

**WOMEN'S ACCOUNTS OF
PREGNANCY:
PSYCHOLOGICAL AND
FEMINIST ISSUES**

A thesis submitted for the degree of
Doctor of Philosophy
By

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This work is dedicated to Inder Kaur.
This one's for you, mum.

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As I write this final piece, I have two sisters in hospital and my thoughts are with them. To Bobsie, keep your chin up, I've got my fingers crossed that you won't have to endure yet another operation. To Bali, well I know we always enjoyed sharing five days that overlapped between our birthdays and use to go round claiming we were twins, but come on we didn't both have to go into labour prematurely by the same time span. Keep those legs crossed otherwise the baby's birth date will be the same date as my hand-in date (which coincides with my original hand-in date and Krishan's due date!). That's spooky.

Abstract

This thesis examines the changing nature of women's pregnancy experiences as progression through the various stages of pregnancy occurs. Ten women are followed through their pregnancies, in order to capture their diverse and dynamic psycho-social experiences. The aim of the research is to highlight the significance of certain psycho-social issues related to the pregnancy experience (both positive and negative) which have been raised by the women themselves during the course of their pregnancies. The analysis has been carried out using the women's own descriptions. The main psycho-social issues that have been analysed are considered under the rubric of the dynamic self, in the form of: identification with the pregnancy; the assessment of risk during pregnancy; and finally, images of the self and baby during pregnancy.

The thesis focuses in-depth on the dynamism and complexity of women's feelings during pregnancy. In particular, it looks at the concept of being obstetrically 'at risk' by analysing women's contradictory and changing accounts of their feelings and concerns. The research also contributes to the understandings of the identities and preoccupations of pregnant women.

The design of the study is longitudinal and biographic. The women kept personal documents in the form of diaries during their pregnancies, and also participated in four unstructured in-depth interviews (three taking place during pregnancy, the fourth taking place after birth). The methodological approach taken is based on a feminist research perspective, which emphasises the value of qualitative methods of investigation. The thesis explores the role of the researcher by examining the location of the researcher in relation to both the participants and the research area. The individual experiential accounts of pregnancy provided by the women are explored in detail using a feminist interpretative style of analysis (Stanley and Wise, 1993).

Chapter One: Introduction

1.1 Introduction to the thesis

This research project centres around women's own accounts of their pregnancy, and uses a qualitative approach in order to collect data that highlights the psycho-social experience of pregnancy. The substantive issues which are explored relate to the dynamics of pregnancy, while the in-depth accounts show how the women's experience changes in terms of the ways in which they identify, describe, relate to, resolve and handle this special status. Particular emphasis is placed on highlighting and addressing the ways in which the women identify with the pregnancy, and the types of dilemmas they face. Each empirical chapter shows how the experiences that the women go through are multiple, changing and contradictory in terms of their feelings and perceptions of the pregnancy. The women's accounts have been examined in light of their own phenomenological identifications with, and perceptions of, the pregnancy.

The research has been conducted using feminist research methods and is based within the sub-discipline of 'the psychology of women'. This is a relatively young discipline, which has only been part of some undergraduate curricula in the social sciences since the 1970s (Matlin, 1996). The reasons why I chose to carry out my research using a feminist approach are multiple, and some of them relate to those which Peplau (1994) describes as leading her to engage in feminist psychology. She states: 'I was attracted to feminism for fairly simple reasons. Feminist perspectives helped me to understand my own life experiences and relationships in new and more insightful ways. Feminist analysis challenged traditional ideas and showed how patriarchal social arrangements constrain the life choices of women and men. Feminist activism sought to improve the lives of women and to work toward a more just society that places a high value on women as well as men. Feminist values have added a sense of passion and purpose to my research. I have found feminist scholarship nourishing when it has inspired me by examples of

creative studies, raised new research questions, and offered provocative analysis and interpretations' (Peplau, 1994:44).

Using a feminist perspective which acknowledges and encourages new research questions and forms of analysis has led me to take seriously the everyday experiences that the women report, as well as the role played by the researcher. Thus, in addition to examining the women's experiences of pregnancy, this thesis also outlines my own experiences as a researcher in that I have endeavoured to outline the influences that the research and those researched had on my own conceptualisation and utilisation of the accounts. This is a central issue, given that the accounts were not produced in a vacuum, but were produced for the purposes of research, and therefore my role as the researcher will have shaped, to some extent, what was documented by the women and what was left out. This selectivity issue goes further in terms of the themes I have selected from the accounts, both on a conscious and unconscious level, to report and analyse.

In addition to examining the above named influences during the course of this thesis, I have also reflected upon how during the early stages of the research project I was perceived to be unsuitable for carrying out this piece of research by the gatekeepers to the access of participants. To this end one of the central themes to be discussed in this thesis is the role of 'difference' and how this came to play an important part in the early stages of the research. This theme is discussed separately in chapter ten rather than in the following subsections, which look at the influences present at the beginning of the research project.

1.2 Background to the study

1.2.1

The role of reflexivity

One of the main criticisms that Stanley and Wise (1993) make of the more traditional forms of presenting research findings in academia is the lack of reflexivity reported in the write up of the research process. They argue that

research is presented as though it is an orderly activity with distinct stages of completion, whereas this is not always the case. Likewise, Oakley (1992) argues that texts on research methods often report the research process as though it is a systematic, linear process, while in practice the simplicity that these texts purport does not reflect 'reality'. The mythology of 'hygienic research', as Stanley and Wise term this style of reporting, is one that has led me to include the following three subsections in my write up of the research. What follows is an account of the changes and problems that I encountered during the course of the research project which led to the end product being substantially different than that I had envisaged at the outset of the research.

1.2.2

The initial research agenda

The research originally set out to explore women's decision making processes and experiences of pregnancy using qualitative methodologies. This area of research was of particular interest to me due to the previous research experience I had gained in an earlier study, entitled 'The psychosocial factors associated with the uptake of prenatal diagnosis amongst women of advanced maternal age', and completion of this earlier study highlighted the difficulties associated with its design.

Firstly, the study was retrospective, in that women were interviewed after they had given birth. Thus, details relating to perceptions of risk and attitudes toward the diagnostic tests may not have been accurately recalled by the women due to the time lapse between their pregnancy and their participation in the study. In addition, the attitudes of the women may have altered during the course of this time, and thus their responses may not have reflected their previous perceptions. For these reasons the chosen design of the current study was prospective. The women were interviewed on a number of occasions at varying intervals during their pregnancy, in order to allow a mapping of the women's experiences of pregnancy at different points in time.

Secondly, the use of a structured questionnaire in the previous study meant that only a small number of the factors associated with the uptake of prenatal diagnosis were investigated. This meant that the analysis of the complexity of the decision making process and the factors associated with the decision was limited. In the current study, a qualitative approach is adopted. No questionnaires were given, instead diaries were provided for women to recount their daily experiences. Open ended interviews were conducted on four occasions (one in each of the three trimesters of pregnancy and one postnatally). This open-ended approach was used in order to allow the women to decide what they would like to report, as well as to recount their daily experiences.

The use of a prospective design using qualitative methods of data collection in the present study was chosen to allow a more contextualised account of women's experiences and decision making processes than the previous study could allow. The interpretation of the data would allow the reconstruction of the experiences of the women who took part in the study, and also permit the analysis of variation that occurred in the beliefs and attitudes held by the women at different stages of their pregnancy.

This study, like the previous study, included women who would medically be defined as 'high risk', thus facing decisions related to the uptake of prenatal diagnosis.

1.2.3

Research in practice

In practice, both high and low risk women were part of the study sample. The reason why low risk were also included, although not considered at the outset, was due to the fact that when I received the consent forms it occurred to me that if I wanted to consider women's perspectives then the medical category of high and low risk may well not be the most important factor. In addition, the literature review I had conducted on high risk pregnancies seemed to concentrate on the decision making processes as

related to the uptake of prenatal diagnosis. There was very little research that examined the way that decisions are related to the social situation and personal experiences of women. This led me to recruit all the women who had responded within the first month of recruitment.

Once the study was under way, I found a disparity between what I was interested in and what the women were actually providing. As it was my intention to take full account of what the women were expressing, the direction of my research subsequently changed. I did not alter the methods of collecting the accounts in order to direct the content of the accounts towards my original interests, but instead changed the way that the data were analysed in order to allow the full range of accounts to be considered. Preliminary analysis of the data took the form of producing the varying categories which emerged from the diaries, and from these categories I chose to concentrate on a small subset of interrelated categories in order to carry out a thematic analysis. This breaking down of the raw data into categories and then choosing a select number for presentation within a theme was necessary, as the substantial amount of data that was produced by the women could not all be analysed in depth. I mainly chose to focus on the conceptualisation of pregnancy (particularly in relation to the changing beliefs of the pregnancy being real), on the construction of risk, and on the changing image of the body and the fetus. Thus, what appears is a fractured account of the pregnancy experience, as no one individual's full experience of pregnancy is presented within the thesis. Instead, I have chosen to outline a number of predominant themes which emerged from the dataset as a whole and show how a number of aspects come to form parts of the pregnancy experience. At the outset of the study I had envisaged being able to cover the majority of the issues that the women reported to be of relevance to their pregnancy experience, and thus thought I would be presenting far more of what constituted each women's experience. It was only when I came to analyse the data that I realised that there was so much that came to form the total experience that it was not feasible to analyse everything. The predominant themes that were chosen for inclusion in this thesis were those for which I

found a gap within the literature, and thus their contribution toward the understanding of the pregnancy experience led to their inclusion.

1.3 Issues of presentation

As mentioned in subsection 1.2.1, Stanley and Wise (1993) argue that published research often gives a false picture of what happens during the course of research, and suggest that researchers need to be more open about the process of research. In this thesis I have endeavoured to include a number of elements which are often ignored when presenting research. However, for the purposes of structuring this thesis the reflexive elements have, in the main, been discussed in separate subsections and not necessarily at the point at which they occurred. For example, discussions relating to the impact my perceived 'difference' made at the point of trying to recruit participants is not included in the methodology subsection but instead appears in a separate chapter. The definition and use of reflexivity is also provided in chapter ten, and not here, as it requires detailed discussion. The structure of this introduction presents two subsections (1.1 and 1.4) in a formalised, non reflexive style while two subsections (1.2 and 1.3) are presented in a more open and reflexive style. The reason for separating the reflexive elements from the description of research which appears in subsections 1.1 and 1.4 relates to my attempts to straddle between the traditional forms of writing research findings (which up until the beginnings of this research was the approach I had been trained in) and the more innovative new forms of writing (which have only been learnt as this research has progressed).

Subsections 1.1 and 1.4 aim to provide a more traditional framework of the thesis which does not include the changes and practices that often take place behind presented research. If I had not included subsections 1.2 and 1.3, then I too would be further colluding with academic conventions of putting forward an account that reflects a sanitised version of the research at the expense of honesty. The need to structure the material and provide a framework for the reader has meant that what follows is presented in line with

accepted conventions, and thus I too have rather sanitised my account in the following subsection.

1.4 Structure of the thesis and summarised description of the material presented

The thesis is divided into four main sections. A brief explanation of each section is provided here in order to outline the work carried out and its order of presentation.

In this, the first main section of the thesis, a synopsis of the study and details of the background to the study have been outlined. In addition to this introduction, this section also contains two substantive chapters.

The second chapter contextualises the present research study in terms of previous research conducted on women's experience of pregnancy. The chapter begins with a summarised description of the ways in which the majority of past research can be conceptualised. Two distinct conceptualisations are highlighted: firstly, pregnancy as a transitional stage to motherhood and secondly, the discrete factors which affect the experience. A brief mention is also made of the levels of analysis that have been used (macro and micro), as well as the substantive areas that have been of interest to researchers (e.g. the predominance of studying the negative aspects of the experience).

Having set the scene, I move on to review a number of the research studies which specifically use a psychological or sociological perspective. Each of the studies is described in terms of the theoretical and methodological stances taken, as well as its major findings. Only a few of the studies reviewed relate to the substantive issues explored in my own research, and fewer still take the qualitative methodological approach I used. These related studies are discussed in greater detail in order to provide an overview of the similarities and differences between them and my own research.

The review of the literature highlights some of the gaps in the field of pregnancy research, as well as detailing the problems associated with

particular styles of research. My own research addresses some of the gaps which have been identified during the course of the literature review, and thus this chapter provides the context in which my own research can be placed.

The final part of this chapter examines the historical and social consequences prior research has had for women. The material used to describe the positioning of women has predominantly been drawn from feminist accounts, which highlight how women have been subordinated within society in general, as well as within academic disciplines that have researched and theorised them. Of particular relevance are the feminist critiques of the dominant ideologies of motherhood which have viewed women as being ruled by their biology.

The third chapter examines the methodological and epistemological issues concerned with the conduct of research on human behaviour. In this chapter a detailed description of feminist methodological approaches is provided together with a discussion of the major debates within feminism and psychology to date. This chapter begins by detailing the relationship between the research I have undertaken and that of other researchers who have carried out similar studies, with emphasis placed on discussing methodological similarities. The discussion then moves on to explore the role of feminist research methods in the social sciences and draws out the comparisons that can be made between the more traditional forms of research and the feminist approach I chose to undertake. This is followed by a description of feminist theory and epistemology, and the related methods of data collection and analysis. Particular emphasis is placed on Stanley and Wise's (1993) approach, as this is the approach I have taken.

The second main section of the thesis aims to outline the research process. Chapter four details the methodological and analytical framework employed, as well as the participant details.

The third main section contains five empirical chapters, with each chapter highlighting certain aspects of the pregnancy experience. The empirical analysis of the accounts produced by the women is discussed in relation to the literature review on the psychology of pregnancy as presented

in chapter two and has been analysed using a feminist interpretative style of analysis, as outlined in chapters three and four. The empirical analysis aims to highlight the multiplicity and complexity of some of the issues women faced during their pregnancy. The use of medical terms (by the participants and myself) to describe certain aspects of the pregnancy is noticeable within the empirical chapters. The definitions of these terms are provided in the glossary of terms to which the reader can refer.

In chapter five, the first of the empirical chapters, entitled 'Pregnancy identification in the first trimester', an analysis of the predominant themes that a number of women raised in the early stages of pregnancy is presented. Each one of the themes highlighted in this chapter reflect not only aspects of the pregnancy experience, but also show how the experience is constructed in terms of dilemmas and contradictions.

In chapter six, 'Constructions of risk', the concept of risk is examined across different participants' accounts, and the number and variety of forms of risk construction and management highlight how diversely this concept appears. In this chapter the analysis of the data shows how the experience of pregnancy is made up of a number of contradictory thoughts and behaviours which affect the women during the course of their pregnancy. In both chapters six and seven the risk assessments put forward by the participants show how particular concepts (such as risk) appear to be in agreement with a number of evaluations (for example, about the appropriateness of certain forms of behaviour during the course of pregnancy).

Chapter seven, 'A case study analysis of a diabetic woman's experience of risk', provides an in-depth account of how risk can be constructed and reconstructed. By taking a case study approach in this chapter I aim to show the changing nature of one woman's experience of the concept of risk during pregnancy, with the detailed examination of a single concept (risk) from a single participant's account providing valuable insights into the emotional aspects of the pregnancy experience. This chapter aims to show how examining accounts from one participant helps to retain the analysis at the level of the individual rather than at the level of the text, which is a possible interpretation when a multiple case study form of analysis is

taken (although analysis at purely the level of the text is not intended in any of the analytical chapters). In addition, the way in which risk was constructed by this participant varied greatly from those offered by the other participants, which enables variations of constructions to be examined. By taking a case study approach the diversity and intensity of her experience of risk could be explored. In the previous chapter diversity across accounts is acknowledged, albeit at the expense of portraying each individual's contextual experience. The reason why this participant's construction was chosen for a case study analysis related in part to the centrality of the experience during the course of her pregnancy experience. For the other participants the role risk played was not expressed as intensely or in such graphic detail.

Chapter eight, 'Images of the pregnant self', examines the way in which the women perceive themselves and their changing bodies, specifically during the second and third trimesters. This chapter highlights the tensions that they experience, and shows how the changes that they experience are the source of both positive and negative feelings. The social construction which comes to form the personal construction of the pregnancy is reflected upon by highlighting the women's evaluations of their own, and other people's, attitudes toward their pregnancy.

Chapter nine, 'Images of the baby', discusses how the women come to perceive and describe their baby. The vivid pictures they receive as a result of ultrasound examination(s) are but one source of information they use to reflect upon their baby. With the passage of time the women come to describe their baby in more and more detail, and begin to reflect on the identity and needs of the baby yet to be born.

The fourth section of this thesis contains two chapters: chapter ten, 'A reflexive analysis of the research process', and chapter eleven, 'Discussion of the research conducted and the main findings'. Chapter ten contains a detailed examination of the links between the researcher, researched and research topic and looks at the influences of each upon the others. The main area of discussion here reflects current debates within feminism and psychology on the representation of difference from feminist standpoint perspectives.

Chapter eleven, 'Discussion on the conduct of research and the main findings', summarises the main points contained within the thesis and explores the contributions it makes to the field of inquiry, in terms of contributing towards both feminist research practice and research pertaining to better understanding of pregnancy as constructed and experienced.

Chapter Two: Past and present approaches relating to the study of pregnancy

2.1 Conceptualising previous research on pregnancy

The reproductive role of women in society has been explored within a number of academic disciplines, ranging from the arts to the sciences. The historical, social, cultural, psychological, biological and medical aspects of reproduction mean that there are a number of perspectives from which the subject matter can be, and has been, approached. However, as Matlin (1996) outlines, within the discipline of psychology pregnancy has received little attention in comparison to other topic areas such as love or sex. In addition, Matlin also points out that popular introductory psychology textbooks fail to mention pregnancy at all. Having carried out an extensive literature search, I also found that none of the general psychology textbooks contain information on the topic of pregnancy. This lack of reporting means that knowledge about motherhood tends to be assumed rather than examined (Phoenix and Woollett, 1991).

Given the lack of reporting that motherhood, and in particular pregnancy, has received in mainstream psychology, anyone interested in this field of inquiry must begin by consulting specialised texts. Having taken this step, I found that the research on pregnancy appears to have been conducted under the rubric of either the transition to parenthood (the term parenthood instead of motherhood appears to have been used more widely except in feminist texts), or the factors which allow prediction and control of various aspects of pregnancy behaviour.

Taking the first of these conceptualisations, studies on the transition to parenthood, Grossman et al (1980) describe the term transition as the process of becoming parents (which is influenced by many factors such as the psychology of the man and the woman, life stresses, and sources of support). The aims of the research carried out relate to the measurement and prediction of the adaptations made during the period of pregnancy (from conception onwards) for parenthood. Goldberg (1988) outlines how research has been

carried out across the various perspectives outlined above. She points out that the research is rooted in several academic disciplines, and that in the last two decades there has been a move toward a more interdisciplinary approach. This interdisciplinary interest in the transition to parenthood is evident in the small, but significant, number of publications that have appeared in which the author takes either an interdisciplinary approach, or presents several different disciplines separately, (and these differing approaches have been reported in one text). Examples of the latter include Miller and Newman's (1978) edited volume, entitled The First Child and Family Formation, in which contributions from psychologists, sociologists, physicians, and anthropologists appear; similarly, the special issue of the Journal of Family Issues edited by Cox (1985) on the transition to parenthood; and more recently, the edited book by Michaels and Goldberg (1988) entitled The Transition to Parenthood. The popularity of viewing pregnancy as a transitional state has meant that much of the work that has been carried out has concentrated on the first pregnancy, which launches the woman into motherhood, with the result that multiple pregnancy experiences have received little attention. Fewer studies still explore the problems faced by parents of triplets and higher order births (see Price, 1989). In addition to the first pregnancy being the first occurrence of this transitional life event, another reason why studies on the first pregnancy, as opposed to subsequent pregnancies, have occurred relates to the perceived methodological advantage, in which the first pregnancy represents 'the 'cleanest' occurrence to investigate and it provides the greatest contrast' (Michaels and Goldberg, 1988:345).

The levels of analysis that have informed research on the transition to parenthood have ranged from the macro to the micro. Within the macro level of analysis, the social and historical influences on the individual experience of pregnancy and motherhood have shown the ways in which motherhood has been shaped and attributed meaning at a societal level (see, for example, Oakley, 1979; Phoenix, 1991). This macro level of analysis has subsequently allowed a greater understanding of the context in which the micro experience of pregnancy and motherhood occurs.

At the purely micro level, the experience of pregnancy has predominantly been examined in terms of the physiological changes that occur, and the risk factors associated with, for example, infant morbidity and mortality (see, for example, Rutter et al, 1993). This leads into the second conceptualisation under which research on pregnancy can be placed.

In this second conceptualisation, interest lies in the discrete factors that affect the behaviour of the pregnant women, and/or the prediction and explanation of the factors involved (see, for example, Marteau, 1994; Norman, 1995). Within this framework more attention is paid to the consequences of various factors on pregnancy outcome, rather than the perceptions that the woman has of her pregnancy.

Returning to the issue of the various perspectives which can be, and have been, applied to pregnancy, it must be noted that even where studies have specifically used a social science perspective, there has historically been a wide variety of ways in which women's lives in relation to reproductive issues have been theorised and researched. The ways in which women have been socially perceived, controlled and treated have led many feminist researchers (see, for example, Ussher, 1989; Rothman, 1994) to critically examine the implications of the theories and treatments that have been advocated, as well as to put forward their own styles of theorising and researching women's lives. However, before providing a feminist perspective, a short review of the psychological literature on pregnancy and childbirth is necessary to show how the discipline of psychology has traditionally investigated and theorised about women's experience of pregnancy. This review will also help to locate my own research, which aims to look at the neglected area of the constructions of the pregnancy experience in light of the meanings of motherhood available at historical and social levels.

Close inspection of the published papers (for example, Elliott, 1984; Fedele et al, 1988; Michie et al, 1992; Marteau et al, 1992) relating to the psychological aspects of pregnancy reveals the predominance of the quantitative approach in examining issues related to pregnancy, and this thesis accordingly sets out to explore the methodology, as well as the research area, by looking at methodological questions and outcomes of the

approach taken whilst carrying out research. The quantity/quality debate linked to the relative merits of quantitative/qualitative methods of research is explored in the next chapter.

The predominance of the positivist model of research has meant that the pregnancy experience has been divided not only into discrete stages by many researchers (just as the bio-medical model does), but has also been split up into discrete components which can then be measured in order to establish their predictive relationships (see, for example, Shereshefsky and Yarrow, 1973; Grossman et al, 1980; O'Hara et al, 1984). This has largely been achieved by adopting the experimental method, which requires factors to be seen as independent/dependent variables.

It is noticeable that the bulk of the research has tended to explore 'the problematic' aspects of pregnancy. The factors which are considered (often in isolation from the overall experience) tend to concentrate on the negative/abnormal/pathological/maladjustment/poor-adaptation, and the 'difficult' aspects of pregnancy (Phoenix et al, 1991; Johnston, 1993; Matlin, 1996). Johnston (1993) argues that this concern with negative reactions and emotions is in contrast to the popular cultural view of pregnancy which sees having a child as a time of joy. Green et al (1990) investigated women's accounts of being pregnant, and found that 74% of the women were happy about the pregnancy, while 46% of the sample reported being anxious due to worries, for example about miscarriage, financial problems, hospital admission and examination procedures. This shows that a significantly higher number of women report being content with the pregnancy in contrast to the number who report any problematic aspects. Yet, as Johnston (1993) points out, psychologists focus more on the negative aspects than the positive which may also occur during the transition to parenthood. What these various findings point to is the complexity of feelings involved in each pregnancy.

Following the work of Phoenix (1991) in relation to young motherhood, I would argue that the predominant form of research, which concerns itself with the problematic aspects at the expense of the positive, neglects the women's own constructions of the pregnancy experience and unduly theorises women negatively (a fuller debate of this issue is undertaken in subsection

2.5). In addition, the terms used (abnormal/pathological/difficult) may themselves be problematic in terms of the constructed image they carry, and thus need deconstructing in order to tease out the significance(s) they carry politically.

Matlin (1996) argues that the study of the positive aspects of pregnancy is, on the whole, ignored by psychologists, and that very few studies are carried out within the discipline which examine 'normal' pregnancy. In my own research the positive emotions are given serious attention, and both low risk ('normal') and high risk pregnancies are considered. Hence, I hope to contribute to filling the gap in the literature which currently exists.

In the following section, I give a brief outline of the work carried out on pregnancy, the methodology used and the associated findings, upon which the above descriptions are based. The review of the literature presented here is by no means exhaustive, as the aim of this literature review is to put forward an indicative sample of the work that has been carried out within the discipline of psychology. An historical approach is used to structure the research material presented, which serves a dual purpose. Firstly, it provides the reader with the context in which pregnancy research has progressed, and secondly, it highlights the changes in the theoretical and methodological positions that have been taken.

2.2 Review of literature on pregnancy

The classic study conducted on the psychology of pregnancy by Shereshefsky and Yarrow (1973) broke away from the previous styles of research, and was hailed as a breakthrough by the authors. They point out that the majority of previous research on pregnancy concentrated on the biological facets rather than the behavioural facets of pregnancy, and they argue that the significance of their study was that it 'laid to rest some previous dogma related to psychiatric pathology during pregnancy' (page v). They also point out that the dominant approach to studying pregnancy involved seeing pregnancy primarily as a physical occurrence, while the emotional aspects

were not considered to be very important, either in terms of the woman's pregnancy experience or in terms of its relation to pregnancy outcome (Grossman et al, 1980). Before an outline of Shereshefsky and Yarrow's work is provided, a brief description of the type of work carried out on pregnancy prior to the 1970s will be provided, in order to contextualise the developments that have taken place in the 'psychology of pregnancy' over time.

In terms of the pre-1970s research on the physical aspects of pregnancy, the predominantly physiological approach taken by Rosen (1951) to investigate pathological conditions such as Hyperemesis Gravidarum (severe nausea and vomiting) shows the emphasis that was placed in investigating the 'pathological' rather than the 'normal' pregnancy. Grimm et al (1967), in their review of the literature on the influence of psychological variables on pregnancy, found that the majority of the articles published described clinical impressions of pregnancy, delivery and outcome. They reviewed a series of studies to find out whether there was a correlation between psychological and physiological measurements, and subsequently found that 'from the studies of pathological conditions considered as a whole, the evidence is ample that physiological disturbances are paralleled by psychological disturbances of some kind. There is, however, no evidence that psychological factors *cause* physiological effects, and, most unfortunately, no assurances from studies conducted after the pathology has been identified that the physiological malfunctioning does not cause the psychological disturbance' (p 18). Grimm et al's (1967) review shows that the main areas of pregnancy research that had been carried out to date did, as Shereshefsky and Yarrow (1973) also point out, concern themselves with the physical aspects of pregnancy.

During the 1940s and 1950s, a small number of psychoanalytic theorists began to utilise the psychodynamic approach in studying pregnancy (see, for example, Deutsch, 1945; Bibring, 1959). These psychoanalytic theorists developed Freud's writings on female sexual identity, by actually examining women's experiences of pregnancy. Freud had said that a healthy female sexual identity would occur once the female child gave up her wish for

a phallus/penis and replaced this wish with a more realistic wish for a child. This he termed a maternal orientation.

Deutsch's (1945) book 'The Psychology of Women' explored the complex psychological processes involved in pregnancy and childbirth, and proposed the theory of 'motherliness'. Healthy ego development in a woman, in this account, closely relates to the development of a 'motherly ego'. The role played by pregnancy is one in which natural fulfilment of the wish for a child occurs.

Bibring (1959) describes pregnancy as a time of 'crisis' which shares many features with other crises that are experienced by women (e.g. puberty and menopause). All three biologically-determined psychological crises, Bibring suggests, revive conflicts experienced during early development, and during the crisis period new solutions are sought. If the crisis is overcome then a higher level of maturity occurs, while failure to do this leads to a less satisfactory level of functioning (problems may arise for the mother and the mother-infant relationship). Bibring (1961) goes on to say that 'The crisis of pregnancy is basically a normal occurrence and indeed even an essential part of growth, which must precede and prepare maturational integration' (Bibring et al, 1961:22). However, although the pregnancy crisis is a normal occurrence, it is seen as an enormous emotional challenge.

The above examples show the application of one particular psychoanalytic approach to the study of pregnancy, in that Deutsch's and Bibring's work examine the pregnancy experience in terms of the intrapsychic factors involved. Later work, still within the psychoanalytic perspective, looks at the interpsychic factors that are involved in the pregnancy experience (see, for example, Melges, 1968 and Ballou, 1978).

Ballou (1978) argues that the object-relations approach allows the pregnancy to be seen as the 'gestation of a person' (where the birth of the child is seen as the birth of a sense of a person), who is born into a network of relationships, and thus this approach looks at the woman's sense of persons, derived from an individual's 'adult character structure, which is organised around a sense of how people are, how they interact, what one can expect

from them, and how one is in relation to them' (Ballou, 1978:2). This sense of people is seen to develop from one's early experiences in the family. Note that by taking an object-relational framework, Ballou investigated pregnancy in terms of how the woman navigates her transition to motherhood, thus placing emphasis on the changing relationships that the woman has with her sense of her own mother, partner, self and finally the child during her pregnancy. This helps to describe how the pregnant woman comes to terms with child bearing and the meaning behind her experience. The psychological task of pregnancy includes the rearrangement of 'one's sense of self and others so as to accommodate a new person in one's life' (Ballou, 1978:1).

A more recent example of research utilising the object-relations approach is Kaplan's (1992) study on mothers' images of motherhood. Kaplan's study uses an in-depth case study approach to investigate how mothers make meaning of motherhood and their images of motherhood, and addresses the ways in which the twelve women she interviewed describe their images of motherhood in relation to their own mothers and fathers, to other women, to cultural ideas of the mother, and to how they see themselves in relation to, for example, men, children and other mothers.

Kaplan predominantly uses Glaser and Strauss' (1967) grounded theory approach to analyse the accounts, and she reports that women do not present themselves in terms of having close connections with their own mothers or other women. She argues that the women in her sample lack this intimate connection, instead constructing their own alternative image of a good mother which is in opposition to their own mother. Kaplan contrasts her findings with those of Chodorow (1971, 1974, 1978, 1979, 1981, 1989), as Chodorow's theory views women as having close connections to their own mothers to the extent that they want to be like their mothers (hence the title of her 1978 book: The Reproduction of Mothering). In comparing her findings (e.g. negative presentation of their own mother; lack of an intimate connection with their mother; describing fathers and husbands in positive terms with sympathetic representations of them) with those of Chodorow's, Kaplan concludes that due to the level of variety in the accounts she analysed and the variety across theorists' accounts of the object-relations approach as

applied to motherhood 'any single model of female object-relations and concomitant vision of females is simplistic' (1992:203).

Shereshefsky and Yarrow's (1973) work was derived from the first psychoanalytic tradition outlined above, which sees adaptation to pregnancy as a intrapsychic task rather than an interpsychic task. They state that the majority of the previous research that had been carried out had been undertaken in the biomedical sciences which have sought to detail the physiological aspects of a pregnancy, rather than the psychodynamics of pregnancy. Their study was centred on what they termed "normal primigravidas from a middle-class urban population' (Shereshefsky and Yarrow 1973: v), these comments about the sample population being 'normal' as well as their criteria for selection of participants is critiqued later in chapter eleven.

Their research was a large scale systematic attempt to examine the psychology of a first pregnancy. One of their main premises is 'that the mother's psychological state is one of the crucial early influences affecting infant development' (p 2). Thus, the pregnancy experience is not of interest in and of itself, for the authors, but more in relation to the well being of the infant (see the feminist discussion which critiques the view of women as childbearers given in subsection 2.5.1). They also suggest that the importance of studying psychological factors, such as the woman's personality and emotional adjustment to childbearing, relates to the significance they place on the relationship between the mother's psychological state prior to the pregnancy; that experienced during pregnancy (pregnancy adaptation); and that experienced after the birth of the infant (maternal adaptation). Since Shereshefsky and Yarrow assumed that a first pregnancy is accompanied by some degree of stress, their study set out to investigate the effectiveness of counselling the pregnant women during this period of stress. A total of sixty families took part in the study, with half being assigned to a counselling group and the other half to a control group. Six sets of variables (life history; current personality of the woman; current life situation; the pregnancy experience itself; maternal adaptation and infant functioning) and an associated number of items were set out in a questionnaire.

The main finding of the study Shereshefsky and Yarrow reported was as follows: 'the statistical findings indicate that if by the time of the first pregnancy the woman has developed nurturant qualities, considerable ego strength, and a strong feminine identification, as evidenced by the clear and confident attitudes she holds with respect to herself in the role of a mother, it can be predicted that she will make a good adjustment during pregnancy' (p 99). They also suggest that the pregnant woman has more of an intrapsychic experience than an interpsychic experience, implying that the woman responds more to physiological and emotional developments (internal/endogenous) than to significant others and events (external/exogenous).

Shereshefsky and Yarrow's (1973) study is typical of mainstream psychological research and is in contrast to the previously mentioned psychoanalytic studies, in that their chosen methodology involved examining the relationship between the independent and dependent variables. This analysis of factor(s) affecting the pregnancy experience means that discrete components have been examined in isolation.

The above studies show that in some instances, psychoanalytic concepts have been used by researchers to carry out large scale quantitative studies to establish levels of significance (see Shereshefsky and Yarrow, 1973) which purport to examine the role of specific factors previously identified. In other instances, psychoanalytic concepts have been examined qualitatively by researchers who are interested in detailing the complexities of individual experiences from the women's own accounts, hence the testing of previously identified factors is not conducted (see Ballou, 1978).

The psychoanalytic approach outlined above also substantially differs from other approaches in the discipline of psychology in its approach to explaining the causes of behaviour. By locating the experience and causes of current behaviour in past childhood experiences, the approach differs to a large extent from mainstream psychology which subscribes to being able to identify and test the current causes of behaviour.

Turning to the mainstream psychological approaches, one of the more popular uses the symptomology model, where symptoms such as anxiety, depression, stress and mood swings are of special interest. This approach, again based on generality rather than individuality of experience, incorporates medical and psychiatric perspectives which often emphasise the pathological rather than the normal. The symptomology model has been applied not only to those pregnancies which medically come to be defined as 'high' risk, but also those which are considered 'low' risk, hence the pathologisation is not confined to particular types/categories of pregnancies. The symptomology based psychological studies (see for example, Grimm, 1961; Gorsuch and Kay, 1974; Elliott et al, 1983) have examined a wide variety of factors (e.g. stress, anxiety and depression) and currently dominate the field of psychological inquiries of pregnancy. Given the magnitude of work in this area, a representative sample of the work carried out and the reasons for its predominance will be highlighted. The research conducted on 'low' risk pregnancies is highlighted below, whilst the research on 'high' risk pregnancies, which has examined the same issues/factors as those applied to 'low' risk pregnancies, is discussed in the next subsection together with the separate issues such as the impact of prenatal diagnosis in relation to 'high' risk pregnancies.

There are a number of reasons why psychologists have been interested in charting the levels of anxiety in pregnant women. The primary reasons relate to the impact that anxiety has on the well-being of the fetus and the mental health of the mother postnatally. High levels of anxiety have been related to poor growth in the fetus as well as complications during labour and the subsequent relationship between mother and baby (Reading, 1983; Istvan, 1986). In addition, high levels of anxiety in late pregnancy have been correlated with postnatal depression (Johnston, 1993). However, as Sherr (1989) reports, the researchers have often found different outcomes for the same factor, and the lack of repeated studies means only inconclusive comparisons of the results can be made. For example, the results for two factors, tension and anxiety, although obtained differently, showed little variation over the course of pregnancy in Murai and Murai (1975) and Elliott's

(1984) studies. They found a curvilinear relationship with time, where the lowest levels occurred in mid pregnancy, whereas in contrast Grimm (1961) found an increase toward the end of the pregnancy. Johnston (1993) reports that anxiety levels are higher for women who have already had a baby than first time mothers to be, and that this occurs toward the end of the pregnancy, arguing that this is due to the additional information they have about late pregnancy and birth. Elliot (1984) reasons that the increase in anxiety toward the end is due to the specific labour worries women may have, while Sherr (1989) argues that Elliot's explanation does not account for the findings of Luben et al (1975), who reported a drop in anxiety toward the end of the pregnancy. The differences found in relation to levels of anxiety between the various studies mean that no firm conclusions can be made as to whether anxiety predominantly occurs during early or late pregnancy. The above studies show the differing explanations which currently exist, and how the application of qualitative approaches alongside the more traditional quantitative studies in this area may enhance the understanding of why particular women are more anxious at particular stages, and the specific reasons for their increased anxiety levels.

Research into levels of depression have shown no significant variation occurring during the course of pregnancy (Lubin et al, 1975; Murai and Murai, 1975; Elliott et al, 1983). However, Elliott (1984) reported that there was a wide range of individual differences on the measures employed between studies, and thus the results should be accepted with caution. Grossman et al (1980) compared the depression that occurred during pregnancy and after pregnancy in the postpartum period with that which occurred in non-pregnant adult women, and found that the level of anxiety and depression in the first trimester was comparable with non pregnant women. At one year postpartum, the women were found to be less anxious and depressed in comparison to any point since the beginning of the pregnancy. O'Hara, Neunaber and Zekoski (1984) carried out similar research to that of Grossman et al and found that depression decreased after the first trimester. Grossman and O'Hara et al's findings further suggest that levels of depression in early pregnancy could predict levels of depression in early postpartum. However,

Notman and Nadelson (1978) found no association between the levels of depression that occurred pre- and postpartum.

Fedele et al (1988) argue that these contradictory findings require further detailed research to be carried out on specific symptom patterns. What these studies fail to address is the level of individual differences in the causes and occurrence of particular symptoms during pregnancy.

The levels of stress experienced by a pregnant woman may be due to, for example, illness or death in the family, financial problems, or the need to move home. These may well change the emotional experience of pregnancy, yet Grossman et al (1980) argue that stress is related solely to the obstetrical outcome of pregnancy. Johnston (1993) suggests that the interaction between psychological and physiological stress processes should also be considered in order to understand the relationship between the biological changes induced by the reproductive event and the emotions experienced at that time. She argues that it may be difficult to determine the causal pathways, for example is it the anxiety of going into premature labour that is responsible for the neuroendocrine processes which induce premature labour, or the threat of premature labour that is responsible for the increase in anxiety? Both directions need to be considered.

