

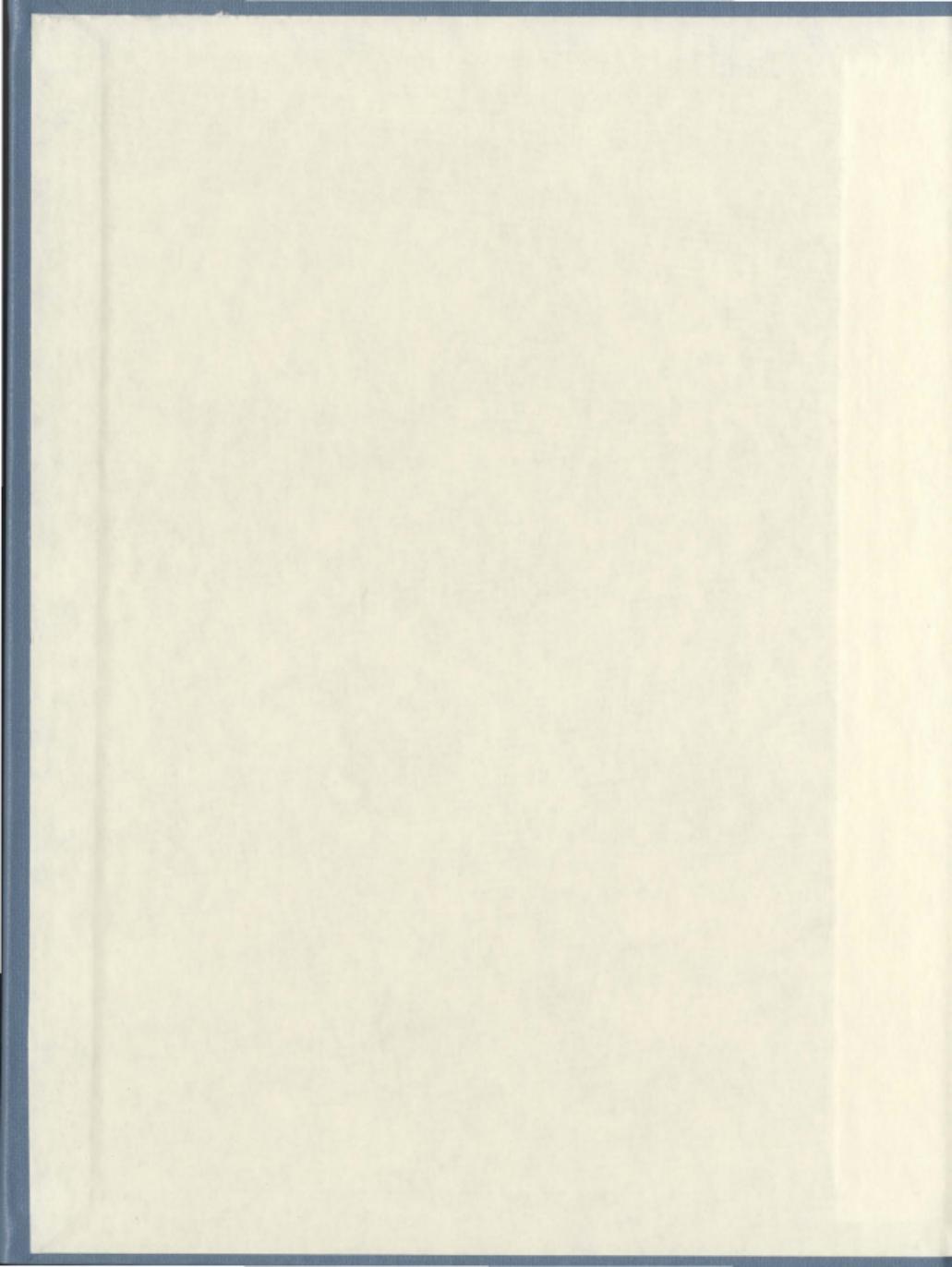
A PHENOMENOLOGICAL STUDY:
THE EXPERIENCE AND MEANING OF BEING
PREGNANT AND ON SOCIAL ASSISTANCE

CENTRE FOR NEWFOUNDLAND STUDIES

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A Phenomenological Study:
The Experience and Meaning of Being Pregnant and on Social Assistance

By: Jeanette Andrews RN BN

**Thesis submitted to the School of Graduate Studies
in partial fulfilment of the requirements for the degree of
Master of Nursing**

**School of Nursing
Memorial University of Newfoundland
St. John's, Newfoundland**

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Dedicated to:

My partner Jeff, a prince among men. And if that wasn't enough, he knows how to fix things.

My parents, Joan and Clifford Andrews. You've always "been there" for me.

My son Michael and stepson Stephen, who have never failed to remind me of what is really important in life: food, friends, and sports, in that order. I believe the women who participated in this study might agree, at least with the first two items.

ABSTRACT

Pregnancy is an important time of physical and psychological adaptation for a woman. A large body of literature has reported on the association of numerous demographic and psychosocial factors, many of which are linked to poverty, with pregnancy outcomes. Although some study results have supported this correlation, many others have shown that this association decreases or disappears when controls for confounding variables are introduced. As a result, reviewers have suggested that more qualitative studies are needed to explore the meaning of pregnancy for women living in disadvantaged circumstances, especially poverty.

This phenomenological study used van Manen's method to explore the question: What is the meaning of pregnancy in the lives of a group of eight women who are receiving social assistance? From the data collected in unstructured interviews, five themes were identified: (1) "settling in" - forging a meaningful balance; (2) giving recognition to disruptions and uncertainty; (3) living on the edge: emotional response to multiple stressors; (4) meaning of supports: facilitators of and barriers to adjustment; and (5) reflecting on the lived world. The essence of the experience was **the search for acceptance.**

The findings show the experience of pregnancy cannot be separated from the context in which the experience is occurring. Supports play a critical role in achieving acceptance of the pregnancy and in dealing with other concerns, both financial and emotional. Care providers may contribute to this process if supportive assistance is offered in a caring, non-stigmatizing way.

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CHAPTER 1

Introduction

Pregnancy is generally recognized as an important health and developmental milestone for the mother and the unborn child and a time of physical and psychological adaptation for the expectant mother (Culpepper & Jack, 1993; Dunn, 1984; Mercer, 1986; Zajicek, 1981). Further, the conditions and events surrounding pregnancy have been shown to have far reaching effects on the future of both mother and child (Avard & Hanvey, 1989; Bor, Najman, Andersen, Morrison, & Williams, 1993; Canadian Institute of Child Health, 1992; Chen, & Millar, 1999; Dunn, 1984; Stewart & Nimrod, 1993; Wadsby, Sydsjo, & Svedin, 1996).

Nurses and other care providers plan and deliver prenatal services with the goal of helping women achieve the most favourable pregnancy outcomes possible, especially for those women considered most at risk (Lundrigan, 1991). In order to work effectively with vulnerable pregnant women, nurses and others would benefit from a greater understanding of the day-to-day realities faced by these women. Understanding of another's experience contributes to insight and an ability to approach others in a way that is thoughtful and tactful (van Manen, 1990). This, in turn, may assist in developing strategies and approaches that have a greater chance for success in the prevention of poor pregnancy outcomes.

Background and Rationale

Poverty is associated with health problems generally (Mustard, 1991; Roberge, Berthelot, & Wolfson, 1995; Segovia, Edwards, & Bartlett, 1995). In 1997, the poverty rate for families living in Newfoundland and Labrador was 19.2%, the highest rate in Canada (Newfoundland & Labrador Centre for Health Information, 1998). Further, the Newfoundland Adult Health Survey found approximately 33% of all Newfoundlanders have family incomes falling within the poverty range (Segovia et al., 1996). Considered together, these statistics indicate children make up a disproportionate number of those living in poverty.

Studies have shown poverty is also associated with adverse pregnancy outcomes such as low birth weight (Canadian Institute of Child Health, 1992; Culpepper & Jack, 1993; Dunn, 1984; Kemp & Hatmaker, 1993; Luke, Williams, Minogue, & Keith, 1993; Olsen & Frische, 1993; Sable, Stockbauer, Schramm, & Land, 1990). The consequences of low birth weight are costly for the health care system and the quality of life for affected children and their families (Avard & Hanvey, 1989; Canadian Institute of Child Health, 1992; Stewart & Nimrod, 1993). When compared to children from the highest household income groups, significantly fewer children in the middle and lower income groups report very good or excellent health (Statistics Canada, Health Statistics Division, 1998). Further, the reported disability rate for Canadian children from low income families was more than twice the rate for high-income families (Oderkirk, 1993).

Canadian statistics reveal that since the early 1970s, the rate of low birth weight (LBW) has been declining (Federal, Provincial &

Territorial Advisory Committee on Population Health, 1999; Millar, Strachan, & Wadhera, 1991). However, in this country, the risk of unfavourable birth outcomes (i.e., defined as the rate of infant mortality, LBW, very LBW, prematurity, small for gestational age, and total fertility) remains strongly and consistently related to low income (Wilkins, Sherman, & Best, 1991), illustrating the need for continued study of the factors surrounding pregnancy and poverty.

In the mainly private American healthcare system, many studies have attempted to demonstrate that inadequate prenatal care, usually defined as medical care, was related to poor pregnancy outcomes (Aved, Irwin, Cummings, & Findeisen, 1993; Goldenberg et al., 1992; Lia-Hoagberg et al., 1990; Poland et al., 1990; Scupholme, Robertson, & Kamons, 1991). Limited access to prenatal medical care is generally not associated with the publicly funded Canadian system, yet poor birth outcome associated with poverty remains an issue. Further, a number of American studies point to the existence of "internal" barriers to care seeking, such as depression, denial of pregnancy, and needing time and energy to deal with other problems, rather than "external" barriers such as limited access to public clinics, lack of transportation, and long waiting times (Burks, 1992; Joyce, Diffenbacher, Greene, & Sorokin, 1983; Kalmuss & Fennelly, 1990; St. Clair et al., 1990).

A large body of literature, spanning several decades, has reported on the association of many diverse demographic and psychosocial factors with pregnancy outcomes. Many of these factors are also linked with poverty (e.g., low educational level, lack of social support, young maternal age, lone parenthood, high stress levels). The

scope of the research conducted in this area was delineated by Culpepper and Jack (1993) who developed a comprehensive framework that included at least fifty different factors that have been studied in relation to pregnancy outcomes.

While some studies have documented a correlation between a variety of demographic factors and adverse pregnancy outcomes (Ahmed, 1990; Amini, Catalano, & Mann, 1996; Hein, Burmeister, & Papke, 1990; Muhajarine, D'Arcy, & Edouard, 1997; Olsen & Frische, 1993), many other studies have shown this association decreases or disappears when controls for confounding variables are introduced (Casper & Hogan, 1990; Grindstaff & Turner, 1989; Ketterlinus, Henderson, & Lamb, 1990; Korenman, Miller, & Sjaastak, 1995; Nordentoft et al., 1996; Nordstrom & Cnattingius, 1996; Silins et al., 1985; St. John & Winston, 1989). Based on the number of studies that have questioned the link between demographic variables and adverse pregnancy outcomes, reviewers have suggested there is little to be gained by continuing to document the influence of these variables. They point to the need for more research on other factors (i.e., personality, stress, poor social support, and other stress related conditions) believed to have a more direct influence on pregnancy outcome (Culpepper & Jack, 1993; Goldenberg, Patterson, & Freese, 1992; Grindstaff & Turner, 1989; Hoffman & Hatch, 1996; Kalmuss & Fennelly, 1990; Kelly, Perloff, Morris, & Liu, 1992; Perez-Woods, 1990; St. Clair, Smerglio, Alexander, Connell, & Niebyl, 1990; St. John & Winston, 1989). In particular, more qualitative studies are needed to explore the role of these and other factors in shaping the meaning of pregnancy for women living in disadvantaged circumstances.

Problem Statement

The purpose of this study was to provide nurses and other care providers with a greater understanding of the experience and meaning of being pregnant while living in disadvantaged socioeconomic conditions. For the purposes of this study, a disadvantaged socioeconomic condition was defined as being in receipt of social assistance.

The objectives of the study were:

- (1) to describe and interpret the day-to-day lived experiences of a small group of women who were pregnant and receiving social assistance; and
- (2) to capture the meaning of this experience in such a way that nurses and others who read the text would develop new insights into the lives of these women and thereby facilitate the provision of more appropriate prenatal care.

Research Question

The study was designed to address the following research question:

What is the meaning of pregnancy in the day-to-day life of a group of women who are receiving social assistance?

CHAPTER 2

Literature Review

This literature review begins with an overview of the experience of pregnancy. The second section examines the key factors of stress and social support in relation to pregnancy outcomes and the experience of pregnancy. The final section presents a review of the literature that focused on the experience of pregnancy for pregnant women living in poverty. Special consideration is given in each section to the few available studies that used qualitative methodologies to examine aspects of women's experience.

The Experience of Pregnancy

The psychological phenomena surrounding the experience of pregnancy were first described in the literature following developments in the field of psychoanalysis (Zajicek, 1981). Interpretations of women's reactions to pregnancy have evolved over time in response to society's changing perspectives on women and new insights gained from research. Theorists have tended to describe the phenomena of pregnancy as a developmental task of the individual or of the family, with most work focusing on the tasks of the individual (Valentine, 1982). However, other writers have pointed out the need to view pregnancy within the larger sociocultural context (Badinter, 1981; Mercer, 1990; Oakley 1986; Young, 1984).

Early writers from the field of psychoanalysis described pregnancy as a positive developmental period leading to the confirmation of a woman's feminine identity (Deutsch, 1947, quoted in

Zajicek, 1981). Deutsch did acknowledge pregnant women might experience some conflicts, especially in relation to the demands of motherhood and the decreased opportunity for self expression outside motherhood, but felt these conflicts should be resolved successfully by most women during the early stages of pregnancy.

Bibring (1959), a psychoanalyst who conducted an early and much quoted study of pregnancy, found a surprising number of transient psychiatric problems among a sample of pregnant women. Drawing on the work of Erikson, she proposed a model of pregnancy as a normal developmental life "crisis", a turning point leading to acute disequilibria, similar to puberty and menopause. Bibring pointed out, like puberty and menopause, pregnancy includes endocrine and general somatic changes along with psychological changes (Bibring, Dwyer, Huntington, & Valenstein, 1961). Under favourable conditions, in which the woman has the opportunity to work through these changes in a supportive environment, resolution of the crises experienced in pregnancy resulted in specific maturational steps toward a new stage of development.

During the 1960s, research findings and clinical observations increasingly suggested the majority of women experienced doubts and conflicting emotions during pregnancy (Caplan, 1965, quoted in Zajicek, 1981; Cobliner, 1965). These findings were incorporated into models of pregnancy at the same time as there was a general re-examination of the place of women in western society (Zajicek, 1981). The findings suggested many women felt a degree of negativity during the early months of pregnancy, especially while they were coming to terms with

the prospect of motherhood and trying to resolve conflicts about it. Later in the pregnancy all but a small minority were able to resolve these feelings and came to accept the pregnancy (Caplan, 1960, quoted in Zajicek, 1981; Coblner, 1965). The view that many women experience an initial ambivalent response to pregnancy was supported by research in the area of fetal attachment (Grace, 1989; Reading, Cox, Sledmere, & Campbell, 1984; Rubin, 1970).

The pioneering researcher Bibring in her later work (Bibring et al., 1961), found the "crisis" of pregnancy was not resolved with the delivery of the child but extended into early motherhood. This finding has been supported by others (Breen, quoted in Zajicek, 1981; Oakley, 1986), leading a number of researchers to argue a woman's response to pregnancy and motherhood must be considered within the larger context of how she adjusts throughout the life cycle (Zajicek, 1981).

In the 1970s, theorists moved away from viewing pregnancy as a "crisis" and described it more in terms of a normative "transition" (Zajicek, 1981). Rubin (1970), an early nurse researcher who drew on the work of Deutsch and other psychoanalysts, stated pregnancy resulted in a change in a woman's "cognitive style" (i.e., a new way of perception, interpretation, and response to situations). Rubin described the phases of transition through which most women will proceed as moving from wanting a baby "someday", to "not now", then to "yes, me", and finally "now". This view of pregnancy as a normal transition remains prevalent in the literature up to the present time (Lederman, 1996, Mercer, 1990).

A number of researchers and theorists have described various

"maternal tasks of pregnancy" (Bibring et al., 1961; Rubin, 1975).

Bibring et al. described three intrapsychic tasks, beginning with acceptance of the pregnancy, moving to acceptance of the coming child as an individual, and finally, moving from a mother-child relationship to a peer relationship with her own mother.

