argue that this is very common among women. The literature did not however discuss the implications of 'taking time out' from 'trying to get pregnant' in women. The closest association was the 'distraction coping mechanism' commonly observed in men (Blagdon, Dixon & Scott, 2002). I would argue that this coping mechanism appears in women; however it comes about at the point of exhaustion, whereby psychological resources are diminished. Interestingly, Stacy and Verity expressed that psychological exhaustion lead to the 'distraction' or 'letting go' behaviour, which ironically appeared to contribute to the ability to conceive.

Pregnancy becoming a reality:

Four out of the five participants made specific reference to the point at which their pregnancy was perceived as real. These moments involved the presence of tangible appraisals which seemed to influence the perceived legitimacy of the pregnancy. Each participant however

required a differing 'level' of tangibility which seemed to be influenced by the expectations that they had constructed around pregnancy.

Researchers (Ammaniti, Baumgartner, Candelori, Perucchini, Pola, Tambelli & Zampino, 1992) have argued that the actual presence or realization that the growing foetus is an integral part of oneself does not generally transpire until an ultra-sound scan is performed, and/or once foetal movements are felt. This notion only appeared to fit with Rose's experience. For instance, it was illustrated that her lack of pregnancy-related cues were validated following an eight week ultra-sound scan whereby she could 'see' her baby's heartbeat. And although Stacy's narrative illustrated that she 'felt' foetal flutters as early as 11 weeks, her experience of severe vomiting appeared to hinder the belief that her baby was real due to her expectation of foetal loss. In contrast, Verity's narrative illustrated that 'seeing' the positive pregnancy reading was sufficient for her to believe that her pregnancy was real, and Ruth's narrative indicated that 'seeing' positive blood results adequately legitimised her pregnancy.

The narratives also illustrated that the utilization of technological equipment too early in the pregnancy could negatively influence the sense of reality that the participant had already established. For instance, Brooke believed that her pregnancy was real after discussing the positive reading with her older sister however her inability to see the baby's heartbeat at a five week scan invited a sense of uncertainty. In addition, Ruth's narrative illustrated that listening for a foetal heartbeat prior to 12 weeks with no result also negatively influenced the sense of reality that she had already established. These two findings appeared to fit with Mishel's uncertainty in illness theory (Weiss, Saks & Haris, 2001, Handley, 2006) because the participants were unable to accurately determine the meaning of the immature or absent heartbeat. Mishel's uncertainty theory argues that when elements of a stimuli frame (e.g. symptoms or cue) as well as input from available structure providers (e.g. credible authority,

education level, and social support) are not sufficient, the ability to make an appraisal or interpret the event becomes difficult, leading to uncertainty (Weiss, Saks & Haris, 2001).

Consequently, although researchers (Ammaniti, Baumgartner, Candelori, Perucchini, Pola, Tambelli & Zampino, 1992) suggest that ultra-sound scanning and/heartbeat monitors contribute to a sense that the pregnancy is real, I would argue that healthcare professions need to be cautious about the timing when using this equipment. Utilising technology too early may have the potential to negatively influence the adaptation into pregnancy and bring about unnecessary uncertainty.

Professional identity:

Rose and Verity's narratives provided an account of the difficulty associated with sharing pregnancy-related news within the workplace. They utilised phrases such as *feeling stink* and *letting down*, which captured what researchers (Medina & Magnuson, 2009) have termed ambivalence and emotional conflict regarding the pregnancy. Ambivalence has been defined as spontaneous and contradictory attitudes or feelings (as attraction and repulsion) towards an object, person or action (Kjelsvik & Gjengdal, 2011), which appeared to fit with the emotional conflict present in these two narratives. For instance, both narratives illustrated a sense of excitement towards their newfound pregnancy, yet concurrently presented a notion of guilt toward the workplace. Elloy and Smith (2004) argued that this trend links with the fact that women are now establishing careers before pursuing motherhood, which was evident in all five narratives. Therefore women are likely to experience role conflict between first-time parenthood and professional obligations (Baum, 2010). I would argue that Rose and Verity's narratives captured the concept of role conflict, which made the psychological adaptation into pregnancy more difficult.