The application of individual differences models have contributed to the understanding of distress in relation to reproductive issues. Johnston (1993) states that transient states of high anxiety could be due to either the event's objective level of stressfulness, or individual differences in trait anxiety which occur due to a disposition to develop high levels of anxiety when faced with a threatening event (e.g. miscarriage or premature labour).

The above examples of research conducted on various symptoms experienced during pregnancy show that the emphasis of the research has indeed been on exploring the negative aspects which may be part of the pregnancy experience. Johnston (1993) suggests that this bias toward measuring factors associated with distress, which occurs in most psychological studies of pregnancy, occurs due to the functions of psychology as a discipline, i.e. the understanding and reducing of distress. She argues

that this has led to psychologists developing satisfactory measures of anxiety, depression, anger etc., while paying little attention to measures of positive emotions such as happiness and joy. A second reason for the bias toward the negative rather than the positive aspects of the pregnancy experience that Johnston puts forward relates to the link that psychologists interested in reproductive issues have with medical practitioners in this field. Johnston argues that doctors spend a disproportionate amount of time with women having difficulties with their pregnancy and hence who are more likely to be suffering distress, and therefore it is for this reason doctors are more likely to call in psychologists with their own understandings and treatments for these particular patients. The lack of commissioning to promote positive emotions, rather than dealing with negative emotions, means that measures for recording positive emotions have been relatively neglected.

Exploring the problems associated with some pregnancies has led to debates about whether pregnancy is a time of illness, requiring medical treatment, as opposed to being a time of health. This issue will be explored further in subsection 2.8 and in chapter five. In the next subsection a discussion of the research conducted on 'high' risk pregnancies will be made, in order to show the ways in which 'high' risk pregnancies are defined and researched.

2.3 Prenatal diagnosis and the 'high' risk pregnancy

Prenatal diagnosis is part of the new reproductive technologies which affect a growing number of pregnant women today and is, of course, related to the course of the pregnancy. 'High risk' populations are defined by multi-stage screening programmes which ascertain information with regards to, for example, age (advanced maternal age is a predictor of an increased risk of having a Down's Syndrome child), family history, and ethnic origin (for example, cystic fibrosis is common in Caucasian populations, whilst sickle cell disease is predominant in Afro-Caribbean populations). Those women who come to be defined as medically at 'high' risk of having a baby with an abnormality such as Down's Syndrome are more routinely offered prenatal

diagnosis (for example amniocentesis), and the obstetric technique used will depend on what is under investigation. Green (1990) points out that prenatal diagnosis is a process, and that there is no single test which will predict that the baby will be 'normal'. What the various tests are capable of doing is defining the probabilities that the fetus is affected by the specific disorder for which the test has been applied.

In the United Kingdom there are a growing number of genetic centres offering prenatal diagnostic services, and there are a number of reasons why provision of such services is considered important in the medical field. These include psychosocial considerations, and reducing the incidence of infant mortality and morbidity due to congenital malformations, gene defects and chromosomal anomalies (Kaback, 1984).

These services are not entirely altruistic as they are also based upon a cost benefit analysis, which contrasts the economic costs of offering such services, where termination is an option, with those of care for those individuals suffering from the various physical and/or mental conditions during their lifespan (Kaback, 1984). The justifications for using prenatal diagnosis, however, do pose difficult ethical concerns for society as a whole. Not only are there debates about the pros and cons of abortion and whose interests are met by aborting fetuses, there are also dilemmas about women's rights, and that of their fetuses. As Rothman (1986) points out, with the advent of new technologies the fetus has been accorded the role of the patient, and the women and the fetus have come to be seen as separate. Hubbard (1982) argues that there is the potential for conflict in such situations. Another central concern is that of eugenics, in which we can see the role of prenatal diagnosis as one which decides who is fit to be part of society. The question thus remains as to how the new technologies are employed. The potential contributions of prenatal diagnosis for those couples who are at risk of having a baby with severe abnormalities and life threatening conditions is self evident. In Western industrialised nations, with the major advances in obstetric care, improved nutrition and environmental conditions, as well as control of a number of infectious diseases, there has been a dramatic reduction in infant mortality, meaning that hereditary diseases and congenital

defects account for a higher rate of infant mortality and morbidity. This is precisely the area of application for the new technologies, and the complexities of the issues involved lead to no clear cut answers.

For psychologists within this field, interest lies particularly with the reasons for, and perhaps more significantly against, the uptake of prenatal services. A second area of interest is the effect of prenatal diagnosis on the women who have undergone diagnostic procedures, for example in terms of the likely increase or decrease of anxiety before and after the testing has taken place. Taking the first of these areas of research (uptake of prenatal diagnosis), concern has been voiced by the medical profession that the rate of uptake is low. Ferguson-Smith (1983) reported that the uptake of prenatal diagnosis by women aged 35 years and above was less than 25%, and this low uptake of the service sparked off a number of studies to investigate the impact of prenatal diagnosis, which have covered a range of factors. For example, Lippman-Hand and Cohen (1980) investigated obstetricians' attitudes to their use of prenatal diagnosis for the detection of Down's Syndrome. Other studies have focused on women's knowledge of prenatal screening and diagnostic tests (Marteau et al, 1988; Naylor, 1975); perceptions of risk (Shiloh and Saxe, 1989; Marteau et al, 1991); knowledge about the tests and attitudes towards the tests (Marteau et al, 1989); moral and religious influences on the decision to have amniocentesis (Seals et al, 1985); the cognitions, emotions and behaviour of pregnant women (Marteau et al, 1989).

The range of factors which have been investigated represent the factors which are suspected to be at the root of low uptake. For example, in one of the studies conducted in Britain on the factors affecting the uptake of screening for neural tube defects, the low uptake of the test was not seen to be due to patient's resistance and it was suggested that the uptake rate could be improved if the women were given the information earlier (Kyle et al, 1988). On the issue of eligible women's knowledge of prenatal screening and diagnostic tests, a number of researchers have developed questionnaires to ascertain this information. For example, Marteau et al (1988) developed a self-administered questionnaire to measure women's knowledge of prenatal

screening and diagnostic tests, and similarly Sauwakon et al (1988) developed a questionnaire to investigate pregnant women's knowledge, attitudes and acceptance of prenatal diagnosis. Sauwakon et al administered their questionnaire to women attending two hospitals in Bangkok. The questionnaire comprised 37 questions which dealt with age, education, socio-economic background, knowledge of congenital disorders and prenatal diagnosis, as well as attitudes towards prenatal diagnosis and selective abortion of an affected fetus. Sauwakon et al's (1988) study found no significant differences between the women based on age, educational levels and socio-economic background, and the level of knowledge was extremely low before the survey, with only 19% of the participants having heard of prenatal diagnosis. In terms of attitudes and acceptance, Sauwakon et al found that 91% of the sample would have accepted prenatal testing if they had thought that they were at risk, with 71% of the sample accepting selective abortion if the test proved that the fetus was affected. The respondents favoured the setting up of prenatal diagnostic services in their locality.

In Britain, a number of extensive studies on the factors associated with the uptake of prenatal diagnosis have been carried out by Marteau et al (1988, 1989, 1991). Using a questionnaire on women's knowledge developed in 1988, two groups of women of advanced maternal age, defined by the take-up/non take-up of amniocentesis, have been compared (Marteau et al, 1989). The take-up group differed in terms of being less concerned about miscarrying the current pregnancy (a risk associated with amniocentesis), and also had more favourable attitudes towards termination of an affected fetus. Marteau et al's (1991) study investigated a range of psychological predictors of uptake, considering the extent to which decisions about uptake of amniocentesis among older women were influenced by knowledge, actual risk, perceived risk, attitudes towards miscarriage, attitudes towards termination of an affected fetus, and value attached to having an affected child. Eighty-six percent of the uptake group held less negative attitudes towards termination of an affected fetus, and had a higher perceived risk of the fetus being affected. No differences were found in knowledge, attitudes towards miscarriage, anxiety levels, socio-economic status, ethnicity or age.

In addition, no significant differences between actual risk and perceived risk were found between the two groups (take-up and non-take-up). The most salient factor in the above study was the attitude toward termination, and thus the decision to take-up or reject the amniocentesis procedure may be based on the attitudes a woman holds.

From the research studies outlined above we can note that psychologists have paid particular attention to the effects of prenatal diagnosis on women, tending to explore factors such as anxiety, depression and stress in relation to the uptake of prenatal diagnosis.

2.4 The move towards investigating the pregnancy experience

In recent years there has been a small number of studies that have taken qualitative approaches which do not use psychoanalytic forms of analysis. The work of Smith (1990) and Gregg (1994) highlights the advantages of following these recent, but as yet atypical, qualitative methods of data collection and analysis. These studies show how the theoretical orientation has shifted from considering pregnancy experiences as isolated variables to examining the relevance of the context of the experience and the meanings associated with the experience for the woman in particular contexts. My own research is epistemologically based within this new tradition, and therefore the little research which has been carried out from this perspective is described in greater detail in this section.

There are, in addition to the few purely qualitative studies of pregnancy, a small number which consider both qualitative and quantitative aspects (see, for example, Oakley, 1992; Roberts, 1992).

First, from a more sociological perspective, the examination of the pregnancy experience within its social context is highlighted by the work of Oakley (1979, 1980) and Rothman (1988). Given that this work is particularly relevant to the present study, because of its influence in the setting up of my own research and the similarities in the methodology employed, their work

should be viewed as extremely relevant to this thesis, despite its being carried out from a sociological perspective.

In 1974 Oakley began her research on the 'Transition to Motherhood: Social and Medical Aspects of First Childbirth', leading to a number of publications, most noticeably two classic texts on the transition to motherhood. The first of these was published in 1979 and was called Becoming A Mother, the second being published in 1980 entitled Women Confined: towards a Sociology of Childbirth. The main division between the two books relates to the use of material collected during the study, with the first book refraining from using academic conventions in which interview quotations are normally italicised. Instead Oakley puts her own interpretations in italics and gives the women's own accounts the centre stage, and indeed her own interpretations are kept to a minimum. She allows the women's accounts to speak for themselves. This novel approach in academic writing places significance on the accounts produced rather than on the analysis of those accounts for academic purposes. In her second book Oakley adheres more to academic conventions in which greater use of summarised tables of statistical data are made.

The first of these two books, Becoming A Mother, provides a wealth of rich material from women's accounts, and was innovative in terms of its research agenda and practice, and the aims and methods of research. Oakley decided to study the transition to motherhood because of the often considered to be synonymous relationship between becoming a housewife and becoming a mother. Her previous research on housewives led her to explore motherhood, as this transition to motherhood led many women to give up paid employment for housework, which she reports is in contrast to the position women were in even twenty years prior to her study, at which time, she explains, women gave up their jobs on marriage. A second reason related to her own experiences of motherhood which intimately linked her as a researcher with those being researched. Oakley carried out her research with 66 women who were expecting their first baby, and her aim was to detail the experiences of first time motherhood which were shared by all women. Oakley conducted four interviews with each woman, the first one at twenty six weeks,

the second at six weeks prior to delivery, the third at five weeks post delivery and the final one at twenty weeks after delivery. Oakley (1979) found that the women's accounts of pregnancy, birth and motherhood which she had taped were far clearer than those a sociologist could produce, and for this reason decided to prioritise their own descriptions. Her choice in representing these accounts followed no single criterion, instead the choices were made on the basis of the representability of each account to the majority of what the sample of women were reporting, and the ones which communicated the experience economically and colourfully. The purpose of the book was to highlight what it was like having a baby in the 1970s in a large industrialised city in Britain, and Oakley justifies the rather bleak and depressing picture that is portrayed of motherhood in the book by stating 'it is to some extent true that the best news is bad news' (p 6). Thus, the criticisms that Johnston (1993) makes of the predominance of exploring the negative at the expense of the positive can also be seen to be applicable to Oakley's work.

The women's accounts are mainly organised according to the chronology of the interviews and the experiences, moving from conception to five months after the birth. The issues that are dealt with are wide ranging and cover broad areas, such as becoming aware of the transition to motherhood via the physical, emotional and social aspects that determine the course of pregnancy, the birth experience itself, the medicalisation of the process, and the management of the baby in terms of establishing feeding practices, as well as the impact of the baby on the marriage and the woman's life thereafter. Oakley (1979) also provides an initial overview of the 'institution' of motherhood and the position of women in society, exploring the role played by the medicalisation of pregnancy and how this has led to debates about natural childbirth and what it means. The issue of the medicalisation of childbirth is central to the experience of women as much today as it was in the 1970s, and thus her account provides valuable insights. For the most part, in the rest of the book Oakley provides her interview question before detailing the participants' responses, and this framework gives coherence to the descriptions/responses documented, although on occasion Oakley does

interpret the meaning of the accounts, in order further to contextualise the separate descriptions.

Rothman's (1988) work explored a number of issues related to the medicalisation of the pregnancy experience. The focus of her research differs from that of Oakley's in that it is the experience itself that is being considered rather than a more general exploration of the issues and outcomes of pregnancy in relation to the motherhood experience. Rothman focuses on 'high' risk pregnancies and the impact of the availability of prenatal diagnosis on the pregnancy experience, and the title of her book The Tentative Pregnancy, indicates to some extent the dilemmas and problems that can arise as a result of the additional choices women who are classified as at increased risk may have to make in this era of increasing medicalisation of pregnancy.

Rothman (1988) carried out research on four groups of women. The two largest groups were those who accepted prenatal diagnostic testing (over sixty participants) and those who rejected the uptake of prenatal diagnosis (sixty participants). The third group consisted of fourteen women who had terminated their pregnancy following the results of prenatal testing. The final group consisted of twenty five practising genetic counsellors. Rothman began her study by observing the work of genetic counsellors in order to gain some insight into the area, and subsequently interviewed all four groups of women, these interviews forming the basis of the majority of her research. The data that she collected was qualitative and was used to represent the variety of ways in which the women described and experienced the many issues that are related to the availability of the new reproductive technologies. Rothman (1988) describes her research as exploratory in that she did not seek to detail the percentage or proportion of women who had particular feelings in relation to the tests available, and in addition her aim was not to make generalisations and have representative samples, which are of uppermost concern for those researchers who prefer positivistic methods of research. Instead, like Oakley in her text Becoming a Mother, the approach she took was one that allowed the women's own accounts to detail the issues involved, although Rothman provides a far more detailed interpretative account of the meaning of the

experience, and thus uses less of the original quotes than Oakley. The similarity between the two texts in terms of style of presentation lies in the largely jargon free form of writing, as well as both texts aiming to reach a much broader readership than just academics or professionals who have an interest in this field.

Rothman (1988) begins her commentary by exploring the links between technological change and social change, and looks at the underlying ideologies which pertain. The main technological change which affects more and more pregnancies, Rothman argues, is the use of amniocentesis for prenatal diagnosis, while other tests such as ultrasound scanning and chorionic villus sampling have meant that there is a growing number of issues faced by the women who come into contact with these technological tests. Rothman approaches the issues that the women outline by exploring the dilemmas and contradictions which they evoke. She puts forward a coherent account which describes the complex emotions and feelings that arise for some women.

One example provided by Rothman relates to the numerous issues that arise when deciding whether or not the amniocentesis test should be undertaken. She states that 'one of the problems, with the technology of amniocentesis and selective abortion is what it does to us...It sets up a contradiction in definitions. It asks women to accept their pregnancies and their babies, to take care of the babies within them, and yet be willing to abort them. We ask them to think about the needs of the coming baby, to fantasise about the baby, to begin to become the mother of the baby, and yet to be willing to abort the genetically damaged fetus. At the same time. For twenty or twenty four weeks. Women suffer in this contradiction of demands. They want to have amniocentesis to identify and to be able to abort a damaged fetus, but are afraid of the procedure's possible harm to their baby.' (p 6). In this quote we can see the issues of timing, bonding, acceptance and harm to the baby as the major problems Rothman identifies, which, if the amniocentesis test is undertaken, become exaggerated and lead to a contradiction of demands. The long passage of time in this state of limbo which occurs up until the results are known makes the pregnancy one which is 'tentative', as the results

will determine whether an abortion should be considered. In various sections of her book, Rothman explores the implications of the advent of the new reproductive technologies, both for the individual women and for society in general.

Turning to the psychology based qualitative studies of the pregnancy experience, Smith's (1990) study examined the impact of pregnancy on individual women during their transition to motherhood. Smith focused on how the women perceived and conceptualised this transition, in order to establish the meanings the transition had for the women. He examined the relationships between personal identity and the transition to motherhood using ten case studies, and his study was longitudinal, idiographic, participatory, and prospective in design. He used a multi-method approach for each of his ten case studies, and largely drew on qualitative methods of data collection and analysis (see Smith, 1993, for a description of the various methods that can be used to analyse case study material). His findings illustrate the importance of using the case study approach to capture the complex, dynamic and contradictory elements involved in self construction. Smith's main aim relates to capturing the process of change rather than to measuring its frequency, and he provides a detailed and intensive picture of each woman's transition rather than giving a number of generalised statements which draw on similarities between accounts. His research reveals the ways in which the women's conception of self changes over time and how this change occurs (through active engagement in construction and reconstruction of self), while also highlighting the individual nature of the changes that occur in the women's self conception. The detailed analysis allowed him to develop a theory of self construction, with the theoretical underpinnings used to develop his theory being drawn from symbolic interactionism and social cognition. Smith coined the term 'self-construction' to refer to a model of the self, which is an active/dynamic agent that reflects on, updates and revises itself. His work differs from the majority of earlier psychological studies that have been carried out in that his starting point does not involve the testing of previously constructed theories and categorisations.

Gregg's (1994) and Currie's (1988) research on pregnancy, like Smith's (1990), use qualitative approaches to collect and analyse data (again obtained prospectively and longitudinally), although they use a purely interview method of data collection and make use of grounded theory. Gregg's and Currie's approach also differ from Smith's in that they conducted the research from a feminist perspective and thus the analysis of data is consistent with feminist epistemology and values (as outlined below). Given that all of the researchers mentioned in this section use a qualitative approach, there are a number of similarities in the conduct of their research, which, for example, involves not subscribing to an orthodox, positivistic model. Due to this overlap, only the substantial differences in the methodologies have been outlined.

Gregg (1994) and Currie (1988) acknowledge the numerous feminist methods and forms of feminism which exist, and each sets out to describe their particular standpoints in relation to these. For example, Gregg (1994) describes the main features she took on board, which, she argues, capture three important aspects of the feminist approach. The first aspect relates to 'bringing the woman back in', and involves representing women's views and personal experiences, which have largely been neglected in academia. The second aspect deals with the need to address the impacts of sexism and patriarchy in society, and the third main aspect is the call for challenging the assumptions of positivism and objectivity via a new methodological paradigm. Gregg's research led her to acknowledge the interaction between the researcher and researched, and to be reflexive and include the empowerment of women as a research goal, which meant that the aims and objectives of Gregg's research substantially differed from Smith's research. In addition, Gregg's aims were to improve health care practice and policies, and thus addressed a number of social work values.

Gregg (1994) conducted 51 interviews with 31 women in order to explore women's experiences of pregnancy and choice. Gregg intended to examine how women made decisions/choices about the uptake of prenatal testing, but as her study progressed the focus of her study broadened, due to the open ended nature of her interviews producing richer data on other

aspects of the pregnancy experience, such as the perceptions of risk. Gregg found that when women make choices about prenatal diagnosis they do not for the most part use rational, cost/benefit models of decision making, which are featured in the medical model. This use of models to determine risk and uptake of prenatal diagnosis within medicine has been influenced by, and in the main been theorised and researched by, psychologists who adhere to orthodox, positivistic and normative approaches within the social sciences. Similarly, Currie (1988) found that women's reproductive decisions were based on the personalisation of social structural issues such as the organisation of the workplace and the family as a social institution, rather than cost/benefit models of decision-making.

Currie argues that although the personalisation of the social processes is outlined in women's accounts of reproductive decision-making, the women themselves do not identify them as structural issues. Hence she argues that feminist researchers who see experiential accounts as self-evident explanations are perpetuating the practice of obscuring the structural roots of women's oppression which exists in established social science research.

Currie argues that feminists have to 'transcend the purely personal worlds of women' (1988:251), and that the personal accounts of women should be seen as a starting point which does not necessarily provide a developed explanation. The researchers task includes 'explaining the explanations' (p 251) in which the relationship between 'structure' and 'people' can be conceptualised. Thus, Currie rejects Stanley and Wise's (1983) feminist approach on the basis that the structural roots which have been personalised in relation to the 'decision' of having children are not perceived and explained as structural issues by the women, and as such Stanley and Wise's approach does not highlight them.

As can be seen from this subsection, there are a number of social scientists who have used a non-psychoanalytic qualitative approach to study pregnancy and childbirth, for example, Oakley (1979, 1980), Rothman (1988), and more recently Gregg (1994). Each of these studies have conducted the research from feminist standpoints which focus on the women's personal accounts. Their work has been of relevance in so far as they have also

examined a multitude of interrelated factors which come to make up each woman's experience in the early stages of pregnancy, and in addition, due to their feminist commitment, they have also discussed the impact patriarchy and medicalisation has on pregnancy (see, for example, Stanley and Wise, 1983, who advocate remaining with the subjective experiences).

2.5 Pregnancy in the context of the institution of motherhood

Pregnancy research has consequences for women in society, and as part of this, one of the main aims of feminists has been to show how the institution of motherhood can be held responsible for socially disadvantaging women in relation to men. By exposing mothering and motherhood as social constructs rather than a biological imperative, feminist researchers have been able to challenge the historical confines placed on women, highlighting in particular the way in which the institution of motherhood has been used to subordinate women.

2.5.1

Feminist critiques of the dominant ideologies of motherhood

Historically there have been a variety of ways in which women's lives have been investigated and theorised. Ussher (1989) points out that until relatively recently, with the advent of feminist accounts of the female condition, the predominant psychological and medical view of women was that they were ruled by their biology, and were framed in such a way that their 'anatomy was seen as their destiny'. Theorising motherhood in terms of biological destiny is predominant, and as feminists point out it has been so throughout history. The ideology of motherhood has also been highlighted by feminist critiques.

Ussher (1989) describes how early psychologists used this biological model to justify the unequal treatment of women in other aspects of daily life. Two early psychologists, Maudsley (1874) and Spencer (1896), were typical

in arguing against the growth in women's higher education in Britain and America, because of the potential 'diminution of reproductive power' (Spencer 1896) which might occur, resulting in a 'deterioration and disappearance of the species' (Ussher, 1989:1). These early psychologists saw women principally as childbearers and crucial to the survival of the species, and thus women were placed under constraint and containment, with their status being relative to their reproductive capacity (Finkelstein 1990).

Due to the interest in women's role as childbearers, their reproductive capacity is a subject that has received a great deal of attention from a variety of institutions which attempt to govern and maintain society. The maintenance, growth and control of a population via institutional practice has meant that the social implications of women's biology (in terms of reproductive capacity) has been of importance not only to women themselves but also to those who govern society at large. This reproductive functional view of women (in terms of their capability of gestation and birth) has had serious implications for women in terms of the status and social roles attributed to them, and, in contemporary western society, political as well as medical institutions have not only exerted power and sought to control women's lives in relation to their reproductive capacity, but have also been largely responsible for the inequalities women face in other spheres of life. Oakley (1979) reports that society's attitudes toward women interlock with the very meaning of childbirth itself, and that this is reflected in society's economic system as a whole. In a capitalist society such as ours, where production occurs predominantly outside of the home, 'the women's role becomes not to produce but to reproduce' (p 10). Thus, to understand motherhood in relation to the way in which society to a large extent sets its course, it is important to see it in the context of the historical economic influences that shape women's status as a whole (Ussher, 1989; Hubbard, 1990; Finkelstein, 1990; Rothman, 1994). The ideology of capitalism and its influence on mothers and children in terms of viewing them as commodities is explored in more detail by Rothman (1994).

Patriarchal ideology of mothering similarly ends up viewing the woman's role solely as one of reproduction. As Glenn (1994) states, 'by depicting motherhood as natural, a patriarchal ideology of mothering locks

women into biological reproduction, and denies them identities and selfhood outside mothering' (p 9). In trying to explain the patriarchal ideology of mothering, Rothman (1994) makes the case for seeing patriarchy (the rule of fathers) as a separate entity to sexism (male dominance), instead of seeing the two terms as synonymous. The need for this distinction lies in the recognition that not all societies are patriarchal, although all societies have some level of male domination. The meaning of patriarchy, as Rothman states, is derived from patriarchal kinship relations in which 'paternity is the central social relationship...In a patriarchal Kinship system, children are born to men, out of women. That is, women, in this system, bear the children of men' (Rothman, 1994:141).

In addition to seeing the ideology of capitalism and patriarchy as central to the construction of the institution of motherhood in western society, Rothman (1994) points out the need to also consider the role played by the ideology of technology. The clearest example of the influence of technology in motherhood can be seen in the utilisation of technology in the medical treatment of pregnant women, with the medicalisation of pregnancy and childbirth meaning that 'the focus is on the "mechanics" of production, and not the social transformation of motherhood' (Rothman, 1994:144). There are a number of benefits as well as losses in terms of the choices that are available to women as a result of the new technologies.

What feminist accounts have exposed is the level of inequality women can face as a consequence of being conceptualised as being ruled by their biology (especially in terms of their reproductive capacity), and the dominant ideologies of a society. Biological aspects of reproduction have also been controlled via the medicalisation of pregnancy.

2.5.2

Medical and technological impact on pregnancy

The history of the medicalisation of pregnancy in England dates back to the fifteenth century. Prior to this period, medicine was practised by many

unlicensed men and women, and although women were seen as healers in this period, in the sixteenth and seventeenth century the dominance of male control over women's health began with the practice of witch hunting, and coincided with the move toward modern science and technology (Finkelstein 1990). The first technological intervention that began to be used in relation to childbirth was forceps, which were introduced in the seventeenth century to aid in the second stage of labour, although their use was not widespread because the majority of women in Britain still gave birth at home with the help of untrained women (Oakley, 1979). By the nineteenth century male physicians held a monopoly over obstetrics, and the male physicians held a powerful role during childbirth in their dominant position over female midwives who, although present, had far less status than the male physician. The position of midwives changed in 1902, when they came under state and medical control (Oakley, 1979; Stacey, 1988), and their role changed from one in which they practised folkcraft to one which was regulated with the introduction of diplomas for midwives issued by the Obstetrical Society of London (Radcliffe, 1967).

The change over from female to male birth attendants was achieved swiftly, as the idea that childbirth was dangerous spread. Donnison (1977) states how this was achieved: 'Men-midwives...anxious to establish their own importance in the eyes of the public...exaggerated the dangers of childbirth and frightened women into believing that extraordinary measures, and therefore male attendance, were more generally necessary than they actually were.' (p 28).

Coupled with the change over from female to male birth attendants and home to hospital births, women gained some significant benefits (Finkelstein, 1990). These benefits include a drop in infant morbidity and mortality rates over time and the availability of pain relief in the form of analgesics and anaesthetics, as well as improvements in caesarean sections decreasing the level of danger to both mother and baby. However, as Oakley (1979) points out, much of the improvements in mortality rates reflect the changes in the health of the population due to better diets and hygiene rather than the medical management of pregnancy. Where the medical management of

pregnancy has contributed toward the alleviation of some of the pain experienced and some of the dangers of childbirth, the interventions themselves may lead to a host of other problems. For example, as Finkelstein (1990) points out, the use of technology to alleviate pain may itself have arisen due to the earlier medical interventions placed on the woman, such as having the woman lying on her back rather than a more upright position.

The number of interventions a woman may experience during the course of her pregnancy and childbirth is extensive, and Oakley (1979) lists some of the common procedures which many women undergo. These procedures are 'Regular antenatal check-ups; Iron and vitamin supplements; Vaginal examinations in pregnancy; Ultrasound monitoring of pregnancy; Hospital birth; Enemas or suppositories in first stage of labour; Shaving of the pubic hair in labour; Artificial rupture of the membranes; Pharmacological induction of labour (oxytocin, prostaglandin's); Vaginal examinations in labour; Bladder catheterisation in labour; Mechanical monitoring of the fetal heart; Mechanical monitoring of contractions; A glucose or saline drip in labour; Epidural analgesia in labour; Pethidine (meperidine) or other pain-killing/tranquillising injections in labour; Birth in a horizontal or semi horizontal position; Episiotomy; Forceps or vacuum extraction of the baby; Cutting the umbilical cord immediately after birth; Accelerated delivery of the placenta by injection of ergometrine and/or oxytocin and pulling on the cord' (pp 17-18). Although some of these many procedures may have benefits as experienced by some pregnant women, Oakley (1979) points out how all of the above procedures have entered into the obstetric profession without having been systematically tested for their effectiveness. Similarly, Stacey (1988) points out that although in principle medical knowledge is based on systematic scientific study and clinical trials, in the case of the female reproductive system, 'clinical practice is based more on hunch than on the scientific method' (p 229). Both Oakley (1979) and Stacey (1988) show how pregnancy came to be controlled by the medical profession without any form of effectiveness testing, and that the medicalisation of pregnancy has itself led to a number of disadvantages and dangers of its own for the women and/or the baby.

Furthermore, the new reproductive technologies are part of the history of the medicalisation of pregnancy, representing a continuum of the physicians' desire to control pregnant women. Rollins (1996) states 'The revolution in this century pertaining to childbirth in industrialised societies has been the introduction of medical technology, which placed childbirth in the hands of physicians and hospitals. For centuries, childbirth took place in the home surrounded by midwife, family, and friends. In 1900, less than 5% of births in the United States took place in hospitals (Wertz & Wertz, 1977). The shift from home to hospital births was almost total by 1979, when 99% of American babies were born in hospitals (Mackey and Brouse, 1988)' (p 392). The statistics of transition from home to hospital births in Britain mirror those of America, Oakley (1979) reports that in 1927, the proportion of hospital births was 15%, and by 1975 this had increased to 99%, with the reason given for this transition being to improve mortality rates (Oakley, 1979).

The above historical account shows not only the transitions that have taken place (female to male birth attendants; home to hospital delivery), but also how women have come to be dominated by male practices. Women have been viewed as vessels for the production of babies (Stacey, 1988). This has further implications for the positioning of women in subordination, in that questions relating to the welfare of the woman and/or baby and the issue of risk taking now no longer lies with the pregnant woman but with professional bodies.

2.5.3

Pregnancy as health or illness

The high level of medical intervention during the course of pregnancy has meant that debates about whether it should be seen as a period of health or illness have taken place. 'In earlier eras, pregnancy was regarded as a 9-month sickness, and that view sometimes persists today (Holt and Weber, 1982; Myers and Grasmick, 1990). However women are increasingly likely to view their pregnancy state as a normal and healthy one - even though at times, pregnancy may be somewhat uncomfortable and inconvenient' (Matlin,

1996:388). In addition, Macfarlane (1990) argues that it should be seen as a period of health and not ill health: 'Pregnancy is so often treated as an illness that it is sometimes difficult to remember that it is not one. For most women however, it is the first time in their lives that they come into intensive contact with the health services' (p 31).

The intensive contact pregnant women are expected to have with the medical profession, and the 'frame of reference' each uses, has been explored by Graham and Oakley (1986) to examine the competing ideologies of reproduction that the women and doctors operate from. They argue that mothers and doctors 'have a qualitatively different way of looking at the nature, context and management of reproduction...[and] use the concept of a 'frame of reference' to indicate this difference' (p 99). In terms of the debate on pregnancy as health or illness, Graham and Oakley point out that the interactions between doctors and mothers show the difference and conflict on the status of reproduction that exists, one in which the doctors see every pregnancy as though it was, or may become, abnormal, while on the other hand the women see it as a natural process. Certain women, prior to their pregnancy, are unaware of the equation between pregnancy and illness and only become aware of it when they come into contact with the multitude of tests and procedures that are carried out in their antenatal visits. The difference in thinking, broadly speaking, is that the women see the pregnancy as a 'natural' biological process while the doctors see it as potentially, or actually, being pathological. The definition and interpretation of various symptoms experienced during the course of pregnancy also highlight the conflicts of expertise (between doctor and mother), in that the doctor may only take account of those symptoms s/he regards important (clinical conditions such as bleeding and blurred vision), while the woman may consider important her subjective experiences which include her physical and emotional changes. Graham and Oakley (1986) found that where there was a difference in views of the significance of physical symptoms, doctors often ignored or dismissed the woman's symptoms as clinically unimportant, even though a significant number of women reported their occurrence. For example, 12% of the 677 statements they collected during a series of

antenatal clinic appointments showed that the women had mentioned the physical pains they were experiencing and that these had been ignored or dismissed by the doctor. In addition, the women also considered the social circumstances which affected their feelings toward the pregnancy (8%), and rarely did the doctor take these seriously, again highlighting the difference in the frames of reference used by the two sides.

2.5.4

The feminist debate on representing motherhood

One of the central issues within feminism concerns how motherhood should be theorised and how the inequalities which stem from its social construction can be addressed, and within feminism there is still a great divide on the issue of the direction women should take to achieve equality with men. Essentially, should women fight for sameness or difference? What are the consequences of each form of action? Glenn (1994) highlights how this divide has run through the history of feminism.

Those who adhere to the similarities perspective believe that there are more similarities between women and men than there are differences in, for example, their intellectual and social skills. They believe the differences found are created by social forces such as the allocation of power (Matlin, 1996). The problem with sameness stems from the unique female experiences, which, as related to pregnancy and motherhood, make them special and distinct from men's experiences. However, the problem with rejecting sameness is that difference can lend itself to the subordination of women, in that they can be relegated to particular functions in society and attributed lower levels of status as a result. The problem with the equal rights, liberal form of feminism as applied to pregnancy becomes abundantly clear when an equivalent position in men cannot be located. This positioning is succinctly expressed by Rothman (1994) 'And a pregnant women is just the same as...well, as, uh...It's like disability, right? Or like serving in the army? Pregnancy is just exactly like pregnancy. There is nothing else quite like it. That statement is not glorification or mystification. It is a statement of fact.

Having a baby grow in your belly is not like anything else one can do. It is unique.' (p 153). Rothman goes on to say that the problem of the uniqueness of pregnancy means that the needs issue becomes ignored within liberal feminism.

Those who adhere to the differences perspective believe that women and men generally differ in their intellectual and social skills, and they believe that the positive aspects of these differences need to be highlighted and not allowed to be undervalued because they are associated with women (Matlin, 1996). Unlike those who follow the similarities perspective, which uses constructivist explanations, the feminists who follow the differences perspective use essentialist explanations. Essentialism explains gender differences as being due to basic attributes that reside within an individual (Matlin, 1996), and women are thus more concerned with caregiving than men due to their internal nature and not because our society currently assigns the care of children to women (Bohan, 1993; Kimball, 1994). The debates within feminism on the issue of motherhood still remain, and provide challenges within the movement in terms of the theory and action the institution of motherhood requires. However, as Chodorow (1978) points out, we do need to break down the differing components of the institution of motherhood from that of pregnancy, since the issues related to child caring and child bearing do vary. Indeed, mothering does take place in certain circumstances (e.g. adoption and surrogacy) where the mother is not the biological bearer of the child, and thus attention will now be turned to the particulars of pregnancy.

One clear example of the way in which women's role in childbearing becomes relegated is in the way in which the role of the woman becomes subordinated in comparison to the role of the man. Matlin (1996) points out that the way in which conception is discussed is often gender biased. Popular descriptions of how the egg and sperm come to unite are often termed in such a way that they are not value free or accurate. Matlin states 'you probably learned in your high school biology book that the male sperm *penetrates* the female egg. However, this description is actually a myth, because the egg is much more active during the fertilisation process' (p 387).

In terms of examining the experience of pregnancy within western society, the feminist approach has produced most of its literature in relation to the medicalisation of pregnancy and the impact of technology (see for example, Oakley, 1979, 1980; Rothman, 1988, 1994; Finkelstein, 1990; Martin, 1992; Price, 1996). The relevance of exploring the medical and technological interventions during pregnancy is to show how they contribute to the individual experience of women via their institutional practices. For example, Cornwell (1984) points out that women's lay beliefs about childbirth have become 'medicalised' over the years, as their beliefs have in part been derived from, and come to be affected by, the medicalisation of pregnancy.

2.6 Aims of the present study and its relation to the literature review

In this subsection I will briefly outline the relation of my own research with the research studies I have outlined. There are two main reasons for this: firstly, it helps to place my own research within the existing body of research on pregnancy, thus helping to clarify my contributions to the field of inquiry, and secondly, the theoretical and conceptual terms that I use in the empirical chapters can be explored in terms of their prior uses and meanings.

The behavioural and emotional aspects of the pregnancy experience explored by psychoanalytic researchers (see Deutsch, 1945; Bibring, 1959; Ballou 1978; Chodorow, 1978; Kaplan, 1992) provides one particular analytical perspective which attempts to convey the inter- and/or intra-psychic factors involved in the pregnancy experience. The psychoanalytic studies outlined above are particularly important as they have examined the psychological complexities of the whole pregnancy experience, which is in contrast to the majority of the other psychological studies that only deal with specific aspects. The studies that have examined the role played by intra- and inter-psychic processes are of some relevance to the aims of this research project, in that they take on board the concepts of adjustment and adaptation and also see the psyche as a symbolic domain. My main point of agreement with the psychoanalytic researchers relates to the importance of seeing the

pregnancy experience as complex, and that the study of isolated variables does not show the complexity or the context of the experience.

The methodological approach taken by Ballou (1978) is particularly informative, especially the use she has made of the multiple case study approach to researching the meaning of the pregnancy experience.

These psychoanalytic approaches have also influenced the conceptual categories I have developed in chapter five, in so far as I have attempted to examine the individuality of the women's experiences alongside the social dimensions which come to shape and give meaning to them. The present research study, however, does not specifically seek to establish the role played by past experience and early development in the pregnancy experience, as psychoanalytic theories do, although where the women themselves describe their impact on their present experience they are acknowledged in the analysis of the accounts. The main reason for paying such little attention to the psychoanalytic explanations given by past researchers in my own analysis relates to my particular interests of wanting to explore the women's own constructed descriptions of the feelings and emotions they are experiencing, and to this end I have adopted a feminist poststructuralist approach, as described in chapters three and four. I aim to work with the participants' explanations rather than the psychoanalytic explanation of the causes/association with/relation of past experiences and relationships to the present pregnancy experience.