Building on her earlier work, Rubin (1975) proposed four interacting maternal tasks in pregnancy: (1) seeking safe passage; (2) ensuring the acceptance of the child by significant others; (3) "binding-in" to the unknown child; and (4) learning to give of herself. Safe passage refers to the activities undertaken in order to make a "good baby", such as information seeking and lifestyle changes. Acceptance of the child, viewed as a key element by Rubin, begins with acceptance of the pregnancy and includes physical preparations as well as re-ordering of relationships. In this stage the woman becomes susceptible to any signs of rejection. Binding-in develops throughout the pregnancy, beginning with binding-in to the idea of being pregnant. Giving of oneself, according to Rubin, is one of the most intricate tasks of pregnancy, mothering, and adulthood. Rubin's theory on the tasks of pregnancy has been incorporated into more recent work of nurse researchers (e.g. Mercer, 1986, Jacques, 1995) and has been successfully used to predict future problems in the parenting role (Josten, 1981, quoted in Mercer, 1986).

Mercer (1986), another important nurse researcher in this area, described pregnancy as a nine-month period that allows the woman to restructure her life and adapt on several levels. In conjunction with the body's adaptation to the physiological demands of the fetus, the

woman adapts psychologically to the idea of being a mother, or a mother of two or more children. She also begins the necessary adjustments to incorporate the coming child into her family and social sphere. Mercer noted this adaptive process is more pronounced for the woman who is pregnant for the first time, an observation supported by others (Lederman, 1996). Mercer and other researchers have also noted that maternal adaptation during pregnancy and early motherhood was significantly influenced by the quality of the woman's relationship with her partner and her mother (Lederman, 1996; Shereshefsky & Yarrow, 1973, quoted in Mercer, 1986).

In reviewing the vast amount of literature on the topic of pregnancy, very few studies were found which described the phenomena of pregnancy from the perspective of the pregnant woman. Exceptions were Colman (1969), Young (1984), Oakley (1986), and Lederman (1996).

Colman (1969), a psychiatrist, conducted an early study describing elements of the psychological state of six women during their first pregnancy. Data were collected through field observations of a first baby support group, combined with observations on the obstetrical unit and in the home. Psychological states were collapsed into three themes: altered fields of consciousness, medical symptoms and concerns, and approaches and reactions to labour and delivery. The researcher noted that in order to understand a woman's post delivery adjustment, the "total pregnancy system" rather than the "clinic visiting woman" must be studied. This included such things as the husband's reaction to the pregnancy, the individual psychology of each woman, and her

openness to environmental and social influences.

Young (1984) provided a phenomenological discussion of her personal experiences during pregnancy, especially those related to bodily changes and encounters with the health care system. She described aspects of bodily existence unique to pregnancy (e.g., split subjectivity, de-centered, altered body integrity, etc.), and reflected upon her encounters with modern health care and physicians (i.e., alienation, pregnancy and birthing viewed as dysfunctional, objectification of the woman's experience, domination of male physicians, and need to distinguish caring from curing). Many of Young's themes centered on the medicalization of the experience of pregnancy.

Oakley (1986) provided a feminist interpretation of the experience of pregnancy and early motherhood based on interviews recorded in the mid 1970s with 60 first-time British mothers from various social backgrounds, mainly middle class. Providing many direct quotes but minimal thematic analysis and interpretation, Oakley addressed topics such as whether or why the women wanted to become pregnant, how they recognized pregnancy, what they imagined motherhood to be like, and experiences in the first year of parenthood. Like Young, a central theme in Oakley's analysis was the effects of medicalization of pregnancy, labour, and delivery.

Lederman (1996) conducted a qualitative, longitudinal study on adaptive and maladaptive responses within seven dimensions of maternal development. Subjects included 32 mainly middle class, married primigravidas. The seven dimensions were: acceptance of pregnancy, identification with a motherhood role, relationship to the mother,

relationship to the husband/partner, preparation for labour, prenatal fear of loss of control in labour, and prenatal fear of loss of self-esteem in labour. The first two dimensions were identified as relevant in the context of the current study. Lederman found acceptance of pregnancy pervaded the pregnant women's overall behaviour. Low acceptance of pregnancy was associated with unplanned pregnancy, as well as more physical discomforts, conflicts, fears, and depression. Ambivalence about being pregnant was expressed overtly in two main areas: concerns regarding financial security and changed life-style, which included motherhood-career conflicts. Ambivalence was expressed covertly in excessive complaints about physical discomforts, being depressed, and body image issues. The dimension of identification with a motherhood role was an unfolding process of moving from woman-without-child to woman-with-child. Lederman noted by the third trimester accommodation had generally occurred. Delays in the process could result from low self-esteem, excessive narcissism, lack of good role models, and motherhood-career conflict.

Lederman (1996) also reported on a second study, focusing on the same seven dimensions, conducted with 73 multigravidae. In this group Lederman found the pregnancy experience was tempered by greater familiarity with the processes and the tendency to refer to their own previous experiences rather than looking to the experiences of others. As might be expected, the multigravida was concerned with the response of her older children as well as the additional pressure on her relationship with her partner.

In summary, the literature on the experience of pregnancy has

suggested the psychological changes associated with pregnancy must be considered within the overall context of the female developmental life span, as well as the family and sociocultural environment. Current research supports the view of pregnancy as a normative transition, one that can be affected by a host of past and present circumstances, including the woman's relationships with her partner and parents, especially her mother, her feelings about her femininity, and her desire to take on the role of motherhood. Further, these circumstances can affect a woman's success in moving through the pregnancy tasks that are an important part of preparing for motherhood.

Impacts of Stress and Social Support on Pregnancy Outcomes

The importance researchers have placed on demographic and psychosocial factors in relation to the outcomes of pregnancy is indicated by the large amount of literature dealing with these issues (Culpepper & Jack, 1993). However, decades of research have failed to demonstrate a link between demographic factors and pregnancy outcome. The research provides more consistent data on the impact of health behaviours such as poor nutrition, smoking, and substance abuse. With regard to the role of psychosocial factors in influencing pregnancy outcome, the literature is inconclusive. Two of these factors, stress and social support, were found to be relevant to this study and are examined more closely in this section. The complexity of the interaction of variables and problems in defining and isolating these factors are illustrated when the results of just a few of the many studies into these key areas are examined.

Stress in Pregnancy

Mixed results on the effect of psychosocial stress on birth outcome were reported in the literature. Following a comprehensive and critical analysis of the literature published between 1986-1996, Hoffman and Hatch (1996) concluded although acute life stressors have not been shown to have direct effects on birth outcome, the literature is inconclusive on the role of chronic stress on fetal outcome. Further, Wadhwa, Sandman, Porto, Dunkel-Schetter, and Garite, (1993) found the average levels of psychosocial stress during pregnancy were significantly higher than normative adult samples, suggesting pregnancy was itself a stressful event. Because their sample consisted of white, married, middle class women, these researchers speculated psychosocial stress associated with pregnancy may be compounded for disadvantaged women.

A number of the studies reviewed found that chronic psychological stress had little or no direct effect on birthweight (Brooke, Anderson, Bland, Peacock, & Stewart, 1989; Cliver et al., 1992; Nordentoft et al., 1996). However, the study by Cliver et al. (1992) found when stress was associated with maternal thinness, there was an increased risk of a LBW infant. Further, these researchers found the increased risk of a LBW infant increased fourfold for thin women with poor psychosocial profiles who also smoked. In contrast, other studies have found stress contributed significantly and independently to early delivery and LBW (Lobel, Dunkel-Schetter, & Scrimshaw, 1992; Wadhwa et al., 1993; Wolkind, 1981).

Following their extensive review of the literature, Culpepper and

Jack (1993) conclude the theory relating stress to pregnancy is less firmly established than that relating stress to general health. These authors proposed that stress may exert an effect on pregnancy through several mechanisms. It may divert a woman's or couple's attention from pregnancy and diminish the priority of pregnancy-related issues. This diversion may result in decreased recognition of problems or may reduce the adequacy of response either through delaying or decreasing compliance with care. Stress may increase the likelihood of unhealthy coping behaviours, including smoking, substance use, inadequate rest, and excessive work. Stress may alter interpersonal relations and decrease the resources available to the woman. The problems causing stress may concomitantly result in diversion of financial assets. Finally, the effects of stress were postulated to be catecholamine, immune system, or hormonally mediated. Lobel et al. (1993) and Nordentoft et al. (1996) support the views of Culpepper and Jack (1993). These researchers concluded their findings were consistent with those studies which found the number of life events have adverse effects only when appraised by the pregnant woman as stressful.

Only one article was identified that used a qualitative method to examine women's views on stress in relation to pregnancy. Although this study is quite dated, the results were identified as relevant in light of the findings of the current study. Helper, Cohen, Beitenman, and Eaton (1968) examined women's views of what constituted a stressful life event, either during pregnancy or during their life previous to pregnancy, that might impact on their adjustment to pregnancy. The sample consisted of five different groups of American

women, mainly chosen by convenience, only one of which was a group of pregnant women. Following a review of the literature and qualitative interviews with pregnant women, the researchers drew up two lists of stressful life events. List I included events that might occur during pregnancy. List II included events that might occur in the woman's life previous to pregnancy. The women were asked to rank the items according to their perceived impact on adjustment to pregnancy. The researchers found generally good agreement between the five groups on List I. There was less agreement between the groups on List II. Four of the top five items in List I reflected rejection of the pregnancy by the father of the child or society in general. The items ranked highest from List II represented a threat to the health and viability of the expected child and/or extra demands on the mother's time.

In summary, there remains a lack of clarity in the research on the role of chronic stress in contributing to adverse pregnancy outcomes. A number of researchers have identified the need for further research to differentiate the extent to which personality and environmental factors contribute to the type of stress that influences birth outcomes (Culpepper & Jack, 1993; Lobel et al., 1993; Nordentoft et al., 1996). In the only identified study that asked women for their perception of what constituted a stressful event that could impede adjustment to pregnancy, circumstances that reflected rejection of the pregnancy by the father or society were ranked highest (Helper et al., 1968).

Social Support in Pregnancy

The literature on the role of social support in the lives of pregnant women was found to be notably inconsistent in results. Some studies found social support was not associated with improved pregnancy outcomes (Brooke et al., 1989; Casper & Hogan, 1990; Cliver et al., 1992; St. John & Winston, 1989), while others found evidence of significant improvements and/or other positive effects (Culpepper & Jack, 1993; Giblin, Poland, & Ager, 1990; Norbeck, DeJoseph & Smith, 1996; Hoffman & Hatch, 1996; Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Poland, Ager, Olson, & Sokol, 1990; Turner, Grinstaff & Phillips, 1990). Closer examination of these studies may help explain the inconsistency.

The studies by Brooke et al. (1989), Casper and Hogan (1990), and Cliver et al. (1992) used large, population-based samples and definitions of social support that lend themselves to quantitative analysis. For example, the Casper and Hogan (1990) study used a rather non-discriminating variable, "proximity to kin" and found no correlation with improved outcomes. Other researchers have pointed to the need to differentiate between different forms of social support. Aaronson (1988) found general social support was not a significant predictor of positive health behaviours during pregnancy (i.e., smoking, drinking, and caffeine consumption). On the other hand, specific perceived and received forms of support (e.g. intimacy, assistance, supportive behaviour of family members) were significant and largely independent predictors of these behaviours. Similarly, the study by Norbeck et al. (1996) used a definition of support that referred only to support from

the woman's partner and mother, a definition previously shown to be valid. Further, Schaffer and Lia-Hoagberg (1997), in their study of 101 racially mixed, low income, urban American women, found professionals such as health care providers and counsellors were not considered sources of support by the women studied.

These findings are supported by other researchers. Hodnett (1998) conducted a meta-analysis of 12 trials on the effects of programs offering social support to vulnerable pregnant women. Hodnett concluded formal support programs have not demonstrated improvements in any medical outcomes for pregnancy. Similarly, Oakley, Rajan, & Grant (1990), while demonstrating slightly improved birth outcomes in a randomized controlled program of social support, concluded that it is unlikely a formal social support program would ever override the cumulative effects of long term social disadvantage.

Only one qualitative study was identified that examined concepts relative to social support in the lives of pregnant women. Richardson (1981) reported on women's perceptions of important relationships, and whether significant changes had occurred during the course of the pregnancy. The participants were a racially mixed group of 14 married American women who were interviewed approximately monthly over the course of the pregnancy. The data analysis method, which is not clearly identified, used a scheme of independent and dependent variables to analyze statements made by participants. Each woman was asked to provide her perceptions on relationships which were important to her, to describe each of these as either stable or changing, and to evaluate each as satisfactory or unsatisfactory. The findings indicated

important relationships were with parental figures, peers, husbands, and children. Relationships were described as more changing than stable, and were experienced as more satisfactory than unsatisfactory. Two dominant themes/functions emerged: differentiation and support. Within the differentiation system, the woman helps others to reorganize for the addition of the expected baby. Within the supportive system, the woman is the recipient of the support and caring action of others. The interplay reflects the workings of the tasks of accommodation and acceptance.

In summary, although the research on the role of social support in pregnancy has shown conflicting results, the definition of social support appears to be an important factor. Studies which have defined support in terms of specific received support from the infant's father or close family members have demonstrated a closer link with improved pregnancy outcome than studies which examined formal supports or used definitions that did not include the woman's perception of the support. Very few studies have attempted to define and refine the concept of social support in relation to positive pregnancy outcomes, illustrating the need for further research in this area.

The Experience of Pregnancy in the Context of Poverty

The vast majority of studies examining pregnancy in the context of poverty have used quantitative methodologies to relate various demographic (e.g., single status, teenage, low educational level, etc.) or psychosocial factors (e.g., stress, social support, etc.), and/or health behaviours (e.g., care seeking, smoking, and substance abuse, etc.) to

pregnancy outcomes. While correlations of demographic and psychosocial characteristics may have some value in identifying risk groups, this large body of research studies has failed to explain why some women within each risk group will have good pregnancy outcomes (i.e., healthy birthweight) while others will not.

Culpepper and Jack (1993) cite studies which indicate poor women are more likely to report their pregnancies as unplanned and unwanted, described under the concept of "poor investment in pregnancy". A number of recent studies from several western countries confirm, in samples of poor pregnant women, a high proportion of pregnancies (up to 75%) were unplanned (Lia-Hoagberg et al., 1990; Lazarus, 1990; Orr & Miller, 1997). According to Culpepper and Jack, women who have a poor investment in their pregnancies are likely to continue smoking and to use alcohol and illicit drugs and to engage in other behaviours that may place the pregnancy at risk. For example, several researchers report higher smoking rates for economically disadvantaged pregnant women, ranging from 42% to 56% (Albrecht, Rosella, & Patrick, 1994; Cliver et al., 1992; Mayer, Hawkins, & Todd, 1990; Oakley et al., 1990; Way, Grainger, & Bungay, 1998). Culpepper and Jack (1993) suggest more research is needed into the phenomenon of "poor investment in pregnancy".

Similarly, Orr and Miller (1997), in their sample of 1,163 poor African-American women, reported unintended and unwanted pregnancies were significantly associated with higher levels of exposure to stressors, higher levels of depressive symptoms, and decreased social support. In this sample, 33% reported they wanted to be pregnant now,

33% reported they wanted to be pregnant later, 11% did not want to be pregnant now or in the future, and 24% were unsure. These studies point to the need for further research into why, in countries where contraception is readily available, a large proportion of pregnancies among poor women are unplanned and possibly unwanted.

A number of researchers, particularly those studying disadvantaged African-American teens, have found in some sociocultural subgroups teenage pregnancy and lone parenthood are the natural result of the complex interplay of sociocultural factors (Farber, 1991; Fernandez Kelly, 1994; Gordon, 1996; Klerman, 1993; Turner et al., 1990; Musick, 1993). Several of these writers concluded, in an environment of deprived and limited social contacts, infants are seen as one of the few sources of joy and human affirmation. Moreover, young women who lack economic and personal resources may view motherhood as a way to achieve individualization, rank, and status (Fernandez Kelly, 1994; Klerman, 1993). Thus, teenage pregnancy and lone parenthood may be both the product of disadvantage and the means through which disadvantage is perpetuated.

In conducting this literature review, very few studies were found that examined the experience of being pregnant in a disadvantaged, socioeconomic context. The exceptions were studies by Zajicek (1981) and Lazarus (1990). The literature also includes some non-research material such as commentaries and letters (Davies, 1978, original work published in 1915).

One of the earliest works which provided a poignant description of the pregnancy and mothering experiences of poor women was the

book Maternity, edited by Davies (1978, original work published 1915). This book is a historically significant record of 160 letters from British working women which provided a window into the daily lives of the poor around the turn of the century. The difficulties chronicled include: extreme poverty, poor diet, hard work, untreated medical and obstetrical conditions, inability to rest in the prenatal and postnatal period, inability to provide the basics of life for children and self, spousal abuse and alcohol addiction, and morbidity and mortality of mothers and babies due to ignorance. The accounts provided by the women were used, successfully, by the Women's Cooperative Guild to lobby for the introduction of a comprehensive package of government sponsored benefits for prenatal and postnatal women.