It also became evident that the pressure to uphold one's reputation in the workplace whilst pregnant contributed to what Baum (2010) has termed role conflict between first-time parenthood and professional obligations. This concept was illustrated in Stacy, Rose and Verity's narratives, which all appeared to capture what Barnett (2010) referred to as worry regarding the loss of work opportunities. This worry appeared to relate to the loss of professional reputation, and the worry around returning to the workplace, being undervalued and assigned an unwanted position.

What supported psychological adaptation to pregnancy:

Rose and Brooke's narratives indicated that a woman's appraisal of her current life circumstance in relation to friends and relatives can influence what researchers (Lederman and Weis, 2009) term, childbearing motivation. For instance, these two narratives illustrated that the social construction of meanings about family and fertility were generated from parental and familial experiences. Rose's motivation to have children was associated with the ages that her parents had children, and Brooke's motivation was associated with her older sister's experience with having children.

These two narratives also fitted with the argument that social interactions (or friendships) can positively influence the motivation for family formation and parenthood (Bernardi, Keim & von der Lippe, 2007). For example, both narratives illustrated that interactions with friends, through conversation, encouraged family formation motivation. They also illustrated that the similarity of the family status of two friends can bring about further desire or realisation (Bernardi, Keim & von der Lippe, 2007). Subsequently, it could be argued that the combination of these two experiences (together with prompt conception and the feeling of femininity) could positively influence the adaptation into pregnancy because the desire for family formation has been validated by two sources, both family and friends.

What made psychological adaptation into pregnancy difficult:

Change in body image:

Verity, Ruth and Brooke's narratives indicated that a change in body image can be difficult during pregnancy. All three narratives illustrated a pressure to remain slim, which Fox and Yamaguchi (1997) argue is common in the Western culture. They also demonstrated what researchers (Fox & Yamaguchi, 1997) have discussed as concern regarding the possibility of disruption to their pre-pregnancy body. This finding appeared to fit with the issue raised by Fox and Yamaguchi (1997) who suggested that during pregnancy, some women with a normal weight prior to conception felt conflicted towards the pregnancy because their body weight was no longer under voluntary control. Consequently, lack of control seemed to generate feelings of doubt regarding their physical and possibly sexual attractiveness, which appeared to initiate to some extent what researchers (Kjelsvik & Gjengedal, 2011) have discussed as feelings of ambivalence and emotional conflict towards the pregnancy. It could be argued therefore that a woman's weight and perception of body image prior to pregnancy may contribute to a more positive or negative pregnancy experience.

Relating to others' pregnancy experiences:

Stacy and Brooke's narratives provided evidence that in first-time pregnancy, it is common to relate to the experiences of relatives' and friends' pregnancies. This notion was proposed by Headt and Keel (2007); however they did not indicate the positive or negative consequences of relating to another's pregnancy journey. The associations made in these two narratives appeared to lead to habitual conducts (e.g. repetitive behaviours or constant/interfering thoughts) which I would argue, had the potential to become psychologically distressing. For example, Brooke's narrative illustrated a behaviour that involved the constant checking for bleeding, which was influenced by her friend's experience. Whereas Stacy battled with the

thought that severe vomiting would last her entire pregnancy, because that is what happened to her sister. As a consequence, they both appeared to be consumed with thoughts around perceived risk and foetal loss, which Thorstensen (2000) argued can cause uncertainty, anxiety and distress. It is therefore possible that in first-time pregnancy, abstractly relating to the accounts of others may negatively influence elements of the pregnancy journey.