The pre-1970s research which predominantly saw the pregnancy state as a physical occurrence (as described and critiqued by Shereshefsky and Yarrow, 1973), does not take centre stage in this research study, instead it is considered alongside the emotional facets of the pregnancy experience. This is particularly evident in the last theme explored in chapter five, which examines the psychological interpretation that the women provide of their changing physical state. Thus, the mental and physical dimensions are both explored, without being separated. One of the reasons for choosing this theme relates to my rejection of the mind-body dualism which separates the two entities and sees them as oppositional. Instead, I have taken on board Stanley and Wise's (1993) position which sees such binary dualisms as

operating at categorical levels with complex relational links. To this end, the final theme explored in chapter five also highlights the links that are present in the women's representations and interpretations of their physical symptoms and aims to show the socially constructed meanings that the women assign to their physical state (as opposed to the psychoanalytic meanings that have been described by psychoanalytic researchers in terms of the women's adjustment and adaptation, which are determined by past childhood psychosexual experiences).

The research which uses a symptomology model to explore levels of anxiety, depression and stress in both high and low risk pregnancies relates to my own interests in exploring the emotions that the women describe experiencing. The research detailed in this section of the literature review uses positivistic and mechanistic approaches, while in comparison I will be using a qualitative approach. In the present study, chapters six and seven in part examine the anxiety the women report in relation to perceiving the self to be at risk. However, the approach that I have taken does not attempt to measure levels of anxiety, but rather examines its construction and experience in relation to the concept of risk. This is because I have aimed to take a contextual approach which highlights the way anxiety and risk are handled in terms of the actions in behaviour they lead to. In chapter seven I have used a case study approach in order to examine one woman's construction and reconstruction of the self in terms of her risk status. This is in order to add to the available literature which seeks to describe how these symptoms come into play in everyday lived experiences. The previous findings relating to the levels of anxiety and depression should not and cannot be ignored given their predominance in the literature, a view shared by Roberts (1992) who states 'in the presentation and dissemination of research, certainty and numbers are often presented together, and the implication is that they are synonymous. But whilst quantitative methods have their place, they are not sufficient to encompass all the important questions raised in studying women's health, or in studying anything else' (p 2). In line with Roberts' comments, more recently there has been an acknowledgement of the validity and advantages of using more holistic and non-mechanistic

approaches to the study of emotions, although the number of studies using these approaches is as yet minimal within the discipline of psychology. What the various quantitative studies show is that there is a complex array of factors which can combine to formulate the overall pregnancy experience. However, what they neglect is the individuality of the pregnancy experience. In subsection 6.1 of chapter six I have explored the up-take of prenatal diagnosis and have highlighted the individual participants' views on the termination of their pregnancy if abnormalities were detected. The analysis of the accounts relating to prenatal diagnosis has been conducted in light of their revelations about the experience of risk in pregnancy. Again, the previous research which has examined the uptake of prenatal diagnosis, and the concerns feminists have raised about the increasing medicalisation of pregnancy as presented in the literature review, provide the backdrop to the understanding of the rational and structural aspects that present themselves in the micro level of experience that is being examined in this thesis.

As mentioned earlier, the predominance of research on the negative aspects of the pregnancy experience, both in terms of high and low risk pregnancies, suggests the need to explore the positive emotions which accompany the negative emotions, and thus in my own research the negative emotions will not take centre stage, but will receive equal attention to the positive emotions the women recount. This will be evident in chapter eight, where the women describe the changes to their body as being both pleasurable and a source of dissatisfaction. In chapter nine, the construction of the images of the baby are examined and show how the women experience positive emotions when considering various images of the baby.

In many ways my own research can be seen in part as following on from Oakley's efforts to record directly women's own experiences of pregnancy, with emphasis being placed on the interviewer's own influences upon the accounts produced by the pregnant women. Having said this, it is still a unique piece of research in that it has been undertaken in a different time (early 1990s as opposed to early 1970s), as well as the participants themselves experiencing their pregnancy in a more medicalised context given the increased use of new reproductive technologies. For example, all ten

women in my sample were offered, and utilised, ultrasound scanning as part of their routine antenatal care. Despite the many similarities the women today may have in their medical care, and the view they have of this in comparison to those women in the early 1970s, there are of course some differences. For example, in addition to the routine use of ultrasound (with the additional choice of asking the gender of the baby), women actively consider the increased choices of method of delivery (which were more limited in the 1970s). All the women medically defined as 'low risk' and one woman categorised as 'high risk' in my sample discussed this issue, and indeed one of the women who was medically categorised as 'high risk' chose, and subsequently had, a home delivery. These examples show how there are potentially different choices women may make today.

The timing of the interviews also differs. Oakley's first interview took place when the women were in their twenty sixth week of pregnancy, whereas in my own research the first interview was conducted before the fourteenth week of pregnancy, the main reason for this departure being my interest in the pregnancy experience. Oakley's aim was to see its impact on the transition to motherhood, whereas I am interested in the nuances of the experience in and of itself, not so much in terms of its meaning for the change in status of becoming a mother. The accounts that Oakley gained of the experience of becoming pregnant were far more retrospective than those I gained, given the difference in the timing of the first interview. However, given the overlap in the accounts produced by my participants and those of Oakley's, there is a need to place my own findings in relation to those that Oakley reports. In chapters six and seven note can be taken of the influence the medical model has made in the construction and experience of risk in pregnancy. Thus, like Oakley, the analysis of the data shows the filtration and impact medical discourse has had on the experience of pregnancy. Some of the similarities and differences in our interpretations will be discussed, as well as some of the similarities and differences in the descriptions that the women provided, helping to highlight the shifts in direction in both theory and practice that have taken place over time in academia and the women's own experiences of pregnancy. For example, epistemologically Oakley worked on the assumption that women

can voice their experiences directly, whereas contemporary methodological debates tend to emphasise the ways in which accounts are constructed, the latter representing my own epistemological position. An example of the pregnant women's own experiences being differently constructed in comparison to Oakley's respondents is the advent of asking the gender of the baby (as is explored in chapter nine of this thesis), and the associated technological advances in the medicalisation of pregnancy. On this theme the research carried out by Rothman (1988) is of special interest. Unlike Oakley, Rothman concentrates on the 'high risk' pregnancy and thus deals with the specific relations between current technological advances and the pregnancy experience certain women face.

My own interest does not lie in the comparison of the number of similarities and differences that exist between the women's accounts documented by Oakley and Rothman and those produced by the participants in this study, although it is important to bear in mind that there will be some similarities and differences in the accounts produced. In my own research, I have interviewed women that have been defined as 'high risk' and thus the findings of Rothman's research will be of direct relevance to the interpretations and findings I report on this group of participants. For example, in chapter six I have also noted how one of the participants in my study came to view her pregnancy as being tentative, thus similarities with, and support of, Rothman's findings can be found in the analysis of the accounts I have produced.

In my own research the methodology advocated by Stanley and Wise has been adhered to, in which the realm of the personal has been of paramount importance. The research questions I address did not require a transcending of the boundaries which in Currie's case were important for the identification of the structural issues which came to form the personal, and yet had not been reported as such by the participants of her study. By transcending the boundary, Currie felt that women's consciousness could be raised by sharing with them the results of the study which shows what social processes lie behind their problems in making decisions about having children.

Gregg's research, which is along the same lines as my own in terms of subject matter and approach taken, addresses different issues in terms of application to those I am able to, and wish to, undertake. Gregg's social work background enabled her to discuss the implications of her findings in relation to social work practice. My contribution, on the other hand, is not directly applicable to issues of social work practice, and thus the interpretations and conclusions drawn in my own research have a different agenda. My own orientation is more toward psychological practice and theorisation of women. I intend to explore the positive and negative aspects encountered by women during pregnancy. The previous research carried out by Oakley (1979, 1980), Ussher (1989) and Nicolson (1986, 1989, 1990) has tended to concentrate on the negative aspects of pregnancy and its negative consequences for motherhood, and thus there is a gap in the literature, in terms of the positive aspects and positive consequences for motherhood.

After having conducted an extensive literature search, what has become evident is that the pregnancy experience is complex. The multitude of issues which are related to the experience would make it difficult to examine every aspect of the experience of pregnancy, and thus the present study will aim to highlight certain individual and psychological issues which come to make up parts of the pregnancy experience for the participants of this study. The account that will be provided is thus necessarily fractured. The main areas that will be explored relate to the ways in which the participants of this study come to construct and identify with a set number of concepts, namely, identifying with being pregnant in the early stages; being at risk; their images of the self and baby at various stages of their pregnancies.

Chapter Three: Research methodologies explored

3.1 Introduction

This chapter begins with a brief description of the similarities and differences that appear in the conduct of my own research and that of the qualitative researchers whose work has been highlighted in the previous chapter. This is followed by a brief account of the use of particular methods of research in psychology, and the placement of qualitative methods within them. In addition, feminist research methods are outlined, with special emphasis placed on Stanley and Wise's (1993) feminist approach, termed: 'Feminist Fractured Foundationalism'.

3.2 Methodological links with past research

In chapter two I emphasised the importance of Oakley's feminist sociological studies on motherhood. This is (as mentioned in chapter one) because of the high level of influence her work had on the conceptualisation and conduct of my own study. One of the main points that is relevant to my research is Oakley's use of documenting the women's own descriptions of their transition to motherhood. As previously outlined, Oakley used both quantitative and qualitative methods of investigation, dependent on the type of data she wished to obtain. I chose to explore the issues the women in my sample raised, and thus followed Oakley's qualitative method. Oakley's book On Becoming a Mother is of particular significance, as the style and methods she used capture the framework I adopted, although my epistemological position differs from that taken by Oakley in that I do not subscribe to the view that women's accounts reflect their experiences directly. Instead, I have taken a poststructuralist position which is sceptical of the notion that there is one unitary basis of knowledge and that experiences can be reflected directly (for descriptions of poststructuralism see Weedon, 1987; Henwood, 1996).

The shift towards examining the discourses/accounts produced by women allows an examination to be made of the pregnancy experience in

terms of the women's attributed meanings, perceptions and sense making of the feelings and identifications they have associated with their pregnancy. This has been carried out by a number of recent researchers who may or may not incorporate feminist goals as part of their research agenda (see Smith, 1990, and Gregg, 1994, as an example of each). Smith's research on the transition to motherhood focuses on how this transition affected the women's conception of self, and makes use of a number of different methods of data collection. In part he uses interviews and diaries to collect data, which provide him with detailed case study material. Similarly, I have used interviews and diaries as methods of data collection, and have also used a phenomenological model as opposed to a psychodynamic model for detailing the women's experiences (the psychodynamic model being the more predominant of the two in the psychological study of the experience of pregnancy). My point of departure from Smith lies not so much in the epistemological and methodological position (there is some overlap), but rather in the use of the specific form of analysis undertaken.

Smith analysed the transitional aspects of the pregnancy experience in relation to how they affect the woman's self concept, which provides a particular interpretation of the accounts. In my own research a different sort of reading takes place, as I have examined the experience of pregnancy, in and of itself.

Gregg's (1994) research on pregnancy is directly relevant to my own research, as we both use a feminist standpoint perspective and use qualitative methodologies, and her research findings will be discussed in relation to my own findings in the analytical chapters on risk (chapters six and seven). My own research supports and expands on Gregg's research, in that the interpretations I make often critique previous psychological studies that have explored certain (often problematic) aspects of the pregnancy experience, using positivist experimental approaches. Gregg's research was carried out at around the same time as my own, and thus her research was not influential in the conceptualisation or design of my own study. It is interesting to note that both of us began our research with the intention of exploring decision making processes during pregnancy, and moved on to

explore other issues related to pregnancy at the time of data collection (see subsection 1.2.3, on the change in research agenda presented in the introduction to the thesis).

3.3 Developments and current uses of methods in psychology

To frame the adoption of the feminist perspective and the methods employed it is important to contextualise them in the broader social science literature on research methods and to highlight what constitutes feminist research methods. This can be done simultaneously, by identifying the ways in which feminist research methods are similar to, and different from, the historical developments and current uses of methods in science. There is no straightforward answer (or a single definition) to questions such as what science is, or what constitutes feminist research methods, as they have evolved over time, but there are a number of descriptions that exist in text books which identify the main elements of science and the transformations which have taken place, as well as descriptions of the key elements found in feminist research (see Nielson, 1990; Griffin, 1995). Before providing an outline of what constitutes feminist research methods, along with the ways in which they can be distinguished from the traditional uses of the scientific method, a brief description of what science can be taken to represent will be given, along with the reasons why alternative research methods have been developed in the social sciences (feminist research methods being one of these alternatives).

3.3.1

The scientific method

One current account of science is provided by Baron (1992) who states that 'science actually refers mainly to a general approach to acquiring knowledge - one involving the use of certain methods plus adherence to several key values or standards. The methods consist primarily of systematic

observation and direct experimentation...The standards involve commitment to such goals as objectivity (evaluating information on the basis of its merits rather than according to one's personal preferences), accuracy (gathering information as carefully and precisely as possible), and scepticism (accepting findings as true only after they have been verified over and over and all inconsistencies have been resolved)' (pp 8-9). This description of science has been termed 'the empirical method', of which positivism is an extreme form. Notice here the role and the importance of standards, such as objectivity, as the means by which 'truth' can be established (inferring that a true explanation can be found, and that objectivity helps achieve this). Feminist researchers heavily criticise these notions, for reasons which will be addressed later.

Prior to the above empiricist view of science, the dominant school of thought (epistemology) was rationalism, which posited logic as the test of truth. Both rationalism and empiricism dominate the scientific tradition of methodology today, and are still widely used to gain or develop knowledge. The transformation of what has been termed as scientific, and the methods employed over time, are most succinctly described in texts on the history of the philosophy of science. For example, Chalmers (1982) points out that science is seen as something special, and that work which is judged to be 'scientific' is labelled as being reliable and having merit. Chalmers discusses the shortcomings of the scientific method and also points out the fallacy in attributing the successes/findings of certain disciplines (especially within physics) to the use of the scientific method. This, he argues, is because theories cannot be conclusively proved or disproved. Chalmers examines some of the modern theories on the nature of science and discusses the strengths and weaknesses associated with them.

The physical sciences such as physics and chemistry are represented as the best examples of areas of study that are scientific, and as such have been emulated by the social sciences (by way of adopting the empirical method) in an effort to be accorded a higher status. However, this preoccupation to be judged a scientific discipline by the social sciences neglects to explore the appropriateness of, and problems associated with, the use of the scientific method.

3.3.2

Resultant challenges to the scientific method within the social sciences

The questioning of the merits of the scientific method, including the problems associated with it (especially in its application to the social sciences), and the realisation that it is not the ultimate test of knowledge, has led to what is now termed the postempirical crisis in knowledge (see Nielson, 1990, for a fuller account). This crisis in knowledge has led to scepticism in the wholesale application of the scientific method to the study of social phenomena across a number of social science disciplines.

The starting point for the challenge to the use of the scientific method in the postempirical period within the discipline of psychology, as well as the promotion of qualitative modes of enquiry, began in the 1970s with Harre and Secord's (1972) book The Explanation of Social Behaviour. However, the movement only began to take off in the 1980s and has continued in the 1990s with a number of texts appearing on the historical developments of the discipline and the crisis which has developed within it, again urging the rejection of the traditional scientific method (see, for example, Reason and Rowan, 1981; Parker, 1989; Harre and Gillett, 1994). For example, Harre and Gillett (1994) not only describe the changes that have taken place within the discipline of psychology, they also demonstrate the reasons for the changes. Their rationale contains a number of similarities with the critiques feminists have provided of the scientific method and its application to the social sciences. Harre and Gillett's (1994) account describes the historical transformations and trends that have occurred within psychology and go on to point out that the existence of old paradigms alongside new ones to this date is of interest. They argue that the clash of paradigms, between the older and more traditional experimental psychology and the newer, more contemporary, discursive psychology, means that both transformation and a lack of transformation has occurred over the last 20 years in psychology.

Similarly to feminist researchers, Harre and Gillett go on to suggest that to understand the new developments in psychology, it is necessary to

point out the metaphysical roots of the old, traditional, experimental psychology paradigm. In this paradigm, psychology is seen as a science (a definition of which is provided in the above subsection 3.3.1), based on a philosophy of positivism. The research methodology employed has its roots in behaviourism, and thus only publicly observable entities (behaviour) can be seen as legitimate material to be studied. Mental processes which are inaccessible to direct observation therefore cannot be considered as part of the science of psychology. The numerous drawbacks of the experimentalist approach have led to developments such as the 'new' social psychology and cognitive psychology.

The 'new' social psychology takes on board ethogenic principles, in which people are seen 'to be active beings, using rules and other normative constraints in jointly constructing their social relations and the episodes in which they were realised in action' (Harre and Gillett, 1994:7). Together with the earlier work of Mead (1934), and the symbolic interactionist approach, the social world is seen as discursively constructed. This approach has become quite well developed (since the 1970s).

In contrast to the social psychological approach, the development of the cognitive approach has led to the study of mental processes. Like the behaviourists, the cognitivists, believe in Cartesianism (mind-body dualism), although the cognitivists have a different concept of scientific work based on a hypothetico-deductive method, which makes possible the study of the mental processes that 'mediated the transition from stimulus to response' (Harre and Gillett, 1994:15).

One current example of the 'new paradigm' in which the discursive approach is utilised to research personal identity is given by Marshall and Wetherell (1989), where they explore the construction and representation of identity as it appears in the discourse of students who were to embark on a career in the Scottish legal system. In this approach, language is seen as an essential constructive feature of social and psychological processes. Marshall and Wetherell (1989) argue that discourse is not accidental or incidental to social psychological analysis, and thus the researcher should work with the

discourse itself, as the discourse shows the construction and negotiation of mental states as well as the production of social realities.

When using the discourse analytic approach, the questions asked relate to why a particular construction appears in a particular context, and what it achieves. By doing this, some of the implications of different versions of the self and personal identity can be questioned, and can highlight how identities are actively negotiated and transformed in discourse. My own research is epistemologically based within social constructionism, although I have used a thematic approach as opposed to a discourse analytic approach. Both approaches are epistemologically similar in so far as they see individuals' accounts as being constructed and negotiated, but my interpretations are made at the level of the individual rather than at the level of the text. Discourse analysts are concerned with details such as why a particular construction appears, as well as what it shows about the individual account, while my own research aims to capture a wide range of themes which make up a significant part of the pregnancy experience for my participants.

3.3.3

The basis of the challenges as located in the quantity/quality debate

An accepted awareness of the need for research methods which take into account the differences between people as objects of enquiry and the objects of the natural sciences has meant that qualitative research strategies have come to the fore as useful methods of observation, data gathering and analysis. In addition, questions about the appropriateness of the scientific method for human participants have meant that a philosophical rationale for qualitative research has been developed and applied across a number of social science disciplines. Quantitative and qualitative forms of research are thus addressing the 'nature and purposes of research in the social sciences' (Bryman, 1988:3).

This development of qualitative methods of research in the social sciences has led to a lively debate about the arguments for and against quantitative and qualitative approaches (see, for example, Lincoln and Guba, 1985; Bryman, 1988; Denzin and Lincoln, 1994; Henwood, 1996). Bryman (1988) points out that on the surface level, questions related to the relative advantages of each approach are based on the techniques utilised (numeric/non-numeric), with assessments being made about the relative strengths and weaknesses of each, as applied to a particular research topic. On the next level, philosophical issues (epistemological concerns) are examined (predominantly by those that apply qualitative methods). The debate about quantitative and qualitative methods (which as previously mentioned, gained ground in the 1970s) thus not only deals with the appropriateness of certain methods (quantitative/qualitative), but also deals with broad philosophical issues. Bryman represents these concerns as the 'technical' and 'epistemological' versions of the quantity/quality debate.

Henwood (1992, 1996) points out that 'Bryman's approach is only one, and a rather oversimplified, way of representing the issues underpinning the quantity-quality debate. However, it does allow the various perspectives and methods in psychology to be compared in relation to wider issues in the quantity-quality debate' (1992:89). Henwood uses Bryman's two dimensional model to help locate various perspectives and methods in qualitative psychology. By doing so she shows why Bryman's model is too simplistic, as well as demonstrating certain methods and perspectives to be multiply placed (for example, grounded theory on the technical scale is located in the non numeric section, however its epistemological positioning can either lead it to be placed in a realist or constructionist domain, while other approaches such as Q sort would be placed in the numeric section of the technical version yet would have a constructionist rather than realist placement on the epistemological dimension). In so doing, Henwood shows that there is not necessarily a direct one-to-one relationship between constructionist and non-numeric, and realist and numeric, methods.

3.3.4

Locating feminist research methods

Nielson (1990) argues that feminist methods are part of the 'larger intellectual movement which represents a fundamental shift away from traditional social science methodology' (p 1). Thus, before we try to address what constitutes feminist research methods, we can note their historical placement within the postempirical crisis in knowledge, and acknowledge that there are some shared assumptions which exist between feminist approaches in the social sciences and other alternative approaches to the scientific method which have arisen since the 1970s. Wilkinson (1986) points out that like the 'new' social psychology, the field of feminist research is also young and is changing rapidly. The historical infancy of feminist based theory and practice can be noted by taking account of when, and how many, texts on the debates about science and method within feminism have appeared. In the 1980s there were only a few key texts that fuelled and contributed to feminist debates on science and method (see, for example, Bowles and Klein, 1983; Keller, 1985; Wilkinson, 1986). Of these, Wilkinson's (1986) text is particularly useful in helping to locate the historical developments that have occurred in the field to date, also helping to contribute to the debate on how feminist research could be characterised and practised. Wilkinson, in her 1996 text, states that the 1986 text 'became a 'landmark' text, often cited as marking the beginning of feminist social psychology in Britain' (p 1).

In the 1990s the field of feminist social psychology has expanded rapidly and has made a number of contributions with its scholarly activity. Wilkinson (1996) expresses the advances which have been made as follows: 'now a decade on, the field has grown and developed very substantially. It is much more varied and sophisticated in its range of theories and methods; it has attained much greater institutional representation; it has many more publishing outlets; and it has become a truly international academic enterprise. These developments have also enabled feminist social psychology to become more influential both within the academy and beyond it. It is now creating change within mainstream psychology; it is a key contributor to

multidisciplinary women's studies; and it is clearly part of the broader feminist struggle to dismantle social inequalities and to improve the condition of women's lives' (p 1). This increased interest in, and use of, feminist contributions has occurred across a number of social science disciplines, and feminist researchers have used a variety of theoretical frameworks (for example, empiricism, poststructuralism and psychoanalysis) in their analysis of particular topic areas. Given the variety and diversity in feminism, Griffin (1995) argues that 'it is inappropriate to treat feminism as a unitary category reflecting a consistent set of beliefs, or even as a coherent social identity. Feminism is a contested space, a category under continual dispute and negotiation' (p 119). Although there is a great deal of diversity in feminist research, there are a number of commonalities that are shared by feminist standpoint researchers, for example, acknowledgement of differing degrees of 'power differential between the researcher and researched; feminist objections to the positivist myth of the apolitical, value-free researcher; and the complex questions which are raised over the feminist focus on women's experiences as a basis for the development of understanding specific issues' (Griffin, 1995:120).

The shift away from traditional social science methods has led to critiques of the positivist emphasis in the scientific method (see Griffin, 1986, 1995; Nielson, 1990; and Stanley and Wise, 1993, whose critique is provided toward the end of this chapter), and this in turn has led to the view that there is a special affinity between feminist research and qualitative methods (Henwood and Pidgeon, 1995b). The reasons for perceiving a special affinity between qualitative research methods and feminist research lie not only in the issues aforementioned (for example, the values of science), but also in how these clash with feminist arguments for recognising the power imbalances between the researcher and researched, and the political nature of research. In addition, the relative strengths of the alternative approaches in acknowledging the interdependency of theory, method and research topic, have meant that qualitative research methods have figured strongly in feminist research (Wilkinson, 1986). In more recent times a number of feminist researchers have identified the potential use of quantitative methods in

feminist research, and as such have argued for their use to be reconsidered in light of the type of research that is carried out (see, for example, Griffin and Phoenix, 1994; Shields and Crowley, 1996).

The question of whether it is possible to identify certain methods as distinctly feminist is still controversial (Nielsen, 1990), and as Henwood and Pidgeon (1995b) point out 'a commonly expressed view in very recent times is that there is no one underlying feminist method, but that a variety of methods may suit the purposes of feminist research' (p 9). This methodological pluralism within feminist research practice has meant that the suitability and relevance of the method(s) employed for feminist research is of paramount importance. However, the term 'feminist research methods' has been seen as a contradiction in terms, given that it can be seen both as 'absolute nonsense while others take it for granted as a useful concept' (Parlee, 1986:5). The reason why the term 'feminist research methods' may be a contradiction in terms lies in what has traditionally been taken to represent methods in science (see Reinharz, 1992, for a description of these as methodogma), and how these seem to contradict feminist based inquiry, which represents a fundamental shift away from traditional social science methodology (Nielsen, 1990). Thus, while for some the contradiction makes the use of the term methods in feminist research nonsensical, others see it as useful, given that feminist research is grounded in traditional methods of science and the postempirical tradition, which is still developing alternative scientific methods. These different viewpoints reflect the acceptance of, and the non-unitary nature of, feminist based inquiry.

3.4 Feminist theory of science and epistemology

Along with a number of the above named researchers (for example, Nielson, 1990; Griffin, 1995; Wilkinson, 1996), Stanley and Wise (1993) point out that feminists have produced a vast and diverse range of work, and that therefore feminist theory cannot be seen as a single body. As a result of this diversity a number of typologies of feminism have been put forward since the 1970s which outline the main differences between the types of theories

produced. The typologies of feminism that Stanley and Wise refer to are theories of theories, although they see these typologies as having more similarities than differences. They also suggest that the various typologies are caricatures, as they give a review of feminism which Stanley and Wise suggest is neither desirable or possible as this results in over simplification. In addition, they argue, clear distinctions are made which do not really exist, as there is a great deal of overlap in the typologies. Thus, addressing the question of what constitutes feminist theory is difficult, if not impossible, as there are a number of feminist theories which exist, and as such cannot be described using general statements.

Given that there are a variety of feminist epistemologies that exist, and there is a need to avoid giving too much of a simplistic account of them, only a selective account of some of the main issues often addressed by feminist researchers will be provided. The selection that follows represents the issues which informed and influenced the conception and research practice of the present study.

As mentioned above, one of the main starting points in outlining feminist theory and epistemology has involved showing its distinction from, and the problems associated with, the positivist approach in the social sciences (see also Bowles and Klein, 1983; Harding, 1986; Stanley and Wise, 1993). In addition to this critique of positivist science, Wilkinson (1986) points out that 'a feminist perspective may be regarded as having far reaching implications regarding changes in research practice...it provides a deeper and more extensive questioning both of the form and function of research, and of specific theories and research techniques. Out of this questioning comes both an active development of traditional ways of doing research and a committed exploration of alternative modes of investigation' (p 6).

In order to exemplify the points Wilkinson makes about a feminist perspective, Fonow and Cook's (1991) account of the epistemological assumptions which exist throughout feminist research will be outlined although, as Stanley and Wise point out, this inevitably means simplification will occur.

Fonow and Cook (1991) used a sociology of knowledge perspective to understand the epistemological and methodological issues in feminist research. In their account, the concept 'epistemology' is taken to be 'the study of assumptions about how to know the social and apprehend its meaning' (p 1), while the concept 'methodology' is taken to be 'the study of actual techniques and practices used in the research process' (p 1). Here, method is extended to include all the phases of the research process.

Four of the epistemological assumptions that Fonow and Cook (1991) outline are: the role of reflexivity; action orientation; attention to the affective components of the research act; the use of the situation at hand. A brief description of each assumption highlights their use within feminist scholarship.

Firstly, reflexivity is seen as a source of insight gained by reflecting upon the research process, as well as examining critically and analytically the nature of this process. Feminists use reflexivity to examine the underlying patriarchal gender relations often inherent in research by reviewing the research setting, including the researcher and the researched. Reflexivity is employed both by examining the stages of research which have been ignored, and by consciousness raising (at the epistemological level in terms of, for example, self awareness and the influences of the research on participants, and at the level of methods in terms of, for example, a research technique such as role playing, to examine consciousness as a source of data).

Secondly, action orientation is used in the approach taken in the research setting. This includes the topic to be studied, the purpose of the research, choice of method, and definitions adhered to. The aims of the research may include political action, which includes liberation and the empowerment of women. This requires critical examination, and often reconceptualisation, of the nature of research past and present.

Thirdly, paying attention to the affective components of the research means that the emotional dimensions in the research process are not ignored. Emotions and their meanings are seen to have a role in the production of knowledge, and are seen to serve as a source of insight which feeds into reflexivity outlined earlier.

Fourthly, the use of the situation at hand within feminist approaches to research refers to what is selected as a topic of research and the methods employed for its study. Feminists have made use of situations which may be termed ordinary in everyday life, and have explored these 'taken-for-granted, mundane features of everyday life' (Fonow and Cook, 1991:11). By examining the everyday situation at hand, feminists are able to study what sustains gender inequality and what otherwise may remain as hidden processes. Thus, many feminists have created the topic of research by transforming the situation at hand into a research opportunity (see for example, Stanley and Wise's study of obscene phone calls).

Fonow and Cook's (1991) four epistemological assumptions outlined above are not separate categories in which no overlap occurs. In fact, they suggest that all of the categories can be connected to each other, as well as to women's subordinate status often encountered in research settings and society as a whole.

Stanley and Wise's (1993) approach falls in line with Fonow and Cook's (1991) account of the main epistemological and methodological assumptions that many feminists share. In the remainder of this chapter Stanley and Wise's specific account of, and approach to, feminist research will be detailed, as I have adopted their approach in the conduct of my own research. Within the review of Stanley and Wise's account, specific mention will be made of the main criticisms they (and many other feminists) make of the traditional use of the scientific method.

3.4.1

Stanley and Wise's approach

The beliefs and values of feminism have been described by Stanley and Wise (1993), as encompassing three central themes. They suggest that the three themes may not come as a surprise to feminists, although there may be disputes about the exact meaning and implication of these. The central themes outlined are:

1. Women are oppressed.
2. The personal is the political.
3. Feminist consciousness.

The ontology that Stanley and Wise (1993) use is one which theorises the 'being', rather than the positivist cartesian binary system which uses oppositions (for example, male and female or mind and body). Instead, their approach recognises and appreciates difference (for example, male and female), but sees them as operating at a categorical level with complex relations without seeing them as oppositional. The 'self' is seen as the product of interaction and social construction (constructed historically, culturally and within specific contexts), where subtle changes can occur.

Stanley and Wise (1993) suggest that there is no single feminist consciousness, and they believe that consciousness is a state of mind as well as a process. As experience is differently situated and contextually grounded, the specific context will provide the meaning that one attributes to a situation. Consciousness is a state of mind in so far as the development of consciousness does not lead to a single end state. Instead, consciousness is, as Coulter (1977) describes, a social fact which is usually construed as an end state that is fixed in reality and in some senses is objective. Consciousness is seen as a process by Stanley and Wise in addition to a state, so far as the state of mind can be construed differently depending on situation and understanding, and so at different times we may be able to point to a particular state of consciousness. It is this change in consciousness at particular times that leads them to see consciousness as a process as well as a state. Feminist consciousness is seen as situated in the everyday experience of women in terms of not only being a woman but also, in part, being treated as a woman. Stanley and Wise argue that feminist research must be conducted by women, and that feminist research should be conducted out of feminism.

3.5 Feminist research practice and the concomitant challenges to the scientific method

3.5.1

Objectivity and Truth

As previously mentioned, the issue of a social reality and the search for a 'true' explanation within the positivist social sciences to understand and explain human behaviour is heavily criticised by feminist researchers. Instead, feminist researchers have argued that, based on the premise that social reality is constructed, one should consider the different and competing explanations of social reality which exist. It is necessary to explore these, often conflicting, realities in order to understand how they interact. Thus, we can move away from the positivist notion that there is a singular objective reality which the researcher is detached from, and can investigate and subsequently report as an objective account which is value-free.

'Feminist fractured foundationalism' also rejects the notion that researchers are the experts and that there is one true reality. Everyday experiences should be the subject of inquiry, with interpretation and subsequent defining being conducted by women (Stanley and Wise, 1993). Detailed examination of personal experiences can provide us with knowledge about women's views of social reality in terms of how it is constructed and lived within. The women's interpretations and understandings are taken on board and are seen as valid, although this does not mean that there is one unified experience or interpretation that can be identified or named, but rather an acceptance and recognition of the various interpretations and understandings that women have of a social reality. The existence of a social reality which goes beyond the competing constructions and interpretations is accepted, since society perceives there to be an objective reality, but what is rejected is the notion that it is a single entity which experts can discover and call the 'truth'. Stanley and Wise state that it is reasonable to assume that people's attitudes and actions are based on their interpretations and understandings, and that if we accept that experiences can be unique, specific, and contextually grounded then the relevance of examining everyday

personal experience becomes altogether clearer, as individual women are seen to experience reality differently. An examination of the personal and the everyday experiences can thus provide us with women's accounts in which alternative views can coexist.

3.5.2

The Researcher/Participant dichotomy

The Researcher

The positivist approach within the social sciences has traditionally seen social science researchers as scientists, whose task is to uncover the 'truth' about social reality, using scientific techniques and modes of thought (Stanley & Wise, 1993).

The researcher's position and subjective feelings at the time of conducting the research are rarely discussed. This, Stanley and Wise argue, is 'the mythology of 'hygienic research' in which the researcher can be 'there' without having any greater involvement than simple presence.' (1993:114). In the positivist tradition it is recognised that the researcher can affect the participant's responses, and thus cause bias, but the participant's influence on the researcher is not considered. Seeing the researcher as 'unaffected and unchanged by the people she does research 'on' is part of the mythology of 'hygienic research' (Stanley and Wise, 1993:115). The failure of the positivist approach to see and acknowledge the relationship between the researcher and the researched, the influence of both upon each other, and the biases which exist within the relationships formed, detract from the understanding and acceptance of the shared and constructed nature of the research setting in the field as well as in the 'knowledge' produced.

Stanley and Wise (1993) argue that the presence of the researcher must be acknowledged and utilised, as is the case in ethnomethodology. The reality of the research process and the description of it are rarely in correspondence. The reason for this is that the descriptions of the process are put forward as 'orderly, coherent and logically organised' (Stanley and Wise,

1993:152), with this acting as the accurate representation of the process. However, while conducting research, one finds a number of problems which are in conflict with the ideology, and research is often not orderly, coherent or logically organised. It is also common to find that the role of the researcher and her experiences be left out of, or only marginally discussed in, the presentation. Issues such as the level of involvement the researcher has with her participants both on an emotional and intellectual level at the time of research, and subsequently the expression of this relationship in the academic presentation, mean that the personal experiences need to be seen as political. The interactions that occur, and the feelings one has, need to be seen as part of the process which has produced the research material, and as such should be explored. Smith (1974) argues that the starting point for social science research should be formed from the experiences gained via the situated nature of the researcher, in terms of how she is located in time, space and place.

The Participant

The positivist approach within the social sciences has viewed participants as irrational, with an inability to use scientific methods and thought processes. The view of participants as 'objects' upon which research can be carried out ignores the fact that they are thinking, deciding, reacting and interacting with their environment, and if these factors are taken on board they are often 'controlled for' to reduce 'bias' (Stanley & Wise, 1993). The empowerment of participants is an issue which has arisen in the light of feminist theory and practice. Initially, there was a move towards addressing the imbalance of power between the researcher and the researched, emphasising collaborative power sharing, while more recently the emphasis has been towards the acceptance and recognition of the power the researcher holds in the relationship.

The researched do not just provide us with the data we seek to extract, there is a level of personal involvement with the researcher which, although initiated through the research, does develop. The participants have feelings

about not only the research but also the researcher, which have their own consequences and agenda.

3.6 Key points adopted from Stanley and Wise (1993)

The key points which have been raised and taken on board in this review of Stanley and Wise's (1993) work contained in the book Breaking Out Again are as follows:

1. Personal/everyday experience is important and valid.
2. Personal experience is to be taken as the starting point to research the social experience.
3. Knowledge for its own sake is useful.
4. Social reality is constructed by means of personal experience being socially situated, and vice versa (the social being personally situated). Thus, social reality can be experienced differently.
5. As women do not share the same experience the forms of oppression can differ.
6. 'Truth' and objectivity are contextually grounded and so many objective realities can coexist.
7. There is a need to locate the researcher in the research process and make her presence known.
8. The power relationship which exists between the researcher and the researched should be encompassed.
9. The reasoning procedures the researcher has used should be made explicit, thus endorsing a reflexive approach.
10. Everyday subjective experiences should be examined using a social constructionist approach
11. Interpretations are made at the level of the individual.

Section 2

Chapter Four: The research process

4.1 Setting up the research

This study was first conceptualised in 1991, when a number of protocols were drawn up in order to try and gain funding and ethical approval for the study. Funding was not achieved, although ethical approval was gained from Hillingdon Health Authority Ethics Committee on the 8th October, 1991. Links were made with a local general district hospital for access to potential participants, and discussions with hospital staff members (doctors and midwives) lasted six months prior to recruitment. During this time contacts were also made with a number of doctors' surgeries. The hospital and three of the ten surgeries contacted agreed to help with the recruitment of participants after lengthy and often difficult negotiations (see chapter ten for details of the problems experienced).

4.2 Preparing for the conduct of the study

Due to my lack of personal experience of pregnancy, I made contacts with a number of organisations in order to gain as much knowledge as possible about the experience of pregnancy. These contacts were made prior to the interviews with participants. I was invited and subsequently observed/took part in antenatal classes offered by one GP's surgery, and also met members of staff running a support group entitled 'Support after Termination for Fetal Abnormality' (SATFA) on several occasions, and went to a number of their annual general meetings at which a number of their members spoke about their experiences.

4.3 Methodological framework of the study

A longitudinal design was chosen for the conduct of the study, in which the participants were followed from early pregnancy to shortly after the birth.

4.3.1

Recruitment procedure and details of participants

Information and consent forms (see Appendix 1) were left at the three doctors' surgeries and the local general district hospital that had agreed to help with recruitment. The medical professionals (doctors, midwives and nurses) who came into contact with pregnant women were asked to distribute the information/consent forms to potential participants on their first pregnancy related visit.