Zajicek (1981) reported on the findings of a study of 105 married, poor and working class women in London, England, focusing on responses to the pregnancy. Zajicek found, while 70% of participants felt positive about the pregnancy in the beginning and 72% were positive at seven months, these were not always the same women. Conflicts about being pregnant which occurred later during pregnancy were not related to whether or not the pregnancy was planned or whether the women initially felt pleased to be pregnant. Rather, the later conflicts seemed to arise directly from the woman's negative experiences of pregnancy, which the researchers felt were linked to more general reactions to womanhood (e.g., history of menstrual difficulties). In her discussion, Zajicek felt the results of her research did not support the theory of pregnancy as crisis. Rather, she suggested pregnancy be viewed as a transition, a period of movement

and change, the effects of which depend on the individual.

Lazarus (1990) provided a rare account of an ethnographic study of pregnancy in the context of poverty. A case study approach was used with a sample of 53 ethnically mixed poor women who were receiving public care in an industrial American city. Although the initial intent was to examine ethnicity and reproductive care, the focus was redirected to poverty when this factor surfaced as the more pertinent variable. The tedium of daily life emerged as a clear pattern, with women reporting their days were spent doing housework and watching television. In this context, having a baby brought meaning into their lives by bringing prestige and a sense of identity, however, their social circumstances resulted in alternating feelings of delight and depression. In addition, the findings suggested most participants had similar desires: a satisfying experience, a healthy baby, quality care, and a positive relationship with a health professional who listened and did not make them feel inadequate. Women in the sample complained of no one caring or willing to provide needed social support. While medical residents interpreted the women's failure to ask questions as disinterest, the women tended to view pregnancy and childbirth as a biomedical event that required medical management. Although they valued information and explanations, and generally had no other sources of pregnancy-related information, they felt intimidated and self-conscious and, therefore, asked few questions.

In summary, poverty has been shown to be associated with poor pregnancy outcomes and adverse effects on health in general. However, like many other socioeconomic variables, it is unlikely poverty is the

direct cause of poor pregnancy outcomes. Studies have shown poor pregnant women are more likely to experience an unwanted pregnancy and to engage in high risk behaviours, especially smoking, during pregnancy. On the other hand, for many poor pregnant women, there is prestige and a sense of identity in motherhood, alternating with ambivalent feelings due to their disadvantaged socioeconomic circumstances.

Summary of the Literature Review

Research into the experience of pregnancy has tended to support the view of pregnancy as a normal transition period within a woman's life cycle. As such, the response to pregnancy must be viewed within the context of the woman's life experience, her family situation, and the overall sociocultural environment. Research has shown, even in environments where women have control over their reproductive capacity, many still experience an initial negative response to pregnancy. For most women there is a gradual process leading to attachment to the developing child and acceptance of the mothering role.

Studies have shown poor pregnant women are more likely to experience an unwanted pregnancy and to engage in high risk behaviours during pregnancy. On the other hand, for many poor pregnant women, there is prestige and a sense of identity in motherhood, alternating with ambivalent feelings toward the pregnancy related to their disadvantaged socioeconomic circumstances.

In conducting this review a number of limitations and gaps in the

literature were noted. Studies examining the experience of pregnancy have mainly used samples of middle class women, the group most conveniently accessed by researchers and most likely to volunteer to participate in research. Thus, we do not know if the stages of adaptation and the tasks of pregnancy described by nurse researchers such as Rubin and Mercer have equal applicability to women in disadvantaged situations.

With few exceptions, the majority of studies on pregnancy and poverty have utilized quantitative methodologies, frequently using epidemiological survey designs. Studies using qualitative methodologies to describe women's experiences related to pregnancy and poverty were much fewer in number. No studies using a phenomenological approach to describe the experience of pregnancy in the context of poverty were identified in the published literature.

Many of the reported studies of pregnancy and poverty have been conducted in the United States (US). Differences in culture and funding of social programs in the US have led to variations in the approach taken by researchers. The American literature on pregnancy and disadvantage tends to focus on various ethnic groups, particularly African-Americans. In contrast, the Canadian and European literature tends to identify low socioeconomic status (SES) and/or education level as a more discriminating variable (Grindstaff & Turner, 1989; Muhajarine, D'Arcy, & Edouard, 1997; Nordentoff et al., 1996; Nordstrom & Cnattingius, 1996).

Very few studies of a qualitative nature have been conducted in which pregnant women, poor or not, have been given the opportunity to

describe, in their own words, their experiences related to pregnancy and prenatal care. No studies were identified that sought to describe the lived experience of being pregnant in a disadvantaged socioeconomic context.

CHAPTER 3

Methodology

This chapter consists of two main sections. The first section presents the research method chosen for this study, hermeneutic phenomenology as described by van Manen (1990), and the rationale for using this methodology. The remainder of the chapter describes how the phenomenological approach was used to investigate the experience of pregnancy for women living in the context of poverty.

Hermeneutic Phenomenology as a Research Method

Phenomenology is the rigorous, systematic study of human experience which aims to produce insightful descriptions of the way people experience their world (van Manen, 1990). It can be described as a human science which strives to "interpret and understand" rather than to "observe and explain" (Bergum, 1989). As a "human science", phenomenology takes as its starting point the empirical realm of everyday lived experience and the thoughts, values, feelings, emotions, purposes, and actions that make up those experiences (van Manen, 1990). This is in contrast to many quantitative research methodologies (referred to as "natural science" approaches) which focus on the objective display of behaviour without looking to the meaning behind those behaviours for that person.

As a form of qualitative research, phenomenology is somewhat different than other more commonly known research methodologies. Whereas another approach might ask, "how or why did this happen?", phenomenology asks, "what is this like for the person who is living

through it?". Phenomenology leads to a construction of meaning and, because it avoids the questions of "why" and "how", it is considered a "pre-theoretical" methodology (van Manen, 1990).

The word hermeneutics stems from the name of the Greek god, Hermes, whose task it was to communicate messages from the gods to ordinary mortals (van Manen, 1990). The term hermeneutic phenomenology captures the fact that the description of the phenomena provided by the participants is interpreted by the researcher. This aspect of interpretation is, according to van Manen, inherent in the act of writing a phenomenological description. Through the mere act of describing, the writer mediates, or interprets, the phenomena to the reader. Van Manen refers to Heidegger's view (1962, quoted in van Manen, 1990) "to interpret a text is to come to understand the possibilities of being revealed by the text" (p. 189, van Manen, 1990). He also refers to Gadamer (1975, quoted in van Manen, 1990) who points out "in interpreting a text we cannot separate ourselves from the meaning of the text" (p. 180, van Manen, 1990).

Van Manen (1990), describes the six steps of his approach to the phenomenological method:

- (1) identifying a phenomena which is of particular interest to the researcher, thereby committing the researcher to the research project;
- (2) investigation of the phenomena as it is lived by the study participants, rather than as it is conceptualized by the researcher;
- (3) identification of themes (or essences) characteristic of the

phenomena (details of this process are described in the section on data analysis);

- (4) describing the phenomena through the art of writing;
- (5) maintaining a clearly understood orientation toward the phenomena; and
- (6) balancing the research by considering both the parts and the whole.

A more detailed procedure for the conduct of these steps was obtained by reference to Hycner (1985) and is described further in the data analysis section.

Hermeneutic phenomenology has gained recognition in recent years as a qualitative research approach particularly suited to many of the concepts central to the science of nursing (e.g., health, dependency, pain, autonomy) (Oiler, 1996). The need to include the context of experience and preservation of the holistic nature of persons has directed nurse researchers to qualitative methodologies that incorporate a human science approach such as phenomenology. The research to date on pregnancy and disadvantage has not provided clear explanations of why poverty is linked to adverse pregnancy outcomes. Demographic characteristics have been seriously questioned as a valid determinant of risk. Even the psychosocial variables such as stress and social support are disputed as factors having a direct effect on pregnancy outcome. Many researchers have pointed to the need to examine other aspects of women's experience yet no studies were found that allowed disadvantaged pregnant women to say what they were experiencing in their own words. Hermeneutic phenomenology provides

a way to gain insight into the deeper meanings of lived experience and the sociocultural context in which that experience is occurring. This in turn may assist both researchers and clinicians in achieving understanding of the factors influencing the observed responses of individuals.

Population and Participants

The target population for the study was all women in Newfoundland who were pregnant and living in a disadvantaged socioeconomic environment. The accessible population was pregnant women in the greater St. John's area who were receiving social assistance. In a phenomenological study, a small number of participants is considered adequate. Eight participants were recruited for this study.

The eight study participants met the following criteria: (1) pregnant at the time of the initial interview, (2) recipients of social assistance, (3) over 18 years of age, (4) mentally competent, (5) fluent in English, and (6) willing to allow audio taping of the sessions.

Procedure

At the beginning of the data collection phase, a pilot study was conducted using two women who met all the study criteria. These two participants were recruited from the clientele of a pregnancy support program that operates in the St. John's area. The pilot study participants were later identified as appropriate for inclusion in the study.

Four of the eight participants were identified by community health nurses employed with Community Health - St. John's Region (see Appendix A and B). A number of other potential participants were referred to the researcher by community health nurses, but either could not be contacted by telephone after a number of attempts or chose not to participate, for various reasons. These reasons included: fear of being audiotaped, not interested in participating, did not keep the interview appointment, or did not return subsequent calls. Difficulty recruiting a sufficient number of participants from the clientele of community health nurses led to approaches to other agencies. One additional participant was recruited from a pregnancy support group and one was recruited by contacting a facility that offers adult education programs to people on social assistance. Nineteen potential participants were referred to the researcher from all sources, eight of whom were recruited for inclusion in the study.

Difficulty contacting and/or maintaining contact with this clientele is not an unusual problem and is commonly experienced by helping professionals, such as community health nurses. In many cases these woman are experiencing multiple problems in their day-to-day lives and may be under too much stress to feel like participating in a voluntary research project that does not meet any of their immediate felt needs.

All study participants were initially approached by an intermediary, either a community health nurse, a support worker, or a school official. The intermediary briefly described the nature of the study and obtained permission for the researcher to contact the potential participant. Some of the public health nurses gave potential

participants the introductory letter (see Appendix C), but this did not occur in all cases. The names and telephone numbers of those women who expressed an interest in participating were provided to the researcher who then contacted them by telephone. Additional explanation regarding the nature of the study was provided during the initial telephone contact, and if the woman had not been given a copy of the introductory letter, the information contained in the introductory letter was reviewed over the telephone. If the woman was still interested, a suitable interview time and location were arranged.

Three of the initial interviews took place in the participants' homes, two in the researcher's office, two in an office of the community health clinic, and one in an office at the participant's school. These locations were arranged in accordance with the wishes of each participant. In all cases, the location provided comfort and confidentiality. Occasional interruptions were experienced in three of the settings (family members, staff of the agency), but not to the extent that it was felt to interfere with the interview process.

Each interview included an introductory, warm-up period, lasting up to half an hour. During this time, the researcher reviewed the contents of the consent form and answered questions, prior to obtaining a signed consent (see Appendix D). Following this introduction, the interviews were audiotaped and lasted a minimum of 45 minutes to a maximum of 90 minutes. Participants were asked to describe their experiences of pregnancy particularly in relation to being on social assistance. Data were collected using a semi-structured interview schedule (see Appendix E).

A second interview was arranged after the data had been transcribed and an initial identification of themes had been accomplished. During the second interview, participants were asked to confirm the interpretative summary prepared by the researcher, in order to validate the researcher's interpretation of the data and, in some cases, fill in gaps in the data. Of the eight participants, seven were contacted for the second interview. One participant had moved and could not be located. The second interviews took place from seven to eleven months after the first interview. Each of these seven participants, by the second interview, had delivered their babies. All these women had live births, and the infants were in good health. Two of the babies had been delivered prematurely but, according to the mothers, were developing normally. At the time of the second interview, the ages of the infants ranged from three weeks to seven months. The interpretative summary was read to each woman and all eight confirmed that the summary accurately interpreted the circumstances of their lives at the time of the first interview, with only very minor editorial changes requested.

Interview Approach

The interview approach was designed to elicit the pregnant woman's thoughts and feelings as they related to her experience of being pregnant. Initially, participants were given the opportunity to describe their experiences without interruption. As necessary, the researcher used the questions in Appendix E to help the participant focus on the aspects of her experience appropriate for inclusion in the

study. These questions were based on areas highlighted in the literature, the researcher's clinical experience, and aspects of experience associated with phenomenological research (van Manen, 1990). Interview techniques designed to elicit further elaboration (e.g., probing, reflection, etc.) were also used.

Ethical Considerations

Prior to the commencement of this study, permission to conduct the study was requested and received from the Human Investigation Committee (HIC), Memorial University of Newfoundland (see Appendix E) and from the Ethics Committee of Community Health - St. John's Region (see Appendix A and B).

Initial contact with potential study participants was made by an intermediary. The purpose and nature of the study and the commitment involved was explained by the researcher both verbally (to allow for limited literacy skills) and in writing (see Appendix D). Participants were assured their participation was voluntary, they could withdraw from the study at any time, and their access to community health programs and services was not contingent upon their participation.

Audio tapes and other records pertaining to individual study participants were treated as confidential throughout the study and during periods of storage. During the taped interviews participants were known only by their first names. Members of the thesis committee were asked to review and discuss the pilot interviews in order to provide feedback on the researcher's interview technique. However, only the researcher was aware of the identity of participants in relation

to the raw data. The typist who transcribed the interviews was given a thorough explanation of the need for confidentiality and provided assurance to the researcher this confidentiality would be respected. Tapes and transcriptions were stored in a locked drawer. At the completion of the study, the tapes will be erased.

The type of in-depth interviewing that occurs in a phenomenological study may have short term or lasting effects on participants. If well done, the process can lead participants to a new understanding of themselves and may result in behavioural or attitudinal changes (Bergum, 1989; van Manen, 1990). If poorly done, the interview process may leave participants with feelings of frustration, anxiety, resentment, and anger, (van Manen, 1990) or embarrassment. In order to avoid any potential negative effects of participating in the study, certain guidelines were used in structuring the interview questions. The questions posed were non-leading and non-threatening. Participants were not asked direct questions about their lifestyle choices or their values. The researcher made every effort to be sensitive to discomfort on the part of participants, providing reassurance they need not discuss anything they did not wish to discuss.

A final ethical consideration related to the possibility participants might have developed a false impression or hope there was some direct benefit for them in participating in the study. This might have been assumed because they were asked to talk about their frustrations and other concerns, and inadvertently might have thought the researcher could do something about these problems. This issue was addressed

and clarified in the introductory meeting, the written consent, and repeated if necessary, during the course of the study. Where indicated and with the consent of the participant, the researcher was prepared to consult with a community health nurse about making referrals to other professionals. This did not prove necessary, although in several instances participants were referred to community health nurses for more information in relation to specific questions raised about pregnancy or child rearing.

Data Analysis

The data collected from the taped conversational interviews was reviewed by the researcher at least twice to grasp a sense of the whole. The interview was then transcribed verbatim by a typist. The researcher reviewed the verbatim transcriptions, in conjunction with listening to the tapes, to ensure accuracy of the transcripts. Additions and corrections were made, as necessary.

Using the written transcripts, the researcher read and reread the text. During this process, the researcher attempted to suspend, as much as possible, her own meanings and interpretations of the participant's world. This process is known as bracketing and phenomenological reduction (Hycner, 1985; van Manen, 1990). The actual process involved going over every word, phrase, sentence, and paragraph, and reflecting on non-verbal communications in order to delineate the units of general meaning. Initially, all general meanings were included, even redundant ones.

In the next step, the researcher applied the research question to

the previously identified units of general meaning in order to select the most appropriate ones. These statements were identified as units of relevant meaning. These units of meaning, as defined by the researcher, formed the framework from which the interpretive summaries were produced for review by the researcher's supervisor prior to being shared with study participants.

An integral part of the analysis and interpretation was the production of the written document. This process is sometimes called "working the text" (van Manen, 1990, p. 167). Van Manen (1990) describes five different formats: thematic (i.e., discussion around important elements), analytical (e.g., reconstructed life stories, anecdotes), exemplificative (i.e., systematic varying of examples), exegetical (i.e. dialoguing with other recognized phenomenological writings), and existential (i.e. the description is built around the existential concepts of time, space, the experience of the body, and social relationships) (van Manen, 1990). This study analyzed the data using a thematic format. The data analysis process was not an attempt to categorize or develop concepts but rather was used to give shape to, simplify, and make sense of various aspects of the women's experiences (Bergum, 1989; van Manen, 1990).