Loneliness:

Researchers (Weis, Lederman, Lilly & Schaffer, 2008) argued that women who experience isolation during periods of pregnancy (e.g. due to military separation) may experience more psychological distress, vulnerability surrounding the acceptance of the baby, and the maternal identity process may be compounded by the additional responsibilities (and stressors) associated with such separations. Brooke's narrative captured periods of isolation due to military separation and appeared to fit with the notion of psychological distress with regards to the experience of loneliness. For instance, her distress was illustrated when she spoke about experiencing what she conceptualised as important pregnancy milestones (such as ultra-sound scans whereby she saw the baby's heartbeat for the first time) on her own.

In addition, Handley (2006) argued that pregnant women living in rural districts may be more vulnerable to anxiety and depression because of the possibility of additional stressors (in comparison to pregnant women living in urban districts). Additional stressors included lower socio-economic status, less education, fewer social supports, and greater distances to healthcare facilities. Consequently, it could be argued that somatic complaints, such as severe vomiting, which can leave a pregnant woman house bound, may also contribute to similar vulnerabilities (such as loneliness), which was evident in Stacy's narrative.

Furthermore, although researchers (Laxton-Kane & Slade, 2002, Weis, Lederman, Lilly & Schaffer, 2008) suggested that supportive sharing and balanced aspirations from the woman's

family and friends encourages positive psychological adaptation, the decision to keep the pregnancy a secret for the first 12 weeks may restrict this from happening. For example, Verity's narrative captured an element of loneliness which did not appear to settle until she shared her news with family and friends. This finding fits with Lumley's (1982) theory who argued that these responses to early pregnancy did not appear to resolve until the more 'realistic' and 'safe' stage of pregnancy, for example the 13th week or the second trimester, had arrived.

Medical illness:

Stacy and Ruth's narratives indicated that the pregnancy journey can be negatively affected when there is also a medical illness. For instance, Stacy mentioned her struggle with Crohne's disease, and how her experience of severe vomiting during pregnancy brought about thoughts that her body was once again failing her. This experience instigated a notion of uncertainty and the need for constant reassurance regarding the health of her developing fetus. Munch (2002) argued that pregnant women with concerns, such as severe vomiting, are usually minimized by health care professionals or ignored because of the way in which female illness is socially constructed and because the actual pathophysiology and cure is unknown. Stacy's narrative suggested that the support from healthcare professionals was insufficient, which encouraged her to purchase a foetal Doppler for regular reassurance. Researchers also stated that it is important to control Crohne's disease activity before conception and during pregnancy to optimize both maternal and fetal health (Mottet, 2005). And as Stacy mentioned, she controls her condition with her diet, which it could be argued was compromised by her experience of severe vomiting. It is not surprising therefore that Stacy experienced worry around the health of her developing fetus and struggled to believe that she would carry to full term.

Ruth's narrative captured an element of frustration towards health care professionals. One area of frustration surrounded the inquiry she made regarding her epilepsy diagnosis prior to becoming pregnant. Her narrative suggested that she was aware that women with a diagnosis of epilepsy tended to have a lower fertility rate. She seemed aware that the foetus can be harmed by anti-epilepsy drugs; that the developing foetus has a two to threefold increase in congenital malformations, and that seizures can increase risk to both mother and baby (Crawford & Hudson, 2003). She mentioned however, that she did not receive any additional information or supplementary care. It could be argued that her health care professional did not feel as though her epilepsy diagnosis was severe enough to warrant concern. However, the lack of information and care seemed to negatively influence Ruth's pregnancy journey. The lack of information appeared to contribute to unnecessary worry, making her pregnancy journey more difficult.

Conclusion

The analysis of the commonalities and overlapping themes provided insight into some of the positive and negative influences around the adaptation to pregnancy. The 'timing' associated with conception appeared to influence the positive or negative experience of maternal identity. For instance, if conception occurs without delay, maternal identity and self definition is less likely to be threatened. The positive adaptation into pregnancy may also be influenced by the validation regarding the desire for family formation by both family members and friends. Ultra-sound scanning and/heartbeat monitors may also contribute to a more positive pregnancy experience because of the sense that the pregnancy is real. If technology is used too early however it may have the potential to negatively influence the adaptation into pregnancy and bring about unnecessary uncertainty.