The medical staff did not discuss the research with the potential participants but did mention that the research was independent from the medical care they would receive. If they were interested in taking part, contact was to be established with me via the consent form. The consent form could either be left with the antenatal department receptionist or posted directly to me (in the event, all were posted to me by the potential participants). On receipt of the consent form, I contacted the women by telephone, and made an appointment to go and discuss the research with them in person within a week. The women were given a choice as to where the meeting should take place (their own home, hospital side room or my office at Brunel), and all participants chose to meet at their house, with one exception who asked to meet at the hospital.

Twelve women had posted back the consent forms in the first month of their distribution. Once contact with these first twelve women was established, the forms were removed from the surgeries and hospital, as, due to the aims of the research, a larger sample of participants was not required.

As I was interested in trying to capture as much of the pregnancy experience as possible, I had set a cut-off date of twenty weeks into the pregnancy as the outer limit for inclusion in the study. All the participants had made contact well before their twentieth week of pregnancy (a question asked over the phone whilst arranging the first meeting), and thus none were rejected on the basis of their length of gestation. No other criteria for exclusion was used.

Out of the twelve women recruited, two dropped out in the initial stages. One of these two women was medically defined to be 'high risk', and cancelled the first meeting as she had decided to terminate the pregnancy. The second woman dropped out of the study three weeks after the first meeting due to heavy work commitments. Thus, the final study sample consisted of ten women, of whom seven were recruited via doctors' surgeries and three from the local general district hospital. Details of the ten women who took part are as follows (names have, of course, been changed to protect anonymity):

Participant one: Jane

Age at conception: 35 years and eight months.

Estimated date of conception: 21/5/92.

Date of expected delivery: 22/2/93.

Pregnancy number: First pregnancy

Occupation: Nurse

Medical definition as described by the participant (High or low risk):

High due to advanced maternal age

Date of recruitment to study (first visit): 22/7/92

Participant two: Sue

Age at conception: 32 years and nine months.

Estimated date of conception: 7/7/92.

Date of expected delivery: 6/3/93.

Pregnancy number: second pregnancy

Occupation: Day centre officer

Medical definition as described by the participant (High or low risk):

High due to Rhesus negative blood group

Date of recruitment to study (first visit): 30/7/92

Participant three: Sandy

Age at conception: 42 years and seven months.

Estimated date of conception: 17/5/92.

Date of expected delivery: 24/2/93.

Pregnancy number: first pregnancy

Occupation: Teacher

Medical definition as described by the participant (High or low risk):

High due to advanced maternal age

Date of recruitment to study (first visit): 31/7/92

Participant four: Karen

Age at conception: 32 years and eleven months.

Estimated date of conception: 2/5/92.

Date of expected delivery: 8/2/93.

Pregnancy number: seventh pregnancy

Occupation: Outwork from home

Medical definition as described by the participant (High or low risk):

High due to four previous miscarriages

Date of recruitment to study (first visit): 3/8/92

Participant five: Mary

Age at conception: 27 years and eleven months.

Estimated date of conception: 6/5/92.

Date of expected delivery: 10/2/93.

Pregnancy number: first pregnancy

Occupation: Clerical assistant

Medical definition as described by the participant (High or low risk):

Low

Date of recruitment to study (first visit): 5/8/92

Participant six: Sam

Age at conception: 25 years and seven months.

Estimated date of conception: 28/5/92.

Date of expected delivery: 6/3/93.

Pregnancy number: first pregnancy

Occupation: District Nursing Sister

Medical definition as described by the participant (High or low risk):

High due to diabetes

Date of recruitment to study (first visit): 5/8/92

Participant seven: Doris

Age at conception: 28 years and 3 months.

Estimated date of conception: 30/4/92.

Date of expected delivery: 7/2/93.

Pregnancy number: first pregnancy

Occupation: Secretary

Medical definition as described by the participant (High or low risk):

Low

Date of recruitment to study (first visit): 8/8/92

Participant eight: Ann

Age at conception: 29 years and 6 months.

Estimated date of conception: 5/5/92.

Date of expected delivery: 9/2/93.

Pregnancy number: second pregnancy

Occupation: Bank Supervisor for tour operator

Medical definition as described by the participant (High or low risk):

High due to previous baby's abnormality (severe talipes)

Date of recruitment to study (first visit): 8/8/92

Participant nine: Pat

Age at conception: 32 years and 10 months.

Estimated date of conception: 16/4/92.

Date of expected delivery: 21/1/93.

Pregnancy number: first pregnancy

Occupation: Community relations executive for a supermarket

Medical definition as described by the participant (High or low risk):

High due to family history of Down's Syndrome

Date of recruitment to study (first visit): 8/8/92

Participant ten: Rita

Age at conception: 28 years and 1 month.

Estimated date of conception: 8/7/92.

Date of expected delivery: 13/4/93.

Pregnancy number: second pregnancy

Occupation: Teacher

Medical definition as described by the participant (High or low risk):

High due to diabetes

Date of recruitment to study (first visit): 12/8/92

All ten participants were White middle class women who lived in West London. Their ages ranged from 25 years to 42 years at the time of conception.

From the details presented above it can be seen that six of the women were expecting their first baby, three their second and one her third.

In terms of risk status eight of the ten women thought they would be medically categorised as 'high risk', at the time of the first meeting. However, at a subsequent meeting one of the participants (Pat) informed me that she was medically considered to be at low risk despite a relative having Down's Syndrome. A further participant (Sue) also discussed her risk status at a subsequent meeting, and said that she was not at 'high risk' of having a baby with abnormalities, as she had had the Anti-D injection. This meant that, in the opinions of the participants, six of them would be medically categorised as high risk, while four would be categorised as low risk. Personal beliefs about their relative risk status differed from that which they thought was medically assigned to them for a number of the participants (as discussed in chapter seven).

The date of the first meeting was dependent on when the consent forms were sent back to me, however all the participants were met within a one week timescale. The period in which contact was made varied between the third and fifteenth week of the pregnancy.

4.3.2

Meetings with the participants and methods of data collection

The data collection phase began towards the end of July 1992 and was completed at the end of August 1993. All of the participants were informed of

the purpose of the study at the first (unrecorded) meeting. If they agreed to take part they were left with a diary in which they could record their daily experiences. At the front of the diary a brief description of the type of information the women may wish to record was provided, together with a format for presenting their experiences (see Appendix 2). Each diary was 160 pages long, and on completion a further diary was provided. Nine women completed two diaries and one completed three.

In addition to completing the diaries, the women were asked to take part in four, recorded, in-depth unstructured interviews (three during the course of their pregnancy and one after the birth). The interviews lasted between 40-90 minutes, in which the women discussed their thoughts about the pregnancy.

The relative advantages and disadvantages of using these two forms of data collection have been discussed in a separate paper (Bola, 1991), a copy of which appears in Appendix 3. The dynamics of the interview process are discussed in chapter ten.

A research diary was also kept by myself in order to enable a fuller examination of reflexivity upon completion of the data collection phase.

4.4 Analytical framework

The analysis conducted here is multifaceted in terms of drawing on various forms of analysis which have been utilised by qualitative researchers in the past two decades, and includes elements that have been drawn from a number of social constructionist approaches, for example grounded theory, discourse analysis, social constructionism, and feminist interpretative analysis (drawn from Stanley and Wise, 1993). The reason for taking several strands from each of the above approaches, as opposed to using one form of analysis, will be made clear in terms of identifying the purposes of the research undertaken, and the complementarity and similarity of different forms of qualitative analysis.

For the purposes of the presentation of the data analysis, a select number of women's accounts are used in each chapter. The accounts contained within each chapter were chosen on the basis of their relevance to the particular theme being explored.

4.4.1

Approaches to the analysis of accounts

Having examined several qualitative methods it became apparent that not only were there commonalities between a number of qualitative methods which could be drawn upon in order to analyse the accounts produced, but also, where the methods differed in terms of emphasis on particular aspects of the text, they could be quite complementary. Thus, aspects of a number of different qualitative approaches have been drawn together to form a coherent qualitative tool to allow sense making of the data. The strands from each approach drawn upon, and the elements rejected from each approach, shall briefly be outlined in turn.

Firstly, the grounded theory approach of Glaser and Strauss (1967) allows the researcher to draw theory from data itself. This has allowed the reading of the texts to be conducted in such a way as to allow the data to form the thematic conceptualisations that the analyst makes via immersion in the data itself. Thus, for the purposes of analysis, no prior theoretical assumptions are consciously made. It is the data that leads to theory building, not vice versa.

In this research all the themes were drawn from several readings of the data itself, and the categorisations produced came directly from the participants' texts. This was achieved by conducting a line by line analysis of the participants' accounts. However, in the analysis attention was paid to how the women made sense of their pregnancy and felt about their pregnancy status, rather than why they had the views that they expressed. Thus, the aim was not to build theory at the point of analysis, but to read the forms of their expression of their everyday experience. The point of departure from the grounded theory approach relates to the concept of saturation. In grounded theory a category has to be completely saturated for it to hold, while in this

research project complete saturation of a category was not set as a necessary criteria for inclusion.

Potter and Wetherell's (1987) discourse analytic approach provides the following elements which have been drawn upon in the current research project:

1. Examining the consistency and contradictions in the participants' accounts (variation).
2. How justifications for behaviour are made (function construction).
3. The context in which the account is given.

My point of departure here lies in paying less detailed attention to the ways in which people use language (the functions the account is trying to serve), and instead focusing more on how their use constructs particular versions. Discourse analysts remain at the level of the text, whereas I have taken a more phenomenological approach in which the text is examined for descriptions of each individual's perception and experience of events (during pregnancy).

The social constructionist approach (Hollway, 1989) allows us to see how everyday experience is constructed from the relations and interactions we have with others, and thus the social environment within which an individual is situated leads to the concepts of reality they hold. As the women reported on their direct interaction within their society, be it with personal relations or medical relations, it is important to look at how these shape the individual experience. However, once again the emphasis in the analysis conducted here is on the individual's interpretation which, as social constructionists view it, is produced as a result of social and cultural communal interchange (Hollway, 1989). Although this may be how the individual's knowledge is produced, which in turn implies there is a structural shaping of any experience, the interest here is not on those interactions which led to the experience but on how the women reflect, report and incorporate this into their own multiple realities. Thus, from this approach the element taken is the constructed nature of the individual. However, the individual is not

being de-centred, as social constructionists would do for the purposes of analysis, but rather the individual is being centred as the organiser of their knowledge.

The feminist approach of Stanley and Wise (1993) has contributed significantly to the style of analysis performed (and is detailed in chapter three). From this approach the emphasis on studying the personal has been paramount. In addition, the differential experience of social reality has been acknowledged, as has the concept of multiple realities co-existing. With this approach, an exploration of the fragmentation of the self and so experience, can be examined. The multiplicity of the self as exposed by the many different dimensions which make up the self (e.g. race, class, age, disability) help to show how it is not just a question of structural dimensions shaping our experiences, but also our interpretations and use of each dimension at any given point in time.

Accounting for the role of the researcher in the research process has also been undertaken, as the researcher's role in the production of accounts is an integral aspect, and shall be further examined in chapter ten.

4.4.2

Aims of the analysis

The main aim of the analysis undertaken here is to highlight women's socially constructed personal identifications with their pregnancy. The desire to represent women's personal forms of conceptualising their pregnancy, and modes of expressing their experience, requires representing the contextual accounts they themselves have produced. Thus, the women's interpretations and understandings are accepted and seen as valid.

My interests lie in this micro level of experience, with the many salient issues that I as a researcher can draw upon as themes coming from within and across the individual accounts. This will be carried out by examining the women's attributed meanings, perceptions and sense making of the feelings and identifications they have associated with their pregnancy.

In summary, the epistemological and methodological approach of this study is located within the feminist approach advocated by Stanley and Wise (1993). However, it draws on a number of qualitative approaches to research (for example, post structural, phenomenological, social construction) in order to carry out a thematic analysis of the personal subjective experiences provided by the women.

4.5 Conclusion

A feminist perspective was utilised for the study by taking account of women's own personal and everyday subjective experiences. These recorded experiences (in diaries and unstructured interviews) were the starting point and the primary source of data, enabling an understanding of the experiences to be grounded in the varying constructions of the pregnancy. The social reality for each participant could be accounted for due to the in-depth, prospective nature of data collection, which would allow for the recording of different experiences. The issues that the women themselves raised would be taken as the starting point for analysing the data. The purpose of the study was outlined as clearly as possible at the outset of the study. A diary was kept by the researcher to reflect on her involvement and relationship with the participants, allowing the influence of the researcher, and any power relationships which existed, to be explored.

Section three: Empirical analysis

Chapter five: Pregnancy identification in the first trimester: an examination of women's perceptions of their pregnancy status

5.1 Introduction

As discussed in chapter two, Grimm et al (1967) point out that the main areas of pregnancy research carried out pre-1960s mostly investigated the physical symptoms encountered by some women during the course of their pregnancy (e.g. severe nausea). This line of research, which investigated and categorised pregnancy as pathological, came to be heavily criticised by a number of researchers (Shereshfsky and Yarrow, 1973; Phoenix, 1991; Phoenix et al, 1991; Johnston, 1993; Matlin, 1996) who pointed out that the 'abnormal' (which affected the few) was being generalised and prioritised over the 'normal' aspects of pregnancy, which included emotional and social aspects of the experience of pregnancy (not just the physical/physiological aspects).

With the cognitive approach still dominating the field of psychology, there remains a bias toward examining a number of discrete factors which come to make up only parts of the pregnancy experience. This examination of isolated factors, however, does not shed light on the everyday lived experience the women encounter whilst being pregnant. In order to gain a more holistic understanding of the ways in which the pregnancy state is experienced in everyday life we need to turn to the accounts provided by the women to gain an understanding of what they construct as being important to them in relation to their day to day experience. By turning to the contextual accounts we can see how the women not only construct their accounts, but also come to provide meanings and understandings of the various factors that they experience (for example, their interpretations of the physical symptoms). The examination of the contextual accounts allow us to pick up the contradictions that occur in the descriptions of the experiences outlined by the

participants. For example, the women say they can't believe they are pregnant and yet prior to this they have reported how they are being affected by physical symptoms such as tiredness and nausea (see themes two and five below).

The material discussed in this chapter deals with the early stages of pregnancy and examines the personal accounts provided by four of the ten participants of the study. Their personal accounts have been examined for emergent themes which relate to the ways in which pregnancy identification can occur (the use of the term identification is described in the final subsection of this chapter). The themes have been taken from the diaries kept by the participants, and the thematic interpretation and analysis of the data has been conducted in line with the feminist/poststructuralist/phenomenological approach I have outlined in chapters three and four. In brief, this chapter substantially uses a (feminist) qualitative perspective (adopted from Stanley and Wise, 1993). In this approach, social reality is seen to be constructed, and thus consideration is paid to the different and competing explanations of social reality which exist in the transcripts. The way in which the accounts of these, often conflicting, realities can be of use is to explore them in order to understand how reality is made up (Stanley and Wise, 1993). The object of enquiry is the everyday experience encountered by the participants. This detailed examination of personal experience can provide knowledge about the views of social reality that the participants in the research hold, in terms of how it is constructed and lived within. The participants' interpretations and understandings are taken on board and are seen as valid in terms of what they see as the reality of the pregnancy experience. This does not mean that there is one unified experience or interpretation that can be identified or named, but rather an acceptance and recognition of the various interpretations and understandings that the participants have of a social reality.

The qualitative approach used places importance on seeing human beings as subjective and complex in nature, who interpret and give meaning to their experiences. In accordance with this approach, various factors from the individual's point of view (albeit based on my interpretation and selection

of them) have been taken into account, thus highlighting the individuality of experience as examined by the researcher. For example, the participants' use of changing prioritisations of objective information (e.g. diagnostic tests) over subjective information in coming to accept their pregnancy status is outlined to show the multiplicity, variability and complexity of their experience.

In the analysis subsection of this chapter I will explore the ways in which the women describe their early experiences of pregnancy: in particular their knowledge of the pregnancy; feelings associated with its reality/unreality; acceptance of the pregnancy coming to full term; the telling of others in the first trimester; the interpretation of the physical symptoms experienced.

The data analysis presented below is by no means exhaustive of the data which were collected and thus available to be analysed. The choices made reflect my own particular interests in the subject matter, and to some extent came to be chosen because of their 'strangeness' to me as possible explanations/accounts of the early stage of pregnancy. By using the term 'strangeness' I do not mean to imply that it is the women who are strange but rather that as a researcher having had no direct experience of pregnancy at the time of analysing the data I found their thoughts and feelings very different to what I had imagined they might say about their experiences. This was especially the case when I chose the second theme, 'pregnancy as real/unreal', for inclusion in this chapter. The movement between these two oppositional descriptions was not something that I had considered prior to the analysis of the data, and its recurrence within and between the accounts led me to examine this issue further. The accounts further support Stanley and Wise's notion of reality being made up of often different and competing explanations. In the subsection below I have attempted to detail some of the dynamics and complexities of the women's experiences, and hope to show that the levels of contradictions within the accounts show the fluid and changing ways in which the women represent their thoughts and feelings.

5.2 Analysis of personal accounts

Although a pregnancy test reveals that conception has occurred, the personal acceptance of being pregnant may take some time. Exploring the personal accounts given by the women reveals the different means by which the pregnancy is acknowledged.

The analysis has been split into five separate subsections in order to highlight the multiple identity roles taken on by the women whilst coming to terms with their pregnancy status. Each of the subsections outlines a particular theme, although they do overlap and often occurred simultaneously throughout the women's accounts. The five themes are:

1. Knowledge of pregnancy.
2. Pregnancy as real/unreal.
3. Acceptance of the pregnancy coming to full term: stability.
4. Telling others in the first trimester.
5. Interpretation of physical symptoms.

The five themes highlight the different forms of representation the women gave in their accounts of the early stage of pregnancy. One common feature in the separate accounts is the points of contradiction contained in the descriptions of the pregnancy. In the analysis that follows, the first two themes shall be presented together, as the same extracts are used to explore both.

5.2.1

Knowledge of pregnancy and the reality/unreality of the pregnancy

Confirmation of conception occurred via personal use of pregnancy test kits in the first instance for all ten of the participants. The positive testing meant they were no longer 'trying to get pregnant'. However, this visible sign of the pregnancy status from the pregnancy test did not lead to an 'inherent' acceptance of this transition. This was especially the case for primigravidas

(first time mothers to be), due to the preconceived ideas of what they thought it would be like to become pregnant.

This can clearly be seen to be the case for participant one (Jane) in the following interview extract.

Extract 1 (Jane - interview):

Question: 'How did you find out that you were pregnant, and what did it feel like?'

'...It was costing a small fortune in pregnancy test kits!!

I knew the day my period was due (I've never been strong on patience). I repeated it again later and again after that.

My boobs were sore but otherwise I felt no different. In fact at first I couldn't believe I was pregnant because I didn't feel different and all the myths are that one is supposed to inherently 'know'. I hoped to death I would be and that I would stay pregnant but I didn't 'know' or feel different until week 6.'

For Jane, the acceptance of the initial test result is difficult. It is not that she doubts the accuracy of the test, but rather that this sole piece of abstract information needs to be confirmed in some other way, in this instance by a direct personal signal that she can identify with. As she does not feel different she continues to conduct pregnancy tests to aid her in forming a belief about the existence of the pregnancy. One possible interpretation of this is that she is prioritising subjective indicators (feelings) over objective indicators, but this is in light of the absence of subjective information that the 'myths' say should occur. It is interesting to see how, on the one hand, she describes the idea of 'inherently' knowing to be a myth but, on the other hand, she seeks to confirm the pregnancy in that fashion (subjectively). Thus, we can see that this participant is questioning her pregnancy as real/unreal. The acceptance of the reality of the pregnancy does not unquestionably occur with the initial pregnancy diagnostic test. Further indicators are sought. We can see how not

only is repeated testing conducted, but also an expressed desire to 'inherently' know she is pregnant. Jane's use of the term 'inherently' is of significance here in that she had believed that once you were pregnant, the personal identification with the pregnancy would occur automatically and without any doubt. With the doubts about the reality of the pregnancy being felt by Jane, she seeks to come to terms with what she thought it would be like in terms of identifying with the pregnancy and the way she is currently feeling (not able to believe its reality).

Jane's account of the 'myths about inherently knowing' that you are pregnant shows how pregnancy prior to its experience is socially and culturally constructed. She uses this prior construction to compare her own feelings and beliefs about being pregnant, and constructs her own sense of what it should be like to be pregnant from the previously available discourses.

In the case of the second participant (Sue), the initial prompt to carry out a pregnancy test came from her suspicions that she was pregnant. However, this objective confirmation was still described as a 'shock', and once again belief in the pregnancy status is problematic.

Extract 2 (Sue - interview):

Question: 'How did you find out that you were pregnant, and what did it feel like?'

'I did a pregnancy test at work and although I obviously suspected I might be pregnant, confirming it was still a shock. I had begun to feel slightly sick that morning, which prompted me into doing the test. Since that time, I still don't believe it.'

In Extract 3 we can see that Sue's belief in the pregnancy as being real is tenuously being associated with its slight visible appearance at week five of the pregnancy. At this time she feels that there may be a turn around in her thoughts related to the reality of the pregnancy. For the first time she has felt pregnant, and hopes that this will serve as a marker.

Extract 3 (Sue - diary):

'Today I felt a little 'pregnant', don't know why. I think I may be noticing a small difference in shape - only slightly, but I am hoping things will seem more 'real' from now on.'

In this extract we can see that confirming the reality of the pregnancy is difficult. Although Sue feels 'a little pregnant', she is not sure why. To know why she feels pregnant may be important to Sue, as having this knowledge could be used for future acknowledgements of the pregnancy being real. Despite feeling 'a little pregnant', in addition to feeling nauseous and very tired (as described in theme five), she still feels that the pregnancy is unreal a few weeks later. She now begins to place an emphasis on objective information as an indicator of the pregnancy existing over her own feelings and thoughts.

Extract 4 (Sue - diary):

'I'm about 7 weeks+ still not showing. I guess that's normal but I don't believe it's really true. I still don't believe it. I guess when I have my first appointment at the hospital and can hear the heartbeat - it will seem real. Now it just seems like a dream.'

The reference to the pregnancy as a dream was a metaphor used by a number of the participants in the study.

All of the participants spoke positively about their hospital appointments in which they would get a chance to hear the heartbeat of the baby, and hoped this would help in their psychological acceptance of the pregnancy status.

Extract 5 (Sue - interview):

Question: 'How did you find out that you were pregnant, and what did it feel like?'

'I bought something for the baby today. It's the first thing I've bought for this baby...Buying this actually made it seem real, it still seems like a dream.'

In the absence of the pregnancy seeming real, Sue seeks to make it feel real by acting against her notions of the unreality of the pregnancy. Her statements seem to imply that if she takes overt actions (buying something for the baby), they will help in her acknowledgement of the pregnancy as real. In the next extract she shows how her psychological acceptance of the pregnancy doesn't occur despite her efforts to fantasise the pregnancy development.

Extract 6 (Sue - diary):

'I keep trying to imagine that there is a little baby growing inside me. It just doesn't seem real.'

For Sue, neither imagining the development nor preparing for the baby by buying baby items has provided definitive evidence which can assist her in the psychological acceptance of the reality of her pregnancy status.

Although acceptance of the pregnancy status is difficult, Sue still acts in accordance with the knowledge provided by the pregnancy test, despite having doubts about the reality on a subjective level. In Extract 7 we see that concern for the well-being of the fetus overrides the feelings associated with the questioning of the reality of the pregnancy.

Extract 7 (Sue - diary):

'It's strange - even though you can't yet see or feel the baby - I feel protective toward the fetus and want to take care of myself.'

This desire to take care of her pregnancy can be seen as a contradiction in her thoughts, in that, on the one hand, she does not feel the pregnancy is real but, on the other hand, she is feeling protective towards it.

In the case of the third participant (Sandy) we can see in the following extract her use of two different constructions of what she was experiencing. On the one hand, there is the possibility that she is pregnant (which is described in terms of the discussions she had with her partner) and, on the other hand, there is the possibility that it is a difficult and late start to her period. She describes how this latter stance is the one that was more

compelling, and as a result of this she is 'stunned' to find out that she is pregnant. Being 'stunned' is not so surprising given that she had not conceived after over twelve years of 'trying'. Thus, Sandy describes how her experience is formed in the light of two very different explanations of her present state.

As the next extract shows, on finding out that she is pregnant doubts about whether the pregnancy really exists also occur.

Extract 8 (Sandy - diary):

'It was my friend, Eve, who suggested I buy a testing kit when my period was a week overdue. I remember thinking what a waste of money when I was buying it - I didn't think there was even a remote chance I could actually be pregnant. I simply thought I was experiencing a bad attack of PMT and a late start to my period. When the test proved positive I was stunned. I rushed to my partner, waving my little blue tipped wand and burst into tears. We discussed the possibility that I might be pregnant beforehand, and although it would mean major upheavals in our lifestyle, we both decided that we wanted the child (if it was there!).'

Here we can see that although she says there wasn't a remote chance she could be pregnant at the outset, Sandy then goes on to say how she had discussed the possibility beforehand with her partner. The shift between 'might be', 'can't be', 'am' to 'if it's there', shows the changes in thinking that occur whilst gaining knowledge and the acceptance of it.

Furthermore, the extracts in this subsection show that what it means to 'really believe' is constructed with reference to many different things (e.g. having to imagine the growth of the fetus due to the lack of visibility, and in relation to feelings of wanting to protect the fetus), hence leading to the experience of contradictions and shifting goalposts.

5.2.2

Acceptance of the pregnancy coming to full term: stability

The risk of miscarriage in the first trimester is a further complication in accepting the pregnancy identity. With the stability of the pregnancy being uncertain in the early days, the acceptance of the pregnancy coming to full term varies. Grossman et al (1980) report how previous pregnancy related traumas, such as miscarriage, become a major factor in the experience of a current pregnancy. They found that 'women with a history of miscarriage showed a strong sense of restraining their excitement about the pregnancy until the end of the first trimester, or until after the point of the pregnancy when they had previously miscarried' (p 24). Similar results were found in the accounts provided by the fourth participant (Karen), who had previously miscarried on a number of occasions and, as can be seen in Extract 15 at the end of this subsection, she restrains from 'bonding' with the fetus and accepting that it will come to full term. However, as can be seen in the extracts below, women who have not suffered previous miscarriages also restrain from accepting the pregnancy coming to full term in the early stages of pregnancy at various points, while at a contradictory level they can also prepare for the baby's arrival (see the contrast between Extracts 10 and 11).

Extract 9 (Jane - diary):

'I hoped to death...that I would stay pregnant...'

Extract 10 (Jane - diary):

'I was also very aware that until one reaches 12/40 pregnancy one is by no means 'home and dry'...'

In contrast to the caution displayed in the above two extracts. We can see in Extract 11 Jane describing her personal acceptance of the pregnancy coming to full term by raising issues relating to after the birth whilst only in her 9th week of pregnancy.

Extract 11 (Jane - diary):

'I intend to negotiate p/t hours for my return to work after maternity leave...I shall have to start looking for a childminder...'

The contrast between these three extracts shows the complexity of the issues involved in coming to terms with the pregnancy status. Although pessimism was evident in Extracts 9 and 10, there is a sudden shift in the account toward accepting the pregnancy and its consequences in Extract 11 (a suitable metaphor that comes to mind is, 'like a swinging pendulum'). The detection of such variation is only possible when qualitative research methods are employed, as only lengthy discussions provide the complexity of the issues involved when individuals find out that they are pregnant.

For Sue, the doubts about the pregnancy coming to full term in the second month of pregnancy still remain. Although she acknowledges that she is pregnant, with accompanying doubts about its reality, there is still a lack of belief in the pregnancy coming to full term.

Extract 12 (Sue - diary):

'I did buy a double pushchair for when the baby arrives. I bought it here because it is less than 1/2 the price of one in England. I just don't know if I'll need it. I always keep thinking something's going to go wrong. Not a feeling of paranoia - more a premonition - I just can't picture this happening.'

In the case of Sandy, the caution placed on accepting the pregnancy coming to full term was based on two risk factors. The first was the risk of miscarriage, and the second the risk of congenital abnormalities for which termination would be chosen.

Extract 13 (Sandy - diary):

'...[GP] who suggested I have an early scan, given my history, to see that the fetus had properly established...I was

amazed to see a little blob, like a broad bean, with a beating heart.

This immediately made me feel anxious that all should go well with the pregnancy. I had a great desire to bond with this little scrap of life inside me, yet afraid to, in case I should miscarry or the baby should prove handicapped, in which case I should have a termination.'

Despite the caution being placed on the acceptance of the pregnancy coming to full term Sandy, like Jane in Extract 11, goes on to describe all of the preparations being made for the arrival of the baby. These preparations are taking place before the end of the highest risk period for miscarriage (12 weeks) and also before the prenatal diagnostic test she undertook. The desire to bond was referred to by a number of the participants. They often referred to 'bonding' in terms of developing a loving relationship with their baby, but did not want to start this bonding until they were sure that the pregnancy would come to fruition.

Extract 14 (Sandy - diary):

'Partner and his brother-in-law, (a builder) are starting work today on converting the loft into a study/workroom, because our back bedroom has to become a nursery.'

The acceptance of pregnancy coming to full term is continually delayed by Karen. The effects of her previous experiences of miscarriage have led to her continually shifting the goal post of when she will be out of the danger period. The following extract shows that even at 13+ weeks (past the highest risk phase) the possibility of loss is still her main worry, and to this end she continues to seek external forms of information (scans) as a means of reassurance.

Extract 15 (Karen - diary):

'I felt quite depressed still thinking that I won't be getting a baby even though I am over my danger period, It has helped having had 5 scans already but I don't want to get excited and then lose yet another baby.'

Extract 16 (Karen - diary):

'Can't wait until I'm sixteen and a half weeks then I should be able to feel the baby kicking...I could feel the baby moving today, not kicking but just moving around. Felt reassured that the baby is still all right.'

In the above extract we can see how a further marker of the pregnancy existing and doing well is being sought. The search for visible evidence (scans) can, at this later stage, be replaced with the detection of movements from the fetus, and this can act as an indicator that the pregnancy will lead to an increased likelihood of a baby being born.

5.2.3

Telling of others (disclosure) in the first trimester

The decision to tell others appears to be based both on the assessment of the risk of miscarriage and circumstantial matters (having to tell employers). The dilemmas and the reasons for them are clearly outlined in the following extracts:

Extract 17 (Jane - diary):

'I was also very aware that until one reaches 12/40 pregnancy, one is by no means 'home and dry' and so began the dilemma of desperately wanting to tell everyone and yet not daring to tempt providence.'

Jane then goes on to say:

Extract 18 (Jane - diary):

'We told a few close friends who knew that we were trying - we didn't tell family until week 7...Because I have my hospital antenatal booking appointment in 2/7 time, I have reluctantly had to tell my employers rather sooner than I had wanted (I am now 9/40 pregnant), in order to get time off legitimately - not everyone at work knows yet though...'

Here we can see how the telling of others is being related to the questions of the stability of the pregnancy. Jane implies that she wants the knowledge of pregnancy to remain private until she is over the danger period for a miscarriage. However, circumstances dictate that she tell her employer.

For Karen, the dilemma of telling others also exists, although for very different reasons. Here, her past history of miscarrying is making her cautious and superstitious.

Extract 19 (Karen - diary):

'Starting to show now, none of my clothes fit. I want people to notice that I am pregnant, but at the same time I am fed up that I haven't got anything to wear. I don't want to wear maternity clothes yet because I think if I do something might happen to the baby.'

The contradiction in the above account can be interpreted in two ways. Firstly, and more simplistically, it could be taken to show the insecurity the woman feels in the pregnancy being stable. Secondly, as Billig (1988) points out, we could see this as further evidence of the ways in which we all think: in terms of contrary themes and everyday dilemmas. In the case of Karen, we can see that although she wants public acknowledgement (by wearing maternity clothes), she also thinks that this may be detrimental to the pregnancy.

5.2.4

Interpretation of the physical symptoms experienced

The first three extracts presented below have been taken from Sandy's account, and have been chosen because she often detailed both the high number and degree of negative physical symptoms that she encountered in the early stages of pregnancy. Her extracts highlight the extent to which particular symptoms can be experienced negatively, although these symptoms were not experienced by all of the participants and where they were, they were differentially reported in the diary accounts. Thus, the

descriptions that follow should not be seen as representative of all of the participants' experiences.

Extract 20 (Sandy - diary):

'Week 9. I started to experience morning sickness. I was late for school a few times because I felt unable to leave the house until I was sure I wasn't going to be sick again. I began to feel overwhelming fatigue and found the run up to the end of term very difficult.

It was a huge relief to finish for the summer, because at least I could throw up and/or rest when I needed to!

Extract 21 (Sandy - diary):

'I'm a bit worried about my diet, because I'm so sick all the time. My normal balanced diet has gone out the window, to be replaced by biscuits, jelly, ice-cream and gallons of lucozade. I'm getting fat and it's not all baby!'

Extract 22 (Sandy - interview):

Question: 'How are you feeling now?'

'The building work continues. I feel ill and desperately tired. I even managed to sleep through sawing and hammering directly above me this afternoon...at the same time I feel a bit guilty because I can't help and I know they are working very hard...but at least I keep them fed - (no easy task when you feel sick!).'

What we can see from the above accounts is that although illness type symptoms are being reported, they are not being associated with a psychological acceptance of the reality of the pregnancy, but instead are used to account for the social and work related difficulties they cause.

In the next extract, taken from Sue's diary, we can see that the initial prompt to carry out a pregnancy test is indeed a physical symptom. However, although the sickness provided a prompt, it does not lead to a belief in the pregnancy.

Extract 23 (Sue - diary):

'I had begun to feel slightly sick that morning which prompted me into doing the test. Since that time, I still don't believe it.'

The lack of correlation between the physical symptoms and the psychological identification with the pregnancy is particularly evident when we turn to further extracts provided by Sue. For example, in Extract 4 we can see that Sue is finding difficulties in coming to accept the pregnancy as real despite, as shown in Extracts 25-27, suffering a number of physical symptoms.

5.2.5

Pregnancy as health or illness

Previous feminist researchers have not examined the ways in which physical symptoms can lead to difficulties in other spheres of the women's daily lives (work and household duties). Thus, in an attempt to label pregnancy as a time of health and not illness, and in an attempt to remove the pathological labelling pregnancy has received, there has been a lack of consideration of the consequences of suffering from certain physical symptoms. By ignoring the physical symptoms that to different degrees can affect pregnant women's daily lives, there has been a lack of consideration of the social and psychological affects these symptoms may have. This neglect (by feminist as well as non-feminist researchers) of the possible effects of the physiological symptoms (as experienced by some pregnant women) leads to a lack of reflection on the practical difficulties and requirements pregnant women may have. For example, in Extract 22 Sandy discussed the guilt she felt in not being able to assist in building work, while in Extract 24, below, Jane talks about her efforts to continue working so as not to be labelled negatively.

On a reflective note, when I myself became pregnant toward the end of this study, I found the level of tiredness and exhaustion so overwhelming and

disruptive that I actually phoned the midwife to ask what was wrong with me. She replied that although pregnancy was a time of health and not illness (in line with feminist arguments), there were stages to the pregnancy that could lead one to feel they were 'abnormal' and not 'normal' because of the symptoms experienced. Her thoughts on the health/illness divide and the allocation of maternity leave for working women contrasted with what is currently on offer. Firstly, she felt that to think of pregnancy as either health or illness was misleading in so far as different symptoms come and go, and the illness-type symptoms experienced by many women can lead to them feeling low in relation to not being able to cope with their normal day to day duties. The guilt, or the feeling of being 'abnormal', which is experienced due to the inability to cope with everyday activities (by some women) is then compounded by the commonly held idea that rest is required toward the end of pregnancy and not the beginning. She felt that if maternity leave could be divided up according to the needs of individual women to take time off at different stages, then there would be more acceptance of the variations that occur, and this would legitimatise the woman's needs to take time off rather than to label her as not being able to cope, or to label her pregnancy as an illness.

These comments by my midwife pointed out the way in which individual experiences can be shaped by social and cultural practices. My experience of the early months was similar to Sandy and Jane's experiences, where extreme tiredness was experienced. Similarly, I too tried to fight the need to take time out from my work (writing up this thesis, and lecturing), and felt that this time off was a poor reflection on me. Thus, what we can see is that the experience of pregnancy is socially and medically constructed and, as such, women attempt to fit in with the constructed image put forward. Where discrepancies occur there is a search for alternative constructions which can legitimise/explain the feelings that are experienced. How this is done varies on an individual level. Jane, in the extract below, shows the dilemmas that can be faced when time out is required but isn't seen as legitimate, while Sue in the subsequent extract takes a different stance.

Extract 24 (Jane - diary):

'Very nearly didn't go to work today as I felt so poorly - but I was determined not to go off sick due to being pregnant - too proud, and I don't want anyone to think or say that I'm being feeble!...Having very bad headaches so resorted to the paracetamol which, whilst I'm told are not tetragenic, worries me; but I couldn't cope without something.'

In contrast, Sue accepts the difficulties her pregnancy is posing, and accordingly chooses to reduce the number of days she works outside the home without this being seen as a poor reflection on her. However, she does complain about her inability to carry out her normal household duties which are also being affected.

Extract 25 (Sue - diary):

'I have had a lot of sickness, as I did with my last pregnancy. I was so sick early on this time that I couldn't even keep water down. The doctor gave me some anti-nausea sachets which have helped and am now eating well. They do make me drowsy though. I have given up my days in the week at work but continue to work weekends.'

The contrast between these extracts, in terms of accepting the need to cut down on the amount of hours worked in the early stage of pregnancy, shows the individual differences in women's acceptance of the additional requirements pregnancy can place on them. The two women are similar in that both continue to struggle against the symptoms and continue to work as much as possible, without seeing this continuation as an achievement. This, however, is not achieved without other negative consequences, for example in the case of Jane taking paracetamol tablets leads her to worry (although medical discourse tells her that her worries are unfounded, she feels this does not prevent her from worrying and as a result does not take on the medical interpretation). In the case of Sue, the negative consequence can be seen in the extract below, which shows how she feels: debilitated in carrying out a few of her day to day household duties (note the 'just trying' attitude as opposed to

'have been able to do' which portrays the down rather than the up side of her achievements).

Extract 26 (Sue - diary):

'Nothing much to report today, I'm so tired. I can't really do a lot, just trying to keep Jamie happy and get the house clean is about all I can do.'

Extract 27 (Sue - diary):

'So tired today. I did some housework this morning and was so tired afterwards, I was almost paralysed. I was so tired I literally couldn't move. I can't wait until this phase is over and I get some energy.'