Through a process of writing and re-writing, the researcher, with the guidance and input of the thesis supervisor, identified the emergent themes. Eventually, the themes were developed to a point where they reflected a hermeneutical interpretation of the text, including a meaningful context for the identified themes. The content reflecting the themes was written and rewritten, as many times as

necessary, until the writing achieved the goal of communicating to the reader in a meaningful way how these women experienced being pregnant while on social assistance.

At this point, the results of the data analysis were shared with another member of the thesis committee who was experienced in phenomenological research. This person confirmed the content of the themes, as well as how they interacted to form a meaningful pattern or essence.

Credibility of Findings

One of the goals of phenomenological research is to present, in as true a format as possible, the meanings given to experiences by the study participants, not the researcher's filtered interpretations of their world (Anderson, 1989). The process whereby the researcher suspends her own beliefs and values about the world is known as "bracketing" or "reduction" (van Manen, 1990, p. 175). This process is essential if the object of a phenomenological study is to be achieved. As a novice in the field of phenomenology, the researcher worked toward this objective through close consultation with her thesis supervisor, in order to provide collaboration and reflection on the analysis (van Manen, 1990).

Other steps taken to avoid bias included:

- (1) selection of participants unknown to the researcher (Oiler, 1986),
- (2) maintaining a non-directional approach during the conversational interviews (Oiler, 1986),
- (3) sharing a draft of the interpretive summaries with the study

participants for review and comment (Kelpin, 1992; Oiler, 1986),
and

- (4) use of a field journal (Kirk & Miller, 1986).

CHAPTER 4

Findings

What is it like to be pregnant and poor? How did the women in this study experience their day to day lives? This chapter attempts to provide insight into the lived experience of eight women who were pregnant and receiving social assistance.

The chapter is divided into three sections. The first section presents a brief introduction to the study participants. The second section describes the themes that emerged from the phenomenological analysis of the data. The third section explores the essence of the experience, that is, the unique element that made the experience what it was.

Introduction to Participants

The women who agreed to participant in this study were all pregnant and receiving social assistance at the time of the interview. The stage of pregnancy ranged from approximately two to nine months. Five of the participants lived in an urban centre and three lived in a rural community not far from the urban centre. Two were pregnant for the first time. The six others had between one to four children. Five were either married or involved in an ongoing live-in relationship. One participant was a teenager. Two of the pregnancies were planned, and five of the pregnancies were unplanned and unwelcomed. One pregnancy, although unplanned, was not unwelcomed. Three participants were attending high school or high school equivalency classes at the time of the initial interview.

Thematic Analysis

In interviewing the eight women who participated in this study, it became obvious very early in each interview the woman's experience of the pregnancy could not easily be separated from other aspects of her lived world. In the space of less than two hours, each woman described in vivid detail the day-to-day events as well as some of the deeply emotional experiences that constituted her and her family's world. As a researcher, I could only conclude, for this group of women, insight into the experience of pregnancy could only be achieved by incorporating the broader context in which that experience was occurring, which included more than just the circumstances surrounding the pregnancy. The themes which follow flowed from the various experiences which the women chose to describe. These experiences represented but a small slice in time for each woman as she experienced a day to day existence that was often difficult and challenging, a summation of factors from her past, and the realities of her current situation.

"Settling In": Forging a Meaningful Balance

Living on social assistance means, by definition, living in poverty with all the difficulties this entails. Some participants viewed being on social assistance as a temporary situation in their lives and, prior to becoming pregnant, were planning to enter the workforce or were working toward obtaining the education necessary to improve their employment opportunities. Others appeared to accept the possibility they would be dependent on social services for an indefinite period.

How does a woman in this situation receive the news of pregnancy? For most study participants, the current pregnancy was an unplanned and unwelcomed event and as a result, rejection and denial of the pregnancy were typical initial responses. Their immediate reactions and emotions to the pregnancy reflected anguish and concern. For several, the initial reaction was one of shock, upset feelings, or disbelief. One woman described her reaction to the news of the pregnancy in the following manner: "When I first found out I was pregnant, I guess I kind of was in shock. It was just like, really, I was thinking, I don't want the baby. . . .It was total shock, confusion, it totally wasn't planned at all." A second woman described feeling quite upset when she first found out she was pregnant: "It was like a roller coaster. I cried most of the day. I was upset most of the day." This sentiment was also conveyed by a third woman: "I was pretty upset. I didn't want to be pregnant at the time." Still another woman, who had taken steps to prevent any future pregnancies, experienced total disbelief: "If anyone asked me if I was having any more, no, my tubes are done. And then all of a sudden I'm pregnant. I still can't get over that. It's pretty disturbing at times."

There were a number of factors that contributed to the perception of the pregnancy as a negative event. Financial worries, feeling trapped, and fear of rejection surfaced as immediate concerns for some women. One woman commented on the anticipated financial difficulties surrounding the arrival of a new baby: "The first thing that went through my mind was, how are we going to afford a baby. . . .At first it was like, we can hardly afford the babies we got, how are we

going to feed another one?" Another woman, who was just beginning to enjoy the freedom of reduced responsibilities of caring for young children, described feeling trapped: "I had them almost raised. And now I got to do it all over again." A somewhat similar comment was made by a second woman who had several children and was going through a difficult period in her relationship with the baby's father: "Now my lifestyle has gone downhill. . . I think this is a wrong period in my life. . .right now was a wrong time.

Some participants expressed a fear the pregnancy would result in rejection by important support people in their lives. One woman commented thus: "When we first told her [*mother-in-law*], I thought she was going to say, what are you doing, you can't afford it". Another woman, a teenager still living with her mother, voiced her fears about her boyfriend's mother's response to the pregnancy:

That's a lot of worry because I don't know what she is going to say. . . I'm thinking everyday, well, maybe she'll be okay. Maybe she'll ask me down for supper or, I'm thinking some days maybe she won't ever want to see me again.

This young woman's fears of rejection may have been intensified by the comments made to her by an acquaintance in her peer group, described in these words: "As soon as he found out I was pregnant, he said I was really stupid because I never thought of getting an abortion. And that makes me sick really, because who is he to say that to me".

Several women expressed sentiments that indicated, for a period of time, they had denied or rejected the pregnancy. Two women went through a lengthy period of denial about their pregnancy status. One woman, who was into her sixth month of pregnancy, made the following

comment: "Last week now was the first time I did accept it, to tell you the truth, because I couldn't get it into my head I was pregnant. Kept on saying no, it can't be." For another, acceptance came even later in the pregnancy. She said: "Well, I'm seven months now and I'm only now getting used to the idea that it's real."

For those women who experienced strong negative feelings about the pregnancy, some had considered abortion or adoption providing a further indication of the extent to which they rejected the pregnancy, at least initially. One woman commented thus: "I thought about getting an abortion and everything when I got pregnant on this one. I didn't know what to do." Another woman described similar feelings: "It got to the point at the beginning I was really contemplating having an abortion. . .or putting the baby up for adoption or something." Another woman spoke of her dilemma in dealing with her situation, not wanting to raise another child yet unable to deny the child's existence:

I more or less thought about adoption more than the abortion. But I don't think I'd have the heart to go through that. I don't think I would, knowing there's another baby out there somewhere that's mine. I don't think I could live with myself.

Although most participants reacted negatively to the pregnancy, for a number of women the pregnancy was a welcomed event. For the two women that planned their pregnancies, having a baby was seen as a source of hope and future happiness, despite having to deal with the problems posed by limited financial resources. Terms like pleasure and excitement were used to describe the pregnancy. One woman elaborated on her reasons for wanting another baby in the following manner:

The good thing for me is I want a life. I want a family. I want a life and a family. I want a family whereas when I get older, then I might have somebody within my family to take care of me.

. . . Like you don't want to be this old lady that's just left alone, put into a home somewhere. You want someone to take care of you. And I'm hoping that, with my family, I might have that somebody. Everybody needs somebody.

Another woman, recently married and anxious to begin family life with her new husband, expressed her feelings of excitement with the confirmation of her pregnancy: "I was like - yes! It was just so exciting. To tell you the truth, I can't wait for the day to come that I go in to have this baby." For another woman, whose pregnancy was unplanned but not unwelcomed, it seemed the pregnancy provided her with a focus, a plan where no plan existed, and something positive in her life: "When I found out I was pregnant, it was good news because it was so unexpected. It didn't mean my plans were ruined because I didn't have any *[plans]*."

For most of the women, the settling in period reflected a back and forth movement from being upset to excitement to tentative acceptance. One young woman commented on her vacillating feelings in the following manner: "Sometimes I get really upset. I'm really emotional. And yeah, it's still hard, but it's not as bad. I'm starting to get really excited now and I can't wait." Another woman, who was totally unprepared for the pregnancy and had considered abortion, identified the fluctuating process she experienced while moving to accept the pregnancy: "Now it's easier. It's easing up and I'm starting to learn, you know, it's not as bad. . . .It's getting more positive than what it was, put it that way." For one woman, who had initially experienced a strong rejection of the pregnancy, a threatened miscarriage was the turning point in coming to accept the pregnancy.

I think it was when I thought I was going to lose the baby. And I started thinking, what happens if we do lose the baby. I started feeling I don't want to lose the baby. . . . And then, when I thought I was going to lose the baby, it kind of got a bit easier. Not easier, it's starting to sink in, we're actually having a baby.

While an unwanted pregnancy often meant a delay in acceptance, all of them eventually "settled in" and came to accept the pregnancy. The settling in process was long or short depending on the factors promoting or impeding personal acceptance (i.e., emotional/psychological readiness) and, as will be shown later, the quality of support provided by others. Whether the pregnancy was perceived as a negative (e.g., greater financial hardship, strained relationships) or a positive event (e.g., creating a family, happiness), all of the women had to adjust to the changes, anticipated or actual, brought on by the pregnancy.

Giving Recognition to Disruptions and Uncertainty

Without exception, the women in this study described the many ways the pregnancy had impacted on their daily lives. Some of these impacts were internal: feeling more emotional, fears related to labour and delivery, fears related to the health of the baby, body image adjustments, and having to deal with uncomfortable symptoms. But, more than dealing with internal feelings and symptoms, the pending arrival of a child meant changes and adjustments would have to be made that affected the day-to-day life of the woman and her family. Again, this is true for all pregnant women, but for the women in this study, these changes often meant increased uncertainty about the future and adjustments to carefully, perhaps precariously, balanced budgets, relationships, living arrangements, and career and education

plans.

Most of the women spoke about the increased financial pressure associated with being pregnant and having a baby. One woman voiced her concerns on how difficult it was trying to manage on a limited budget while anticipating the added financial pressure of a new baby in the following way.

If you haven't got the money, you're just struggling by. . . You can't go and say, okay, well tomorrow I'm going to go out and buy five hundred dollars worth of stuff on layaway for the baby because you don't know if you're going to have it. . . It's just totally, it's a lot different. . . Because on the other two boys I always had money put away just in case of an emergency or something. Now it's like, when I go in the hospital, we're going to have to maybe get a loan of money or something.

A somewhat similar sentiment was expressed by a second woman who had planned her pregnancy but nevertheless anticipated financial problems:

And right now, I don't know where we're going to get the money. Like I said, the bills are stacked up pretty high. . . Now mind you, if it's a girl, I'm going to need major help for clothes. . . I'm not saying I don't want a little girl, but it's going to be a lot more expensive to get those things. . . We mostly need the necessity things, the little things which eventually cost a lot of money.

In addition to the participants' distress resulting from added financial pressures, the pregnancy and pending arrival of the new baby raised concerns about the potential impact on family relations. A couple of women were worried about how a new baby would affect relationships with their partners. While this may be a concern for many pregnant women, when viewed within the context of living with the stress of poverty and past difficulties with relationships, these concerns were magnified. This was articulated clearly by one woman.

Me and my husband, I guess we've always had problems, but things are a bit better. . .like we're talking a bit more and stuff. . . .Our lives are going to change again. I'm thinking, we're not going to get any time out any more, because we don't spend a lot of time together now. . . I think we got to get a little more time together now before we have another baby on top of us to look after.

Another woman, involved in a relatively new relationship, recognized the pressure on the relationship as a result of the pregnancy and felt uncertain about the future.

It's going pretty good, too good, I don't want to rush. I want to take my time. The pregnancy wasn't planned. . .I want him to move in because where he is the father. . . .But I'm not going to rush into it right now because I've got seven months left.

Although relationships with partners were important concerns, participants also commented on how their children were reacting to the pregnancy. Some women derived pleasure from knowing their children were looking forward to the baby's arrival. The following comments illustrate this perspective: "Like the kids are right excited because they're going to have a baby brother or a baby sister." "All of a sudden [*son*] comes over. . . .and puts his hand on my belly. Mom, I just felt that! You know, stuff like that really perks your mind up about having another baby, right." In contrast, one woman talked about the difficulties she was experiencing because of her teenage daughter's dissatisfaction with having to make sacrifices to accommodate the new baby.

She said the other day the baby is ruining her life. . . .When [*landlord*] builds on the other bedroom, it was supposed to be hers. . . .But like I said. . .it's going to the baby, girl or boy.... Damn baby, she said, is ruining my life.

Another area of family impact was the anticipated or actual changes required in living arrangements to accommodate the new infant.

Most of the women spoke about the need to rearrange living space or to seek new accommodations. One woman commented on the difficulty of finding the necessary funds to make the needed changes.

So, I've been wanting to take *[older child's]* room and move it down to the end of the house and make the baby's room into the middle room. And right now, I don't know where we're going to get the money.

Another woman spoke about "the hassle of moving" to a new place but felt it was necessary to do so because of the lack of space and other problems with her current living arrangements.

But that more or less convinced me even more I had to move. Because my two boys are in the one room which is okay, they're in bunk beds, but I'd never fit another bed in there, even if I had a boy. Plus the place is cold, it's hard to heat. I would have had to move anyway, but being pregnant just meant I have to.

A third woman, with four older children, also commented on the need to move in preparation for the baby: "But when this baby comes, then there's going to have to be a place for her. I won't be able to put her in with a thirteen year old."

For some of the women, the pregnancy presented major challenges to career and education plans. Most of the women struggled with trying to balance their plans with current family responsibilities and the emotional and physical adjustments to the pregnancy. One woman who had been looking forward to returning to the workforce viewed the pregnancy as a major set-back.

Before I got pregnant all I wanted to do was go to work, get myself situated, get a career going. . . .Here we got *[youngest child]*, he's pretty well on his own now. He doesn't need mommy as much. I can go and start on a career. And now it's like, I'm back at the same way again. Okay, I'm not going to be able to commit myself to a job right now with a small baby and everything.

A second woman who had taken steps toward finishing her high school education expressed her disappointment with the disruption brought on by the pregnancy.

I was going to get Teachers on Wheels to come to the house and try to upgrade my education. I already went down to the College and did a written test to see what level I am. So all that is ruined right now, at least for another couple of years.

Another young woman, who was motivated by the pregnancy to return to high school, found herself overwhelmed with all the emotional, psychological, and physical adjustments and was unsure if she could continue.

I can't cope with school at all. I'm trying to do it as best I can, but I can't. I really don't think I'm going to be able to keep it up much longer, so I'm going to see now if they're going to let me do home study.

For most of the women, the many adjustments and changes brought on by the pregnancy contributed to stress and uncertainty about the future. Each woman, in some way, had limited resources which contributed to feelings of uncertainty about the future. All the women were faced with limited financial resources and for others there were limited external supports and personal resources. Thus they were not able to face the future with a sense of confidence things would be okay. There was always the fear things would not turn out as they hoped, and a underlying fear life could become even more difficult as a result of this pregnancy. While all the women were faced with the need to make changes and deal with disruptions, the extent to which these disruptions impacted on the woman's coping ability was closely related to the emotional and physical reserves the woman brought to the situation.

Living on the Edge: Emotional Response to Multiple Stressors

For the women in this study, pregnancy related events were interpreted within the context of their lived world. The events of the past and present interacted to shape how equipped they were to deal with the pregnancy. Some of the study participants had experienced a life-time of disadvantage, whereas others had good support networks and had only recently been subjected to poverty conditions.

Among the participants in this study there were women who, in the past, had experienced traumatic events such as serious physical abuse by a spouse, chronic eating disorder, death of mother at an early age and being raised in a foster home, episodes of poverty when there was no food in the house, and the birth of a low birthweight infant. In their current lives some of the women were experiencing ongoing concerns such as behaviour problems of school age and teenage children, chronic illness of partner or older children, a terminally ill parent, and strained relations with the fathers of older children. All these events contributed to each woman's lived world but are not elaborated on in the context of this study as the circumstances were not common among participants. For most of the women, the pattern that emerged was one of preoccupation with the struggle to overcome multiple challenges. Thus, their stories portrayed a picture of "living on the edge" with limited physical and emotional reserves to deal with existing stressors and the additional ones brought on by the pregnancy.