Furthermore, because many women are now establishing careers before pursuing motherhood, they may be more likely to experience role conflict between first-time parenthood and professional obligations, which has the potential to negatively influence the pregnancy journey. The pregnancy journey of Western woman may also be negatively influenced by the pressure to remain slim. In addition, in first-time pregnancy, relating to the pregnancy experiences of others may negatively influence elements of the pregnancy journey and women who experience isolation may experience more psychological distress. And lastly, women who experience medical illness alongside pregnancy may need additional psychological support from healthcare professionals to provide reassurance and influence a more positive psychological adaptation.

Implications of the study's findings

Pregnancy is often a stressful event that brings about more profound changes than any other developmental stage of the family life-cycle (Deave, Johnson & Ingram, 2008). Even when pregnancy is planned, the process of adapting to such a life changing is often difficult (Handley, 2006). The findings from this study indicate that the pregnancy journey can begin prior to conception, and that first-time mothers may require psychological support throughout the process of trying to conceive. During the first 12 weeks, they may also benefit from the opportunity to experience tangible appraisals as well as support around identity (this may include support around physical bodily change, difficulties around professional identity and the emerging maternal identity). The opportunity to ask questions and obtain pregnancy-related information from healthcare professionals might also aid in a more positive pregnancy experience and address some of the difficulties associated with such change.

Furthermore, screening tools, such as the Edinburgh Postnatal Depression Scale, which has been validated for antenatal use (Johnson, et al, 2000) are not being used throughout antenatal care. I would argue that this would be the ideal opportunity for screening and prevention as most women are in regular contact with health care professionals (Dennis & Ross, 2006). Subsequently, even if a first-time mother does not meet the criteria for anxiety or depression during pregnancy, the screening process may provide an opportunity to discuss less distressing pregnancy related concerns, which may prevent psychological issues from developing and lead to a more positive pregnancy experience.

Limitations:

This narrative inquiry may be considered limited because of the similarities amongst the participants' demographics. For instance, each participant identified as New Zealand European, they were all married, each pregnancy was planned, and they each had established careers prior to conception. In addition, the nature of this thesis with regards to timeframe and word count limitations meant that no more than five participants could be selected. Subsequently, the field of pregnancy-related research may have benefited from a longitudinal inquiry with a greater number of participants to explore the adaptive psychological processes in more detail.

Future research

This research could be built upon in a number of ways, for instance:

- Conduct a larger scale study with wider demographics
- Seek participants with planned as well as unplanned pregnancies
- Explore the psychological experiences of men/partners involved

- Determine the level of psychological support in the community during pregnancy
- Interview healthcare professionals to explore the experiences and opinions around psychological screening and support during pregnancy

Future research could also investigate more specifically the challenges that were identified in this study, and explore how first-time mothers can be better supported throughout the first 12 weeks of pregnancy. For example, with regards to:

- The experience of ‘not trying’ to get pregnant or ‘taking a break from trying to get pregnant’ and the association with conception
- The psychological impact of utilizing technological equipment too early during pregnancy
- The challenges around the transition from professional to maternal identity and how to find balance
- The psychological impact of an existing medical illness on the pregnancy journey

As more research is conducted, it is hoped that an increased understanding of the first-12 weeks of pregnancy will promote a more positive psychological adaptation into the pregnancy journey.

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APPENDIX 1



Consent Form

Project title: *First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.*

Project Supervisor: *Sonja Goedeke*

Researcher: *Amanda Smith*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 15.04.2011
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes may be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (tick one): Yes No

Participant's signature :

Participant's name:

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 14th June 2011 AUTEK Reference number 10/107.



Participant Information Sheet

Date Information Sheet Produced:

06 April 2011

Project Title

First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.

A. An Invitation

Hello, my name is Mandie Smith and I am conducting research for my Master's thesis, which is a requirement for the Bachelor of Health Science (Masters) Psychology program at AUT University. I am hoping to explore the experiences of the first 12 weeks of pregnancy for first-time mothers.