In the above extract Sue discusses her experience of tiredness in terms of a phase of the pregnancy. This terminology was often used together with other medical descriptors of certain times of the pregnancy, for example in terms of trimesters. Thus, the way in which the medical professionals construct/categorise pregnancy is familiar to, and used by, the women at various times. For two of the participants this was no surprise, as they were nurses (notice how Jane dates the pregnancy in Extract 10 as 12/40 weeks). For the other participants the use of medical descriptors may have come from the contact they had with medical staff during their pregnancy; from the antenatal care books that they received (and referred to) during their pregnancy; or from the medical discourse's incorporation into social discourse more generally.

5.2.6

Relational issues: physical symptoms and psychological acceptance

What can be seen in the extracts below, taken from Sue's diary (which chronologically appeared after the extracts presented above), is a complete absence of reflecting upon the negative physical symptoms in terms of helping to believe in the reality of the pregnancy, although as Extract 27

above shows, she shows knowledge of the symptoms being caused by the pregnancy. As Extracts 4 and 5 (repeated below) show, belief in the pregnancy is being sought by other means:

Extract 4 (Sue - diary) (repeated):

'I'm about 7 weeks+ and still not showing. I guess that's normal but I don't believe it's really true. I still don't believe it. I guess when I have my first appointment at the hospital and I can hear the heartbeat - it will seem real. Now it just seems like a dream.'

Extract 5 (Sue - interview) (repeated):

Question: 'How did you find out that you were pregnant, and what did it feel like?'

'I bought something for the baby today. It's the first thing I've bought for this baby...Buying this actually made it seem real, it still seems like a dream.'

The negative physical symptoms that the women describe form far less of the overall discourse that they record in their diaries in relation to the early stage of pregnancy (the first trimester). The significance of these negative symptoms (in terms of level of reporting) is far less than the positive ones they detail. Where they are mentioned, the participants on a number of occasions counter the negative effects the symptoms have on them by interpreting the meaning the symptoms carry in positive ways, namely their representation of a successful pregnancy in which the chances of miscarriage are reduced if they suffer from nausea.

The variation in the degree to which negative physical symptoms such as nausea were experienced by the ten participants showed that, while for some there was a great deal of suffering, others experienced very little. Despite this difference, the physical symptoms were still not interpreted as reflecting on the reality of the pregnancy by any of the women. In addition, symptoms such as tiredness and nausea can be caused by a number of different conditions, and as such cannot be taken as evidence for the confirmation of a pregnancy in and of themselves. Nausea and tiredness are

only two of a number of possible physiological indicators that may occur due to the onset of pregnancy. In coming to believe in the pregnancy status, the extracts provided in this subsection show that the construction of the pregnancy's reality is not referred to in relation to these physiological indicators. Instead, other indicators such as 'showing' (as described in Extract 4) are being sought, and thus various aspects related to the changes that occur during pregnancy are involved in the psychological acceptance of the pregnancy.

This subsection of the chapter has aimed to examine the lack of correlation between the physical symptoms and psychological acceptance of the pregnancy. In aiming to account for its occurrence there may be a number of possible explanations that could be accepted. One possible explanation for this apparent lack of correlation may relate to the lack of willingness we have in embracing states that make us ill as part of ourselves. Thus, the negative physical symptoms experienced are referred to, and seen, as an illness state and not as part of the pregnancy state, despite the women knowing that the symptoms are occurring due to the pregnancy (with pregnancy not being perceived as an illness). Another possible explanation for the women not wanting to equate the physical symptoms with the psychological acceptance may be that, for the participants of this study, the pregnancy is very much wanted and desired, and therefore they may wish to only refer to the positive aspects which reflect this want and desire. The negative aspects are seen as something that must be acknowledged and lived with, that is that they are there and affect their daily routines, but are not relational to their thoughts of the pregnancy (a mind/body dualism operating at a categorical level). Thus, the women may be reporting the physical symptoms because they know they are brought on by the pregnancy, but due to their negative impact on themselves and their daily lives they do not refer to them as reflecting on, or impacting upon, their feelings and beliefs toward the pregnancy. Therefore they may say 'I feel awful' not 'this pregnancy is making me feel awful'. None of the accounts show that when they may be describing 'feeling awful', they are implying that this is a negative reflection on the pregnancy.

5.2.7 Discussion

The analysis of the accounts has partly been conducted by reference to a rather unitary bio-medical model. I do not wish to imply that there is a unitary medical model, and would like to point out that the medical terminology that I have, on occasions, imposed on the interpretation of accounts has been as a result of its usefulness in helping me make sense of the data. I have also used terms such as subjective/objective and positive/negative to describe various aspects of the experience. Again, these terms were used in order to make sense of the data, and their use should be seen in terms of the usefulness in constructing aspects of the experience rather than as fixed states. For example, the use of subjective/objective indicators of the reality of pregnancy is not meant to imply a straightforward personal/medical discourse. The women actively moved between the two forms of representation, and even when they referred to objective indicators (often medical ones, such as scans) they did not see them as straightforwardly objective, but used them to partly construct the reality of the pregnancy.

In line with Stanley and Wise (1993), we can see from the analysis of these personal accounts that indeed there seem to be multiple realities that co-exist (for example, knowledge that they are pregnant but not believing it). By recognising the various interpretations and understandings that the women have of their early pregnancy experience, we can see that the individual is not whole and unified, but instead operates with split subjectivities (as poststructuralists argue).

Within each of the realities we can see different identities and roles being taken on (can't believe that they are pregnant, but buying baby clothes or converting rooms). Thus, at one level, there is an acknowledgement of the pregnancy status which begins with the result of the pregnancy test. The immediate effects of the pregnancy on the women's general wellbeing are mentioned, although the nausea and tiredness experienced do not seem to be directly linked to the pregnancy in terms of its stability and reality. The belief in the pregnancy continually shifts between acceptance and non-acceptance. With the absence of physical changes in size and shape, and no detection of

fetal movement in the early stages of pregnancy, we can see the women searching for indicators of the pregnancy. The morning sickness and tiredness, however, are not presented as indicators. The complexity of the thoughts and feelings associated with the pregnancy and its consequences can be seen to be shaped by the specific context and the social situatedness of the particular experience. What is most evident in the women's accounts is a contradiction in the beliefs, actions and behaviour adopted whilst coming to terms with the pregnancy status.

Looking at the separate issues as well as the interplay between the five themes shows not only the diversity of the issues which can play a part in the early pregnancy experience but also the reasons why a conceptual framework which allows multiple realities to exist is appropriate. The five themes outlined have been tied together in this chapter in order to examine pregnancy identification. The analysis shows that identification is not straightforward, but instead is a process in which its occurrence is continually being sought and is not easily formed. If we were to take each of the themes and were selective in their application to acquiring knowledge from participants in a questionnaire study we would more than likely find different answers to those currently being reported. For example, taking the first theme, 'Knowledge of pregnancy', a questionnaire study would be able to establish that the women know they are pregnant and that this knowledge is generally acquired via pregnancy test kits. However, what would be missing is the way in which this information is interpreted in terms of identifying with the pregnancy status. The data analysis in this study shows that this objective information is reacted upon in different ways. Psychologically, it does not help in the belief of the pregnancy being 'real' (theme two), although it does lead to overt actions such as negotiating part-time hours at work and changing dietary and drinking habits. The complexity of the process in trying to identify with the pregnancy status is shown to be affected by a number of other issues, such as the higher risk of miscarriage in the early stages of pregnancy. This lack of predictability of the stability of the pregnancy (theme three) places caution on the acceptance of the pregnancy coming to full term, and thus may be pulling the women toward not identifying with the pregnancy fully. The psychological work required at

different and competing levels (accepting that you are pregnant in terms of making changes to diets, etc., and yet not accepting that you are pregnant in terms of your thoughts about being pregnant) show the many directional pulls that occur on the woman's thoughts, feelings and behaviour. The private pregnancy identification that is being sought by the women occurs at the same time as overt actions having to be taken. For example, the telling of others (fourth theme) causes a number of dilemmas in so far as the women feel that due to the risk of miscarriage it is preferable not to make the news of their pregnancy public, and yet they may also want public acknowledgement at another level. In certain circumstances, 'others' have been told as a requirement (employers), although the women would have preferred not to mention it at that point in time. The fifth, and major, theme of this chapter points out the ways in which overt physical changes (nausea and tiredness) occurred at the same time as the attempts to identify with the pregnancy, and yet they were not described as helpful in their psychological identification with the pregnancy. At first sight this appeared to be at odds with what may be taken to be obvious (the symptoms are their due to the pregnancy which, as in theme one, has been confirmed at an objective level). It is only possible to detect the contradictions which occur when prospective, contextual accounts are used for data collection and analysis.

The term 'identification' (as used in the title of this chapter and as the overarching category for tying the separate themes detailed in this chapter together) has a different meaning within psychoanalysis than the one I have used. Identification in psychoanalytic terms refers to a defence mechanism, one in which the ego (that part of the personality that deals with reality) is equated with that of an admired or feared individual. In developmental terms, identification occurs during the third (phallic) stage of psychosexual development when, in the case of girls, the daughter identifies with the mother and subsequently forms her sexual identification through attachment to the same-gender parent.

The interpretation of identification as I have come to use it sees pregnancy as a particular state, one which produces a pregnancy identity that is itself derived from the meanings it is assigned both historically and

culturally. I have used the term in such a way that the women attempt to identify with what they think it should mean and feel like to be pregnant, and the recognition process by which this occurs. The reason why I have chosen this term, along with the interpretation presented, relates to the concept's potential ability to show how the pregnancy identity is formed across time and within a cultural context. As Martin (1992) points out, the obviousness of statements being presented as 'matter of fact' or as 'common sense' within one's own society needs to be teased apart in order to see how they have achieved their meaning.

Identification with the pregnancy status in the early stages of pregnancy is a complex process and involves a multitude of changes for the woman. Previous research by Grossman et al (1980) has examined the issues involved in coming to terms with the pregnancy status, and their research shows that adaptation to pregnancy is, on the whole, a positive experience for both first time and experienced mothers. In their sample of pregnant women, the majority reported 'that they had felt delighted, excited, or very happy' (p 23). This aspect of the pregnancy experience is examined in my own research within the first category outlined (knowledge of pregnancy).

The above analysis shows that pregnancy identity is by no means static and that it is sought continually. We can see that although the women are questioning the reality of the pregnancy, they still react overtly in line with what it means to be pregnant, for example changing diets, adjusting the house to accommodate the new baby and buying baby items. The meanings that pregnancy holds are shown to be assigned both historically and culturally, in that the women talk about 'inherently knowing as the myths say' or 'I don't want to take time off just because I'm pregnant', and yet these meanings may not be easy to comply with. The women have attempted to identify with what they think it should mean and feel like to be pregnant (for example, not taking time out early on in the pregnancy), but have not found it an easy process. This has been the case for multigravida mothers (as in the case of Sue and Karen) as well as primagravida women (Jane and Sandy), and thus we can see that past personal experience does not provide fixed definitions by which further pregnancies can be judged. For example, Sue reported:

Extract 28 (Sue - diary):

'I keep trying to imagine that there's this baby growing inside me. It just doesn't seem real. Last time I had no trouble believing it - so I can't figure out why it seems so strange this time.'

The variations between past and present pregnancies, as well as within the accounts of present pregnancies, show that pregnancy is a state that is not easy to come to terms with, or define, in the early stages. Past personal experience of pregnancy and/or vicarious identification with which pregnant women may attempt to identify, serves to provide particular meanings which the women may or may not find themselves able to relate. Thus we can see that prior abstract or experiential knowledge plays a part in how pregnancy identification is thought to occur, in comparison to how they are finding the process (which, as the data presented in this chapter shows, is complex and problematic).

There are constant attempts at reconciling the difference between what they feel (pregnancy not being real) with what they think they should be feeling (that it is real). The questioning of whether it is real or unreal shows that there is a constant battle going on in terms of them trying to identify which state they should accept, and yet if one was to observe their behaviour alone they show full acceptance of the pregnancy being real, given the level of changes they report to have occurred. The women do not see their overt behaviour and their inner thoughts to be contradictory, and it is only by examining the data thematically that these contradictions have been noted. The women's accounts report on the different aspects of the experience, and while these can be contradictory in comparison to one another, they are often not seen or reported in such a way. This indeed shows the multiple realities which come to make up our experience.

Chapter Six: Constructing and experiencing risk, a multiple case study analysis

6.1 Introduction

The ways in which individuals experienced risk as part of their pregnancy experience was commented upon by a number of the participants (both those defined medically to be at 'high risk' and those at 'low risk'). At the outset of this project I had thought that the impact of being categorised to be at a 'high risk' of having a baby with 'abnormality(s)' by the medical profession would lead to these women's descriptions of being categorised and labelled in this manner being reflected in their accounts. This occurred in some of those members of the 'high risk' category but not others. I was initially interested in how 'high risk' women came to experience this external categorisation and how they constructed their accounts of the pregnancy experience in light of having this knowledge and/or being given such information. The accounts from this group of participants were then to be compared with the accounts produced by the participants who were not subjected to such labelling.

In addition, as a result of reading psychological literature on the perceptions of risk and its correlation with negative psychological consequences such as anxiety and depression (as presented in chapter two), I had assumed that the women categorised as at 'high risk' would mainly report their experiences of anxiety, and that this would especially be the case during certain stages of their pregnancy, such as at the times when they were to make decisions relating to the take-up of prenatal testing and at the waiting times of having tests carried out and receiving the results.

However, whilst reading the diary entries and whilst conducting face to face interviews, it soon became apparent that the women often showed resistance to their medical categorisations whilst simultaneously accepting them, thus making the representations of risk far more complex than the previous literature had reported. This was the case not only for some of the 'high risk' women but also for those categorised as 'normal' (hence at 'low risk').

As an example, in my study I found that one of the women who was labelled 'normal' perceived herself to be at 'high risk' because one of her distant relations had Down's Syndrome. Her initial disagreement with the label assigned, and the medical health plan she was offered (routine), led her to question her medical care and resulted in her paying for blood tests outside of the routine tests offered to her on the basis of her pregnancy being considered 'normal'. At the same time as her perceiving herself to be at 'high risk' and questioning her label as being 'normal', the same participant talked about all of the things she had done in preparation to be fully healthy prior to becoming pregnant and how she believed that all her preparations would 'pay off', in that she would have a healthy baby, hence perceiving herself not to be at 'high risk'.

Extract 29 (Pat - interview):

Question: 'Were there any issues that you considered before you became pregnant that relate to your pregnancy?'

'Well, Steve and I have always been quite health conscious and so we didn't have to make too many changes to our diets when we were planning to have this baby. We both took up exercise though and looked at all the pros and cons of having children. I suppose now that we have our own place and we are both settled in our jobs we are better off having children now rather than later when the odds of having a Down's child is higher. Mind you, that's something that really worries me as my mum's cousin has Down's so it's there in our family. When I mentioned this to our doctor he just dismissed it really, and that made me angry because it concerns me and both of us had discussed what we would want to do if we found out that our baby had Down's. You see, if the doctor won't see that I might be at risk it means we can't even find out and that means I couldn't terminate, which is what I'd do. I'll make an appointment with one of the other GP's at the practice and see if I've any better luck with one of them.'

Examples such as the one presented above, meant that the simple dualism of either/or categorisation of risk and its psychological acceptance had to be questioned (this woman wanted to be categorised at risk in order to have prenatal diagnosis). Such accounts also made me aware of the inadequacy of applying a simple compare and contrast formula across the two groups (high vs low). My initial interest in solely comparing the two groups using dualistic notions was dropped in favour of the social constructionist approach, which recognises levels of variation both within and between the accounts of individuals in each group, as well as the variation within any one account, such as seeing the self to be and not to be at risk simultaneously.

In this chapter I will be exploring the ways in which risk is constructed by both those considered high risk and those considered low risk, in order to not solely locate the points of departure (differences) between the two predefined categories of women as occurring as a result of their external categorisation. In addition, this will help to avoid perceiving such categories of risk as presenting homogeneous groups with homogeneous interpretations and experiences. Simply comparing the accounts of the two groups would have led to me imposing a structure on the analysis which prohibited/denied the diversities within and between accounts, and so the analysis of accounts provided is divided into two chapters. In this first chapter on risk construction an examination is made of the similarities and differences found within and between different participants' accounts. The next chapter deals with the diversity of explanation contained within one individual's account of her risk of having a baby with abnormalities.

6.2 Analysis of accounts

The thematic analysis presented in this chapter has been split into four subsections in order to highlight the different ways in which risk has been constructed. Subsection one contains three themes which have in common the use of, and reference to, medical matters. Subsection two contains three themes which aim to show how risk is variously experienced and constructed using medical, social and cultural ideologies. Subsection three, which contains

one theme, examines social and cultural constructions of risk. This subsection differs from the first subsection and parts of the second subsection in that it only details the lay (non medically based) expressions of risk. Subsection four contains two, very different, non-relational themes, in so far as they explore extraneous descriptions of risk. The first theme explores three participants' accounts of the reasons why they would terminate if abnormalities were found, while the second theme explores one woman's categorisation of being at risk of postnatal depression.

At the beginning of each subsection of the analysis, more details about the overall content are provided in order to show what aspect of risk is being highlighted.

6.2.1

Subsection one of the analysis: Medically based constructions of risk

The first theme of subsection one examines the accounts of participants in which risk is discussed in relation to their up-take of prenatal diagnosis. Here, medical issues have significantly contributed to its construction and/or consequence for action. In my interpretation of these accounts I have attempted to examine whether the women's constructions are presented in terms of their perceptions of having different choices and levels of control in determining particular outcomes.

In the second theme, risk is examined in relation to being at high risk of miscarrying past the twelfth week of pregnancy. Three of the ten participants experienced symptoms which put them at risk of miscarrying, and their accounts have been analysed to show how they experience this risk, as well as the impact different forms of medical advice had on their experience. Again, medical issues significantly contribute to the construction, perception and experience of the pregnancy.

Similarly, in the third and final theme contained in this subsection, medical matters are explored in relation to one participant's risk status due to her rhesus negative blood group.

Theme one: The impact of prenatal diagnosis on risk assessment and outcome

The extracts presented in this theme have been taken from participants who had opted to take up prenatal diagnostic testing in order to find out their chances of having a baby with congenital abnormalities. All of the women who had opted to take up prenatal diagnosis had previously mentioned that they would terminate if they were found to be at 'high risk' after the testing took place. Prior to the data analysis, I had become interested in the way in which women made such decisions, in order to find out whether they perceived the uptake of prenatal diagnosis and subsequent decisions about termination to be very difficult. In the sample of participants that I followed all of those who were labelled at 'high risk' (and two who were defined at 'low risk') took up some form of prenatal testing. The decision to take-up prenatal testing, and the decision to terminate (if abnormalities were detected), were not described as difficult. All of the accounts showed how the women had come to their decisions (having discussed it with their partners) as being the most appropriate course of action for them, and therefore described them as fairly straightforward.

As can be seen in the extracts below, although the women who opted for prenatal diagnosis described their decisions as being firmly based, they did desire the pregnancy to go ahead and very much hoped that abnormalities would not be found.

Extract 30 (Sandy - diary):

'I was amazed to see a little blob, like a broad bean, with a beating heart.

This immediately made me feel anxious that all should go well with the pregnancy. I had a great desire to bond with

this little scrap of life inside me, yet afraid to, in case I should miscarry or the baby should prove handicapped, in which case I should have a termination.'

Sandy's account clearly demonstrates one of Rothman's (1988) points (detailed in chapter two, subsection 2.4), that women who are categorised at 'high risk' are placed in a position that requires them to accept their pregnancy and simultaneously be willing to abort if they find their fetus is damaged. Thus, for those who do undertake prenatal testing, the pregnancy would appear to be 'tentative' until the results of testing are known, and so bonding with the fetus may be delayed.

In Sandy's case the 'limbo' state (of wanting to bond and yet being afraid to do so) can be seen to be a result of her knowledge about the possibilities of miscarrying and her decision to terminate if abnormalities were detected. Sandy does not differentiate between the two possible reasons which would lead to the loss of the baby in terms of her level of choice and control over their occurrence. One of the interpretations that could be made, is that with miscarriage there is no choice or control that can be exercised, while with termination there is the possibility of seeing the decision to be your own choice and therefore in your control.

Given that Sandy does not describe her decision to terminate (if required) as being optional but rather fixed (what should be done), we can see that she is constructing her decision in line with medical expectations of terminating if severe abnormalities are detected. The prevailing social, cultural and medical views about the ethics of such decisions allow such decisions to be made without them necessarily causing dilemmas, and for them to be seen as acceptable courses of action. The acceptability of this course of action may naturally be related to a number of reasons, such as the extra costs and difficulties encountered when bringing up a child with special needs.

Sandy accepts that she may be at risk of miscarrying, or may be carrying a baby that is at risk of having Down's syndrome due to advanced maternal age. The way in which she handles this risk is to construct it as possible outcomes which lead her to delay 'bonding' with the baby.

In contrast to Sandy's lack of discussion of the role of personal choice and control of being at risk, Sam's account (described in the next chapter) showed how she considered her role in placing the baby at risk to be central. The variations found across accounts show how different individuals handle and relate to being labelled 'at risk'. For example, Sam, in the early stages of pregnancy, questioned whether she was irresponsible in becoming pregnant, and seemed to blame herself for any abnormalities that may be detected, whereas Sandy has not blamed herself or considered herself to be irresponsible. Jane's account is very similar to Sandy's in that she describes the decision to terminate as one that is firm, despite her desire to have the pregnancy continue:

Extract 31 (Jane - diary):

'Adrian and I have had a chat re whether or not to have a blood test for AFP (Down's syndrome and spinabifida). The spinabifida could be 'picked up' on ultrasound but Down's can't; [hospital] don't routinely test for AFP - some other units do.

I discussed it all with [midwife] yesterday, and she didn't think it was a bad idea to get an AFP done through my work as [name] don't do them. It should be done next week at 16/40.

This will be our one concession to caution due to advanced maternal age. If AFP comes back raised a) scan's due anyway b) we can always then opt for amniocentesis if we are advised/decide its necessary, as we both decided that Down's or spinabifida would lead us to termination. However neither of us want routine amniocentesis with its risks of miscarriage just for the hell of it!

Jane's extract demonstrates what course of action would take place after the initial testing and, like Sandy, shows that termination would be the final outcome if abnormalities were detected. Jane demonstrates that she has chosen to find out about the possibility of being at risk, and describes her

actions toward finding out as being a 'concession to caution'. Thus, one interpretation that could be made is that Jane does not consider herself to be at risk, but instead is being cautious by attempting to find out using non-invasive methods.

In Pat's case the decision to take-up prenatal testing was one she had to fight for, given that she was not categorised as at 'high risk'. She had to argue for the tests she wanted. Extract 32 demonstrates her way of taking control (which included side-stepping those who rejected her choice and paying for the tests to be carried out privately).

Extract 32 (Pat - diary):

[hospital doctor] checked my notes and we discussed Down's syndrome.

He disappeared around the curtain and came back with the statistic that my chances of having a Down's syndrome baby were approx. 725/1 I went on to mention my cousin and the age of my aunt when she gave birth...he said that would only increase my risk slightly say a 724/1 chance.

I showed him my leaflet and he explained that the Barts test would not tell me if I would have a Down's syndrome child only what chance I would have i.e. 500/1 or 200/1 or even 20/1. He also said that even if the result came back that I had a 20/1 chance he would not recommend me for an amniocentesis test.

He explained it would cost £50.00 and that they couldn't do it at the hospital. He said if I felt I should go ahead, he said I would need a date scan to determine how many weeks pregnant I was, as the best time for the Barts test is between 16 - 23 weeks. He said I would have to come back for the date scan, as they would not be able to fit me in then as they were too busy.'

Pat demonstrates quite clearly how she resisted the hospital doctor's advice. By later taking the test she shows that she was not swayed by his

arguments that all she would get is a statistic, and that even if that statistic was 20/1 she would not get the amniocentesis test authorised by him because of the cost.

Given the diversity between accounts, note can be taken of the variations that occur as to whether certain factors (choice and control) are considered at all by some participants, while others see them as central (for Sam and Pat they were central, while for Sandy and Jane they were not). In addressing why such variations may occur across accounts, particular emphasis needs to be placed on the local context in which the experience occurs, and the differential positions each individual is located within. For Sam, her risk was due to diabetes, while for Sandy and Jane the risk was due to advanced maternal age. The difference in the type of risk posed to their babies, and the type of testing they went through, means that the context of their experience was very different.

In Extract 33, Sandy further emphasises her decision to have amniocentesis by referring to the risks of miscarriage as being lower than her risks of having a Down's baby. Again she does not put forward her decision as one based on choice, but rather presents it as an action she will take. Sandy discusses the issue of losing the baby as a result of the testing procedure (spontaneous abortion) using rational terms (chances being lower than the risk of Down's), and shows that this decision is definite despite her desire to have 'this child'. What is noticeable in the extract is that the risk is not portrayed or experienced as a dilemma but rather as a matter of fact which has particular set outcomes.

Extract 33 (Sandy - diary):

'Paul's mum is lovely and supportive and asked us if there was anything we needed.

Discussed amniocentesis with her. She is a bit worried about the chances of aborting spontaneously after the test, but that risk is a lot lower than my chances of having a Down's baby. If that were the case, then I would definitely have a termination, even though I want this child.'

As mentioned in the introduction to this chapter, one of the assumptions I had made prior to the analysis of the data was that just before prenatal diagnosis was undertaken the participants would express their concerns and would be anxious about the testing. Another assumption I had made was that waiting for the test results would lead to a great deal of anxiety. However, as can be seen in Extracts 34 and 35 (taken from Sandy's diary entries), the need to know, and to terminate if the baby was at high risk, outweighed any concerns about the procedure itself or the waiting time. In addition the testing itself was perceived to be 'successful', and therefore reassuring. The lack of reporting relating to any negative impacts of prenatal diagnosis, may of course, have occurred as a result of the women filtering out these feelings.

Extract 34 (Sandy - diary):

'Amnio test not too painful - lovely to see the baby on the scan - baby shaped now, no longer a blob.

Again, very impressed with kindness and good humour of staff.

The procedure was uncomplicated and successful - of course this has no bearing on the test result, but somehow I felt it to be comforting - my dark thoughts about Down's Syndrome not so haunting.

I have a 98% chance of having a perfectly healthy baby.'

Extract 35 (Sandy - interview):

Question: 'Have you had the results of your tests?'

'I thought I might have had the results of the amnio by now. Just as well I've been working, with not much time to brood - strange I was more worried before the test than now.'

In Extract 36, Sandy shows that receiving her test results allows her to be happy. She interprets the results as showing that her baby is 'normal' despite the test's ability to only determine the level of risk rather than no risk.

Extract 36 (Sandy - diary):

'Wonderful news - the baby is normal and he's a boy.

After my scan I asked at the reception desk if my results had arrived, and the midwife said that she had just tried to phone me at home. I also have a scan photo of him. Everything seems normal from that too - he has all his organs and is developing as expected.

I went back to school this afternoon on a cloud - I can't think of anything else, I'm so happy and so is Paul.'

Similarly, in Extract 37 Jane also describes the happiness she felt at receiving her results.

Extract 37 (Jane - diary):

'AFP = 40. Upper limit at 16 weeks = 70 - 80 it's Okay! (Relief!!) and Gerry has altered the maternity uniforms so that they fit just right.'

Overall, the above subsection has demonstrated that, for the above participants, considering the self to be at risk led to wanting to know about their level of risk in order to be able to terminate. For these participants the question of choice, control, blame, fault and responsibility were not centrally linked to their experience of being at risk, as was the case for Sam (see next chapter).

The high level of congruence found in the accounts presented in this subsection (in terms of presenting the up-take of prenatal diagnosis and possible termination as straightforward decisions) should not be taken to show prenatal diagnosis as a process with no negative consequences for individual women. Rothman (1988) clearly demonstrates how the process can be detrimental and harmful for some women, and as Extracts 33-37 show, the women were worried prior to the testing that the baby may have to be terminated, and subsequently on receiving the results experienced relief and happiness that they did not have to terminate.

In this subsection of my data analysis I have concentrated on the use of prenatal diagnosis by the participants, and not on their attitudes toward it and their opinions about the effects it has had on them. Such interpretations can be made by re-examining the extracts. Another form of analysis that could be conducted is the examination of the perceptions that the women had of their encounters with medical staff, and the impact that these had on their experience of the pregnancy. Within the next theme I have highlighted the importance that participants place on having positive encounters with medical staff, and the detrimental effects negative encounters can have. Thus, parts of the analysis contained in the next theme serve to show the ways in which a number of the extracts contained in this subsection could be further analysed.

Theme two: The experience of the risk of miscarriage beyond the first trimester

One area in which there were very contradictory accounts of appropriate behaviour during pregnancy related to the preparation for the arrival of the baby. As discussed in the previous chapter (see subsection 5.2.2: 'stability of pregnancy'), the high risk of miscarriage prior to the twelfth week of pregnancy meant that the women would both plan and take active steps toward preparing for the arrival of the baby (for example, converting rooms and negotiating part time hours), and yet also reported not preparing for the arrival in case they should miscarry. In this subsection I hope to show that the possibility of risk remains paramount after the twelfth week for some of the women and that this possibility of risk, like that which occurs in the early stages of pregnancy, leads to a number of contradictory thoughts and behaviours (as mentioned above, both planning and not planning for the arrival of the baby). This state of flux is highlighted in Extracts 38 and 39.

Extract 38 (Pat - diary):

'I was watching breakfast T.V. one morning and the T.V. doctor was talking about travelling (air travel) whilst being pregnant. He mentioned that the best time to travel is after 18 weeks when your risk of miscarriage is dramatically

reduced and he implied that after 18 weeks you had passed the danger period.

I remember feeling quite shocked and worried that I was and still am at risk of miscarriage. I now can't wait for the 18th week of my pregnancy to pass.'

Here we can see that Pat talks about the risk of miscarriage still remaining after the twelfth week (she was in her fifteenth week of pregnancy), and is anxious to go beyond this period. The medical knowledge that labels the first twelve weeks as the highest risk phase of pregnancy has been contradicted by a doctor and she now sees her pregnancy in light of this doctor's account. In Extract 39 (taken from Pat's diary, and written the next day) we see that the possible loss of the baby due to miscarriage means that she decides to hold back from fully preparing for the arrival of the baby:

Extract 39 (Pat - diary):

'Steve and I decided to decorate the second bedroom today. My sister came round and helped me clear it out.

...I chose a pretty border for the room with clowns and lovely bright colours. We decided to just paint the room white...

...Steve started the painting but I don't want to put the border up until after I have had my scan and perhaps the Barts test.'

The medical knowledge used to perceive the pregnancy as being at high or low risk of miscarrying did not always lead to the high risk category of women experiencing higher levels of worry and anxiety. In Extract 40, Sandy shows how, even when physical symptoms often associated with the risk of miscarriage occur, they do not always lead to negative feelings. Sandy describes how she experienced the possibility of miscarrying, and how she came away having gained from the experience

Extract 40 (Sandy - diary):

'Woke up Wednesday morning to find I was bleeding slightly. Went to the loo and no more blood - What to do? Had an antenatal appointment that afternoon so waited till then.

Midwife rang the hospital and I was advised to go in immediately. Paul came with me and I was put in one of the delivery rooms as they were very busy. I felt quite alarmed by all this sudden action but very impressed by the efficiency and kindness of the staff. Swabs were taken and sent for analysis as well as routine listening for the fetal heartbeat. Everything seems okay but I was moved to the labour ward for bedrest.

There was no more bleeding and my cervix was closed.

Next morning I had a scan and the placenta was normal. Bleeding had probably come from the cervix but no sure diagnosis was made.

Swab tests showed no abnormalities and I was allowed home on Friday.

Although I was alarmed I didn't at any point feel the baby was at risk - this may have been wishful thinking, but it seemed so to me.

I feel very happy and confident about having him at [hospital].'

For one of the other participants (Mary) who had the same symptoms as Sandy, the encounter with the medical staff was not as pleasant, and the interpretation of the event differed.

Extract 41 (Mary - diary):

'On Monday I woke up and found that I had been bleeding slightly. I also had some pain. I went to work, and told my colleague. She suggested that I phone the doctor.

The receptionist I first spoke to was quite unhelpful, telling me to phone back after surgery hours if I wished to speak to the doctor. I had explained what was wrong already so I asked to speak to someone else, a nurse perhaps! I spoke to another receptionist who put me through to a doctor. He told me to go home go to bed and rest and he made me an appointment to see my antenatal doctor the next day.

The next day I saw the doctor who reassured me that although it is not 'normal' to bleed there wasn't a great deal of danger, as I was past 12 weeks...

I was told to rest and not to have any sex for 2 weeks.'

In contrast to Sandy, Mary does not see the bleeding in a positive light, but instead just mentions how she has been told that she is not in danger because she has passed the twelve week period. From Sandy and Mary's accounts we can see that the type of medical advice received, and the manner in which it is presented, has a significant impact on the two women. For Sandy, the positive encounter leads to reassurance, while for Mary the encounter is one that does not lead to discussions about its effect on her.

Continuing with Sandy's account, in Extract 42 we can see that the repeat of the same symptoms (bleeding) leads to a different effect (worry) in comparison to the reassurance she felt a few days earlier (as was described in Extract 40). Thus, positive encounters with medical staff may not be enough to remain reassured.

Extract 42 (Sandy - diary):

'Blood tinged discharge this morning. Rang the labour ward and was told to see my doctor unless I really started to bleed in earnest, otherwise go to hospital.

I was worried this time. The doctor prescribed rest again and signed me off sick...

He's given me some pessaries to use and I must go back in a week.'

This state of worry now continues for Sandy, as Extracts 43 and 44 suggest.

Extract 43 (Sandy - diary):

'Still some discharge - it's the blood that's worrying although the scan showed that my placenta was intact.'

Extract 44 (Sandy - diary):

'Discharge hasn't stopped - going back to the doctor on Monday.'

In the above extracts it was noticeable that Sandy began to worry about risk as the symptoms continued. However, as Extracts 45 and 46 show, the worry and the thoughts about risk at times did subside (often as a result of temporary relief from the symptoms), and so the experience of risk must be considered within context to acknowledge the variation and impact it has.

Extract 45 (Sandy - diary):

'There doesn't seem to be any diagnosis at all. The doctor says that sometimes bleeding occurs for no apparent reason.

At least I know the baby is okay and securely inside.'

Extract 46 (Sandy - diary):

'I'm feeling okay, getting lots of rest, reading for pleasure, happy about my pregnancy and generally at ease.'

Extracts 45 and 46 contrast with the worried state Sandy describes earlier (see Extracts 42 and 43), and show that during pregnancy there is often a mix of emotions, even at times when the women experience symptoms that could indicate risk. Being at risk does not automatically lead to increased worries all of the time.

In Extract 47, Sue shows how she fears the possibility of miscarriage due to contractions whilst only in her seventeenth week of pregnancy. Her decision not to contact anyone contrasts sharply with her advice seeking on many other occasions.

Extract 47 (Sue - diary):

'I've felt funny all day, a sort of heavy, tight feeling where the baby is. This evening, it really felt like Braxton Hicks contractions, which aren't suppose to happen till near the end of pregnancy. I was very concerned today that I was going to lose the baby, I didn't ring anyone about it because I don't want to be a pest. I'll see how it is tomorrow.'

The threat of miscarriage was variously handled by the participants. At times it led to increased concern and worry, yet coupled with this were a number of positive experiences which helped in alleviating the impact they had. For example, Sandy felt reassured by the positive actions taken by medical staff and felt happy about her pregnancy, while Sue and Mary only stopped worrying when the symptoms of a threatened miscarriage stopped.

Theme three: Risk due to unknown Anti D status

In Extract 48 Sue describes the feelings she experiences as a result of having to wait before she can find out her Anti D status. Sue has a rhesus negative blood group and hence would receive antibodies (Anti D) shortly after the birth of her first baby. Her antibody status needs to be checked in the early stages of subsequent pregnancies and it is this checking that she is referring to. She feels that she has insufficient knowledge about her status,

and therefore would prefer an earlier appointment in order to have her questions answered.

Extract 48 (Sue - diary):

'I am not too happy about having my appointment for booking in so far away - I want to get my blood tested to make sure my Anti D has taken. Perhaps I'm worrying for nothing but I don't really understand the whole rhesus negative thing.'

For Sue, not having all of the information/knowledge related to her risk status worries her, and the wait she has to encounter leaves her feeling unsure about whether there is any risk. Here we can see that she relies on medical advice, and wishes that it was available sooner.

Where the women consider themselves to be at risk (due to a variety of factors), there is a heavy reliance on the expertise of the medical profession. If the medical experts do not respond quickly or positively, the women do become concerned and indicate that they are dissatisfied with the advice/care that they are receiving.

6.2.2

Subsection two: Medical, social and cultural concerns and expressions of risk

In this subsection, accounts which emphasise the ways in which risk is perceived on a day to day basis will be explored. In themes one and two, medically based knowledge is one of many cultural forms of knowledge that are considered by the participants. Where medical advice is discussed the advice is not as easily accepted and adhered to, as was the case in theme one of subsection one. For example, in theme one of this subsection, on taking mild medication, we see that the medical acceptability of taking certain drugs during pregnancy is questioned, and the women often make a number of evaluations, such as gauging the severity of their symptoms prior to accepting or rejecting certain medications. Similarly, in theme two on smoking,

diet and drinking, medical knowledge and pressure to avoid smoking is one of many sources that relay the damage smoking can do to the baby. Other sources of information which may be used to form opinions and evaluations include danger messages printed on packets of cigarettes, and the media generally.

Themes two and three present examples of the types of accounts women provided and/or came across whilst they were pregnant. These accounts show how the women identify with different elements that could potentially affect their baby, and that as a result of having this knowledge they seek to be reassured in some way. Here, risk is being examined in relation to the knowledge that the women have acquired about risk prevention (from medical and non-medical sources), and the courses of action that they take based on this knowledge.

Theme one: Decisions about taking medication

In all ten of the participants' accounts reference was made to the conflict of interest often experienced between the mother's health and that of her baby. This was particularly the case over mild ailments experienced by the mother, such as coming down with colds and flu. On certain occasions the conflict of interest was not described as a conflict leading to a dilemma as to the appropriate course of action, but instead was described as a matter of fact, which led to a particular course of action in favour of the baby not being put at risk:

Extract 49 (Mary - diary):

'I have a really bad cold. I have used some Olbas oil on a handkerchief to inhale. I haven't used anything else as I read that cough mixtures/cold remedies can be very bad for the baby.'