One common challenge confronting all these women was having to deal with the realities of living, and in most cases raising children, in

poverty. Regardless of the recency of financial difficulties, it became readily apparent the prospect of bringing another child into this compromised environment affected how the women viewed the pregnancy. One woman in particular expressed an overwhelming worry about being able to provide financially for her family. As the family's resources became scarcer and scarcer, she struggled to define and redefine what was basic and essential and to come to terms with living in poverty and having to say no to her children.

I think it's figuring out, okay, as long as the kids got their food and their clothes, that's all they need. They got love. That's all they need. I think we got that in our mind. As long as we can provide a bit of food, they're okay. I think we got ourselves down to that situation. At first it was, our kids are going to have this, this, and this, and now they're lucky they got a crib.

With resources so scarce, tough choices had to be made about providing the basics and, inevitably, there was competition between providing for the new baby, older children, themselves, and partners. One woman clearly voiced her struggle with this dilemma.

I find with me. . .if I eat this banana, the kids can't have it. . . . I'm still the type of person that my kids come first. I don't care, even though I'm carrying a baby, still [*there's*] my other two. I said to my husband, my other two are there, I can see them. Not that they're more important but I guess they are to a point. I'm thinking, I got to look after the baby but still . . .I got to look after them now. And that's the way I feel. And [*husband*] says. . . . "you got to worry about the baby too." But it's not that I don't worry. . . .I guess the two are here and I can see them.... So it's always a bit of an argument.

Frequently, there was no financial cushion to deal with even the smallest additional financial demands. As expressed by one woman, even something as small as a bottle of cough medicine for her children presented a budgeting challenge. She elaborated on the careful planning, and sometimes outside assistance, required to deal with these

small demands.

If I end up with the kids, in between cheques, getting sick or something like that, for a prescription or something, then I'll get a loan. But I only allow myself to get a loan for so much in between cheques because I know if I go over this, then I won't have it to pay back.

Another woman, who spoke of the very limited income she had for living expenses for herself and her two daughters, described her response when confronted with extra demands. "It was only the other day I had to turn around and take sixty dollars out of my cheque and get a pair of boots for [*oldest daughter*]. It's some hard".

Despite feeling relatively secure with being able to provide the bare essentials, with finances so limited, all the women spoke about having to do without the "extras". For the women with children this led to an ongoing struggle with how well they were attending to their children's needs. School age and teenage children, in particular, were subjected to peer pressure and did not easily accept the need to do without material things. The emotional distress felt by these women was apparent in their descriptive commentaries. One woman's struggle was reflected in the following comments:

And you feel bad to a point because. . .the kids don't get to do this, don't get to do that. . . I'm thinking, all his friends are into this and into that. . . and I can't afford it. . . And I'm figuring, am I a bad parent because I don't give it to them?

She further elaborated on the difficulty in making tough choices within the constraints of a limited budget.

But it's hard because you still want to do what you can for your kids. And that's the thing, that's the biggest thing every day we're kind of struggling with, I think. You know you got enough for your groceries and your clothes or whatever. . . It's not a problem. But when it comes to other things, there is a problem.

One woman with a teenage daughter referred to the stress she experienced as a result of not being able to provide her daughter with the expensive brand name clothes worn by others in her daughter's peer group:

I find my daughter hanging around with this one, and they got clothes on their back, probably a hundred dollars and more.... and I can't afford to turn around and buy that for my daughter. Right now I think that's why she's out *[pause]*.

Another woman, also with a teenage daughter, spoke of her distress in having to say no to her children: "The only thing about not having money, is you can't get what the children want, and sometimes it hurts. When a child comes along and says well this one and that one got this in school". She elaborated further on how difficult it was to help her teenage child understand the family's financial situation: "I could sit there and explain to her all I want. She's still not going to understand. She's a teenager." Another woman experienced similar difficulties in providing an explanation to her school age child: "He'll say, 'Mom, can I get into this, can I get into that?' No, we can't afford it. Then you feel, he's thinking you don't want him to do it. And it's kind of hard to explain to him."

Several women in the study described how having a low income contributed to negative feelings. With no money to pay for entertainment or hobbies, the women spoke of feeling down or being bored. One woman made the following comment on the flow of her daily life: "Sometimes the days are the same, sometimes they're the same thing over and over". Another woman, still a teenager and feeling the need to be with her peers, described how a lack of money contributed

to boredom and ultimately affected her outlook.

Money, money makes me depressed an awful lot. I can never do anything. I can't go and call my friends and say, do you guys want to go and see a movie and go have lunch or something. I can't do that because I never have any money to do that. So that's what leads me to boredom a lot.

Besides dealing with ongoing financial difficulties, most of the women spoke of other concerns and challenges they faced on a regular basis. One difficult part of being poor and a social services recipient was having to live with stigma. Not all the women interviewed spoke of experiencing stigma, but for those who did, these descriptions were poignant and usually charged with emotion. One woman described her experiences thus:

Oh, everywhere you go you get those experiences if you don't have very much money. Pregnant or not you get those experiences. So I try not to let anybody know [*I'm on social assistance*]. . . People will definitely talk to you different. You can tell when they're talking to you, they're looking down on you.

Being a mother and watching your child experience the stigma of poverty was a particularly difficult ordeal. One woman described her son's reaction to a situation at school:

[*Speaking quickly, appearing agitated*] He came home a few weeks ago and he was talking about one of the kids in school. . . who called him a "welfare bum". And he came home crying... He said, they're saying if you're on welfare, you got no money. . . I was trying to explain to him, because I guess the kids are into this thing now, if you're not working, you're on social services, you got nothing. . . He was totally scared to death and frightened because the kids were telling him that.

Another woman told a similar story about how negative comments from peers affected her teenage daughter:

The children in school are calling her down because she's not dressed in the same style they are. By the time she dresses in their style, that style is out. . . When she sees that she comes

home and starts bawling and roaring, upset and contrary.

The typical mood swings of pregnancy, coupled with the other stressors experienced by these women, often contributed to greater emotional volatility because the women had fewer reserves to draw on. One woman, who was in a strained relationship with her boyfriend and trying to raise two children on her own, expressed feeling overwhelmed with her situation: "I had that much stress on me, the youngsters, and being pregnant, and him [*boyfriend*] coming down and fighting and bawling. . . .I used to sit down there and I used to cry with pains in my stomach". With the extra emotional demands of a troubled relationship and other concerns, she sometimes found it difficult to find the energy or motivation to perform housework routines: "Some days I just say to hell with it. . . .Not very often I do it, but sometimes I just turn my back on it and say to hell with it all".

Another young woman indicated she too felt overwhelmed by all the changes and uncertainties in her life. She described moving from being a carefree teenager to having to assume greater responsibility for herself and her unborn child as being quite difficult for her: "It's been really different. It's been really hard. And it's not only the money aspect either. It's just the whole [*pause*]. It's school and everything just piles all together at once. . . .But yes, it's really hard."

Another woman, with two older children and a husband who was partially disabled, also indicated she sometimes felt overwhelmed with things. She related many of her mood swings to worries and concerns about how they were going to manage financially.

I think where I'm pregnant too I'm more emotional . . . I'll say, where are we going to get the money for this week, and I'm probably taking temper tantrums and going mad and saying I got to work, I got to work, I got to work. . . I guess I'm more scared thinking, well okay, we're not going to have enough for this month or we're not going to have enough for that month. . . I'm just like, oh my God, what am I going to do?

Another woman, a single mother of four children with few supports in her life, felt overwhelmed by her children's constant demands on her time. Faced with the prospect of a yet another child, she found it difficult to carry on with her normal daily activities. She described her feelings thus:

Like the way I feel here lately is I want the urge to do things, but I just put it off. . . All I want to do is lie down. That's the truth. That's all I want to do is just go and lie down.

The depth of her dependency was reflected in these words:

I said why should I bring up a child by myself, a little baby, where I already have two little babies still on the floor. Why does it have to be me? You wouldn't wish it on anybody else, but then you say, why does it have to be me?

How did these women cope with these feelings brought on by the many adversities present in their lives? Faced with multiple stressors and limited reserves, it is not surprising some women resorted to withdrawal as a coping strategy. A couple of women indicated they tried to cope by avoiding contact with others or withdrawing from difficult situations. One young woman spoke of her response to situations and people she viewed as contributing to the pressures in her life: "Sometimes I get up in the morning and I can't go to school because I feel gross that day. I don't feel like I want to be around people". She described a good day as: "not having to listen to anybody who's giving me a hard time". For this young woman, the help and advice from supportive persons were sometimes viewed as

extra pressure that left her feeling less in control:

It's just some days with *[support group]*, I happened to miss. . .
 . filling out a form. . . and I got my *[support worker]* phoning
 me and telling me . . . I can't stay in it, to get my supplements.
 And I'm supposed to be going to school, and I can't handle this.

A second young woman also indicated she responded to stressful situations by withdrawing from family and others in her social network:

When I have a bad day, I keep to myself. . . I don't let anyone come near me because it's as if I'm angry. And when I have a bad day, I don't talk. . . I just want to be in the room by myself and just do whatever I have to do, whether it be lie down or smoke a half pack of cigarettes.

Another woman, overwhelmed with constant child care demands, talked about how at times she felt the urge to leave it all behind her: "Oh my God, I don't know where I'd go *[if I had a night out]*. I'd be that let loose I wouldn't know what to do. I probably wouldn't come home no more. That's true". But, she went on to indicate just some time away from the house and children would help her to cope better:

I'll need more than one night to do what I want to do *[laughs]*... just to go dancing and go out to dinner, and you know, go to a movie. Anything as long as it's out of the house. I wouldn't care if it was just for a walk.

For this woman, it was a struggle to remain strong while trying to cope with all the demands of single parenthood. Although on one level she recognized the pointlessness of giving in to her distress, her attempts to suppress her feelings were often only partially successful:

[Crying as she spoke] But crying, to me crying doesn't get you anywhere. . . Like being sad and being down doesn't get you anywhere. You're better off if you're that hardy person and forget about it all. But then, when it's going on in your own life, well then you can't forget about it.

The lived world of the women in this study reflected a daily life that was often challenging and stressful. With finances so limited, there was never any "extra" money to deal with unexpected demands or to participate in the activities that would contribute to enjoyment of life for the woman, her partner, or her children. Difficulties from the past, challenges of the present, and the additional stress of pregnancy left many of the women in a precariously balanced emotional state, and presented a portrait of "life on the edge". Just how close to the edge each woman lived was influenced by her coping mechanisms, her emotional reserves, and the quality of the supports in her environment.

The Meaning of Supports: Facilitators of and Barriers to Adjustment

The participants frequently spoke of the important role of their support networks in helping them cope with the realities of the pregnancy while living in poverty. Partners, family members, and friends were included in the network of informal supports. Physicians, nurses and other care providers were sometimes mentioned as part of the formal network. The women in this study usually spoke of their informal support networks as a positive feature in their lives. With regard to the formal support provided, the women noted the helpfulness, while occasionally identifying barriers or frustrations which limited the usefulness of some of these supports.

The woman described how their support networks facilitated the process of acceptance of the pregnancy, helped them deal with the many adjustments and impacts of the pregnancy, and provided tangible assistance in dealing with financial difficulties. Most of the women were

involved in an ongoing struggle to come to terms with being pregnant and seemed to treasure each and every demonstration of support.

The contributions of partners were especially highlighted. One woman was trying to come to terms with the responsibilities of caring for a small child plus a new baby while pursuing her cherished goal of completing her education. She indicated she began to view the pregnancy more positively when the difficulties between her and her partner were resolved.

I thought I was going to be a single parent. . . .But now, me and my spouse are together, and I'm feeling a whole lot better. . . . Because now I know I have somebody else by my side to help me get through it.

The women in stable relationships highlighted the importance of their partners' acceptance and support in helping them come to terms with being pregnant. One woman, who initially viewed the pregnancy as a crisis, was deterred from pursuing other options (abortion, adoption) by the presence of strong support from her husband. She commented thus:

When I first got pregnant, my God, I got to have an abortion. He said, "Well, I'm not filing for nothing." And I said, "I'll go down and tell them you're gone." "Don't be so foolish," he said, "it's mine too." He said, "You know I care about the baby."

Another woman, who had planned her pregnancy but nevertheless anticipated a negative reaction from some members of her family, also appreciated the acceptance of the pregnancy demonstrated by her partner.

And you can see this look that comes over his face when I talk about babies or when you see a movie on TV. You know, this look of excitement; this look he had when [*first child*] was being born. . . . You know then he does want the baby.

One of the ways partners helped the women deal with the impact of the pregnancy was to encourage them to take care of themselves. One woman spoke about her partner's attempts to persuade her to eat healthy foods: "He's the one that's always making sure I'm eating healthy. . . .He's always making me eat carrots and all that stuff, and I'm not fussy. [*He says*], "Eat them, they're good for the baby". A second woman spoke with appreciation of her partner's efforts to help her cope with the effects of the pregnancy:

And even now, just the little things he'll do sometimes. Like if I'm really tired, he'll say, "Go and have a nap. . . .don't be so foolish, you got to look after the baby." And things like that. And I'm like "The baby is not here yet". And he says, "Yeah the baby is here you know." But he is real supportive, in his own way.

The provision of emotional support or "being there" was another important way partners assisted the women in dealing with the pregnancy. One young woman emphasized the importance of her boyfriend's being there to provide a listening ear for her concerns and validation of her feelings.

Well, he comes to the doctor's appointments with me. . . .He's just there. If I need to talk to anybody, I'll go to him first. . . .unless it's something I don't feel comfortable talking to him about. That's not very often. And if I talk to him, he's usually okay with everything. He'll make sure I know it's all right.

Another woman spoke about her partner's efforts to provide her with reassurance in helping her cope with the many worries brought on by the pregnancy: "He knows how I feel this time and he'll say, well just think, it's not that bad. We'll get by. Don't worry about it". She elaborated further on the comfort derived from her partner's demonstrations of emotional support: "It's just his little ways of doing.

. . .There's times when I think he doesn't care, but he does. . . .But he's always been there, like whatever I've decided, he's always been there".

The women also spoke with appreciation about the tangible assistance provided by partners with child care and household chores. One woman commented thus:

He does the cooking. He takes care of our son a lot. He bathes and feeds him, does whatever he can. He's perfect. Keeps the baby contented, takes him for walks. He's the one that gets the groceries. So he is a big help.

A second woman also commented on the helpfulness of her partner in caring for older children: "If I have to go anywhere like to a doctor's appointment, he'll watch the boys, and get the kids out playing in the snow".

A couple of women in the study were estranged from their partners. These women indicated it was their partner's lack of support in helping them deal with the pregnancy and other aspects of their lives that contributed to the break down of the relationship. One woman, overwhelmed with the burden of caring for four children and very much in need of her partner's assistance, made the following comment: "I consider. . . me and [*partner*], broke up at this moment. I consider it's over. And in my mind it's over until he changes. And if he isn't going to change, well then, I'm going to get on with my life". Despite these feelings, and with few other supports in her life, she continued to hold onto the hope things would turn out well for them:

I was hoping, pregnant or not. . .for everything to be okay. It will never be perfect I suppose, but to a certain point. I'd like to have their father do more with the children and take them off and come back with surprises, and make everything so happy.

Another woman, who had ended a particularly difficult relationship, described in detail her reasons for rejecting her partner. Her comments indicated the reasons for the breakup were in large part related to his unsupportive attitude toward her and her older children.

He drinks day and night, and like I told him, I never had it around my other two girls, I'm not putting up with it now. . . .I said, the next time you come in this house and you're arguing and fighting with me, you're going and you're not coming back. So, ever since October, he's gone. . . .He's got no patience with mine [*her children*] at all. And I said. . ."we'll never be a family". It's because of a bit of everything - his drinking. . .and he's strict. . . .I don't treat my children like that, the way he wants to treat them. And he doesn't want to change.

Besides the importance of the partner's support, coming to terms with the pregnancy and the subsequent adjustments were also facilitated by the woman's family and friends. Demonstrations of emotional and tangible support were appreciated by the women, especially those who struggled to accept the pregnancy. One woman, who had an estranged relationship with her partner and was experiencing strong rejection of the pregnancy, spoke of the comfort she derived from the supportive gestures of her youngest daughter.

The only thing that gives me any comfort at all is [*daughter*]. [*She*] comes along and rubs my belly and says, "Good night big bird". . . . And she can't wait for the baby to be born. The only bit of comfort I got is [*daughter*] and mom.

Another woman, also struggling to come to terms with the prospect of another child, found the support of older children and family members helpful.

I think it's just the family and everybody is excited about the thoughts of a baby. . . .And my mom, she's totally ecstatic. . . . Everybody is really, even my mother-in-law. . . .And everybody is right into the baby bit now, can't wait to see what it is.

One woman, who anticipated negative responses to the pregnancy

from some family members, showed her pleasure when she received understanding and acceptance from an unexpected source.