I would like to invite you to participate in this study where you will have the opportunity to share your journey through the first 12 weeks of pregnancy with me in a conversational, story-like manner. The telling of your story may provide insights into experiences that may have taken place, subsequently leading to a greater appreciation as well as a stepping-stone for future research on the prenatal period. Your participation in this study is entirely voluntary and you will be neither advantaged nor disadvantaged whether you choose to participate or not. You are able to withdraw at any time prior to completion of data collection.

B. What is the purpose of this research?

The purpose of this research is to explore the experiences around the first trimester of pregnancy. This study will fulfill the requirements of a Master's thesis.

C. How was I identified and why am I being invited to participate in this research?

You have been invited to partake in this study through your coffee group.

If you are...

- a first-time mother who has experienced no complications leading up to conception (e.g. no previous miscarriage, conception occurs within 1 year of trying to get pregnant, no infertility treatment)
 - Do not have a post natal depression diagnosis.
 - A mother whose children are aged 3 months or less
 - Living within the Auckland region.
 - Able to communicate well in English as no translators will be available
 - Between the age of 25 and 35
-you may select yourself to be a part of this project ☺

There are no restrictions regarding ethnicity or socio-economic status. Approximately 8 participants will be involved in this study.

D. What will happen in this research?

You will be interviewed face to face by the researcher. The interview will be conducted in English at a private setting convenient to you. The interview should take approximately 90 minutes and will be audio taped with your permission. During the interview session, you will be invited to share your journey throughout the first trimester with me in a story-like manner. The environment will be informal and the interview itself will be unstructured so that you can relax and express your experiences comfortably. You are also more than welcome to bring a support person along with you to the interview.

E. What are the discomforts and risks?

The telling of your story may bring about unexpected emotions causing you to feel upset throughout the interview and maybe even afterwards.

F. How will these discomforts and risks be alleviated?

To me, interviewing is a privilege and I will do my best to make you feel comfortable and safe. If at any time you feel too upset we can take a break or if you are finding it too difficult, you are more than welcome to withdraw from the project. This can be done during the interview or via email and there will be absolutely no discrimination against you if you chose to withdraw yourself from this project. Your consent in this research indicates a sense of trust in me, the researcher; therefore I will make every effort to maintain this by adhering to ethical principles of research.

Counselling services will be available if the interview brings up issues that cause you distress. This service entitles you to three free counselling sessions. You do not have to inform me if you wish to utilize these services.

Services can be utilized on both AUT campuses as follows:

- Contact our centres at WB219 or AS104 or phone to make an appointment **09 921 9992 City Campus** or **09 921 9998 North Shore campus**
- Let the receptionist know that you are a research participant
- Provide your contact details to confirm this
- You can find out more information about AUT counsellors and the option of online counselling on AUT's website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

G. What are the benefits?

There are no direct benefits however you may feel a sense of personal growth and empowerment by sharing your experience. In addition, the documentation of your journey could assist future research on the prenatal experience and support those who are thinking of starting a family. This study may also help facilitate a better understanding and appreciation of the challenges of the first trimester.

H. How will my privacy be protected?

Every piece of information about you will be kept private and confidential. . All computerized documentation will have password protection, audiotapes and written documents will be under lock and key and unwanted information will be shredded and discarded. Your name, including any information that might reveal your identity, will be protected and changed. No part of this research will be used for any other purposes than this study and during the analysis of each transcription I will strive to ensure that my dissertation reflects a true description of your experiences.

I. What are the costs of participating in this research?

You will need to be available for approximately 90 minutes for one interview session with the researcher.

J. What opportunity do I have to consider this invitation?

You may take up to two weeks to consider this invitation from the day that you receive this information sheet in coffee group.

K. How do I agree to participate in this research?

You will need to communicate with me via email or telephone indicating your interest. We will then arrange to meet so that we can complete a written consent form and arrange an interview. Additionally, if you have any further questions I will be happy to answer them via email, telephone or when we meet.