Extract 50 (Sandy - diary):

'Think I've got flu.

Can't take anything because of sproglet.

Going to sleep.'

In contrast to the above extracts, where the risk of taking particular medications led to an unquestionable course of action (not to take anything), on other occasions this course of action was not seen to be viable despite it being the ideal. The dilemmas occurred when the severity of the symptoms they were experiencing were such that they could not cope with them.

Extract 24 (Jane - diary) (repeated):

'...Having very bad headaches so resorted to the paracetamol which whilst I'm told are not tetragenic worries me; but I couldn't cope without something.'

In Extract 24, repeated above, Jane questions the safety of taking paracetamol tablets, before going on to justify her course of action (taking the tablets). She does this by making clear the impact that the headaches are having on her. Thus, what is evident in Jane's account is that when she does take medication she feels that it is justifiable, given that the alternative is not viable (couldn't cope). Also, what can be noted is that medical discourse would not prohibit the use of paracetamol, but rather that it is Jane constructing the risk. Thus, Jane's use of this construction may be related to her desire to be seen as a responsible person in considering possible harms and her resistance to them.

In addition to risk being discussed in relation to medical ailments occurring during the pregnancy, there were a number of other factors that the women reported they had to consider from the outset of the pregnancy in order to not put the baby at risk. These included smoking, eating certain foods and drinking alcohol. Each of these factors will be demonstrated in turn.

Theme two: Smoking, Diet and Drinking

Continuing with the theme of risk prevention, a number of participants reflected upon their use of preventative measures, namely in relation to smoking, dietary changes and drinking alcohol. The importance placed on these preventative measures differed across accounts, and to this end in the

subsection on drinking I have presented one participant's account of how she simultaneously accepted that drinking may affect her baby (caused her to worry about her drinking), whilst also rejecting it (justifying her continued drinking).

Smoking

Extract 51 (Mary - interview):

Question: 'How did you find out that you were pregnant, and what did it feel like?'

'After doing two home tests which were positive I decided to ring the doctors surgery.

I was told that because I had only missed my period by two weeks, this wasn't long enough and to phone back in three weeks, and I could have a test.

I was going on holiday the following week and felt really that I should know whether or not I was pregnant.

I didn't know if to cut down on alcoholic drinks or whether or not I should go horseriding, etc.

After I had been in Cornwall for a few days my sister persuaded me to have another test at the chemist. This was positive.

Therefore I knew then to cut down on drinking and to give up smoking.'

Mary shows how the general knowledge about risk factors for the unborn baby are considered from the outset (prior to a medical consultation). She felt that the confirmation of the pregnancy from an official source was required before she could (subjectively) accept the pregnancy, and thus reduce her drinking and give up smoking in the interest of her baby.

Diet

Risk prevention in relation to diet is demonstrated in Extract 52.

Extract 52 (Jane - diary):

'Going to Gay's for tea tonight - we are having chicken salad at my request. She's absolutely lovely but isn't very good at cooking. The way I feel lately I don't want to risk not being able to eat what she served!'

This extract appears slightly ambiguous in terms of who/what the risk is being related to. However, previously Jane had talked about her concerns about the importance of having a healthy diet and avoiding particular foods during pregnancy. In light of this contextual information the risk is being interpreted in terms of not being able to eat certain foods for the sake of the baby. Another similar example from Jane occurred a few weeks later:

Extract 53 (Jane - diary):

'Went to a study day on hypertension - food was a problem it was all cook/chill foods that weren't chilled, and so rather than risk Listeria I went without.'

Drinking

In Extracts 54 and 55 we can see a difference in opinion between two participants as to the role of alcohol in causing harm to the baby. Sue interprets the consequences of her drinking in a mixed way (both being worried about it and arguing that it is not harming the baby), whilst Jane interprets the consequences of drinking as putting the baby at risk and thus avoids it despite her desire to have a drink.

Extract 54 (Sue - diary):

'I've been a bit worried that I've been drinking too much alcohol. I find it easy not to smoke but I do like a drink and have been drinking probably more than I should. I don't drink spirits but I've been out socially 3 times last week. Each time I had a couple of pints of lager. I'm sure it's not harming the baby, if I really thought it was I'd not touch any

at all. I find it difficult to not drink at all because I find it relaxes me and I really enjoy it - in a way I resent feeling tired, sometimes depressed, stretched - having been through the morning sickness etc and with the pain of birth and stitches to come and with all that a woman can't even have a drink. Men have it so easy.'

Sue begins her commentary by discussing her concerns about drinking alcohol, however she quickly moves on to justifying her drinking in an attempt to argue that she does not think this can harm the baby (if it did she wouldn't drink). She continues to argue her position by relating the drinking to her personal circumstances in an effort to show how aspects of the pregnancy experience itself are making it difficult to resist. This elaborate justification can be interpreted to show how Sue seeks to acknowledge her drinking, whilst at the same time wanting it to be perceived as being responsible behaviour in light of the difficulties she has experienced and its beneficial effects for her (help in coping with present and future difficulties related to being pregnant). Thus, in Sue's account we can note variation within the account, just as we can note the variation between accounts when comparing Sue's account with Jane's:

Extract 55 (Jane - diary):

'I'm also slightly fed up with always having to drink soft drinks - but rather than risk Fetal Alcohol Syndrome.'

Theme three: Acquiring and handling knowledge about putting the baby inadvertently at risk

The course of action most often taken when participants found out that they may have put their babies inadvertently at risk was to seek medical advice. The women were reassured by the opinions of the midwives/doctors, and thus, even where risk is not first identified/pointed out via the medical

profession, they are still the ones the women most often turn to for advice and reassurance.

Extract 56 (Sue - diary):

'I am obsessed with a new worry tonight. Keith came home from work today and said he'd heard on the news that pregnant women shouldn't have hot baths because it can damage the fetus. Particularly in the early stages. I went in a very hot (104) jacuzzi while on holiday (I was approx. 13 weeks then) at the time I didn't see that it could do any harm, now I am obsessed with worry. I'm thinking what if I boiled the poor little brain, or I've heard that if you have a real high temperature when you're pregnant, it can make the baby deaf. I don't know why I didn't think more carefully about it when I did it. I'm going to contact my midwife tomorrow and ask her. I don't think I'll sleep tonight. There's so much to worry about when your pregnant.'

Extract 57 (Jane - diary):

'Up all night with catastrophic vomiting - looks like it was something I ate - probably that slice of turkey.

Feeling awful - didn't go to work and neither did Adrian - he stayed off to look after me.

I phoned Julie (my friend who is a midwife) at 0700 as we were both very worried about CJ (nick name of baby) who was going bananas and virtually 'juttering' - it must've felt to him like he'd spent the night in a washing machine!!

Anyway I've just been on limited fluids - (I keep being sick if I drink more than a few sips) and by tonight he's more settled - poor thing.'

In Extracts 56 and 57, the potential risks to the fetus cause Sue and Jane to worry and show sympathy toward the baby. Both participants highlight

the way in which behaviours often encountered whilst not pregnant take on new meanings when they are pregnant.

In Extract 58, Sue highlights how she relates to other people's experiences, and the effects their experiences have on her. The vivid descriptions she provides relay the impact the information had on her.

Extract 58 (Sue - interview):

Question: 'Are you worried about anything at the moment?'

'I saw a thing on telly yesterday that's (of course!) got me worried again. It was about miscarriages. Some people miscarried at 5 months which is where I am now. They told awful and sad stories. One lady had to pick the pieces of her baby out of the toilet, put it in a plastic bag and take it to hospital. This idea is so appalling. I think a miscarriage is much harder if you've already had a baby because *you're so* much more emotional and you know how much that baby would mean to you, whereas the first time I had my baby, I was totally unprepared for the amount of unconditional and overwhelming love I would feel for him. I think to lose one now, especially as it is fully formed - though still very small, would be heartbreaking.'

Sue compares the impact a late miscarriage would have on a first time mother with that of second time mothers, and considers the latter to be the ones that would find this more difficult. She bases this opinion on the differences she is experiencing in relation to how she thought about her first pregnancy in comparison to this, her second pregnancy. In this extract, Sue does not talk about the risk in terms of predefined factors, and so shows how risk can be experienced as a result of identifying with other people's experiences. Hearing about other people's experiences is one form of information gathering which then becomes part of one's own repertoire, and can lead to comparing and contrasting different experiences.

6.2.3

Subsection 3: Lay expressions of the causes of risk

Extract 58 is but one of the many examples of the constructions of risk that have been provided so far in the analysis of the accounts. Further examples of perceiving the self to be at risk were found across all ten of the participant's accounts. Given the predominance of their occurrence in the diary entries I will now present further examples. In this subsection of the analysis, I will highlight the non-medically based descriptions that the participants used.

The risk of miscarriage during the first and second trimester of pregnancy was, on occasions, due to medical complications (see for example, theme two in subsection one of the analysis). However, there were cases where risk was experienced without there being any physical symptoms requiring/having available medical explanation(s) to account for them. In these cases the perception of risk was often referred to, or framed in, terms of superstition and fate, and the course of action most often taken was to hold back on fully preparing for the arrival of the baby.

Extract 59 (Sandy - diary):

'Eve has given me a big bag of Kate's baby clothes. It's fun sorting through the sizes, but I'll have to ask her advice on what to get for the first months. Most of what she has given me start at 6 months...

I haven't yet bought anything. I feel a bit superstitious about jumping the gun, although I'll have to have some things ready before he's born.'

In the above extract, Sandy describes how she is preparing for the arrival of the baby and is also trying to hold back at the same time in case she is 'jumping the gun'. Putting this possibility of risk down to superstition rather than medical reasons shows how risk is variously constructed using cultural repertoires. In Jane's case, risk is constructed as 'tempting providence' as can be seen in Extract 17, repeated below.

Extract 17 (Jane - diary) (repeated):

'I was also very aware that until one reaches 12/40 pregnancy one is by no means 'home and dry', and so began the dilemma of desperately wanting to tell everyone and yet not daring to tempt providence.'

During the second trimester Jane again shows her concerns about discussing her pregnancy in detail in case it leads to loss:

Extract 60 (Jane - diary):

'Went to Oxford with Heather...She's very excited about the baby, but I find it a little uncomfortable talking so much about baby clothes and labour so early in the pregnancy - it seems like tempting fate!'

In Extract 61 we can see that, as with Sandy and Jane, Sue also holds back in terms of fully preparing for the arrival of the baby. However, she feels that the possibility of the risk of miscarriage is far more likely to occur (premonition) and questions her decision to have bought a pushchair:

Extract 61 (Sue - diary):

'I just don't know if I'll need it. I always keep thinking something's going to go wrong, not a feeling of paranoia - more a premonition - I just can't picture this happening. I could the first time - it's a strange feeling.'

In Extract 62, the continual worry Sue is experiencing in relation to harming the baby leads her to think that she is paranoid and that this is due to 'some kind of worry hormone'. This extract also shows Sue comparing her previous pregnancy with her current one.

Extract 62 (Sue - diary):

'I'm not as tired these days. The big problem with my pregnancy this time is that I worry about everything. I never worried like this when I was pregnant last time. I am almost paranoid - I'm always sure something's going to go wrong or if I smell fumes from the fire I'm convinced it's damaging the

unborn baby by being inhaled by me. I don't know why I'm like this this time. Maybe having the first baby released some kind of 'worry hormone'. Something that helps protect the baby by causing the mother to be very careful! I don't know.'

The feeling of something being wrong (or going wrong) was not only expressed by Sue, but was also mentioned by a number of other participants. See, for example, Extracts 63 and 64 where fetus movements are used to assess well being.

Extract 63 (Jane - diary):

'Awoke after a pretty grim night - (Adrian has a cold too). And the baby didn't move like he normally does the minute I start to talk - so had a panic attack!! A few prods elicited a response though - poor little soul he was just asleep.'

Extract 64 (Mary - diary):

'Since last night I hadn't felt any movement from the baby.

My mum phoned her doctors and made me an appointment for 12 o'clock.

I was worried that something may be wrong.'

Where the participants mentioned that they worried about something going or being wrong, they were concerned about the wellbeing of the baby. This was not expressed in terms of risk directly, however it is feasible to see their concerns and worries about something being wrong as lay expressions of risk. This interpretation of something going or being wrong as a lay expression of risk has been based on the context of their discussion relating to the baby's well being.

Another type of experience which often led to worrying about the risk of miscarriage was dreams. Not only were the dreams about miscarriage described, but also how they affected the participant on a day to day basis. In

Extracts 65 and 66 we can see that Sue's dream is not only described, but its possible cause is also being discussed.

Extract 65 (Sue - diary):

'Last night I again dreamed that I was having a miscarriage. It was such a realistic dream. I dreamed I was in bed (in my dream I was saying to my self - this is not a dream - this is really happening). I felt contractions and was pushing involuntarily and could feel the sensations - it was so real. I think it will take a long time to forget this feeling. I think I've been worried because, when you're first pregnant - you book in with the doctor and the midwife comes to see you then - nothing for 6 - 8 weeks. I wonder if all is well and I think subconsciously I am quite worried. This is obviously manifesting itself in my dreams.'

On another occasion Sue confirms her thoughts about the issue behind the dream.

Extract 66 (Sue - diary):

'Last night I dreamed I was miscarrying Again. It's the first time I've dreamed that in weeks...

I think the real problem is that once you see your midwife initially, there is no contact until about sixteen weeks when your hospital appointment is. I think there should be a check up in between these two to make sure all is well.'

Sue's description of the possible cause of the dreams (having little contact with medical professionals after receiving intense contact) links back to one of the points made in the previous chapter, the search for external sources of information to help with subjective acknowledgements (in light of doubts about the pregnancy being 'real'). In this instance it is the lack of contact (with people who are seen to be objective in their interpretation of the pregnancy) which is seen to be the cause of the disturbing dreams.

6.2.4

Subsection Four: Relating to the outcomes of risk

In this final subsection of the analysis, two different aspects relating to risk are described. In the first theme, examples of what it means to have a baby with abnormalities for four of the participants are outlined. These were provided in the context of the participants wanting to terminate if abnormalities were found. In the second theme, one participant's experience of being categorised as being at high risk of postnatal depression is outlined in order to show how risk can be related to the mother rather than her baby as a consequence of pregnancy.

Theme one: Reasons for not wanting a baby with abnormalities

In light of the discussions about possible risk of 'abnormalities', I became interested in finding out whether any of the participants had described what having a baby with abnormalities would mean for them. Whilst re-examining the diary accounts only a few examples of thoughts related to having a child with abnormalities were found. The descriptions that follow show how four women came to construct particular outcomes.

Extract 67 (Sam)

'...Felt like crying for the rest of the day, why us?
Huge, fat, flabby babies are so ugly - I have done everything right, so why should I develop this? So much for good control?'

Extract 68 (Sandy)

'Saw a boy, about 14, with Down's syndrome at the showroom.

He was shouting. I didn't really want to look at him - mixed feelings pity, revulsion, fear.

Feel disturbed.'

For Sam and Sandy the perceptions held in relation to the 'looks' of the baby led them to be disturbed. In Sam's case she felt that it would be unfair if she had a 'huge, fat, flabby, baby' given that she had tried her best to prevent such an outcome. For Sandy, her thoughts were based on the observation of a boy with Down's Syndrome and showed how she was concerned about her own reflections, to the extent that she would rather not observe him as this led to her having negative thoughts, both in relation to the boy's appearance and in relation to what it would mean for her 'fear'.

Extract 69 (Sue)

'I would never want an abortion unless I found out there was a serious mental or physical problem with the unborn baby. I don't think I could cope with that. I realised that if when I have my scan, there was something seriously defective about the baby it would be too late to have an abortion. This worries me.'

Sue discusses her concerns, not in terms of what the baby would look like, but rather in terms of her own ability to cope. Thus, for Sue the meaning/consequence is not based on what the child 'looks' like but rather on practical issues (self management).

Extract 70 (Pat)

'She [sister] also told me that she met a girl who had a Down's Syndrome baby today. She was only thirty one when she had the baby and a heart defect had been detected and she had been told her baby would be born handicapped but she had chosen to keep the baby anyway. My sister said she was a very unhappy lady. In my mind I was imagining me in that position and I felt that I would easily be able to decide to terminate the pregnancy but I'm sure it wouldn't be as easy as that to make the decision.'

Extract 71 (Pat)

'Later on in the afternoon a really attractive lady arrived with her daughter who was about 14 years and had Down's Syndrome.

My brain started ticking over I was thinking I wonder how old she was when she had her daughter? She only looked about 38 - 40 so I worked out that she could only have been in her mid to late twenties when her daughter was born. I wondered if she had known?

The daughter was really happy and dancing and enjoying herself. Her mum obviously adored her and had taught her to dance - she was really good. I suppose you have to accept it and get on with things making the best of the situation although I don't think I would be able to cope at all.'

In Extracts 70 and 71 we can see how Pat reflects on the meanings that a Down's Syndrome child would have for her as a mother. She contrasts her own hypothetical situation ('I don't think I would be able to cope at all') with that of the observed mother who 'obviously adored her and had taught her to dance', and thus reflects on how people must 'accept it and get on with things making the best of the situation'. Her construction in terms of 'the situation' shows how she perceives having a Down's Syndrome baby as being something to put up with and a negative experience, but also acknowledges that making the decision to terminate may not be as straightforward as she thinks it would be.

Pat's own fear about having a Down's Syndrome baby was expressed on a number of occasions. She continually considered the age of the mothers who had Down's Syndrome children and from her evaluations knew that advanced maternal age only accounted for a percentage. Although she was not of advanced maternal age herself, she knew of others who had Down's Syndrome children despite their age, and hence she worried about the possibility that she too may have a Down's syndrome baby.

Theme two: Woman's resistance to being labelled at risk of depression

The concept of risk has so far been explored in terms of the risk the unborn child may be under. However, risk was, on occasions, discussed in terms of that faced by the mothers themselves. In Jane's case, the risk she was labelled as being liable for (postnatal depression) was something she disagreed with, and showed her resistance to:

Extract 72 (Jane - diary):

'1st antenatal visit at the GP. On the whole this was an entirely disappointing experience. I came away feeling angry, depressed and persecuted. My mother, who in my opinion is an hysteric, and my sister have both experienced clinical depression. Both have their reasons, but [GP] seemed determined to 'label me a dead cert' for post - puerperal depression. She spent the whole consultation discussing treatment regimes, suggesting I start counselling now, and generally painting a very grim picture of my personality as she saw it - not bad for someone who had known me for all of 10 minutes!'

Extract 73 makes explicit Jane's resistance to being labelled at risk. This extract also shows how resistance is difficult, due to the power differential between herself and the doctor. She is concerned that her resistance may be taken to be a further indicator of her 'risk' if she was to mention it:

Extract 73 (Jane - diary):

'Try as I did to stay calm on the outside, for fear that any overt display of anger or denial of her interpretation of my personal risk may further jeopardise my 'health' assessment, inside I was furious. Wasn't this suppose to be a happy event?...

If psychology is her sideline then my advice to her would be 'don't give up your day job'. I discussed this event

with friends, colleagues and of course my partner and nauseam until I filed it away under 'unfortunate experiences'...

What if all this is blindly transcribed from one set of notes to another?'

6.3 Discussion

In this chapter the concept of risk has been discussed using a number of participants' accounts in order to show how risk has variously been handled by the women.

In summary, the first subsection of analysis examined the decisions related to the up-take of prenatal diagnosis. These decisions highlighted the ways in which risk was constructed in line with medical knowledge and forms of intervention. Previously, Rothman (1988) had described the period of waiting for prenatal testing to take place to be 'tentative'. This was also shown to be the case for one of my participants, although, unlike Rothman's findings on the conflict experienced in relation to the decision to terminate, if abnormalities were found, none of my participants described their decision to be one that caused them conflict, in terms of what they wanted and what was expected of them. In my own multiple case study analysis I found more similarities than differences in the way in which the women discussed their uptake of prenatal diagnosis, and thus only a select number of quotes were provided as they were representative of the types of descriptions other participants had provided.

The variation detected between the respondents in my study and those of Rothman's demonstrate the high level of diversity that can be detected across accounts. I am therefore not attempting to make any generalisations from my data set, but instead aim to show how considering the self to be at risk and having prenatal testing to detect abnormalities can lead to various constructions of particular forms of action.

Each subsection in the second half of the analysis shows a different aspect/way of looking at the concept of risk and reflects upon the way risk was handled.

The participants often compared and contrasted their present pregnancies with others (previous ones or friends). For example, Sue outlined the high level of difference between her present pregnancy and her previous one, while Sam (material presented in the next chapter) compared her pregnancy with that of her friends. By comparing and contrasting the experience of pregnancy, the participants (like myself) aimed to show the diversity of their experiences. Comparing and contrasting was a popular device used to make sense of and perceive the individuality of each pregnancy.

Given the diversity found within individual accounts as to the likelihood of considering the self to be at risk (e.g. 'low risk' individuals seeing themselves at 'high risk'), we can see that the medical categorisations assigned are not necessarily accepted in full. Instead there seems to be fluidity (movement) between the two categorisations, which is in contrast to the medical categorisation of falling in only one set category. We can also see that the medical label assigned may not be representative of the women's interpretation of their risk. Subsection three of the analysis highlights the way in which individuals can see themselves to be at risk for non-medical reasons, and thus risk is a concept which has been variously discussed and experienced.

Having said this, this chapter also demonstrates some of the similarities that were occurring across accounts, for example in terms of wanting to be reassured by medical personnel when they were worried about potential risk. As with previous studies examining anxiety during pregnancy, the analysis carried out shows that the women do worry about potential risks to the baby, although the intensity of this worry does alter both within and across accounts. See for example, extracts from Sue's accounts for instances of within case study analysis to show how she continually worried about the possibility of losing the baby, while extracts from Sandy's accounts show how

worry occurred less frequently for her, despite experiencing symptoms that could indicate miscarriage.

Chapter Seven: Risk Construction - a case study analysis

7.1 Introduction

The material presented in this chapter has been taken from one of the participant's (Sam's) diary accounts. Sam herself is a nurse, and on many occasions used medical discourse to describe her physical symptoms. Because of this, the reader may need to turn to the *glossary of terms* at the end of this thesis for definitions of the medical terms she has used.

Sam's accounts of the impact that the concept of risk had on her will be examined, so as to provide as much contextual information as is possible for the reader to be able to make their own interpretations. There are of course a number of interpretations that you, as a reader, may make in addition to the ones I have made, for example in terms of this participant's assessment of 'normality' and 'abnormality' of herself and her baby. In addition, providing full details of Sam's diary entries about risk helps to contextualise the interpretations I have provided.

There are two reasons why I have chosen to consider Sam's accounts of risk in a separate chapter. Firstly, the concept of risk during pregnancy is emphasised in Sam's account rather more than in others, and, secondly, her difference in the descriptions of its impact. Taking the first reason, if Sam's descriptions were represented within the themes outlined in chapter six, then the level of significance that she placed upon the impact risk had on her experience of pregnancy could not have been as easily portrayed. In addition, Sam continually referred to her perceived risk throughout her pregnancy which provided the opportunity to examine the longitudinal effects of being at risk (as experienced by Sam).

With reference to the second reason, note can be taken of the many differences in her construction of risk as compared to those of the other participants. This is highlighted in the analysis subsection in so far as the majority of the themes presented tackle very different issues than those presented in chapter six.

The analysis that I have presented examines the links between perceiving risk during pregnancy with issues such as levels of choice and control (similar to one of the issues explored in chapter six), fault, blame and responsibility (issues which were only highlighted by Sam).

Furthermore, by taking a longitudinal case study approach to investigate risk in this chapter, I aim to highlight the individuality of experience as opposed to highlighting the many and varied constructions of risk across different participants' accounts. This chapter thus builds on the content of the previous chapter in so far as it not only describes further constructions of risk but also presents a longitudinal overview of the ways in which subtle changes in its conceptualisation and usage occur.

Thus, in the analysis of the accounts I have aimed to represent Sam's multifaceted constructions of risk together with her assessments of the risk she is experiencing over time. Her longitudinal account shows the shifts she went through in terms of her assessment of risk and its consequences for herself and the baby. Sam also discussed at length her thoughts about a friend's pregnancy and compared the risk she was under with that of her friend. Sam described at length her feelings about having a baby who may have complications due to her own diabetic condition.

Both the medical profession and Sam labelled her pregnancy as being 'high risk' due to her diabetes, and so this account does not highlight this participant's movement between categories of risk (as the account provided in the introduction subsection of chapter six showed). However, we can see that she does perceive her level of risk to vary in accordance with a number of other factors, for example when she receives reassurance from doctors she likes, and at times when her diabetes is under control (as represented in Extracts 74, 102 -105).

Prior to examining the above named issues (levels of choice and control, fault, blame and responsibility) a brief account of Sam's experiences of both the effect her pregnancy is having on her diabetes and that of the diabetes on her pregnancy are described in relation to the concept of risk.

7.2 Sam's experience of a diabetic pregnancy and its association with risk

Extract 74 - diary:

'Good blood result - perhaps things will be okay after all.'

Extract 74 shows Sam's awareness of the risk of having a baby with 'abnormalities', and her good test results are being interpreted as a sign that although she is at risk this may not affect her. She uses her test results as a means of assessing whether 'things will be okay', and on this occasion reasons that they may well be.

Extract 75 - diary:

'Not getting blood sugars under control - too many hypos - I wonder if the baby is using up the glucose.'

Although Extract 75 shows that the level of the blood sugars is not as Sam desires, we can see that Sam does not relate this to a higher chance of her baby developing abnormalities. One of the reasons for this is her knowledge that 'hypos' are not directly linked to the increased risks that babies of mothers with diabetes carry. This knowledge is shown more clearly below:

Extract 76 - diary:

'Two hypos last night, still not in control, at least hypos aren't meant to affect the baby.'

Extract 77 - diary:

'I felt the BS were getting more under control but I had a hypo at work today and needed help. I was so scared to be seen as helpless.'

I know hypos don't have too drastic an effect, but this sudden loss of control is very difficult to deal with. At least when the placenta takes over next week, things should be easier to control, I hope.'

In the above extracts, we can see that Sam phrases her knowledge of the likelihood of hypos being related to fetal damage in ways that reflect an uncertain acceptance of there being a link ('aren't meant to' and 'don't have too drastic an effect'). Despite Sam's attempts to see her hypo attacks as separate from her baby's level of risk, the continuation of the attacks, together with her uncertainty of there being no association, leads her to turn to her doctor's view points as a means of finding out whether 'everything is okay' (see Extract 78 below). Previously, reassurance as to whether the baby may be okay was achieved with the good blood test results (reported in Extract 74), and now such reassurance is being sought from the doctor.

Extract 78 - diary:

'Still low blood sugars - must reduce insulin further, at least I can see [GP] next week to see if everything is okay.'

Extract 79 - diary:

'Hypo again today - I wish, can't wait for next week, when this will stop.

I may be very hard on myself but I have never been able to achieve BS between 4 and 8, but the HBAI have always been okay. All I want is a healthy baby.'

Extract 80 - diary:

'No problems today I hope the baby is okay.'

In Extracts 74, 78, and 80, we can see that Sam talks about risk in terms of whether things will be 'okay'. In other words, she does not present risk as a continuum but rather as an either/or situation (okay/not okay). Her assessment of risk as either/or (okay/not okay) is very different to the way in which risk is calculated and used in research and medicine (in which she has some training), which uses numerical probability ratios or percentages.

The experience of risk in terms of thinking about the baby being either okay or not okay (with not okay often being expressed in terms of doubt that the baby is okay), fluctuated for Sam in relation to how well her diabetes was being controlled by her medication. However, even where there were no

problems experienced, Sam always phrased her wish for the baby to be okay in terms of possibility and/or hope rather than certainty.

Extract 81 - diary:

'Awful weekend at work, hope this hard work is doing me good and not harm. Just let me get through to twelve weeks and maybe the hypos will stop and the nausea, and I will feel that the baby is okay.'

Here we can see that Sam is referring to a stage in the future (going beyond the twelfth week) as one which will lead to her being more confident in the baby being okay. This stage is important to Sam because the placenta takes over, and thus the problems with blood sugar levels and the hypos should theoretically decrease. However, as can be seen in Extract 82, the hypos do not stop as soon as she is twelve weeks, and as a consequence she begins to wonder whether the baby is suffering and returns to wondering whether the baby 'is okay'. One possible explanation as to why Sam is increasingly becoming concerned may relate to her medical knowledge and the discrepancies she is finding in relation to her own experience. The medical knowledge itself may be making it harder for her. What is evident so far is that there is variation in Sam's interpretation of her risk, and that this is being directly linked to her diabetes.

Extract 82 - interview:

Question: 'How are you getting on?'

'Well, I am 12 wk's and 2 days and I thought the placenta would be working by now, maybe it takes a while to get going, I suppose I expected my insulin requirements to be rising by now and the hypos to stop - well it isn't working yet!

I hope the baby isn't suffering. I feel so responsible about this child, I hope it will be okay.'

7.3 Constructing risk as lack of choice and control

One of the strategies that Sam constantly used to locate her own position in terms of putting her baby at risk was to refer to her own situation as one over which she had little choice or control (in terms of the level of risk her baby was in). This was offset by her accounts of a friend's pregnancy which was marked by her friend's perceived (by Sam) choice to put her child at risk despite her friend's option not to do so. Sam's own lack of choice and control was vividly described in her reports of her friend's behaviour, which she perceived as risk inducing.

Extract 83 - diary:

'Julie is four weeks ahead of me and is still smoking. She is up to 10 a day. It makes me so annoyed that she has a choice to stop harming her child, when my diabetes is something I can't change. Why harm your child when you have a choice? I am trying so hard to create the right environment for my child. I wish I could say something to her, but she is such a close friend, I think in my present state of mind it would come out wrong and she is too valuable a friend to risk hurting - so I'll just have to keep those frustrations inside at present.'

Here Sam has compared her lack of choice and control over diabetes with her friend's choice and control over her risk-taking behaviour (smoking). One of the main differences between Extract 83 and 84 (presented below) relates to the way in which her friend's pregnancy is used to either directly or indirectly portray each of their positions (in terms of the risks each of them is under and the subsequent allocation of control that could be exercised). In Extract 83 Sam directly compares and contrasts her own pregnancy with that of her friend, and shows her annoyance with the fact that her friend has a choice (as Sam sees it) while she doesn't, and that while she is trying to do everything 'right' her friend is deliberately choosing not to. In Extract 84, Sam compares her own pregnancy with that of her friend only indirectly, by referring to the label 'normal' as allocated to her friend to be 'so called'. Sam's

construction of her friend's behaviour highlights the way that she feels about the label 'normal', that it doesn't mean there is 'no risk' in relation to its assignment to her friend, but rather that it implies that she is less at risk. In addition, her own pregnancy circumstances and those of her friend are now no longer being compared, as she discusses her friend's situation in a detached manner (she does not talk about her own pregnancy explicitly).

Extract 84 - diary:

'Spent the evening with my pregnant friend, whose scan stated she was 17/40 and not 19/40. She was upset by this, could her baby be smaller because she smokes? Why does this bug me so much? I am not anti everyone smoking, but could it be affecting her baby? She is also having lots of pain and has been in hospital, she really is having a tough time for a so called 'normal pregnancy'. I hope she will be okay.'

Extract 85 - diary:

'Julie my friend who is also pregnant, but still smokes and has been off sick since the last 2/12 rang. I did not want to speak to her. I am awful as I really feel she is malingering and should come back to work. So many people I have spoken to have had pain in pregnancy like Julie's, but still worked. I feel I must be so bad, as she is annoying me so much, sitting at home smoking, when she could be at work. I can't feel sympathy anymore, especially when she says I am so bad having to go back to work again at 12 wk's, when she is going to stay off 6 - 12 months.'

Extract 86 - diary:

'Julie came in today to say that she would not be at work at all. She was so annoyed that personnel is forcing her to leave at 28 weeks due to having been off sick, she was looking at me for support in this, but I could not give her support...I sound so unfair and unreasonable, but when she

still smokes so heavily when she knows the risks and spends her sick time shopping etc. I don't feel I am unreasonable, or maybe I am.'

In the above extracts, Sam continues to show the effects that her friend's behaviour is having on her, while at the same time attempting to justify her feelings and present herself in a positive light. She shows how she is angered by her friend's risk-taking behaviour, but appeals to the justification she has for her feelings of annoyance and anger (by raising questions as to whether her feelings are 'unfair and unreasonable'). She counters the idea that she is the one that is unreasonable by stating the unreasonableness of the behaviour of her friend (knowingly taking risks she need not take).

Extract 87 - diary:

'Alison and Julie came over for tea, Julie still smoking!
How stupid can she be?'

Extract 88 - diary:

'Julie still smoking ++, yet Dave her husband has given up. Her excuse is that if she gave up now, her baby would suffer nicotine withdrawal - how stupid! Yet she will probably produce a perfectly healthy child!!'

In Extracts 87 and 88, Sam continues to have little sympathy for her friend and now perceives her friend's behaviour as 'stupid'.

In Extract 83, Sam located her risk status as being outside of her control and showed feelings of anger and frustration toward her friend, who was seen to be abusing her position of having choice and control over her risk status. However, in the extracts below (Extracts 89 - 92), we can see that when Sam does have a choice about placing the baby at increased risk, she does not frame her possible risk-taking behaviour in the same negative terms as she has done for that of her friend. What is important here is the medical and social significance and justification that is related to the dangers of particular behaviours (at present smoking is considered far more dangerous than taking some forms of pain relief tablets). Thus, factors such as the type

of behaviour and the level of risk it represents, as well as the reason for taking the risk, come into play in the construction of what constitutes risk and choice.

Extract 89 - diary:

'I felt awful today, sick, dizzy and abdominal pains. Surely this can't be good for the baby and I hope this isn't a part of pregnancy yet to experience. The difficulty of not being able to take medications was highlighted today, in the end a Rennie tablet came to my rescue, I felt it would do my baby no good if I felt so horrible. I hope I was right.'

Sam details the severity of her symptoms and outlines her consideration of the acceptability of her apparent risk-taking behaviour (taking tablets) prior to its occurrence. She shows how the contradiction in what is right for her (taking medications) as compared to what is right for the baby (as she, rather than medical discourse, perceives) leads to a dilemma which has to be resolved. She justifies her decision to take the tablets by stating that in her judgement 'I felt it would do my baby no good if I felt so horrible', but again ends her account by leaving her actions as only possibly being right, and so her decision is again one that is not one that can instil certainty (just as occurred when she talked about her blood sugar levels and their possible link to risk). This interlink between risk, choice and consequence is again portrayed in the next two quotes:

Extract 90 - diary:

'Felt awful today, have got a cold, had to reason with myself and have 2 paracetamol this afternoon. This fight between what is right for the baby and what is not, is quite a dilemma. I felt so lousy in the end, Steve and I felt it better that I take the risk. Hope we were right. Felt better afterwards!'

Extract 91 - diary:

'Went to GP to get some antibiotics today, I'm sure neither baby or me need feel rotten with flu any longer.'

Why when I should be feeling so happy do I feel horrible?'

Extract 92 shows how risks other than medically based ones are also considered in terms of dilemmas, and again shows that, where choice may be present for the individual, the interpretation of it and the decision based upon it, in terms of the course of action to be taken, is often represented in justificatory terms ('I know it is stupid, but...').

Extract 92 - diary:

'Attacked the garden today, I know it is stupid, but I'm trying to get all the jobs done like washing the curtains etc. while I'm still able to be agile enough to climb up on chairs etc.'

7.4 Variations in the construction, perception and reporting of risk as a product of choice and control

What remains to be discussed, and is crucial to the understanding of Sam's interpretation of risk, is the way in which she comes to see and label what does and does not constitute risk. So far we can see that Sam has discussed her diabetes as being a definite risk factor. From this definite factor, we move on to see how she experiences risk in other situations in which she has a level of choice and control over taking risks (see Extract 92). What we see here is a change in her reporting style of accounting for risk-taking behaviour. That is, when she takes risks (rather than the diabetes imposing risk upon her) she attempts to justify her reasons for doing so.

In addition, Sam's account of her own risk-taking behaviour contrasts sharply with her accounts of her friend's risk-taking behaviour (smoking). In this instance it is the consideration that Sam reports to have made prior to taking the risk that is used to excuse her behaviour, whereas her friend's risk-taking behaviour is seen to be without merit.

Sam's juxtapositioning of the positions of herself and her friend, in terms of having choice and control over risk, was only evident when she

talked about her own inability to exercise choice and control (due to the diabetes). When Sam discussed her semi-choice based decisions to take risks (e.g. taking tablets) she did not compare her behaviour with that of her friend. This may have been because of the lack of contrast that existed in these situations and/or her lack of consideration as to whether her friend's choice to smoke may not have been a full choice at all (addiction as a possible factor in removing choice, just as she saw suffering with flu as a factor removing full choice from her). Bhavnani (1991) suggests that the silences which occur in our data should also be discussed, and that they too carry meaning. Thus, not only should we consider where and how the friend's risk-taking behaviour is discussed, we should also look to where it has been left out. Another noticeable silence I found in Sam's accounts related to her lack of reporting of possible choices she had made in relation to risk. For example, Sam had planned her pregnancy and had known about the risks associated with diabetic pregnancies, as shown below, and yet this was not put forward as a choice of hers.

Extract 93 - diary:

'I must stop being so hard on myself. I must sit back and look at what I have achieved in life. I got my Sisters post at 24! I have never had a problem getting a job or promotion, I became pregnant after only a few months of trying so didn't have to cope with infertility. My HBAI have been very good and so far all is well - so why do I feel a little flat? Maybe next week I will feel more positive and able to cope. I really am very lucky.'

One of the reasons for not acknowledging or perceiving her planning as choice may be that she did not see not having children as a choice for her. Similarly, termination is a choice for some women and not for others. The point is that we cannot generalise as to what constitutes choice across groups of individuals, nor can we say that interpretations of what constitutes risk or choice remain the same for any one individual. There are degrees of choice ranging from none at all to complete, and identifying where on the spectrum

you are, in relation to particular and specific behaviours may depend on your interpretations, beliefs and values.