And I thought she would be the one to downgrade this second baby. . . . But out of all the sisters and brothers I have, this is the one sister that actually looked at me and said, you know, I think you done that just in time. . . .It's like she totally turned opposite of what I thought of her. And she showed me the good side.

This woman went on to comment on the strength and reassurance she derived from the emotional support provided by her sisters:

It's only for the three sisters I got that I am as far as I am.... But if ever I'm in, even just a state of mind, just discouraged.... [*they*] come in and they talk to me. They let me see the brighter side of things.... One I only see on the weekends, and it's like everything changes when she's around. It's like, she makes everything that's bad, it's like it's gone [*fills up with tears*].

Another woman highlighted the helpfulness of the emotional support provided by her mother in helping her deal with an unwanted pregnancy.

Mom helps me get through. . . .Like I was telling mom, I don't know if I can handle it, when I first got pregnant. And mom said, "Look at it this way, they're healthy, they're fed, they're clothed, and they're happy. You reared them the best way you could". . . .I don't know, just something in her voice that sort of soothes me when I get upset, when she sits down to talk.

Friends were another important source of emotional support. One woman commented on how the helpful gestures of friends helped her with acceptance of the pregnancy: "Just now everybody is coming, 'oh I got this for you', 'do you want this?', or 'I got clothes here'. And now, it doesn't seem as bad". Another young woman made the following comment which reflected how much she appreciated her friend for "just being there":

My friend, she's helped me out a whole lot. She switched schools just to help me out and just to be there. She'll phone me up

sometimes and say, do you need anything? Do you want any help? She's perfect like that.

A second woman also appreciated knowing her friend "was there" for her and made this comment: "My friend. . .helps me with everything. Anything at all and she's there. . . .She'll come down every day just to check on me and see how I'm doing". This woman went on to sum up the importance of having supportive family and friends in helping her cope with her current situation.

I think family and friends have a lot to do with it. If I didn't have them I'd probably be lost, because when I was married I didn't have anybody and that was hard. Because if you haven't got friends and family, well, you'd still make it, but it would be a lot harder.

Family and friends also helped the women cope with financial difficulties. Their comments reflected the reassurance the women derived from knowing there was someone available they could turn to for help with financial difficulties, child care, and transportation. For one woman financial support came from members of her husband's family: "If we run short, he'll usually phone his brother or his mom. His mom is really good. And his dad, when he was alive". Another woman also spoke about the financial support provided by her and her partner's families: "My family I can rely on if I get stuck with financial situations. Also my spouse's parents. They help out with getting baby clothes and stuff like that". Still another woman spoke about the tangible support provided by her sisters:

My sisters are the helpfulest people I got. . . .*[they]* can help you over a hard time that you're feeling or, there's times you run out of money, so you phone either one of the three and they'll back you all the way. You need anything, they'll help you. If you need a baby sitter, one of those three will baby sit.

One woman spoke of how having access to transportation provided by family and friends reduced her financial worries. She commented: "I'd be gone crazy on taxis if I didn't have friends".

Another, less frequently mentioned, source of support was health care providers and others outside the network of family and friends. Formal supports had both positive and negative aspects for the women in this study. For several women who were struggling to accept their pregnancies and trying to reassure themselves their lives and experiences were normal, the encouragement and reassurance provided by care providers was valued. One woman, preoccupied with worries about the health of her unborn child, spoke of the support she derived from her family physician: "So she more or less said, you're fine. Your baby is the right measurement and stuff like this. . . .Go and get your ultrasound done. It's stuff like that really helps you out." A second woman, faced with rejection of the pregnancy by a number of people in her life and worried about how she would cope with all the changes and uncertainties brought on by the pregnancy, commented on how much she appreciated the positive approach demonstrated by her family physician:

When I go in there with a problem, he'll sit down and wonder what's going on and how I'm doing lately. And when he's giving me the results of my tests, he seems happy too. I've sat down and I'm really happy he just gave me good results and he's just as happy as I am. He's a really good doctor.

Similar comments were made by a third woman about how much she appreciated the encouragement given to her by her physician while she was struggling to accept her pregnancy:

She's good, she's really supportive. She'll ask if you have any problems. . . .If I walk in and I don't look myself, she'll say,

"what's wrong with you. . . . You're a mommy, what's wrong with you? You're going to be a mommy again".

When asked about their encounters with healthcare providers, a number of the women spoke about the qualities that were important to them. Several women mentioned the importance of being treated as a normal person and as an equal. One woman made the following comment: "He [*physician*] talks to me like I am a normal person". This woman went on to highlight the importance of not being stigmatized: "She [*community health nurse*] communicates with everybody like they're on her own level. She doesn't look down on anybody, I don't think, because of their money". Similar comments were also made by another participant: "Some [*nurses*] are. . . stuck-up. I'm after having that experience. Now [*clinic nurse*] isn't like that. . . .you can go in, you can carry on with her, you can talk to her, and she won't turn away".

Besides the formal supports offered by health care providers, several women spoke of their encounters with other formal supports. For one woman, who had experienced extreme poverty in her life and worried a great deal about the financial implications of this pregnancy, the support offered by a family resource centre was appreciated. This additional source of support again highlighted the importance of having somewhere to turn for help:

They are really good down there. . . .They're there. If you need them for anything, you phone them up. . . .You got a resource mother and she's there if you need her for anything. . . .It's good to know there's somebody like that. . . .There a couple of months ago it was like, what are we going to do, there's no one to talk to. You're by yourself. There's no one to go to for help. . . .I must say I think that's what has gotten me through a bit with this pregnancy.

Several participants made special reference to the lack of support they perceived from teachers and social services. One young woman, who had chosen to attend a particular school because of its special supports for pregnant teenagers, spoke of the perceived lack of support from the teachers which she felt was due to her being new to that school:

If I miss school, all they do is harp on it when I come back. . . . And they're not very helpful at all. I guess they could be if they knew me better, but where they don't know me and I don't know them. . . they can't be at their best.

Although social services provided the financial assistance necessary for the women and their families, this form of support was almost always described in relation to the problems encountered. Several women spoke of how social services rules and restrictions limited access to needed services and negatively impacted on their choices and decisions. One young woman, who had made the decision to return to school to provide a better future for herself and her unborn child, described her frustrations in the following way: "I can't get no good out of them. I'm getting less money now I'm gone back to school than. . . when I was quit. They took money away from me when they found out I was going back to school." Another woman expressed similar frustrations. "I don't know if you understand it or not, but I mean it's hard. It's like they [*social services*] won't help you in no way possible".

One woman described her frustrations with social services transportation rules which limited her choice of physicians, and made her believe her feelings were not important. She commented thus:

I want Dr. [X] who is the doctor that delivered my son. . . .In order for me to get to go visit that doctor, social services won't help me at all. . . .But if you want to go to a specialist, they will give you transportation to go. Which I don't understand, because nobody here [*this community*] delivers babies. So you need to go to town to see somebody. . . .They expect on the day you're ready to have your baby, to take you to town in the ambulance and you'll get whatever doctors we give you, which is not a nice feeling.

Another aspect of support accessed by participants was public housing. Six of the eight participants were either living in, or hoping to move into, a public housing unit. For most of these women, this type of housing was seen as better than private housing as it provided a better standard of accommodation for a controlled cost. One woman described how she viewed gaining access to public housing as a positive event in her life: "Well, actually, everything's been on the up and up since I got pregnant. I applied for a housing unit and I got one". Currently living in confined quarters with a high heating bill, she was able to appreciate the benefits of this type of living space for her growing family: "They're warm and comfortable. They're not small. Where I'm living now has only two bedrooms. . .and it's a three bedroom there. They help out with the rent. . . .so I won't have to worry". Another woman explained how the move to public housing helped her family better cope with a limited budget: "But then I got into housing, it's subsidized, a forty-five dollar heat and light [*bill*]. So that's the reason why I've been budgeting".

But for others, public housing was associated with stigma and other problems and, in some ways, was viewed as less desirable. One woman, who had lived in subsidized housing for many years, spoke strongly about some of the problems associated with living in a densely

populated public housing complex.

I would like to get an infill, or a place where there's not that many housing [units] around. Because in this neighbourhood. . . it's a hundred and forty-four. There's too many [housing units]. There's kids coming from everywhere. You know what I'm saying? I suppose everywhere. . .you're going to see trouble, but I mean I'd rather go somewhere where there's only probably about thirty, forty houses.

Another young woman spoke with distress of being stigmatized by her schoolmates because of where she lived: "You know, the guys whose parents are lawyers and stuff like that, they'd be saying, oh here comes [X], she lives in the projects".

The emotional and tangible support provided by family, friends, and others was acknowledged by participants as making an important, if not vital, contribution to their ability to cope. The information, encouragement and support offered by the formal support networks of care providers were valued by the women when it helped them in their struggle to deal with the realities of being pregnant, provided information they viewed as helpful, and contributed to their feelings of well-being. An uncaring approach, rules that limited their choices, restrictions on being able to access needed services, and associated stigma were some of the barriers that limited the usefulness of formal support systems.

Reflecting on the Lived World

For the women in this study, living in poverty did not mean living without plans and hopes. As they reflected upon their lived worlds, most were able to imagine a better life beyond the current difficulties, and some had formulated plans to improve their situations.

For a couple of women, their plans and hopes for the future included becoming a mother. For most there was hope things would soon get better or at least not get any worse. For a couple of women, as a means of coping with the overwhelming problems in their lives, it seemed they lived without plans and simply hoped today would be a good day.

Several women acknowledged the experience of pregnancy and/or motherhood had resulted in a new, positive orientation. For two of the women, pregnancy and motherhood meant a move to a healthier lifestyle. One woman commented thus: "When I found out, I mean, the exciting thing about it was geez, now I've got to start looking after myself, getting proper rest and staying off my feet as much as I can, and trying to eat healthy". A second woman also spoke of buying healthier foods and making positive changes in her family's eating habits:

When I managed to pick up my appetite, I started eating healthy foods. . . .With him [*first child*], I used to eat a lot of fatty foods and this one I'm certainly eating healthier foods. . . .We're starting to cook more. We're starting to get the vegetables in, and chicken rather than bacon and hamburgers and hot dogs. . . . Before, we didn't know how to shop. We didn't know what kinds of foods to get. We'd buy more fatty than we would fresh. But now, where I have a son, we know he has to start eating healthy, so that's when we started buying better foods for us. We're buying grapes and all that, vegetables, fruits, milk, meats. That's when we started eating healthier, when he was little.

Another woman, prior to becoming pregnant, had dropped out of school and was drifting along, caught between teenage dependency and adulthood. Becoming pregnant gave her a new sense of responsibility and resulted in focused efforts to create a better future for herself and her child.

Before I was never worried about it [*getting a job*]. I was just lazing around like a normal teenager and going out and having fun with my friends. But now it's in my head, when I have the baby I'm going to have to change a whole lot. I'm not going to be able to go out and party, all this stuff I used to do before. But it's good. I'm going to have a baby. I've got to deal with it and I'm happy about it now. That's why I went back to school.

Another woman also expressed a strong determination to pursue her education, despite the struggles and disruptions brought on by the pregnancy. For this woman, getting an education was the pathway to independence for herself and her family and leaving behind a life on social assistance. It seemed having a second child to support made her even more determined to pursue her education. Her determination was reflected in these comments:

Well, I'm going to school. I want to accomplish my education. I go six or seven days a week....I want to be able to move on.... I know how hard it is to struggle while taking care of children on a low income. I want to be independent, and be able to do that on my own....I want to be the one that is able to get up on my feet, take care of my children, show them I can support them by myself, rather than being dependent on government....my independence means a lot to me. In order to have independence, you need education. And I am determined to get it. I don't care whether I have to go in labour while I'm in school. If it happens, it happens.

In describing the ups and downs of daily life, each woman spoke of areas in which they felt they were coping reasonably well and were achieving small successes. These successes were highlighted and often identified as a source of pride. For a couple of women there was a measure of success in finding ways to avoid, or at least learn to live with, the stigma of being a social services recipient. One woman spoke of the pride she felt from ensuring that her son had acceptable clothes to wear while attending school:

I'll be up there and the kids are in rags. I've never been the type of mother to send my kids to school like that. [*Oldest child*] has always had to have, not the best, but he's always had to have the clean clothes, the good clothes. . . .To me, if you don't have the money, you don't have to go around looking like it. There's no excuse for it. Because I mean there are second hand stores you can get clothes. . . .They're not getting designer name clothes or they're probably not getting brand name new clothes, but they're going around in good clothes. . . .I feel proud for myself that way.

As a way of coping with her situation, one young woman learned to rationalize the negative comments directed towards her because she lived in public housing: "It doesn't bother me any more. I don't care. I don't mind telling anybody where I live. . . .It is upsetting but you learn to deal with it after being like it for so long".

In some cases, experiencing and living through crises had contributed to feelings of self-reliance, mastery, and inner strength. One woman had previously left an unhappy marriage where she felt she had no control over her life. Although she now had to rely on her own resources and struggled to make ends meet financially, she voiced her satisfaction with the degree of control she had over her life: "I'm not worried. I'm not suffering, I got a low income budget, but I'm handling it". Another woman was able to reflect on the challenges of the sudden loss of income due to her husband's illness and identified the positive aspects of having lived through this type of adversity. She noted her family had managed in the face of overwhelming odds and became stronger through "learning and thinking". The following comments capture her perspective on how the family became stronger as result of the lessons learned: "We went through so much last year, it's like no matter what comes now we can get through it.... It's for the

better I guess because it's made us stronger; it's made us better".

Life for the women in this study was difficult at times but not without hope. Despite many adversities, each woman identified areas of her life that gave her purpose and pride. For most participants, this included their children and family life. For some, the current pregnancy had disrupted established hopes and plans but as they struggled to come to terms with the pregnancy, they also struggled to identify the new ways in which they could re-order their lives and restore their sense of well being. Their journey through life continued on a road that was sometimes smooth and sometimes rough. Given time and a reasonable measure of support, each woman found a way to incorporate the pregnancy into her life, to seek out whatever support was available, and to carry on in hope of good things to come.

The Essence

Through formal, unstructured interviews, participants were encouraged to reflect upon and describe their lived experience of being pregnant while on social assistance. The themes identified from the data presented by the participants were: settling in, giving recognition to disruptions and uncertainties, living on the edge, the meaning of supports, and reflecting on the lived world. Having identified the various themes that emerged from the data, the researcher turned to the question: What was the one unifying feature of this particular experience? The researcher identified the essence of this experience as **the search for acceptance.**

Initially each woman had to accept the reality of the pregnancy.

For some women this was a major hurdle. Each one had to search within herself for acceptance and for some, this did not come easily. The women's search for acceptance of the pregnancy included an acute awareness of the responses to the pregnancy from those around them. Even the women who had planned their pregnancies searched for signs that others - partners, family, friends, care providers, society in general - were prepared to accept the pregnancy. All indications of acceptance by others were welcomed and cherished and in turn, helped them to accept the pregnancy. Conversely, signs of rejection or fears of rejection were a source of anxiety. Experiences involving stigma were a particular source of distress for these women as it meant they and/or their children were somehow not fully accepted by society. Being pregnant brought these experiences of stigma, recent and from the past, into focus and seemed to underline fears of rejection of the current pregnancy.

Part of accepting the reality of the pregnancy was giving recognition to the disruptions and uncertainties introduced into their lives by the pregnancy. In recognizing these disruptions and uncertainties each woman was acknowledging the pregnancy meant accommodations would be necessary. They then searched for acceptable ways to re-establish a sense of order and balance in their lives. This search for acceptance and accommodation of the changes brought on by the pregnancy came easier for some than others but was nevertheless present for all the women.

For the women in this study multiple problems in the present, and sometimes from the past, left them with limited resources to deal

with the many new challenges brought on by the pregnancy. These circumstances affected how difficult or how easy it was for each woman to accept the pregnancy and the many disruptions brought on by the pregnancy. For most, the struggle to integrate the pregnancy into their lives involved more than dealing with the financial realities. The ease and degree to which each woman accepted the pregnancy was affected by her circumstances, her emotional reserves, her coping strategies, the difficulties from the past, and the challenges of her present life.

All the women in this study referred frequently to their support networks and how these supports helped them accept the pregnancy, deal with the adjustments brought on by the pregnancy, and to cope with life in general. The sources of support most valued by the women were those that offered unconditional acceptance of their situation, along with tangible assistance to help them deal with the impacts of the pregnancy on their lives. The numerous references to support persons "being there" indicated to them that person accepted the pregnancy, and was prepared to offer assistance when needed. In describing their contacts with care providers, the women highlighted those encounters in which the care provider offered encouragement to them in their mothering role. Support for the woman in her mothering role was welcomed as a sign the pregnancy was accepted and supported by the care provider.