L. Will I receive feedback on the results of this research?

You will be given an opportunity to review your interview transcripts as well as the analysis prior to finalization of the report. Your feedback will be respected and amendments will be made accordingly.

M. What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Sonja Goedeke* , sonja.goedeke@aut.ac.nz, 921 999 ext 7186.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, *Madeline Banda*, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

N. Whom do I contact for further information about this research?

Researcher: *Amanda Smith (known as Mandie)*; mandals_jandals@yahoo.com.au

021 298 2482.

Thank you for taking the time to read this information sheet. If you have any queries please do not hesitate to contact me ☺

Approved by the Auckland University of Technology Ethics Committee on *June 14 2011*, AUTECH Reference number *10/107*.

APPENDIX 3

Interview Protocol

First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.

- The interview will take place in a private location that is mutually agreed upon by the participant and the researcher.
- The participant will have the opportunity for a support person to be present throughout the entire interview.
- This interview will begin by thanking the participant for her time, followed by an introduction of myself (the researcher) and a description the study.
- The study will be explained using the information sheet as a guide to describe the purpose, how the participants were identified, and what will happen during the interview. Additionally, each participant will be reminded of the risks and discomforts, and how these can be alleviated through the AUT Counselling services.
- Counselling services will be available if the interview brings up unanticipated or upsetting issues that cause emotional distress. This service is free of charge and entitles the participant to three free sessions. Participants will also be reminded that they do not have to inform me (the researcher) if they wish to utilize these services.
- Confidentiality in the use of narrative will be maintained with the use of pseudonyms to protect participants' identity. Participants will also be reminded that they do not have to discuss certain topics if they feel uncomfortable in doing so and that they have the right to withdraw at any time - up until the point that the transcript has been viewed and acknowledged by the participant.
- The interviewing process will commence with the collection of demographic information, followed by exploratory research questions.
- Participants will be contacted via their preferred method (telephone or email) to arrange an opportunity for them to review their interview transcript if desired; transcripts will be available to read approximately 2 weeks following the interview. Feedback will be welcomed and respected, with amendments made accordingly.

APPENDIX 4

Demographic Information Sheet

First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.

It would be useful to have your demographic information for this study, **however you are not obligated to answer any questions that you are not comfortable answering.**

This can be done by yourself or together if you wish.

How old are you? _____

What is your current marital status? Single, de-facto, married, divorced, separated, widowed, other: _____ (Please circle).

What is your ethnicity? (E.g. New Zealand European): _____

How old is your baby? _____

What is your baby's gender? _____

Was your baby planned? _____

What is your occupation? _____

If applicable, what is your partners occupation? _____

APPENDIX 5

Interviewing Participants Question Guide Sheet

First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.

The main research question is ‘I’m wondering about your experiences throughout the first-12 weeks of pregnancy, where would you like to begin....’

This question is very broad and it allows the participant to start from a place in their story where they feel comfortable. Probing questions may be used as a guide for further exploration if the need arises. Where necessary, questions will ask about experiences such as:

Finding out about the pregnancy e.g.:

- I’m wondering about your life leading up to conception... Can you tell me a little bit about yourself?
- I was wondering what it was like to discover that you were pregnant for the first time.
- How did you decide to share your news with others, and when did this take place.
- Tell me about your support networks throughout the first 12 weeks.
- Was there anything that you found difficult or distressing during the first 12 weeks?
- Was there anything that you enjoyed about the first 12 weeks?
- During the first 12 weeks, how did you view motherhood, and how did this image fit with your current identity.
- During the first 12 weeks did you have to make any adjustments due to your newfound pregnancy? How did you find this?
- If you could sum up the first 12 weeks in a few words, what would be your overall perception of this period of pregnancy.

Access to information e.g.:

Tell me, how was your accessibility to pregnancy information throughout your first 12 weeks.