7.5 Risk as expressed in relation to blame, fault and responsibility

The increased risk that Sam has of having a baby with 'abnormalities' due to being diabetic resulted in Sam feeling that she would be blamed by others (although she did not mention anyone actually having blamed her) and would also blame herself if the baby was to be born 'deformed':

Extract 94 - diary:

'Felt very lazy today, I never used to be like this. I can't blame every feeling on being pregnant, I think I'm just Lazy. Hope the baby is okay. Only one hypo today. 2/7 until the clinic - at least Steve can come with me. Its nice to have him there.

Am I irresponsible being pregnant and diabetic, if the baby is deformed, everyone will blame me and say it is due to being diabetic. Trouble is it will be my fault. I must be so irresponsible. I just hope everything is okay.'

Extract 95 - diary:

'...[Dr] didn't catch his name or rank. He was rather dismissive of Steve and I. He reassured me my baby was putting on weight, but I'll be glad to see [Dr] next Wednesday and hopefully have a scan.

If the baby is deformed in any way I know it will be my fault, which scares me. I hope I will have another scan next week at the clinic.'

Sam questions her responsibility for putting the baby at risk and says that she believes it would be her fault if the baby was deformed, and therefore has to 'hope' that this would not be the case.

As a result of seeing herself to be at fault should the baby have any 'deformities', Sam again hopes that this will not be the case and looks to the scan as a means of finding out that she will not have a baby with 'abnormalities'.

In Extract 86 (repeated below), Sam moves from discussing herself back to discussing her friend who she sees as not thinking or blaming herself for the danger she is putting her baby under. The extract shows how Sam thinks her own unsupportive attitude toward her friend is reasonable, as her friend is taking risks and is behaving inappropriately in other ways too (going out shopping while off sick), and as such should not escape negative consequences (personnel's reaction). Sam's reaction may be due to her own feelings of having to blame herself for the possibility of having a baby with 'deformities' (because of her diabetes), and she may feel that as such, given that her friend is not blaming herself, negative reactions toward her are justified.

Extract 86 - diary (repeated):

'Julie came in today to say that she would not be at work at all. She was so annoyed that personnel is forcing her to leave at 28 weeks due to having been off sick, she was looking at me for support in this, but I could not give her support...I sound so unfair and unreasonable, but when she still smokes so heavily when she knows the risks and spends her sick time shopping etc. I don't feel I am unreasonable, or maybe I am.'

Comparing the above extracts, it can be seen that Sam is accepting blame for her risk-taking behaviour, whereas she thinks her friend is not.

The way in which Sam sees blame to lie centrally with her can also be seen when she talks about her diabetes and its relation to the outcome of the baby's health:

Extract 79 - diary (repeated):

'Hypo again today - I wish, can't wait for next week, when this will stop.'

I may be very hard on myself but I have never been able to achieve BS between 4 and 8, but the HBAI have always been okay. All I want is a healthy baby.'

Extract 82 - interview (repeated):

Question: 'How are you getting on?'

'Well, I am 12 wk's and 2 days and I thought the placenta would be working by now, maybe it takes a while to get going, I suppose I expected my insulin requirements to be rising by now and the hypos to stop - well it isn't working yet!

I hope the baby isn't suffering. I feel so responsible about this child, I hope it will be okay.'

As Sam's pregnancy progressed, it became evident that Sam may have complications that could increase the chances of her baby having 'abnormalities'. The first suspicion that things may not be okay (apart from prior knowledge that this was a general possibility) came when her husband felt Sam may be too large for her dates. Having large babies is one of the complications that can occur due to diabetes, as Sam explains:

Extract 96 - diary:

'I know this sounds silly, but Steve thinks I'm too big for dates, I told him, he can't compare me to Julie, but he has set a doubt in my mind. Diabetics can have huge babies, but surely I can't? My BM's and HBAI have been okay - I must remember to ask next time I see [Dr]. I know the weight has piled on, but maybe that is just something I'm going to be prone to. I hate it when doubt creeps in. The book says my baby should be 2 1/2 inches by Thurs. so the next scan should confirm things are really okay.'

Sam attempts to counter the possibility that her size is due to her diabetes by appealing to the common-sense knowledge she has of some non-diabetic women putting on too much weight. She also does not want to

believe that there is a chance she would have a 'huge baby' and tries to justify this by referring back to her diabetic tests that 'have been okay'.

What is noticeable below is that now that there is potential 'evidence' that there are complications Sam changes from blaming herself to seeing what is occurring as unjust and unfair given how hard she tried to control her diabetes. She shows a great deal of anger at the possibility of having a 'huge baby' despite her good control, and reacts by making explicit how she does not find the outcome at all attractive because she only wanted a healthy baby.

Extract 97 - diary:

'Scan first - baby huge - 5 LB 11 oz - far too large for dates. Fluid +++, but cephalitic at least. Feet swollen [Midwife] worried re pre- eclampsia and advised to have BP done daily and if goes up to 140/90 I have to be admitted. Abdomen huge, heavy and sore. Head not engaged. Another scan in 2/52. If the baby gets too large it will have to be delivered even earlier. Why should I have a macrosomic baby yet all the HBAI have been perfect and I've tried so hard. Why should I develop polyhydramasis and the possibility of a huge baby?

...Felt like crying for the rest of the day, why us? Huge, fat, flabby babies are so ugly - I have done everything right, so why should I develop this? So much for good control?

I do not want a macrosomic baby - I want a healthy one. Must protect the placenta, as if there already is polyhydramasis the placenta might be ineffective too. Baby not moving as much, but I think that is my imagination as I am so worried about things.'

As Sam's pregnancy progressed, she changed in her view that she was to blame for any potential 'deformities' her baby may have. At first she reported she would be to blame (see Extracts 94 and 95) and then, when complications occurred, she did not discuss blame at all and thought that the

complications were unjust ('why me') because of her 'good control' (Extract 97). She then moved on to resist being blamed by others and thought that she was not to blame herself (shown in the two extracts below).

Extract 98 - diary:

'...a phone call from Steve's mum, she was very concerned re: the baby and had got some information very confused. Steve told me my mother had told her. I was furious - the large baby is being blamed on the diabetes, don't people even think some women just have large babies.'

Extract 99 - diary:

'Went back to antenatal clinic today. [Midwife] reassuring, but I do get the feeling my diabetes is being blamed for the polyhydramasis and large baby, although no one is honest with me.'

Note how Sam doesn't want to be blamed and wants others to see her problems as one of those things that can happen to anyone. She questions and disagrees with the people that attempt to blame her, or the diabetes, and as such can be seen to be defensive about her diabetes.

In Extracts 100 and 101 we can see that Sam tries to disassociate her complications from those that are caused solely by diabetes. She does this by stating that her diabetes is under control and so can't be the cause of the problem.

Extract 100 - diary:

'HBAI fine - it always has been. Diabetes okay anyway and BP. [Midwife] very encouraging.'

Extract 101 - diary:

'I felt so depressed and low, from the last antenatal and the thought that I have polyhydramasis - probably spelt completely wrongly!

I know my blood tests have been okay and so why should I develop this. If any of the HBAI had been abnormal then fair enough, I could be causing damage, but they have, so far, all been okay. BP up today because I was upset. Also why do I only have glycosing on clinic visits - typical!!

Felt reassured after the visit.'

What can be seen here is that Sam is now attempting to counter the idea that it is her or her diabetes fault. This is in light of her perceiving/constructing the possibility of being blamed, as she has not mentioned anyone that has actually blamed her.

In summary, there has been noticeable variation as to whether Sam blamed herself and saw the risk as her fault. Sometimes she did, while at other times she didn't. At first she directly linked risk to her diabetes, and so she saw herself as being responsible and at fault, while a little later she linked particular indicators to other potential causes (e.g. some women just being prone to put on weight) and so she was not blaming herself. Once the situation of others blaming her turned from hypothetical to actual we saw that she denied the link between the diabetes and her risk, and as such thought she should not be blamed.

7.6 A backdrop to the analysis of risk and its portrayal of Sam's negative experiences

The quotes that have been used from Sam's diaries so far have mainly portrayed the anxiety and problems that she experienced. However, these quotes do not capture all of her thoughts about the pregnancy, but instead have highlighted the negative aspects of her experience. This highlighting of only the negative aspects of the pregnancy experience has been unintentional on my part (in so far as I was not looking to portray only the negative aspects) and occurred because of the quote's ability to capture the theme of 'risk' which had emerged from my data readings. In my analysis and write up of the women's accounts I have, like the majority of other researchers, put forward

one particular sanitised constructed version of events. In order to demonstrate a few of the other possible reflections I could have made on the basis of Sam's accounts I have presented below a select number of quotes that could be analysed and interpreted to show the positive aspects of the pregnancy experience which, as Matlin (1996) states, have been neglected by psychologists. The quotes below demonstrate that despite the worry and anxieties Sam experienced at certain points of her pregnancy, there were other times when she positively enjoyed the pregnancy and felt that her baby was not at risk:

Extract 102 - diary:

'I can feel a bump today. I'm 10+6 days. Its very exciting. I hope the baby is okay.'

OPA today, ECG and Echo went okay. ECG technician rude and rough, I hope she is not always like this. Echo technician very nice - was called to an arrest during procedure - a reminder of the fragility of life.'

Extract 103 - diary:

'Meet [Dr] - very nice man, more reassuring and understanding than the Dr last week. HBAI fine so all is well.'

Extract 104 - diary:

'Insulin requirement rising, it is good to know this should be happening and that the baby is growing. Felt better at work, maybe a little more positive.'

Extract 105 - diary:

'[Midwife] lovely! So reassuring - re: baby. Heartbeat fine. Was disappointed re: mistake re: scan booking and arranged another then. So had a more detailed Scan i.e. the kidneys and saw the bladder filling. We saw the Aorta and pulmonary artery and vein and all 4 heart chambers working properly. Also we saw our baby's brain and found out its sex,

which we are overjoyed about, we will keep it a secret until the birth.

It was fascinating and I'm so glad Steve was there. It is so good to know our baby will be okay and is the right size etc. Am really looking forward to the birth now, I feel more reassured.'

By providing these contrasting quotes at the end of the case study analysis on risk I hope to have shown one other thematic interpretation of Sam's experience that could be made. This, however, would still be a partial representation of Sam's experience and I fully accept that there would be numerous other ways of seeing Sam's experience. I have focused my attention on some aspects of Sam's account and not others, and thus I have provided one blinkered account that has cut out the other possible ways the accounts Sam provided could be seen (as Oakley, 1974, states: 'a way of seeing is a way of not seeing', p 27).

7.7 Alternative methods of analysis which could be applied in the explanation of experiencing risk

Extract 84 - diary (repeated):

'Spent the evening with my pregnant friend, whose scan stated she was 17/40 and not 19/40. She was upset by this, could her baby be smaller because she smokes? Why does this bug me so much? I am not anti everyone smoking, but could it be affecting her baby? She is also having lots of pain and has been in hospital, she really is having a tough time for a so called 'normal pregnancy'. I hope she will be okay.'

Extract 84 has previously been used in subsection 7.3: 'risk as choice and control' to highlight Sam's interpretations of what constitutes a 'normal' pregnancy. Another form of interpretation that could be applied to examine the construction of risk would be to look at the same extract in discourse analytic

terms. Using this style of analysis we could perceive and interpret the account in the following way.

Sam begins by outlining her friend's problems in a factual manner and then goes on to show the effects that her friend's smoking behaviour have on her (being 'bugged'). She attempts to justify her reactions by appealing to her fairness in attitude toward smokers (not against everyone smoking), and locates her frustration in relation to the affect that smoking may be having on her friend's baby. Sam then returns back to a factual style of reporting, with her questioning the meaning of what is taken to be a 'normal pregnancy', and finally ends with a wish for her friend to be okay. Sam's appeal to being seen as a fair person who does have sympathy for her friend's welfare is representative of one aspect of discourse analysis aims, that is, to show how accounts are produced/constructed in order to *do* things such as justifying beliefs and presenting the self in a positive light (see Gill, 1996).

7.8 Discussion

As mentioned in chapter two, previous research investigating risk and anxiety has concerned itself with examining the detrimental effects of each on pregnancy outcome, with poor pregnancy outcome being defined in terms of infant morbidity and mortality. Thus, the impetus for the conduct of much of the previous research has been concerned with outcome issues related to the baby. Where the mother's outcome has been of concern, symptoms such as anxiety and depression during pregnancy have been investigated in order to find out whether they are predictors of problems post-partum (e.g. postnatal depression). The concern with predicting potential outcomes has meant that women's personal lived pregnancy experiences have been neglected.

One of the main goals of feminism has been 'to bring the woman back in', and to this end I have attempted to highlight the personal experience of risk and associated anxiety. By taking this approach the woman is being centralised, rather than being treated as a vessel of production with the product (baby) being the major concern.

The aim of the analysis in this chapter, like that of chapter five, has been to show how risk is variously constructed and experienced whilst pregnant. In this chapter, the concept of risk has primarily been discussed in relation to concepts of choice, control, blame, fault and responsibility, whilst in the previous chapter risk was primarily discussed in relation to assessments of being at risk and behavioural outcomes. These findings support Douglas's (1992) assertion that 'risk is a culturally conditioned idea, shaped by social pressures and notions of accountability' (Price, 1996:88).

Sam's experience of risk led to a great deal of distress. The thematic analysis shows how Sam constructed risk in relational terms, in so far as risk was related to the ways in which she and others may perceive her choice to have a baby when there was a high risk of the baby having 'abnormalities'. The analysis therefore highlights the role of context in the construction of experience.

The collection of prospective, longitudinal data has meant that it has been possible to pick up the contradictory changes in thinking that Sam made in relation to how she perceived herself whilst being at risk. See, for example, how blame was discussed at different stages of her pregnancy.

Sam often constructed potential risk using medical discourse which shows her alignment with, and knowledge of, medical constructions. The medicalisation of pregnancy has meant that risk can be identified in many instances, and control and prediction of risk is of paramount importance. This can be seen in Sam's case to have led to her experiencing doubts about whether it was appropriate (responsible behaviour) for her to choose to become pregnant. She questioned whether she was blameworthy if the baby was born with 'abnormalities'.

By examining risk as lived experience in both chapters we can see the effects it can have on individuals, and can examine the constructed impact it has whilst it is experienced. Thus, in line with one of my aims of the research I have attempted to examine pregnancy in and of itself rather than examine it in terms of its relevance to the well being of the baby or the transition to motherhood.

Chapter Eight: Images of pregnancy (part 1): Personal and social reactions towards the pregnancy.

8.1 Introduction

In this chapter I will be highlighting a number of the positive experiences the women reported having during their pregnancy. By positive, in this context I mean the happy and enjoyable aspects of their pregnancies. I chose to explore a number of themes which conveyed the positive aspects of the pregnancy experience for a number of reasons. A number of researchers (see for example, Johnston, 1993; Matlin, 1996) have discussed the ways in which psychologists have neglected the positive aspects as a result of their preoccupation with the negative aspects, and Green (1990) points out that 74% of pregnant women are happy with their pregnancy experience. In the present study, I too found that the women often described the enjoyable aspects of their pregnancy, and thus I decided to examine how the women in my sample constructed and experienced positive emotions during the course of their pregnancies.

However, during the data analysis for this chapter I became aware of the inappropriateness of trying to portray only the positive aspects of the pregnancy experience. This was because the positive aspects were often simultaneously reported with a number of negative aspects, and thus I realised that if I wanted to highlight the contextual experience it would be necessary for me to present both the positive and negative aspects. These analyses fit with what social constructionists (Stanley and Wise, 1993) have found and argued in relation to the use of binary dualisms (e.g. the use of positive and negative). Such dualisms fail to detail the complexities of the issues involved within and between dualistically based categories. For example, the meaning of one category often comes about as a result of its oppositional counterpart. In addition, many experiences may not be constructed in terms of an either/or dualism but instead may involve both (for example, feeling both excited and anxious). Thus, while not simply presenting

the positive over the negative, this chapter contains both the positive and negative aspects of the pregnancy experience.

The contexts in which both the positive and negative experiences occurred were many-fold, and thus only a select number were chosen for the purposes of this chapter. The choices I made in selecting which contexts I would highlight were made on the basis of their representation of two highly and recurrently discussed aspects of the pregnancy experiences by the participants: the personal and social reactions toward the pregnancy at various stages. The frequency with which the participants raised their own feelings about, and other people's reactions toward, the changing nature of their pregnancy and body shape was high, and thus I have chosen to explore the multiple meanings these changes held for them.

The data analysis subsection contains four themes relating to the personal and social perceptions and reactions toward the pregnancy. The four themes are: 'Sharing the experience', 'The role of medical interventions', 'Images of body changes (self)', and 'Images of body changes (others)'.

The first theme examines the participants' accounts of sharing their pregnancy experience with others. The ways in which a number of people were seen to have expressed an interest in, and supported, the participants whilst they were pregnant are outlined. Each group of people (e.g. work colleagues and friends) with whom discussions or reflections took place are reported in separate subsections. In this theme only the positive aspects have been highlighted with reference to six of the participants' accounts.

The second theme examines the role of medical interventions in order to examine their influence on the pregnancy experience. Special reference is made to the hearing of the heartbeat and the role of the midwife. In this theme the positive aspects and the combined positive and negative aspects related to the medical interventions are outlined with reference to five of the participants' accounts.

The third theme looks at the impact that the changes in body size had on the women at various stages of their pregnancy. The changes in their thoughts about their appearance are outlined, as well as the impact these

changes had on them. In this theme both the positive and negative aspects are explored with reference to six of the participants' accounts.

The fourth theme explores the ways in which other people commented upon the changes experienced by the women as their pregnancies progressed. Here four of the participants' accounts are explored to highlight how a number of women experienced uncomplimentary remarks about the changes in their body shape, and how the pregnancy was often joked about. This theme also looks at the societal reactions that a number of women experienced from strangers, and how for some this was a positive encounter while for others it made matters very difficult.

8.2 Theme one: Sharing the experience

This theme contains five subsections, with each detailing a different set of people with whom the women held discussions (work colleagues; friends; mothers; partners; pregnant others). It builds on theme four of chapter five which examined the dilemmas of disclosure in the early stages of pregnancy. The quotes that appear in the present theme were produced after the twelfth week of pregnancy, since by this later stage many of the women looked forward to sharing the knowledge of the pregnancy.

The extracts presented below show what aspects of the experience they often shared, and the reactions they received from various individuals. Note here that the women did not experience any of the hesitations or dilemmas in wanting to share their experiences evident in theme four of chapter five, where disclosure was an issue for consideration in the early stages.

Work colleagues:

Extract 106 (Pat - diary):

'Back to work Monday and I was really excited about telling my work mates.'

Extract 107 (Doris - diary):

'I told some more of my work colleagues today that I'm pregnant, and they're really happy for me. I feel happy that I've told them because they can now share my excitement and joy when we talk about it, the same as my friends and family can. It's like a secret that only my family and myself shared and enjoyed, and now it seems that the whole world can join in and share our happiness, it's wonderful.'

Here we can see how two of the participants described their feelings relating to sharing their knowledge of the pregnancy. Both the participants were looking forward to telling their work colleagues and, as Doris points out, the reasons for this were related to being able to share the experience (in terms of describing and updating on the progress of the pregnancy and their own feelings about it).

Doris went into detail in terms of describing the reasons why she wanted to tell her work colleagues, and likened the disclosure to a joyous revelation (a previously kept secret being revealed). This revelation was seen to allow 'the whole world' to share a very happy event. Her account graphically illustrates the pleasure she was experiencing in relation to being pregnant, and also shows her positive perception of other people's reactions toward her news. Disclosing the pregnancy was also seen as allowing her to be able to talk about the pregnancy with others, which again was something she particularly looked forward to.

Extracts 108 and 109 come after Doris subsequently shared her pregnancy experiences with her work colleagues. She often told them about the check-ups she received, and how they allowed her to gain an insight into the baby (e.g. hearing the heartbeat, which was interpreted as everything being alright).

Extract 108 (Doris - diary):

'Told some of the girls at work about me and my husband hearing the baby's heartbeat, they were pleased that everything is alright.'

Sharing details such as hearing the heartbeat was a common feature in all of the participants' accounts, thus Extract 108 from Doris' account is but one of the many examples I found of this aspect of the experience.

Extract 109 (Doris - diary):

'One of the girls at work felt the baby move, she put her hand on my stomach just after I'd eaten and the baby was kicking away quite a lot. She asked if the kicking hurt me, I said it didn't it just felt like wind moving around in me. It feels quite funny really.'

In Extract 109 Doris describes the interest that one of her work colleagues has in her experience of pregnancy, and as a result Doris attempts to describe what it feels like to have the baby moving. She also allowed her colleague to feel her baby moving and chose the most likely time that the baby would move (after eating), hence she can be seen to be actively wanting her colleague to feel the movements her baby makes.

In contrast to Doris, Rita constructed her experience of sharing the progress of her pregnancy with work colleagues in terms of mutually shared experiences, as she was able to share her pregnancy experience with those who were also pregnant at work. She points out that it is an advantage for her and her pregnant colleagues to be pregnant at the same time, as it allows them to talk and understand how each of them is feeling.

Extract 110 (Rita - diary):

'In fact there are now 3 of us out of a department of 6 staff that are pregnant. Two of us are expecting in April and the head of the Geography department is expecting 1 month later. We find it's good because we can all talk about it at

work and chat and we all understand how the others are feeling.'

Being able to talk to work colleagues about different aspects of the pregnancy experience was a positive experience for the women in this study. They often discussed various issues with them and looked forward to being able to share their experiences.

Friends:

Close friends were often told about the pregnancy before work colleagues (see Extract 111) and the discussions held with them were often more frequent and more detailed (see Extract 112). As with the sharing of the experience with work colleagues, friends were seen to be supportive and interested in the women's pregnancies.

Extract 111 (Pat - diary):

'The pharmacist confirmed the result was positive and I was over the moon. I felt very emotional. My friend was also very excited (she had insisted on coming with me which I thought was really nice).'

Pat had informed one of her friends about her own suspicions about being pregnant and found her friend to be very interested in finding out whether Pat was pregnant. As can be seen in Extract 111, Pat thought that her friend was being very nice in her insistence on going with her. Pat's friend thus came to know that Pat was pregnant at the same time as Pat, and her reactions were seen to be as strong as her own.

Extract 112 (Doris - diary):

'We chat a lot about our pregnancies and what our similarities and differences are. She's a couple of months more pregnant than I am and what she goes through and experiences, I often wonder if I will be going through the same.'

In Extract 112 Doris refers to the frequency of her discussions with her close friend who is also pregnant. Her friend's experiences are also taken very seriously by Doris, as she points out that it leads to her wondering whether she will experience the same. Once again we can see that the women often compared their own experiences with those of others, although they do recognise the individuality of their experiences and so question whether they will experience the same.

Extract 113 (Doris - diary):

'A friend asked was it a strong movement or was it just a little movement. I told her it varies. Sometimes it's strong and other times not so strong. She said that that would be what she would look forward to when she's pregnant, feeling the baby moving around. I said that it is lovely, and I couldn't wait until I felt the baby moving, it's a really nice feeling that something inside you is part of you and is showing its existence by moving and kicking. It's a life that you have created.'

In the course of describing how Doris experienced the movements of the baby to a friend, she reflects on what the movements of the baby mean to her. Again she describes the sensations she experiences as being 'really nice' and goes on to show the impact the pregnancy has on her in terms of thinking about it as 'a life that you have created'. Thus, in Extract 113 as well as in Extract 107 we can see how Doris comes to construct the pregnancy as being something 'wonderful'.

Mothers:

The help that the mothers of the participants provided was often referred to in the diary entries. There was only one of the participants of this study that had a poor relationship with her mother (who did not get in contact even when the participant wrote to tell her she was pregnant). For the remainder of the participants, similar experiences were described to the ones presented below from three of the ten participants.

From the three participants' accounts we can see how different women reflected upon the interactions with their mothers. Each of the quotes presented describe the positive reactions toward the help and support received from the mothers.

Extract 114 (Rita - diary):

'I had a good talk to mum about how I feel. She can be very supportive at times.'

Extract 115 (Ann - interview):

Question: 'Do you have anyone to help you out?'

'My mum came round to help with my housework. She has been great, always rings me every day.'

Extract 116 (Mary - diary):

'Mum and Mandy came to stay for the weekend. They arrived at 6.30 pm. It's really nice to have some company especially from family. I know that they will help me with the cooking etc. and I won't have to do everything myself.

Mum had made some more things for the baby which are lovely.'

Extract 117 (Ann - diary):

'I am getting out of breath very easily. My mum comes with me when I have appointments which is a great help.'

Extract 118 (Mary - diary):

'Mum stopped until about lunchtime. She helped me sort some things out for the baby ready to be packed in a bag.'

The type of help and support offered by mothers varied from helping with the housework to accompanying the women to hospital visits and helping with the preparations for the arrival of the baby. The help and support received from the mothers of the participants made practical day-to-day

matters much easier for the women. Having a network of support is seen to have positive effects on the women.

Partners:

Women's reflections on their partners' views and levels of support, as with those on the mothers, were interpreted as being helpful. Additionally, the partners were seen to have developed a keen interest in the baby by the way in which they took active steps to become involved in the changes during the pregnancy, as well as the preparations they made for the arrival of the baby.

Extract 119 (Pat - diary):

'Steve's mum and dad were really pleased to see me and when Steve came in from work he proudly showed off my lump to his mum.'

Here Pat interprets her partner's actions to be reflecting the pride he has in relation to the pregnancy. As Pat's pregnancy becomes increasingly visible, her partner can refer to the pregnancy by directing others toward the visible signs.

The visibility of the pregnancy in terms of the increase in their body size and the baby's observable movements was something that the women themselves often looked forward to, not only because these changes were confirmations of the pregnancy progressing (see theme three for further examples and discussion of this point), but also because their partners could also 'see' and be more involved in the experience, as shown below.

Extract 120 (Doris - diary):

'This morning when I woke up I looked at my stomach and there was more of a lump one side than the other, I showed my husband and he felt it and said that he could feel something quite hard. We both were quite excited because we had felt the baby.'

Extract 121 (Pat - diary):

'Steve has booked the day off work so he can come to the hospital and be with me for the scan. He's very excited and I think he will feel more involved when he has seen the baby. So far it's only been me that's seen the baby and heard its heartbeat.'

With the visibility of the pregnancy, the women felt that they were better able to share their experiences with their partners as there was something that the partners could refer to. The ability to be able to feel or see the changes allowed the couples to discuss the pregnancy with the same reference points. Prior to the visibility the women felt that they were less able to share the experience as it was only them that could feel and acknowledge the changes (see Pat's comments at the end of Extract 121).

In Extracts 122-124 Jane describes the ways in which her partner repeatedly goes shopping for baby related items. He is seen to express his interest by the number of times he visits shops that sell baby items and his desire to buy things for the baby (Extracts 123 and 124). Again, these can be seen as outward expressions of acknowledging the pregnancy and the arrival of the baby. The keen interest Jane's partner takes is a positive experience for Jane.

Extract 122 (Jane - diary):

'Adrian bought a book for expectant fathers...

Adrian felt the baby move for the first time.'

Extract 123 (Jane - diary):

'Went shopping to Harrow - Adrian had to go into Mothercare for his weekly fix!'

Extract 124 (Jane - diary):

'Went shopping to Harrow and bought several baby outfits - Adrian just can't stop looking and wants to buy things!'

In Extract 125 Pat describes how she became aware of her partner's anxiety during the pregnancy. The participants often described their partners as seeking to take more of a part of the pregnancy experience, in particular looking forward to when they would be able to take a more active role (after the birth). The lack of control and involvement may explain why Pat's partner was anxious, although Pat saw his anxieties as reflecting his concerns, and therefore his support, and felt she was lucky that she had a partner that was concerned for her.

Extract 125 (Pat - diary):

'Steve worries and my friend told me that Steve had told her that it seems like I have been pregnant forever. He just wishes the baby was born and everything's ok. I don't really appreciate how much he worries I am lucky he is so supportive.'

In Extract 126 Pat again refers to her partner's perceived level of support in that he preferred, and chose, to accompany her to a parentcraft class when it clashed with a works outing. To have a partner that aims to get involved is seen as 'lucky' by the participant. One feminist explanation of this that comes to mind is that this is likely to be in light of the patriarchal system which predominates in western societies, in which fathers have traditionally been less involved in taking care of their children and women are expected to manage and rear the children with little support from partners.

Extract 126 (Pat - diary):

'Steve found out that his Christmas works outing is next Wednesday the same night as our parentcraft class. He said he'd rather go with me and won't go on the outing.'

He's so supportive I'm really lucky. I must admit I'm really glad he's coming with me it wouldn't be the same without him. We like to discuss everything afterwards.

Tonight he massaged my back for me it's good practice!

Pregnant others:

In this last subsection on the sharing of the pregnancy experience two quotes are presented to show how other women in the same position can be seen to be valuable and supportive. Being able to talk to other pregnant women who were previously unknown provided positive feedback and reassurance for two of the participants:

Extract 127 (Rita - diary):

'I got chatting to a really nice woman whose second baby is due in February. We had a lot in common and it was nice to talk to someone else.'

Extract 128 (Doris - diary):

'It's nice to know that I'm not the only one who has fears and anxieties about being pregnant and becoming a mother. It did make me feel a little better talking to the other mothers-to-be about their feelings and worries.'

The above extracts show that the women enjoyed discussing their common experiences. One of the issues this raised for me related to my method of data collection which was carried out on a one to one basis. The enjoyment the women got by talking to people with common experiences has led me to see the value of using focus group discussions as a method of data collection, as this would allow the women to share their experiences. Focus groups would also be more empowering for the women as they would be able to learn from, and be able to interact with, another social network which could be mutually beneficial.

8.2.1 Implications of sharing the experience with others

Overall, in this theme on 'sharing the pregnancy experience' we can note the various ways in which the women came to share particular aspects of their pregnancy experiences with five different sets of people (represented in separate subsections).

There are a number of similarities as well as differences in the types of discourses the participants used with each set of people. The sharing of the experience with different people was important to the women in different ways. For example, the issues raised relating to the role played by their mothers were ones which were mainly based on practical support such as helping with household duties and accompanying the women to hospital visits, while the issues and discussions held with partners tended to be based around the ways in which they were sharing the experience more equally (often as a result of the growing changes in the physical appearance of the woman and the movements of the baby, especially when the fetus could be seen and felt externally). The partners' interest in the baby was also referred to by stating the ways in which they were preparing for the arrival of the baby, and by their desire to look at baby related items/issues. The women described themselves to be lucky in having supportive partners and mothers, and acknowledged this on several occasions.

The role played by work colleagues, friends, and pregnant others was based more on what it felt like to be pregnant, rather than on the sharing of intimate emotions (as with partners). There were some similarities in outward behaviour and the meaning behind the sharing of the experience across the different sets of people (see for example, Extracts 109 and 120, from Doris' account, which show how a work colleague and partner both felt the baby move). However, the type of involvement and the type of support received from each set of people held different meanings. For example, the women were actively seeking to engage their partners, while with friends and work colleagues the emotional involvement was not as evident. It was often the friends/colleagues who asked if they could feel the baby, rather than the women themselves asking them to feel the baby.

The discussions about the commonalities experienced during the course of different pregnancies were discussed with other females (most noticeably with the other women the participants knew who were also pregnant). Again this shows how the meaning and type of discussion held varies in accordance with who is addressed and the person's relationship and ability to relate to different aspects of the pregnancy.

The discussions that the participants held with me during the course of the research have so far not been mentioned. I interpreted the participants' interest in sharing their pregnancy experience with me to be one which they enjoyed, as their commitment to the research remained high throughout the study, which resulted in them providing me with a great deal of information about their experiences (both in their diary accounts and during the one to one interviews). In chapter ten, as part of my reflexive analysis, I have outlined some of the women's comments about taking part in the study and how much they enjoyed this.

Having a range of social networks and being able to discuss the pregnancy experience was, on the whole, a very positive experience for the women in this study. The women perceived other people's reactions and behaviour towards them and their pregnancy to be supportive and involving, in that they too wanted to share the happy and enjoyable aspects of the pregnancy. In theme four some of the negative reactions the women received from others will be presented, and thus sharing the pregnancy experience should not be seen always to be a positive experience for the women.

8.3 Theme two: The role of medical interventions

In this theme a select number of quotes have been used to show how different women experienced certain medical interventions. There were numerous medical interventions that the women encountered during the course of their pregnancies (with for example, midwives, doctors, and nurses). Of these, a number of the visits were perceived to be very positive experiences, while others were perceived to be simultaneously positive and negative, in that the women were looking forward to certain appointments but were also anxious and concerned about what would happen.

Within this theme a brief examination will be made of the impact certain medical interventions had on the participants, in terms of how they felt about the interventions and the information they received as a result. The quotes that have been chosen highlight the positive aspects and the aspects that caused both positive and negative feelings simultaneously. In various other

parts of this thesis reference has been made to the negative aspects of some of the medical interventions, and therefore the solely negative aspects are not exemplified here.

Extracts 129-132 show the level of importance that was placed on being able to hear the heartbeat. Extract 129 shows how Doris felt while she was waiting for the day of her first hospital appointment, while Extract 130 shows what happens when she attends the appointment.

Extract 129 (Doris - diary):

'I am also getting excited and nervous about my 1st hospital appointment on Wednesday. I'm wondering what tests they will do, and if they will be listening to the baby's heartbeat, and if so will I get to hear the heartbeat. It's all so new and exciting but at the same time quite frightening because you don't know what to expect. Still Wednesday will tell all.'

Doris is unsure of what her visit will entail, and feels both positively and negatively toward the appointment. She looks forward to the appointment in so far as she wants to be able to hear the heartbeat but is also concerned about the possibility of not being able to hear it. Doris, unlike Pat (see Extract 131), makes explicit the reason why she would like to hear the heartbeat and relates this to finding out whether the baby is alright.

Extract 130 (Doris - diary):

'Well today is the day that I've been looking forward to and also feeling nervous about... When I got to the hospital the staff were very helpful and friendly to us. (My husband came with me)...

We waited a further 15 minutes and then went to see the doctor, this is what we'd both been looking forward to, hopefully we were going to hear the heartbeat of the baby. I was especially looking forward to this because until you hear the heartbeat you do have thoughts going through your mind as to whether everything is alright, I was worried that

perhaps they may not be able to hear a heartbeat then I would have been very worried, Oh I was feeling very anxious at this stage. They put the gel on the lower part of my stomach... there it was, we heard the heartbeat... I looked at my husband and he had the same delighted look on his face that I must have had on mine. We heard our baby's heartbeat.'

The procedure by which the heartbeat can be detected, and the subsequent sharing of the information with the husband, is referred to in Extract 130. Having heard the baby's heartbeat Doris, like Pat (in Extract 131), shows that this means a lot to her, in so far as her and her husband gained the information they wanted.

Notice also that in Extract 130 Doris does not provide any details about the rest of the appointment, which can be taken as a further indicator of how important the listening of the heartbeat was for her. Other details which are likely to have been provided during the appointment may well have passed her by, given that she does not refer to them at all in her diary account of the day. Alternatively, she may not have considered the other details to have been important enough to note in the diary.

Extract 131 (Pat - diary):

'I forgot the most important part of my visit from the midwife. She went out to her car and brought back a device by which you could hear baby's heartbeat. She rubbed a jelly substance on my tummy and tried to find the heartbeat. My insides were very noisy and it took some time to find the heartbeat but eventually we heard it - it was so exciting she showed me how to feel my pulse which was slow and normal and we compared it to baby's very fast heartbeat it was thrilling.

...After she left I rang Steve in his shop and told him I had heard the baby's heartbeat.

He was really excited but sad that he hadn't heard it as well.

I think I bored everyone to death telling them I had heard the heartbeat.'

Extracts 130 and 131 are good examples of the type and level of detail a number of the women provided when they were describing their experience of hearing the heartbeat. What is noticeable in these quotes is that the women experience a mixture of feelings about their pregnancy related visits.

In Extract 131 Pat highlights that the most important part of the midwife's visit for her was related to being able to hear the heartbeat. Having heard the heartbeat Pat uses this information in a very positive way (becoming excited and using it to tell others about the pregnancy). The number of times she referred to having heard the heartbeat ('bored everyone to death') shows how much it meant to her. In addition, the way in which she describes the whole experience (giving details such as having the jelly substance put on and comparing the pulse rates) can be taken to be a further indicator of the high level of impact this intervention had for her.

Extract 132, taken from Karen's account, shows the importance that she placed on hearing the heartbeat even in the later stages of the pregnancy. Thus, although hearing the heartbeat is considered to be very important and significant in the early stages, we can see that for Karen the importance continues, as hearing the heartbeat provides her with continued reassurance that the baby is still alive. Karen had previously had a number of miscarriages, some of which had occurred after the twelfth week of pregnancy, and thus she had past experiences which were leading her to want to be continually reassured.

Extract 132 (Karen - diary):

'The midwife came today and brought the sonic ear with her. We were able to hear the baby's heart beating (what a relief). The midwife told me that if I had phoned the labour ward a midwife would have come out at anytime

because they are on call for 24 hrs. I wish I was told this then I wouldn't have worried so much.'

In the diary accounts, other participants did mention the times when they heard the baby's heartbeat in the later stages, although they did not provide graphic details in relation to these instances in the same way as they had in the earlier stages. Thus, although the heartbeat was still important, the familiarity of the event, as well as possibly having other indicators of the well-being of the baby, meant that the accounts relating to their occurrence and the meanings behind them were not seen to be as powerful. For participants such as Karen the significance, however, remained high. This shows the importance of investigating the individuality of experience.

In Extract 133 we can see that the role of the ultrasound scan in terms of finding out whether the baby is okay is also considered, and thus, like the listening of the heartbeat, scans help in identifying the baby. This issue is addressed in the next chapter in more detail, and thus only one extract is provided here to illustrate the point.

Extract 133 (Rita - diary):

'I'm really looking forward to going to the hospital tomorrow for my first antenatal appointment.

I hope I can have a scan to prove whether everything is ok and to see how many there are!'

Here Rita mentions how she is looking forward to the hospital visit, and thus this extract serves as another example of the many differing positive experiences women have during the course of their pregnancy.

The remaining four extracts have been taken from Ann's diary accounts, and show how she variously considers the role of medical interventions and their consequences.

Extract 134 (Ann - diary):

'Have mixed feelings about going to the hospital tomorrow. I'm looking forward to it but at the same time feel apprehensive.'