In reflecting on their lived world, the women identified how the experience of pregnancy and/or motherhood had resulted in a new, positive orientation. For some, there was an awareness the changes

and challenges presented an opportunity for learning, growth, and maturation. These positive reflections were the outward signs they were learning to accept and integrate the challenges life had brought their way. Within themselves, they were finding acceptance for the circumstances of their lived worlds.

People who are on social assistance are often faced with subtle, and sometimes not so subtle, disapproval by society for being a burden. Pregnancy is looked upon favourably by society when the woman is no longer a teenager, is married, and the family has the means to support itself. For the pregnant woman not in this ideal situation, pregnancy brings with it the fear of further disapproval by those around her. Nevertheless, faced with the reality of a coming child, the woman searches for acceptance, first within herself, and then from those around her. For the participants of this study, all of whom were pregnant and living on social assistance, this search for acceptance of the pregnancy was the single common thread that made this experience what it was.

CHAPTER 5

Discussion

This first part of this chapter discusses study findings in relation to the literature on the experience of pregnancy and the experience of pregnancy in the context of poverty. In the second section, discussion is provided on new insights gained as a result of this study and the meaning of these results for care providers.

Discussion of Themes in Relation to the Literature

One of the early challenges presented by the current study was acknowledging the inseparability of each woman's experience of pregnancy with other aspects of her lived world. A number of writers have recognized this reality, suggesting pregnancy must be considered within the larger framework of adjustment throughout the woman's life cycle (Zajicek, 1981). Similarly, Colman (1969) noted, in order to make sense out of a woman's adjustment to pregnancy, the "total pregnancy system" must be studied, including the husband's reaction to the pregnancy, the individual psychology of each woman, and her openness to environmental and social influences. The findings of the current study offer support for these views and to those of other writers who state further pregnancy must be considered within the larger context of the sociocultural environment in which the event is occurring (Badinter, 1981; Mercer, 1990; Oakley, 1986; Young, 1984).

"Settling in": Forging a Meaningful Balance

This theme described the back-and-forth process experienced by

each woman that eventually lead her to accept the pregnancy. A number of researchers have documented the initial ambivalence many women, of all social classes, feel on learning they are pregnant (Caplan, 1960, quoted in Zajicek, 1981; Cobliner, 1965; Deutsch, 1947, quoted in Zajicek, 1981; Rubin, 1970). Research into the area of fetal attachment supports this view (Reading et al., 1984; Grace, 1989). These writers also point out all but a small minority of women eventually come to accept the pregnancy, as was the case with the participants in this study.

Six of the eight study participants in this study indicated their pregnancies were unplanned and for five of these women the pregnancy was also unwelcomed. For several women there was a lengthy delay in reaching acceptance. A number of researchers have noted, in samples of poor pregnant women, a high proportion of pregnancies are unplanned (Lazarus, 1990; Lia-Hoagberg et al., 1990; Orr & Miller, 1997). A woman who does not plan to become pregnant and further denies she is pregnant may delay initiation of the activities described by Rubin (1975) under the maternal task "seeking safe passage" (i.e., information seeking and lifestyle changes undertaken in order to make a "good baby"). This course of events may offer some explanation for the association of poor pregnancy outcomes and poverty.

During the time the women were struggling to reach acceptance of the pregnancy, several indicated they worried about rejection by important people in their lives and became very sensitive to any sign of rejection. This response was noted by Rubin (1975) under the maternal task "ensuring acceptance of the child by significant others",

during which the woman becomes susceptible to signs of rejection. For the women in this study comments indicating rejection or even thoughts of possible rejection by partners, parents, older children, friends, care providers, or acquaintances were a considerable source of distress and worry, providing support for Rubin's task of ensuring acceptance.

For the two participants who had planned their pregnancies, their reasons for wanting a child related to, among other things, bringing meaning into their lives (e.g., a plan where no plan existed) and a sense of identity (e.g., "the good thing for me is I want a life and a family"). Similar findings are reported by Lazarus (1990) who found, in a context of poverty, having a baby brought meaning into the lives of participants in her study by bringing prestige and a sense of identity.

Giving Recognition to Disruptions and Uncertainty

This theme captured the many ways pregnancy influenced the lives of the participants and their families. The women spoke of incorporating changes into their lifestyles because of the pregnancy (e.g., eating healthy food, getting more rest, etc.). They also spoke of giving consideration to the responses of older children, effects on relationships with partners, accommodations in living arrangements, changes in career/education plans, etc. These comments provide additional support for Rubin's (1975) task of pregnancy, "seeking safe passage", which included making all the physical preparations, accommodations, and the reordering of relationships within the immediate family and outside the family. The work of Mercer (1986) and Richardson (1981) also supports this theme. Mercer stated that during

the nine months of pregnancy the mother-to-be recognizes the need for accommodation and begins the necessary steps to incorporate the coming child into her family and social sphere. Similarly, Richardson (1981) identified the theme of "differentiation" in which the woman helps others reorganize for the addition of the expected baby.

This theme was linked with the previous theme of "settling in" by Lederman (1996) who noted low acceptance of pregnancy was expressed overtly in two main areas: concerns regarding financial security and changed lifestyle, including motherhood-career conflicts. Many concerns were expressed by participants regarding their financial security and changed lifestyle. This could be interpreted as a reflection of the difficulties these women were having in coming to terms with the pregnancy. On the other hand, for most of the women in this study, pregnancy presented a very real financial threat. For some it set back carefully planned educational and career goals, viewed as providing the means by which the woman and her family might break free from the confines of poverty. Thus, Lederman's interpretation of adaptive and maladaptive responses may need to be reviewed and validated in the context of pregnant women living in poverty.

Living on the Edge: Emotional Response to Multiple Stressors

This theme captures the way in which events of the past and present interacted to shape how equipped the women were to deal with the pregnancy. The pattern that emerged was one of struggling to overcome multiple challenges and having limited physical and emotional reserves to deal with existing stressors and the additional ones brought

on by the pregnancy.

Five of the eight participants were quite distressed to learn they were pregnant. The fact that pregnancy introduces additional stress into a woman's life was documented by Wadha, Sandman, Porto, Dunkel-Schetter, and Garite (1993). Having determined the average level of psychosocial stress during normal, middle-class pregnancy was significantly higher than non-pregnant adults, these researchers speculated psychosocial stress may be compounded for disadvantaged pregnant women. The findings under this theme support Wadhwa et al.'s theory in this regard. Even those who had planned their pregnancies experienced a high level of stress in dealing with what might be considered the normal accommodations of pregnancy (i.e., added financial pressure, changes in living arrangements, effects on relationships, etc.)

Under this theme, participants commented that a lack of financial resources led to feelings of boredom and depression. Lazarus (1990) noted tedium of daily life was a clear pattern that emerged in her findings, with women reporting their days were spent doing housework and watching television. She went on to say, although in this context having a baby gave meaning to the lives of the women, their compromised circumstances resulted in alternating feelings of delight and depression. Alternating feelings of anticipation and concern were evident in the comments made by several of the participants.

The Meaning of Supports: Facilitators of and Barriers to Adjustment

This theme captured the important role of support networks in

helping the women accept their pregnancies and cope with their daily realities and the realities of being pregnant. The results of this study augment those studies which define social support in terms of specific received support from the infant's father or close family members (Aaronson, 1988; Norbeck et al., 1996). Partners, older children, other family members, and friends all played a vital role in helping the woman accept the pregnancy. Similarly, family members and friends were the sources of support mentioned in dealing with financial issues and other concerns.

Physicians, nurses, and other care providers were much less frequently mentioned, as noted by Lazarus (1990) and Schaffer and Lia-Hoagberg (1997). Comments from the women revealed that when formal supports were seen as non-judgemental and non-pressuring they were viewed as helpful. Conversely, formal support networks viewed as contributing to pressure and added frustration were not viewed as helpful. Lazarus (1990) found, more importantly than having control over their care, the women wanted a physician who knew their case, who cared about them, and could provide the emotional support they needed. She found most women had similar desires: a satisfying experience, a healthy baby, quality care, and a positive relationship with a health professional who listened and did not make them feel inadequate. The comments of participants in the current study regarding their views of helpful behaviour by formal care providers lend support to Lazarus' findings.

Richardson (1981) described two themes regarding relationships during pregnancy, one of which was support. Within the supportive

system, the woman is the recipient of the support and caring action of others. Similarly, Rubin (1975) includes the acceptance of the "gifts" offered to the pregnant woman as one component of the task of pregnancy, "learning to give of oneself". The women in the current study also reported, in response to the pregnancy, family and friends came forward with offers of support which were welcomed by the women.

Reflecting on the Lived World

This theme captured the comments of the women on their successes of the present, their hopes for the future, and their reflections on how they, and in some cases their families, had grown stronger from learning to deal with adversity. Bibring (1959) describes how, in a supportive environment, resolution of the crises experienced in pregnancy resulted in specific maturational steps toward a new stage of development. Although more recent theories have moved away from viewing pregnancy as a crisis, the findings of the current study offer support to the view that, even under disadvantaged circumstances, pregnancy can lead to a new stage of development and maturation.

This theme speaks to Rubin's (1975) fourth psychological task of pregnancy "learning to give of oneself". According to Rubin, giving of oneself is one of the most intricate tasks of pregnancy, of mothering, and of adulthood. This denotes a process of growth and learning to accept the trade off between costs and benefits. Under the theme "reflecting on the lived world", the women in this study reflected on the learning that had occurred that resulted in movement toward a new

stage of personal and family growth.

The Essence

The essence of this experience was identified as the search for acceptance. The theme of acceptance is woven throughout the literature on the experience of pregnancy (Bibring et al., 1961; Helper et al., 1968; Lederman, 1996; Rubin, 1970; Rubin 1975; Zajicek, 1981). Helper et al. found generally good agreement between five groups of women on what might constitute a threat to adjustment to pregnancy. Four of the five top items in the list represented rejection of the pregnancy by the father of the child or society in general.

Rubin's (1975) work on the psychological maternal tasks in pregnancy, specifically "ensuring the acceptance of the child she bears by significant persons in her family" is supported by the essence. According to Rubin, after accepting the reality of her pregnancy, a woman looks for confirmation that others will accept and welcome the baby. Rubin states unconditional acceptance is sought by the woman but is not always obtained, thus the woman becomes susceptible to any signs of rejection. "Ensuring acceptance" occurs concurrently with "seeking safe passage", as was brought out by the current study. Rubin emphasized "ensuring acceptance" seemed to be the keystone of a successful pregnancy. This view was supported by the current study.

New Insights: the Meaning of Pregnancy in the Context of Poverty

The present investigation has uncovered a number of new insights into women's experiences of pregnancy in the context of

poverty. One such finding, not well developed in the literature on pregnancy and disadvantage, was the element of struggling that was an almost constant feature of their daily lives. "Settling in" to the reality of the pregnancy required effort and adaptation, even when the pregnancy was wanted, but even more so when the pregnancy was unwanted. For most, the struggle to cope on a day-to-day basis was more than a financial struggle. Multiple problems in the present, and sometimes from the past, left the women with limited resources to deal with the many new challenges brought on by the pregnancy.

But while struggling to cope on a day to day basis, the women also longed for and took steps toward achieving some sense of normality in their lives. Seeking normality was another feature brought out by this study. The women very much wanted to be treated as normal people and as equals in society. Whenever possible, they highlighted the ways they were coping, surviving, and managing. Being stigmatized was a source of distress for the women. For the women who had children, it was important the children fit into society. When this did not occur, this became a source of considerable anxiety for the women.

In many ways, the responses of the participants to their pregnancies fit within the realm of typical responses any pregnant woman might experience. Some examples were: initial rejection of the pregnancy, the need for financial adjustments and changes to living arrangements, and worry about the effect of a new baby on relationships. However, because these women had fewer financial and personal resources, the challenges and stresses typical of pregnancy

brought crisis or near crisis responses. Thus, while many of the responses were typical, the normal adjustments to pregnancy added many new challenges in a daily life already filled with more than enough challenges. Near crisis response precipitated by the normal adjustments of pregnancy was another element brought out in the current study. Throughout this study, the comments of each woman indicated the availability and quality of supports had a major impact on how well equipped the woman and her family were to deal with the challenges brought on by the pregnancy and other aspects of their lives. For some of the women in this study the nature of their supports tended to be more limited, fewer in number, and restricted in various ways thus making the network of supports less than ideal. Although the concept of social support is present in the literature on pregnancy and poverty, the critical role attributed to supports as described by the participants in this study is not well portrayed. Very little research was identified that described the meanings of support for vulnerable pregnant women.

Uncertainty about the future was also a common element in the women's lived experience not identified in any of the literature reviewed. Each woman, in some way, had limited resources in that all the women were faced with limited financial resources and for others there were limited external supports and personal resources. Thus they were not able to face the future with a sense of confidence things would be okay. There was always the fear things would not turn out as they hoped, and a underlying fear life could become even more difficult as a result of this pregnancy. This uncertainty about the

future played an important role in determining how the women viewed the pregnancy.

The struggle faced by these women with regard to allocation of resources was not documented in the literature reviewed although this reality is well known by care providers in the area of pregnancy support (Melba Rabinowitz, personal communication, 1992). Care providers who are not familiar with the day-to-day realities faced by a pregnant woman living in poverty, especially those with older children, need to be aware of their clients' difficult choices to be made around the allocation of healthy food and the provision of other needs and wants. Further, many middle class care providers may not appreciate just how tight the budget may be and something as small as a bottle of cough medicine may present a major budgeting challenge for some women.

The tendency to withdraw in response to the overwhelming nature of the challenges faced by these women was not highlighted in the literature, although Culpepper and Jack (1993) did note stress may divert a woman's attention or financial resources. Care providers need to be cognizant of this important aspect of caring for vulnerable women.

The way in which care providers contribute to helping women accept their pregnancies has not been addressed in the literature in the way described by the participants in this study. Rather than dwelling on the care or information provided, participants focused on the things care providers said or did that indicated the person supported the pregnancy and thought the pregnancy was a happy

occurrence.

The impact of pregnancy on living arrangements was felt by six of the eight participants in this study. Four of these participants indicated they would need to seek new housing as a result of the pregnancy. This feature was not highlighted in any of the literature reviewed but may be another important consideration for care providers.

The essence of this experience was the search for acceptance. Although the theme of acceptance is woven throughout the literature, this study revealed, for a woman living in poverty, acceptance is a dynamic process, a search that involves looking concurrently within herself and being acutely tuned in to the responses of those around her. The response of partners, older children, other family members, acquaintances, and care providers all played a critical role in helping the woman to accept the pregnancy and to accept and deal with the challenges presented by the pregnancy.

Summary

This study has shown the lived experience of pregnancy cannot be separated from the context in which the experience is occurring. For various reasons, pregnancy among disadvantaged women may be unplanned and unwanted, and this situation may result in a delay in initiating the activities that contribute to a healthy pregnancy outcome. Even when the pregnancy is planned or viewed as welcome, the woman living in poverty often faces many challenges in meeting the accommodations required by pregnancy.

In this study, supports were shown to play a critical role in achieving acceptance of the pregnancy and in dealing with other concerns, both financial and emotional. Partners, family and friends are the most important sources of this support. Care providers may contribute to this process if the assistance offered is based on support for the pregnancy, offered in a caring, non-stigmatizing way.

Pregnancy, by its very nature, is a time of growth and maturation for a woman. When acceptance is attained at an adequate level and reasonable supports are available, the pregnant woman will find her own way to incorporate the coming child into her and her family's future. Finding acceptance in those around her is a central element in this experience.

CHAPTER 6

Limitations, Nursing Implications, and Summary

The issues around providing support to women and families in overcoming the threats to health associated with poverty are among the most basic questions facing policy makers at every level. This chapter begins by outlining the limitations of the current study. This is followed by discussion on the implications of study findings for nurses involved in practice, research, and education, as well as other public service providers, and concludes with a brief summary of the study.

Limitations

Although it is not the aim of phenomenology to generalize results to the larger population, it must be noted participants in this study did not represent all the attributes of the context of poverty or more broadly, all the attributes of women living in disadvantaged circumstances. Aspects of disadvantage not represented in this study included the experiences of: teenagers, homeless women, women with psychiatric illness, victims of physical and emotional abuse, and women with substance abuse problems. The experience of women of other cultural backgrounds, in particular aboriginal women, was not represented. It is possible the experience of pregnancy might be different for these women.

The sampling method in this study did not differentiate between teenage versus adult age, married versus single women, women living in an urban versus rural setting, women who had been on social assistance for a long time versus new to the experience, women who

had varying educational levels, or women who were pregnant for the first time versus women who had older children. If the sample criteria had focused on only one aspect of any of these criteria, it is possible different findings might have been revealed.

All the women in this study had reached a stage of acceptance of pregnancy at the time of the interview. This acceptance of the pregnancy may have been a necessary state of mind prior to agreeing to be part of the study (i.e., women who had not come to terms with their pregnancies were not likely to volunteer to be part of a study of pregnancy). Thus, the reflections of women at an earlier stage of coming to terms with the pregnancy may not be reflected in these findings.