Experience of health care professionals e.g.:

- I'm wondering about your experiences and interactions with health care professionals (if applicable), can you talk me through that journey?
- Tell me about your ultrasound experiences and opportunities (if applicable).

These questions have been developed from current literature, with particular reference to Medina and Magnuson (2009).

APPENDIX 6



MEMORANDUM

TO Amanda Smith

FROM Kevin Baker

SUBJECT Research participants psychological support

DATE 21 April 2011

Dear

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled: *“First-time pregnancy: a journey into the psychological experiences of the first 12 weeks.”*

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project. Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone to make an appointment **09 921 9992 City Campus** or **09 921 9998 North Shore campus**
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Kevin Baker

Head of Counselling

Health, Counselling and Wellbeing

APPENDIX 7

Researcher Safety Protocol

“First-time pregnancy: a journey into the psychological experiences of the first 12 weeks”

The nature of this research may require the researcher to interview participants in their homes. To protect the safety of both parties, the following protocol will be followed:

- The researcher will inform a colleague of the research interview schedule timetable, which includes dates, times, and venues. The researcher will inform her colleague via text message on arrival and after each interview session.
- If the colleague does not hear from the researcher at the expected finishing time they are to text the researcher. If no reply the colleague is expected to phone the researcher. If still no reply and concern arises they are encouraged to inform the police.
- The researcher will ensure that she approaches each participant with respect for cultural and social sensitivity.

APPENDIX 8

Evidence of consultation with Social Group from OHbaby

From: Amanda Smith <mandals_jandals@yahoo.com.au>
To: angel_babe650@hotmail.com
Sent: Wed, 27 April, 2011 5:48:02 PM
Subject: Consultation with Social Group

Hello Mercedes,

This email is to confirm that a consultation took place today at 3pm to discuss my research project with you entitled:

"First time pregnancy: a journey into the psychological experiences of the first 12 weeks"

This is an overview of our discussion:

Mercedes is a first-time mother and is a current member of the OHbaby forum which she accessed via www.OHbaby.co.nz. This website connected Mercedes with other first-time mothers in the Auckland region who now meet regularly for coffee group to discuss their baby's development and for friendship.

During our consultation Mercedes was informed about my research project and was asked to provide feedback, with particular reference to the exploratory questions.

Mercedes felt that the exploratory questions were very relevant however she also recommended that the questions include the experience of ultrasound scans. For example, during the first 12-weeks did the participant feel satisfied with their scanning opportunities, as this was a concern for Mercedes during her pregnancy. Mercedes felt that first-time mothers with no complications is a group that is often overlooked and that the study does have relevance with regards to providing greater support for first time mothers. It was also mentioned that further studies could investigate the experience of the Father/or partner during this period.

Please let me know if there is anything that you would like to add/or correct :) If you have any questions about anything that we have discussed you are more than welcome to email or phone me.

Thank you so much for your time today and all the best with baby Marlee.

Kind regards,

Mandie Smith (PH) 0212982482

From: Mercedes Stewart <angel_babe650@hotmail.com>
To: mandals_jandals@yahoo.com.au
Sent: Wed, 27 April, 2011 6:57:00 PM
Subject: RE: Consultation with Social Group

Hi Mandie

It was nice meeting with you today to discuss your thesis idea. I think your study will definitely benefit first time mothers.

Kind regards
Mercedes Stewart

APPENDIX 9

Demographic information chart

Participant name	Age	Ethnicity	Baby's age and gender	Planned/ Unplanned pregnancy	Marital status	Occupation	Partners occupation
Rose	29	NZ European	3 months Female	Planned	Married	Solicitor	Automotive industry
Stacy	29	NZ European	3 months Female	Planned	Married	Makeup artist and hair stylist	Engineering industry
Verity	29	NZ European	2 ½ months Female	Planned	Married	Stores Accountant	Electrician
Ruth	31	NZ European	3 months Male	Planned	Married	Primary school teacher	Medic
Brooke	28	NZ European	1 month Female	Planned	Married	Student	Seaman officer