Implications

The findings of this study have provided insight into the lived experience of pregnancy in the context of poverty and highlighted the role of care providers in supporting women in their search for acceptance of their pregnancies. An overriding implication for care providers in all sectors is the need to be aware that the context of the lived world is of primary importance in the understanding of another's experience. Further, this study has shown poverty may be only one of a number of challenges facing the pregnant woman and her family.

Nursing Practice

This study has highlighted the significance of the words and actions of care providers and others that convey to a woman her

pregnancy is accepted and supported. Behind the face of disadvantage is a woman who, as Lazarus (1990) reported, has the desire for: a satisfying experience, a healthy baby, quality care, and a positive relationship with a health professional who listens and does not make her feel inadequate. Thus, strategies to enhance self esteem in the client and avoid feelings of being "put down" are needed. Arborelius and Nyberg (1997), in their qualitative study of how women perceive their smoking during pregnancy, noted greater success in smoking reduction was achieved by care providers who were supportive without being judgemental, and who supported the women in their roles as mothers-to-be.

Health care providers need to be aware initial rejection of pregnancy is not uncommon in women of all social classes. A woman living on social assistance is especially likely to express rejection of her pregnancy at the same time as she is searching for signs of acceptance from others. Care providers need to be aware initial rejection of a pregnancy, even strong rejection, will likely be replaced by acceptance later in the pregnancy when a woman has had a chance to work through her feelings and "settle in".

Care providers need to bear in mind the "normal" adjustments required by pregnancy may precipitate crisis or near crisis responses for a pregnant woman living in poverty, some of whom are struggling to overcome a lifetime of disadvantage. Dealing with these responses positively is aided by the availability of supports, both financial and emotional. A woman's first response will likely be to search among her family and friends for these needed supports. Care providers may be

called upon to assist in this process by informing women of available financial support programs, housing options, community services, and/or pregnancy support groups. The knowledge that access to these services is available may assist the woman in her struggle to accept the pregnancy.

Another aspect to be considered in providing nursing services to this client group is the need to avoid any hint of stigma in non-verbal communication, words, and actions. It is important all practitioners remain vigilant of the need to display an attitude of caring, understanding, and respect in their encounters with women and families on social assistance. Further, social programs need to be carefully designed so as to be non-stigmatizing.

In response to overwhelming worries and emotions, several participants commented they tended to withdraw, to prefer to be left alone, to sleep, or to avoid facing those who were viewed as "hassling". The desire to be alone in response to perceived overwhelming demands provides further insight into the difficult living circumstances of these women but also helps to explain why it is sometimes difficult for care providers to reach those who would seem most in need of support. Care providers need to understand and accept this response.

Although prior research on social support in pregnancy has not shown consistent results, this study provides support for the value of social support networks. Strategies are needed to enhance access to the type of support known to be most helpful (Aaronson, 1988; Norbeck et al., 1996), such as the resource mother model (Way et al., 1998). This model, which has been incorporated into the Newfoundland Healthy

Baby Clubs, has been shown to improve pregnancy outcome in vulnerable women (Way et al., 1998). More of these programs are needed in this province.

This study has shown the importance of looking beyond the first impressions and investing time to gain understanding of the client's lived world. Asking the question "What has this pregnancy been like for you?" and taking the time to listen to each woman's experiences can reveal much about the challenges faced. Clients would benefit if time was allowed to establish this type of rapport. This in turn may uncover issues that could be addressed jointly by the nurse and the client, or alternatively, sometimes providing a supportive, listening ear may help the woman find her own solutions. As this researcher found, sometimes the pregnancy is among the least of the client's worries.

Nursing Research

From the present investigation, a number of suggestions can be made for future research in the area of prenatal care and services for vulnerable women. To begin with, more phenomenological study is needed on the experience of women dealing with other aspects of disadvantage (e.g., teenagers, aboriginal women, women who have problems with substance abuse, etc.). In addition, replication of this study, or a study of this population using a grounded theory or another qualitative approach, would augment the current study's findings.

Qualitative studies are urgently needed on the meaning of social support in the lives of vulnerable pregnant women. The literature has

identified partners, parents, and other close family members as the most important sources of social support. Research is needed to explore the ways in which support from these sources contributes to a more satisfactory pregnancy experience and to a healthy pregnancy outcome. As well, research is needed to study the role of friends as sources of social support. Research is also needed on how care providers can enhance access to beneficial social support as a means to achieve improved pregnancy outcome.

Difficulties were encountered in recruiting participants for the current study. This may have been a reflection of the level of stress experienced by potential participants and/or the desire to avoid the "hassle", etc. Researchers need to allow for this in their sampling strategies with this group. Moreover, researchers need to be aware women who are in denial of pregnancy may be inaccessible as participants.

Nursing Education

Developers of community health and maternal-child courses in basic nursing degree programs should ensure content is included to address sensitivity to poverty issues, including respect and avoidance of stigma. Pregnancy is much more than a time of physical adjustment for a woman and curriculum content regarding psychological adjustment in pregnancy should be given equal emphasis in order to provide appropriate care to clients. Attention should be paid to the role of partners, older children, and other family members in this important transition period in the life of a woman and her family.

Continuing education instructors and professional practice coordinators in community health and maternal-child areas should ensure periodic seminars focusing on raising awareness of poverty issues and challenging stereotypes are offered to practitioners. As research reveals new insight into the phenomena of pregnancy, in particular psychological adjustments, these insights need to be communicated to practitioners in the area. This information is also important for practitioners working in labour and delivery areas since, as shown by Lederman, Lederman, Work, and McCann (1979, quoted in Lederman, 1996), conflicts concerning acceptance of pregnancy were shown to be significantly related to duration of the active and descent phases of labour.

Public Service and Other Community Service Agencies

Financial support programs, community agencies, schools, and recreation programs for children and adults need to give consideration to the needs of families on social assistance. Avoidance of stigma is a critically important feature if these services are to be acceptable to, and respectful of, the client group.

As a community, we need to consider our values around quality of life issues for children and adults living in poverty. Society may well benefit in the long run if greater access to activities that contribute to enjoyment of life and avoidance of boredom are made more readily accessible. This is especially true for school age and teenage children for whom it is so important to be accepted by their peers.

Policy makers and program developers in the area of health

promotion need to instill the message of healthy pregnancy behaviour long before pregnancy is established (i.e., in early adolescence). Statistics indicate Newfoundland and Labrador rates for teenage pregnancy have exceeded national rates since 1986, the first year for which rates are available for this province (West, Bavington, James, Ryan, & Longrich, 1994). This programming should include awareness of fetal development, good nutrition, and the risks of smoking, alcohol and substance abuse in pregnancy.

Special approaches are needed to support pregnant women who are attending school. Financial support programs should encourage women in their commitment to obtaining an education. Teachers need to be aware of the many challenges faced by the pregnant teenager and offer as much support as possible, including flexible, innovative programming. If the woman feels she must withdraw from the education program as a consequence of the pregnancy, assurance should be provided she can return at a time when she is in a better position to cope with the challenges.

Finally, society must continue to explore and implement innovative policies and programs aimed at ameliorating poverty. These programs should contribute to dignity and independence while continuing to provide the financial support needed for a reasonable standard of living.

Summary

This phenomenological study on the experience and meaning of being pregnant and on social assistance used van Manen's (1990)

method to explore the question: What is the meaning of pregnancy in the day-to-day lives of a group of women who are receiving social assistance? From the data collected in an unstructured interview conducted individually with eight participants, the following five themes were identified:

- (1) "Settling in" - Forging a Meaningful Balance;
- (2) Giving Recognition to Disruptions and Uncertainty;
- (3) Living on the Edge: Emotional Response to Multiple Stressors;
- (4) The Meaning of Supports: Facilitators of and Barriers to Adjustment; and
- (5) Reflecting on the Lived World.

From the themes, the essence of the lived world of pregnant women in the context of poverty was seen as **the search for acceptance**.

The findings were discussed in light of the current body of knowledge on the experience of pregnancy and the experience of pregnancy in the context of poverty. Additional discussion was provided on new insights provided by this study. Implications for nursing practice, research, and education were presented as well as the limitations of the study.

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Appendix A: Letter to Community Health - St. John's Region

Jeanette Andrews RN BN
15 O'Dea Place
St. John's, NF A1C 3C6

April 30, 1996

Ms. Gail Rogers, Assistant Executive Director
Community Health - St. John's Region
20 Cordage Place P.O. Box 13122, Station A
St. John's, NF A1B 4A4

Dear Ms Rogers:

I am a registered nurse currently studying towards a Master's of Nursing degree. During my program I have concentrated much of my study on the issue of prenatal care. I am particularly interested in how nurses can best help women who face special problems in their pregnancies such as low family income, troubled family backgrounds, and being single.

I have discovered that very little research in nursing, medicine, or social work has asked pregnant women to tell their own stories about their daily lives; for example, the things that are important to them, the concerns they have about themselves and their families, their relationships, and so on. Because I think it is important for nurses to understand the lives of the women they are working with, I am planning to do a study of this nature for my thesis.

I am writing to ask if I could work with community health nurses in order to make contact with my subjects. I will need to talk to 8 to 10 expectant moms in quite a bit of detail to complete this study.

I would appreciate the opportunity to meet with you, and/or other members of your staff, at which time I would explain the nature of this study in greater detail, inform you about the steps I have planned regarding the conduct of the study, and answer any questions you might have.

Thank-you for your consideration of this request. I look forward to hearing from you.

Sincerely yours,

Jeanette Andrews

Appendix B

Letter of Support from Community Health - St. John's Region



September 19, 1996

FAXED
Sep 23

Ms. Jeanette Andrews
15 O'Dea Place
St. John's, NF
A1C 3C6

Dear Ms. Andrews:

RE: Research Project - A Phenomenological Study: The Experience and Meaning of Being Pregnant and on Social Assistance

Thank you for your amended proposal. I am pleased to inform you that your research project has been discussed by Senior Management and that approval has been granted. Congratulations!

Upon completion of the project, please submit a copy of your report to Community Health - St. John's Region for sharing with your colleagues.

Sincerely,

ANN ROBERTS, MD
Assistant Executive Director/
Medical Officer of Health

AR/dg

Appendix C: Letter to Potential Study Participant

Jeanette Andrews RN BN
15 O'Dea Place
St. John's, NF A1C 3C6

July, 1996

Dear Pregnant Mom:

My name is Jeanette Andrews and I am a registered nurse. I am currently attending Memorial University part-time, working towards a Master's of Nursing degree. I am interested in learning about how nurses can best help and understand pregnant moms who may have special problems such as being single, having a low family income, and so on.

I believe that one of the things nurses need to understand is the day-to-day life of a pregnant woman who doesn't have a lot of money to spend. As part of my nursing program I would like to do a study of a small group of pregnant women about their day-to-day lives. Some of the things we would discuss might be: what things are important to you, what are the things that bother you, what things have changed in your life, and so on. We may need to meet once or twice for an hour or two but this would be arranged to suit you.

After our talks I will write up a description of some of the things we have talked about. Then I will go over what I have written with you to make sure you agree with what I have said. Eventually I will put all the writing together and submit it to the School of Nursing. When the project has been passed by the School I would like you to have a copy of it, if you want one.

As you can see, in this study you will be helping me, and other nurses, to learn about your life. If you are willing to work with me on this study please let the community health nurse know. If you would rather not participate that's quite alright too. It's your decision. Saying no will not cause any problems for you (or me). If you think you might be interested in doing this we can get together and I will explain the project a bit more and answer your questions. You can still say no at any time, even after we have started, if you decide it's not for you.

Sincerely,

Jeanette Andrews

Appendix D: Consent Form

SCHOOL OF NURSING
MEMORIAL UNIVERSITY OF NEWFOUNDLAND
ST. JOHN'S, NEWFOUNDLAND A1B 3V6

CONSENT FORM

TITLE: The Experience and Meaning of Being Pregnant and on Social Assistance

INVESTIGATOR: Jeanette Andrews RN BN Telephone: 739-5464

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time without affecting your access to community health or social services.

Confidentiality of information concerning participants will be maintained by the investigator. The investigator will be available during the study at all times should you have any problems or questions about the study.

Purpose of study: Pregnancy is an important time in the life of a woman. Nurses would like to know that the support they offer pregnant women is useful and appropriate. In order to do this, it would be helpful to know about the day-to-day life experiences of pregnant women in different situations, especially those with limited financial resources. This could help nurses better respond to women who are pregnant.

Description of procedures: You are being asked to participate in two interviews which will be conducted at a time and setting of your choosing. Interviews will be audio-taped.

During the first interview you will be asked to talk about your day-to-day life experiences and the people and things that are helpful to you. During the second interview, the researcher may follow up on some of the things you talked about in the first interview.

The experiences you and the other participants have shared will be written up in such a way that anything you say will be anonymous. Later, when the study has been written up, you will be shown or read a copy of the information as it relates to you to ensure you are comfortable with what has been written. Again, your name will not be included. When the study is finished, the results, in the form of a book, will be made available to nurses in the library at Memorial

University.

Duration of subjects participation: Each interview will last approximately 1 to 2 hours. Both interviews should be completed within a two to three month period.

Foreseeable risks, discomforts, or inconveniences: There are no expected risks from participating in this study. You may refuse to answer any questions you are uncomfortable with and you may request termination of the interview at any time.

All information that you provide will be kept strictly confidential, held in a locked file accessible only to the researcher, and the tapes will be erased at the completion of the study. Your name will not be used in the written copy.

Benefits which you may receive: Although there are no direct benefits to you, you will be helping nurses better understand your day-to-day life. You will have the opportunity to tell about your experiences to an interested listener.

As a researcher I will not be able to help you resolve problems in your daily life, but I may be able to refer you to someone else for help.

Other information: The results of this study will be available to you and health care providers upon request. Findings may be published, but you will not be identified. The researcher will be available during the study at all times should you have any problems or questions about the study.

Your signature of this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researcher, or involved institutions from their legal and professional responsibilities.

I, _____, the undersigned, agree to my participation in the research study described.

Any questions have been answered and I understand what is involved in the study. I realise that participation is voluntary and that there is no guarantee that I will benefit from my involvement. I acknowledge that a copy of this form has been given to me.

(Signature of Participant)

(Date)

(Witness Signature)

(Date)

I, _____, the undersigned, also agree to be audiotaped during each interview.

(Signature of Participant)

(Date)

(Witness Signature)

(Date)

To the best of my ability I have fully explained to the subject the nature of this research study. I have invited questions and provided answers. I believe that the subject fully understands the implications and voluntary nature of the study.

(Signature of Investigator)

(Date)

Phone Number

Appendix E: Interview Schedule

Introductory Script

I am interested in hearing about your day-to-day experiences as they relate to being pregnant. Please tell me in your own words what this experience is like for you. Feel free to talk about whatever incidents, thoughts, or feelings that come to mind.

Examples of Probes/Questions to Facilitate the Interview

1. Can you tell me what being pregnant is like for you? What are some of the positive aspects? Negative aspects?
2. We all have good days, bad days, and average days. Can you tell me about what a good day like for you since you became pregnant? a bad day? an average day?
3. Can you tell me about the people or things that are most helpful to you in your day-to-day life since you became pregnant?
4. What are the things that make your day difficult since you became pregnant?
5. Can you tell me about your experiences with the health care system since you became pregnant? Where these experiences positive or negative? What made the difference?
6. How have others in your life been responding to you since you became pregnant?
7. What are the things that are important to you now? Have they changed since you became pregnant?
8. Can you describe incidents in your life, since you became pregnant, that stand out for you? What was it about these experiences that made them stand out?
9. Is there anything else you would like to tell me about your experience of being pregnant?

Appendix F: Letter of Approval from the Human Investigation Committee
(HIC), Memorial University of Newfoundland



Memorial

University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

6 August 1996

Reference #96.113

Ms. Jeanette Andrews
c/o Dr. Christine Way
School of Nursing

Dear Ms. Andrews:

At a meeting of the Human Investigation Committee held on **August 1, 1996**, your application entitled **"A Phenomenological Study: The Experience and Meaning of Being Pregnant and on Social Assistance"** was considered. The Committee recommended approval of the study but was interested in knowing the permissible range of gestational age at which a participant will be interviewed.

We take this opportunity to wish you every success with your research study.

Sincerely yours,

Roger Green, Ph.D.
Acting Chairman
Human Investigation Committee

cc Dr. K.M.W. Keough, Vice-President, Research
Dr. Eric Parsons, Vice-President, Medical Services, HCC
Ms. Kay Matthews, Supervisor



Memorial

University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

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Roger Green, PhD
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Dr. Eric Parsons, Vice-President, Medical Services, HCC
Ms. Kay Matthews, Supervisor

EL 4827