Here Ann, like Doris (see Extracts 129 and 130), points out how she is experiencing a mixture of feelings in relation to her hospital visit. Thus, again we can see how women can feel both positively and negatively toward the same event.

Ann began to experience difficulties with her pregnancy during the second trimester, and as a result sought help and reassurance outside of the routine antenatal visits. After the complications subsided, Ann found that she was missing the attention she had received. This was a result of the changes and adjustments she had to make to her own routine when the visits were required, and once the extra visits were no longer required she had to establish a new routine which was not based around the hospital visits.

Extract 135 (Ann - diary):

'Now that things have settled down, I feel I want something to happen. Maybe because I have had so much attention, keep going to the hospital and seeing the doctor, that I miss it.'

Extract 136 (Ann - diary):

'Have been thinking a lot lately if the baby will come before expected due date.

I also want to be more prepared for the birth and more in control.'

In Extract 136 Ann continues to want something to happen (as was initially presented in Extract 135), and as a result begins to think about the arrival of the baby. However, she now shifts from wanting medical interventions to wanting to be in control herself. She later mentioned in an interview she was considering a home birth to achieve this goal.

Once the baby was born, and the routine antenatal care had finished, Ann was disappointed in losing the contact/relationship she had with her midwife. She had become quite close to her and mentioned her specifically in the diary toward the end. She wanted the relationship she had with the

midwife to be acknowledged and felt that the interactions with the midwife were enjoyable and helpful:

Extract 137 (Ann - diary):

‘Denise the midwife visited me for the last time today. I must say that she was great and I felt that I could ask and tell her anything, which I think is very important.’

The role of the midwife was for all ten participants a positive encounter. The help and support they received was valued and the participants looked forward to their meetings, and thus the role of the midwife in contributing to the positive pregnancy experiences can be seen to be central. However, once the intense contact ends the women experienced a sense of loss, and so we can see that there are some disadvantages to having developed a short term relationship for the women. Having said this the advantages outweighed the disadvantages for this close relationship.

The small number of extracts presented in this theme on ‘the role of medical interventions’ do not fully highlight the many and varied descriptions that appeared in the participants’ accounts. To have provided a full account would have meant devoting a full chapter to this theme and, as there were a number of themes I wished to make reference to, I chose to select a very small number. In the next chapter further reference is made to one particular type of medical intervention (the ultrasound scan), and examples related to this theme again appear later in the thesis, meaning that the material presented here should not be seen in an isolated way.

What can be noted from the data analysis presented in this theme, is that the ability to hear the heartbeat was a very exciting and meaningful experience for the participants in the early stages of the pregnancy, while for those who experienced difficulties in pregnancy the significance and meaning continued till the end. The significance that they placed on such interventions may well have related to the reassurance and confirmation of the pregnancy that they provided. Being able to hear the heartbeat may have been desired as a result of the lack of other indicators relating to the reality of the pregnancy in the early stages.

Listening to the heartbeat was a positive experience, although the lead up to this produced anxiety for some of the women (see Extracts 129 and 134), and thus we can see how the positive and negative aspects cannot be separated, as they are experienced simultaneously, or at least are both present in relation to the same event/issue.

8.4 Theme three: Images of body changes (self)

One of the most noticeable changes that occurs with the progression of the pregnancy is the increase in the woman's body size. In this theme I will explore how the women reflect on the changes that occur to their bodies, in order to highlight the multiplicity of the interpretations they make in relation to these changes. Again the positive and negative interpretations made will be highlighted.

Extract 138 (Pat - diary):

'Whilst in the car park a young man came to my car and offered his pay and display ticket to me as it had two hours left - I thought that was a very nice gesture and when I got out of the car I wanted to say thanks and his friend shouted out that he would like my phone number. I laughed to my sister but felt this was a great compliment as I feel very unattractive at the moment, with my spots, dry hair and big breasts. I love my lump but it's nice to think you are still attractive when pregnant. Steve laughed when I told him. He thinks I should know that I am still attractive.

I am looking forward to getting bigger. At the moment, especially this morning I look like I've just had a good meal!

In Extract 138 Pat reflects on the changes that are occurring to her appearance as a result of the pregnancy. She feels that the spots, dry hair and big breasts make her unattractive and as a result of this sees the request for her telephone number by an unknown male to be complimentary, as this implies she is not unattractive.

Pat goes on to say that she likes one particular change (the increase in the size of the 'lump') and thus we can see that certain changes are more readily accepted than others. The 'lump' is not perceived to be unattractive (although it is as yet fairly small), while other physical changes that Pat is experiencing are.

Pat does want to be known to be pregnant in that she is looking forward to getting bigger, although there is an element of ambiguity in her account. Although she loves the lump, and is looking forward to it getting bigger, she may well see this to be desirable only in certain respects (e.g. as a reference to the baby), but in other respects she may see it as also making her unattractive (especially to males). This is because the same change can have multiple meanings, and can affect the woman in different ways, depending on the context of interpretation the woman herself is using in relation to the pregnancy (e.g. thinking about the self or the baby).

The desire to get bigger around the stomach was a common feature of all of the participants' accounts during the early stages of pregnancy. As can be seen in the next three extracts, taken from Karen and Doris' accounts, the women are pleased to be looking pregnant.

In Extract 139 Karen explains that she likes looking pregnant, although she does not want to put on too much weight as this would make it harder for her to come to terms with the possible potential loss of the baby, as the weight she would have to lose afterwards would be a reminder.

Extract 139 (Karen - diary):

'I am getting bigger and bigger around the stomach which I like. I haven't put on as much weight on this time, with my last pregnancy I was a stone heavier than I am now. I suppose I have been watching what I eat just in case I lose it, then I won't have so much to lose afterwards.'

In the following extract Karen again acknowledges that she is pleased with her weight gain but again qualifies this with a reference to it being due to the level of weight gain being lower than it was with two of her previous pregnancies. The level of control she is exerting in keeping the weight gain to

a minimum is having other effects in that she needs to take supplements for nutritional purposes.

Extract 140 (Karen - interview):

Question: 'How do you feel in yourself?'

'I'm still pleased with my weight I am still a lot lighter than I was when I was pregnant with my son and my daughter. I am taking vitamin and iron tablets now.'

The pleasure related to the weight gain in Karen's account can be seen to be constructed in light of her fears about losing the baby and in relational terms with previous pregnancies.

In Extract 141 Doris shows her pleasure in having gained in size around the stomach, as it means that the weight gain can now visibly be seen to be related to her pregnancy rather than the alternative explanation of her just being overweight. In Extract 142 Pat also refers to the possibility of mistakenly being considered overweight, and as a consequence finds herself informing other people that she is pregnant so that they do not perceive her as being overweight.

Extract 141 (Doris - diary):

'Now I'm looking pregnant and not just overweight. It feels quite nice being big because you are pregnant. It's tiring though as you get bigger.'

Extract 142 (Pat - diary):

'I bought a size 14 green jacket for the christening which had plenty of room in it. I wouldn't normally have chosen it but lack of variety and time meant I had to get something quick. Whenever I try things on lately I feel I have to explain to the assistants that I am pregnant in case they just think I'm fat! Silly really.'

Toward the end of Extract 141 Doris shows one of the consequences of carrying the extra weight. The problems encountered during the pregnancy were often reflected upon by the women. Extracts 142 and 143 provide further

examples of how the changes in size and appearance resulting from the pregnancy can lead to different types of problems (finding suitable clothes and changes to the skin).

Extract 143 (Pat - diary):

'Perhaps I'm starting to 'bloom' I doubt it as my hair and skin are so dry and I seem to be more spotty than usual even on my chest. I also noticed whilst in Spain that a freckle had appeared on my face. It is very noticeable and Dr (name) explained that this is common in pregnancy as the pigment in your skin can change. I was relieved to hear this as I was thinking the worst Malignant Melanoma perhaps? At least I don't have to worry about that as well.'

In Extract 143 Pat is referring to the mid stage of pregnancy in which many women are thought to 'bloom'. However, in Pat's case she does not feel as though she can identify with this aspect, given that she is still experiencing problems with her hair and skin (as was also described in Extract 138).

In Extracts 143 - 145 we can see how the women thought about their pregnancy in terms of stages, with each stage being expected to bring about different sorts of changes (see also Extract 153 for a further example).

Extract 144 (Doris - diary):

'I don't think I've put any weight on since a week ago, and other days I think I'm putting on a couple of lb on each day. It's quite funny how you notice yourself getting bigger more days than others.'

Extract 145 (Doris - diary):

'I suppose you put the weight on in stages. One minute you hardly notice your pregnant, the next you think you're having twins. At least I know I am having one child and not twins.'

In the next set of extracts the changes to breast size and their effects on the women are considered. For Doris the changes led to a positive

experience, while for Pat and Sandy the changes led to negative experiences. The reasons provided for why the women felt as they did are contained in each of the quotes.

With the differences found across the differing accounts, the need to consider both the positive and negative reactions, as well as the individual and general aspects of the pregnancy experience, becomes more evident. Taking a phenomenological approach allows the complexities of the experiences to be noted within context. What can be seen in this data analysis subsection is the way in which the experience of the same event can be, and has been, variously constructed and interpreted by different participants.

Extract 146 (Doris - diary):

'I have noticed that my breasts are getting bigger. In fact it's quite nice to have a bit of a bust because normally I'm quite small in the bust.'

Here we can see that Doris likes the changes that have occurred to her breast size as a result of the pregnancy, while the following extracts show that Pat and Sandy feel more negatively about the changes:

Extract 147 (Pat - diary):

'I went shopping with my sister this afternoon and bought a 36c bra which is much better. I daren't buy too many of the same size as I am certain in a few weeks I will have changed again.

I must admit I am very self-conscious of my breasts they look so large and are so firm. My sister laughs when she sees them. Sometimes I get a little sensitive about them.'

Extract 148 (Sandy - diary):

'I really am looking huge these days, especially as I'm so short. Getting sick of my maternity clothes, too.

Found a nice linen shirt in my wardrobe - size 8! Will I ever be able to wear it again? My latest bra size is 40DD!! I don't look so enormous while the bump is bigger than my bust, but when I give birth I'm going to look ridiculous.

Five foot nothing and a 40 inch bust!

In Extracts 147 and 148 Pat and Sandy are concerned about the changes to their breasts due to their large appearance (rather than pain or tenderness, which was a problem for a number of women). The rapid increase in size requires the women to adjust very quickly, and yet, as the two extracts above show, the adjustments are not easily made. The level of the increase may also be one of the reasons why some of the women found it difficult to adjust, with Sandy explaining that she went from a 34 inch bust to a 40 inch bust, and Pat moving from a 34 inch bust to a 37 inch bust by the fifth month of the pregnancy (Extract 149). Such dramatic changes in such a short space of time leave the women feeling very self-conscious.

Remaining with the theme of interpreting the dramatic changes to the body, and the women's feelings in relation to these, the following extracts show how the increases to the body begin to become progressively more difficult to handle. Pat, in Extract 149, describes how she feels she has put on enough weight and thus wants less dramatic changes to occur. Thus, from wanting the lump to grow (see Extract 138), she now wishes for the weight gain to slow down:

Extract 149 (Pat - diary):

'I measured my chest today and I am 37 ins! I have gone from 34 - 37 ins in five months. I also weigh 10 stone 4 lbs which means I have now put on 1 stone. I hope I don't put on more than 1 more stone.'

In Extract 150 Pat describes how she feels in relation to the amount of weight gain when five months pregnant. She feels that she is bigger than she should be. Making such comparisons was also a feature of other participants accounts, and Extract 151 from Doris' account provides a further example.

Extract 150 (Pat - diary):

'I caught a glimpse of my self in a shop window today.
I look so big! I look more like 7 months not 5!'

Extract 151 (Doris - diary):

'I showed the other girl at work (magazine) and we were discussing the size of both our baby's at this stage. Also how big we should be at this stage. I seem to be a little fatter in the stomach than the magazine says I should, but I suppose all people are different when it comes to the size you should be. People do carry differently, and some put more or less weight on. I said to the girl at work, it's probably the food I'm eating, I do seem to be making a pig of myself lately. Still I blame it on the baby being hungry.'

Doris shows how she uses a magazine article to make comparisons. Being bigger than the article states as 'normal' leads Doris to justify why she is bigger than what might be expected. However, she also acknowledges the differences between women and therefore does not feel too negatively about her weight gain. In Extract 152 (which was written a few days later) Doris begins to think of different reasons as to why she may be bigger than expected and now shifts from joking (in seeing the baby being to blame) to considering more serious explanations:

Extract 152 (Doris - diary):

'I do seem to be getting quite big maybe I'm carrying a lot of water.'

Further still, in Extract 153 Doris changes her account from thinking that she is too big to one which indicates that she herself does not think this is the case. Instead she suggests that it is other people who think she is big.

Extract 153 (Doris - diary):

'Looked through some pregnancy magazines to find out how big the baby is at this stage. It's surprising what size the baby is. The photograph shows the baby to be quite big

now, and yet I don't feel that big, in fact I don't really think I look that big compared to other pregnant women who are as far gone as I am. Some people think I'm a lot bigger than most people who are as far gone as me.'

Such contradictions across time show that the women change their views about how they look, and thus feelings related to the changes in the body are not static (a point acknowledged in Extract 151).

In Extract 153 Doris believes that her own size is not so big given that the size of the baby is big (due to the stage of the pregnancy). Another reference point she uses to judge her own size is the size of other women who are at the same stage of their pregnancy as her.

In the following four extracts the mixed feelings relating to the way the women perceive themselves to look are highlighted. We can see how the women both want to look pregnant, while also wanting the look to be self-contained (concentrated around the stomach and not too much).

Extract 154 (Rita - diary):

'I wonder whether I'll carry on putting weight on all over, at this rate I'll look like a balloon. You expect the stomach to grow and that's quite nice but as for the rest of it.'

Extract 155 (Pat - diary):

'My weight is definitely all at the front, I hope it stays that way.'

Pat was satisfied with the weight gain being concentrated around her stomach, although she did not know whether this would remain the case and therefore she could only 'hope' that it would be so.

The lack of control that the women have in terms of the ways in which their bodies will change means that they are faced with a number of ambiguities. As a result they often refer to wishing or hoping for the changes to their body to occur in certain ways. Other mechanisms by which the level of weight gain was judged used the compare and contrast formula. Some of the women compared their opinions with those expressed by others:

Extract 156 (Jane - diary):

'My tummy feels to me to be enormous although everyone else thinks it's 'neat' or 'dinky'!!'

Jane shows how there are differences in opinion as to how big she looks, and thus this was another form by which ambiguities crept in.

Extract 157 (Pat - diary):

'I felt really fat and gross as I watched my sister trying on swimsuits, she looked so trim next to me. When I commented to her she said - well you can't have everything can you? Of course she's right and I wouldn't change my situation for the world.'

Pat is envious of her sister's figure and what is noticeable is that she wants both her figure and the pregnancy. As there is a conflict she sides toward the pregnancy, although there is an element of regret about losing her figure to achieve this.

As the women reached the final stages of pregnancy (*the third trimester*), they became more and more dissatisfied with the way they looked and felt. The extra weight made things difficult for them, and they now no longer wanted to look heavily pregnant (or on occasions still be pregnant). This was especially the case when they were out at social events. During this stage the women started feeling quite detached from their bodies as they often could not identify with the changes that had occurred. Some went as far as considering themselves to be purely vessels, simply there to carry the baby. Given this shift in thinking, the images of the self as being a vessel will be provided at the end of this theme (Extract 163 onwards). Prior to this I will present the ways in which women held mixed feelings about the way they looked, and progressively became more dissatisfied in the later stages. These changes can be contrasted with the way they felt (happy and satisfied) earlier on in the pregnancy (see for example Extracts 139 and 141 above) to show how changes occurred across time (at different stages) as well as having mixed feelings within a particular stage.

In Extracts 158 and 159 Karen makes explicit her mixed feelings about both wanting to be pregnant and also wanting to have had the baby so she can get her figure back:

Extract 158 (Karen - diary):

'Went to a wedding today I really felt fat compared to all the other people that were there. One minute I want to be quite big and then when we go out somewhere like to a wedding I wish that I had my figure back.'

Extract 159 (Karen - diary):

'I'm feeling really fat now, I can't wait until I've had the baby and can get my figure back. I don't think it bothers Steve how big I get, it doesn't put him off at all.'

Feeling fat was a commonly expressed concern, and as a consequence the women were keen to see the pregnancy completed so that they could regain their figures.

In Extract 160 Doris describes the level of changes that have occurred by stating the size of clothes she presently fits into compared with before her pregnancy. Again for Doris the pregnancy is referred to in terms of making her feel fat:

Extract 160 (Doris - diary):

'I feel quite fat being able to fit in size 16 clothes when I'm normally a size 12.'

In Extracts 161 and 162 Doris and Pat explain the way the pregnancy is making them feel. The feelings are described in relation to the difficulties they are experiencing:

Extract 161 (Doris - interview):

Question: 'What physical changes are you experiencing?'

'I'm not so steady on my feet now I'm putting on weight, my balance isn't as good now. I'm starting to waddle now, it's quite annoying really. I'm feeling fat and ugly.'

Extract 162 (Pat - diary):

'I felt very heavy and bloated today. Not like I'd eaten too much, but just that I felt very heavy in my stomach. It felt like the baby was lying stretched out, instead of curled up like a ball. I even thought I looked a lot bigger today in the stomach. Every thing seemed like an effort.'

The above extracts show how Karen, Doris and Pat are dissatisfied with the way they look. They also highlight some of the problems they are experiencing toward the end of their pregnancy, which may well be contributing toward their dissatisfaction with the way they look and feel. All three women relate their feelings to their increased size.

8.4.1

Image of self as a vessel

The following extracts have been selected to show how the women experience the pregnancy in terms of conflicts of interest. For example, at times they see the demands that the baby is making on them to be in direct conflict with what they would want (e.g. amount of food and rest required), while at other times they reflect on what is of relevance to both the self and the baby, and thus show no conflict of interest.

The women also reflected upon the way in which, at times, they felt totally detached from their bodies during pregnancy in that they felt their bodies were not their own:

Extract 163 (Sandy - diary):

'It's hard to reconcile feeling ugly and feeling sexy at the same time because one should cancel the other.

Still, Paul doesn't seem to mind my being huge, so I suppose that's lucky!

Feeling detached – body not your own doesn't feel like me.'

Here Sandy reflects on the contradictory feelings she experienced during her pregnancy. Sandy experienced a range of emotions whilst pregnant and felt differentially toward the way she looked throughout her pregnancy. She described on a number of occasions that she experienced a heightened sex drive and yet at the same time found herself to be ugly because of her weight gain, which for her was a contradiction.

The weight gain made it difficult for a number of women to see their bodies as their own, and this was especially the case when they had to change the ways in which they operated within small spaces:

Extract 164 (Jane - diary):

'I'm finding that I can no longer 'squeeze' in between chairs and desks and people - I get caught more often than I make it. I can't hold my tummy in however much I try! It's strange but I haven't quite adjusted to big boobs and big belly - it still seems a bit detached like it's not really me.'

Jane, like Sandy, explains how the changes to the body are difficult to identify with. She also points out the ways in which she attempts to still get through narrow spaces without success.

In the next extract Rita explains how the demands of the pregnancy mean that she feels her own desires have to come second to the needs of the baby. Being a diabetic, Rita had to control her diet and forgo some of the foods she could eat prior to the pregnancy. The restrictions meant that she felt that her own body was a vessel which was there for the development of the baby. However, as she knew that the restrictions were for a purpose she accepted them by considering the welfare of the baby.

Extract 165 (Rita - diary):

'...I daren't eat anything like that at the moment because of the baby and my blood sugars. It does feel sometimes as though I'm only around to provide a 'safe and healthy' place for the baby to develop. However I don't really mind as it's for a good cause.'

In Extracts 166 and 167 Doris also shows the ways in which contradictions occur as a result of looking after the interests of the baby. She experiences the needs of the baby to be demanding and in direct conflict with what she would ordinarily have done. The lack of control she perceives herself to have leads her to think of the baby's needs to be totally separate from her own, and to see the baby as having power over what she has to do.

Extract 166 (Doris - diary):

'It's as if the baby is making the decision for you, saying 'come on feed me I'm hungry' or 'You have to go to sleep because I want my rest'. You don't seem to have as much control.'

Extract 167 (Doris - diary):

'I seem to be eating a lot lately...I suppose it's because the baby's getting bigger and needs more feeding, but I feel such a pig eating and eating nearly all day long.'

In the next extract Doris describes the changes to her stomach in a negative way, yet she does not equate the stomach size with the baby. The baby is described in more positive terms and thus we see how women can think positively about the baby but negatively about themselves whilst pregnant. In this extract, Doris does not see a conflict of interest between herself and her baby in that she herself enjoys the swimming and wonders whether the baby does too.

Extract 168 (Doris - diary):

'My huge bump of a stomach didn't feel heavy at all. Also while I was swimming around I felt the baby moving, I wonder whether the baby was enjoying the water as much as I was.'

Overall, in this theme I have attempted to show how the women change their views about the increases to their body sizes and what they mean to them. Taking a feminist approach, and relating these findings to feminist literature, we can begin to understand why the women may feel as

they do (often very negatively) about the increase in size. Women have been treated as objects of desire, and thus their levels of attractiveness become a central component. One of the ways in which attractiveness is judged is by the comments received from others. Pat, in Extract 138, shows how she felt complimented when she was asked for her phone number (which was an indirect reference to her attractiveness), although, as a feminist, I would have seen this type of request as a slight on my persona. What these differences in interpretation show is that we differentially interpret the sexist behaviour we come across in society. It is such differences that led feminists to engage in consciousness raising as *one of their main goals for feminist practice*.

As women have been treated as 'objects', we can see how the pressures to conform to particular types of appearances have led to them wanting to keep the changes to their body to a minimum. Thus, although the pregnancy is desired, and the women on one level wish to see the changes in size (as it is an accepted part of being pregnant and reflects on the pregnancy), they also come to perceive these changes in a negative way, with this resulting in them feeling complimented if they are perceived to be still quite small in size. One of the reasons for this may relate to the social construction of what is considered beautiful in our society. Thinness is equated with beauty, and being fat is something that leads to discrimination and is perceived to lower the sexual appeal of the woman. As a result we can see that Pat, in Extract 142, seeks to qualify her size by stating that she is pregnant rather than fat or overweight, and Sandy, in Extract 163, sees feeling sexy at the same time as feeling ugly (due to the increase in size) to be a contradiction.

Given the social context in which personal interpretations are made, an examination of the ways in which others perceive pregnant women will be outlined in the next theme to show how the treatment of women occurs on an explicit level. The opinions of others as experienced by the participants show how women operate within a system of expectations.

8.5 Theme four: Images of body changes (others)

In this theme, as with the previous one, a range of perceptions and reflections relating to the ways that pregnant women look over the course of pregnancy will be outlined. This time the accounts that the women provided in relation to other people's views about them will be used. One of the main points of similarity between the accounts provided by others (as described by the women) and those of the women themselves relates to the progressive changes, from the use of positive constructions to more negative constructions, over time.

In order to illustrate these changes, the accounts provided by two of the ten participants will be used. Pat and Doris' accounts have been chosen as their accounts were more widely used in the last theme, and thus their accounts provide a level of continuation.

In Extracts 169 and 170, Pat and Doris describe how their pregnancies were becoming more visible. As well as the visibility becoming more apparent, the women were also finding that their appetites were increasing, and this in turn was also being considered by the people that they were in contact with:

Extract 169 (Pat - diary):

'Getting more and more comments, from colleagues on how I am starting to show. My appetite is increasing one lady in the canteen seems to give me extra portions now.'

Extract 170 (Doris - diary):

'My husband said that my appetite had certainly got bigger, and my family agreed with amusement when they saw how much I had eaten tonight. Also we discussed just how big I am getting, considering I'm only four months pregnant. My husband jokingly said that most of my stomach is food and only a little bit of my big bump is the baby.'

The changes that occurred in the early stages, and the comments and reactions received, were not interpreted in a negative way by the women. However, when the women were at their midway stage, comments relating to

being smaller than one would expect were seen to be pleasing, hence the smaller the increase, the more positive the interpretation:

Extract 171 (Pat - diary):

'Our friends were really pleased to see us and were surprised I wasn't bigger. My friend Jan said there was nothing of me which made me feel better. They both thought I looked well. They have two children and Jan said she put on 3 stone when she had her son and much less when she had her daughter. With her daughter she just put on weight on her tummy and bust but with her son she put weight on all over. So looking at me at the moment we decided it must be a girl.'

Pat describes how the way the woman carries is variously interpreted in terms of identifying the gender of the baby. This form of cultural interpretation will be discussed in more detail in the next chapter. What can be noted here is the way in which the increase in size is interpreted on the basis of the gender of the baby rather than on the basis of the woman herself.

In Extract 172 Pat describes how others can mistake the woman to be just putting on weight whilst in the mid-stage of pregnancy. Again, Pat saw this as a compliment and was pleased to be receiving such comments.

Extract 172 (Pat - diary):

'Someone at work whilst I was in the queue for lunch heard me discussing my lump and commented that she had no idea that I was pregnant and that she thought I was just putting on weight!'

For Doris the weight gain was more marked, and thus she received a number of comments relating to how big she was getting even in the early stages. At this stage Doris did not reflect on the way she interpreted the comments she was receiving.

Extract 173 (Doris - diary):

'Went and saw one of my friends in the evening. She hasn't seen me for about six weeks and she was surprised at how big I was. She said I was certainly showing now and was surprised at how much weight I had put on in such a short time.'

The changes occurring to one's body were not only described in the diaries, but were also described to those in a similar situation. Sharing the experiences, and noting the similarities across women, show how the pregnancy experience is seen to be both a very individual event as well as a shared common experience:

Extract 174 (Pat - diary):

'A colleague of mine asked me about my visit from the midwife as she is having hers tomorrow. She tells me of the changes in her body and I think she is reassured by the fact that I have experienced similar changes.'

In the next two extracts Pat describes how she was variously being described by others (in non-flattering terms). In Extract 175 she describes how her brother in law uses a characterisation/stereotype to describe the way she appears.

Extract 175 (Pat - diary):

'Steve's brother came round and he said I was developing a really noticeable pregnant type walk!'

In Extract 176 Pat describes the way in which her ex-boss was characterising her in a derogatory manner. Although Pat says she did not mind being called a 'fatso', she finishes her account by saying how she did feel unattractive and fat at times. Here we can see how the ex-boss considers it to be acceptable to call a pregnant woman fat, and how he uses Pat as a reference point to state that this would normally be unacceptable to her.

Extract 176 (Pat - diary):

'I met my ex-boss this evening as it was his birthday. I had a glass of wine which was very nice.

He kept calling me fatso but I didn't mind. He said that 6 years ago when I worked with him I would have been really upset at putting on 10 lbs in weight!

I don't really mind but some times I do feel so unattractive and fat.'

In Extract 177 Doris describes how members of her family comment on the size she is, and shows how she differs in her opinion from that expressed by others. Again, what we can see is that her size is seen to be more than it should be, and this in itself is something the women thus consider from their own perspective as well as from others.

Extract 177 (Doris - diary):

'My brother and his fiancée told me how big they thought I had got since last week. They said that when they haven't seen me for a while they notice it more than they would if they saw me everyday. I said I notice it now and again. But I don't think I'm as big as other people make out.'

8.5.1

The experience of differing reactions toward pregnant women in society

In the remaining extracts (taken from three of the participants' accounts), descriptions of how the women were treated whilst in a social environment are provided. The interpretations that they made about the treatment they received will also be highlighted in order to show how individuals interpret the behaviour of others, and to highlight the discursive formation of self identity as part of the process.

In Extracts 178 and 179 Doris and Sandy show the ways in which other people reacted towards their pregnancies. Both of the women experienced people coming up to them wanting to feel the baby. The two women did not object to this, and indeed Doris enjoyed the interest that was being paid to her.

On a personal note, whilst I was pregnant I also experienced people coming up to me to ask whether they could feel the baby. Before I could reply that I did not want them touching my stomach, they would already have done so. This showed that the request was not posed as a question, but instead was there to indicate the behaviour that was immediately going to follow. For me it was an invasion of my personal space, and a behaviour that most people would object to if they found acquaintances just coming along and touching them if they were not pregnant. Thus, being pregnant is interpreted by some to be an open invitation for invading the woman's private space. For me, this was a further confirmation of the way in which the woman's body comes to be seen as a vessel, with the interest being directed toward the baby. Such experiences can thus (as was the case for me) be experienced as disempowering.

Extract 178 (Doris - diary):

'Went out in the evening for a meal and the baby seemed to move about a lot while I was eating. It's quite incredible just how many people touch your stomach when your pregnant. A lot of people have felt my stomach and hoped to feel the baby moving. Some have felt it move and thought it was nice. It's nice that so many people at work are interested in my pregnancy and how it's going. Mind you I have found that people seem to be more friendly and chatty to you when your pregnant. Maybe they look at you as being fragile when your pregnant. It's nice though being treated like a fragile doll. Every one seems so friendly towards you.'

Doris points out that having people come up to you in order to feel the baby is a common experience. It becomes a talking point, which for Doris was

a nice experience. Being considered 'fragile' for Doris showed that she thought that she had a special status which required being cared about. Again, this is a very individual interpretation and one that I would consider to be quite sexist, in that the woman would be deemed to be unfit to operate on an equal basis with others whilst pregnant.

Sandy also makes clear how often she was approached and touched as a result of the pregnancy. This serves as another example of an invasion of personal space and being treated as a vessel.

Extract 179 (Sandy - diary):

'My stomach ended up getting touched by a lot of people again wanting to feel the baby moving.'

Sandy describes the kindness she experienced when she was out socialising with friends. All of the participants enjoyed being asked about their pregnancies, and often described in detail how they were feeling in response. Being asked about the pregnancy was a way of sharing the pregnancy experience, and thus this extract serves as another example of sharing the pregnancy experience (which is the topic of theme one).

Extract 180 (Sandy - diary):

'It was good fun and I enjoyed my self.

Lots of enquiries about my health and the baby.

People are very kind.'

In Extracts 181 and 182 Doris and Mary show the differing reactions they experienced whilst out shopping. Doris found people to be very caring and accommodating, while Mary found the opposite:

Extract 181 (Doris - diary):

'I went shopping today, and I found it quite interesting in how people treat you because you are pregnant. It was nice, people seemed to go out of their way to assist me in helping me get items off the shelves. Also, while I was standing in the queue the assistant came over to me and

asked me what I wanted, I told her and she said I won't keep you waiting, I know you shouldn't be standing for too long in your condition. Then she hurried the other assistant up with my order so I wouldn't be kept waiting for too long. It seems that everyone is more friendly towards you when you are pregnant. It's really nice.'

Extract 182 (Mary - diary):

'Debbie and I went shopping. After an hour I had had enough. People can be so rude. Even when they can see that you are pregnant they still push and shove and let doors go in your face. I came home from the shops exhausted.

I'm glad that we bought most of the things we will need for the baby earlier on.'

Doris shows how she once again interpreted people's behaviour towards her in a positive light. She acknowledged the differential treatment to be a result of her pregnancy, and found the responses of others to be 'really nice'. Throughout her pregnancy Doris interpreted people's reactions far more positively than the other participants. She herself was also very pleased and excited about being pregnant, and often remarked on the positive aspects rather than the negative aspects that were also part of the pregnancy experience.

For Mary the experience of going shopping was not so positive. The people she met ignored the fact that she was pregnant, and thus her needs for more space (not to be pushed and shoved) were not being accommodated. This also shows how Mary had a general expectation that people should treat her differently.

Overall, in this theme we can see that the reactions of others toward pregnant women do vary, and that where the same reactions occur different women interpret them differently. Although people can be supportive at times, there are others who are rude and unaccommodating. How the women feel as a result of the exposure to others in social settings does vary, and it is the

variety of experiences that they come across that needs to be taken into account.

8.6 Discussion

This chapter aimed to capture certain positive experiences as part of the predominantly discussed themes (during the interviews and in the diaries of the participants). However, negative images also became an important aspect for consideration as they often occurred in conjunction with the positive aspects.

The first theme highlighted the ways in which the participants were able to share their pregnancy experience with a number of people, and concentrated solely on a number of the positive experiences. The sharing of certain aspects of the pregnancy experience showed the ways in which the participants not only constructed their pregnancy in positive terms but also showed how they enjoyed making it a shared event. The participants often found the individuals with whom they shared their experience to be very supportive. Being able to share their experience is likely to have been beneficial, as a number of researchers (e.g. Brown and Harris, 1978; Oakley et al, 1982; Leven and DeFrank, 1988) have found that a lack of social support is a risk factor for maternal distress and poor pregnancy outcomes in terms of, for example, low birth weight (see Newton and Hunt, 1984; Pagel et al, 1990). The high level of social support the participants of this study received may partly be due to their social class. Studies by Oakley et al (1982) and Oakley and Rajan (1991) show that women from lower social class backgrounds are more likely to experience a lack of social support. As the women in this study were all from middle class backgrounds (self-reported) they may have benefited from the networks of support that many socially disadvantaged individuals may not have available to them. For example, all of the participants of this study were employed, and thus were able to share their experiences with a number of their work colleagues. In addition, all of the participants were either married or were living with partners, and also had close family members to call on. This in turn may account for

their often high levels of satisfaction with their pregnancy, which may be a missing feature for some working class women. Thus, the results of this study should not be seen as applicable across all pregnant women. In addition, social class is a complex issue and therefore the simple analysis provided above should not be taken to be a full explanation, but rather as one that could be a contributing factor to the satisfaction experienced by this group of participants.

The second theme explored the role of certain medical interventions in helping to construct positive and negative images of the pregnancy. Here the reassurance of having heard or seen the baby was used to construct positive images, although the waiting for the appointment was a negative experience.

The third and fourth theme explored how the changes to the women's body were interpreted. This area of research has received very little attention, and thus I have outlined the ways in which the changes were variously interpreted as being positive and/or negative.

Of the little research which has been conducted on body images during pregnancy, studies on women of average weight in the pre pregnancy stage show that they experience dissatisfaction with their weight gain during pregnancy due to the negative connotations fatness has in relation to physical attractiveness (see for example, Oakley, 1980; MacIntyre, 1981; Price, 1988). My own research findings support these findings in so far as when the women were in their later stages they did become dissatisfied with the way they looked and described themselves as looking fat. Wiles (1994) study on the impact of pregnancy on fat women's body image found that the majority of the women (84%) reported dissatisfaction with their weight before pregnancy whilst only (35%) of them expressed the same views during pregnancy. Wiles found that the level of satisfaction or dissatisfaction experienced is associated with the woman's pre-pregnancy size. The increase in satisfaction with body image during pregnancy for fat women was associated with the social acceptability of fatness during pregnancy. In my own study, the women did not always find people to be socially accepting of their large size during pregnancy, and thus for some women acceptance of fatness during pregnancy may not be experienced.

Linking images of self to the social stereotypes present within society and the pressure to conform to these has shown that failure to do so leads to lower self esteem (Wiles, 1994). The women in my sample were of average weight prior to the start of their pregnancy and, as with previous research conducted on women of average weight, the results of this study show that there were a number of difficulties experienced with the increase in body size.

One way in which women formed images of themselves as pregnant was via the clothing they wore. Dress as an indicator of identity has been under-researched and yet it has been a powerful indicator of personal identity for women. Research by Kaschak (1992) and Woollett et al (1994) has explored the role of dress (as represented by clothing and appearance) for ethnic identity, although there is little comparable research looking at dress for pregnant women's identity. Wiles (1994) found that the women in her study who were fat prior to their pregnancy onset became more satisfied with their weight during the pregnancy because of (amongst other reasons) the acceptance they found in relation to the buying and wearing of certain clothes (e.g. shorts and t-shirts). In contrast, the women in my study found that the increase in weight led to a more limited choice of clothing and associated some of their dissatisfaction with the weight gain to this problem (see extracts below).

The range of clothes available to women of average size as compared to larger sizes is at present much wider and thus the average size women would experience a reduction in choice, unlike those women who are larger and have in comparison had less of a choice before pregnancy. The following extracts show how the choice of clothing, and the limits to the options available to pregnant women of average size, has impacted upon the women in my sample.

8.6.1

Accommodating the changes in body size (the case of maternity wear)

Looking at the increase in body size with special reference to the availability and use of maternity clothes shows that the women in this study were experiencing a lack of choice. The lack of choice, and questions about the appropriateness of maternity clothes during the 'in between' stage, show how the women had to 'put up with' wearing clothes that they were not always happy with.

Extract 183 (Pat - diary):

'Kate and I went clothes shopping after work today. I was looking for something with room in it but smart, for a wedding and christening coming up.

I had no luck some maternity dresses were nice but I'm not big enough to fill them yet and they looked silly.'

Extract 184 (Jane - diary):

'We went to [town] today, and I bought a sailor dress, pinafore and new blouse. All maternity wear from Mothercare. They're nice but there is so little choice for maternity wear in this country. In Cyprus every other street has a maternity shop! Anyway all that cost £80!! I sent for a catalogue of clothes and all it had in it were endless sloppy suits and leggings - which is ok as long as you don't have to look smart at anytime during pregnancy. There's a real gap in the market as with for evening wear - presumably expectant mothers are expected to crawl into a 'social hole' because there certainly isn't anything decent on sale for them to wear.

Dress makers could make a real killing here!'

Extract 185 (Doris - diary):

'I enjoyed today because my husband and I went shopping for some maternity clothes. At last I would have some clothes to fit me. I'm still in that in-between stage, where my clothes are too small and most of the maternity clothes I tried on were too big. While I was trying on a maternity dress in the changing rooms I started to talk to another girl who was also trying some clothes on, and she said that she knows what my problems are like, she told me that she went shopping with one of her friends who was between 4 and 5 months pregnant and she too found the maternity clothes too big for the stage she was up to.'

Extract 186 (Doris - diary):

'I bought a few maternity clothes. That felt good, me being a 'little fatty'.'

Extract 187 (Pat - diary):

'As the boss is on holiday I wore a pair of stretch leggings to work today! What a difference, they feel so comfy. I am running out of things to wear to work. The skirts I bought in the summer are a little too short now the weather is getting colder. I really do not want to spend out on longer maternity skirts which I will only wear for the next six weeks.'

All of the above extracts show how the women felt restricted by the choices available to them whilst they were pregnant. The women did enjoy wearing maternity clothes, although the clothes were often seen to be too expensive or inappropriate for the stage that they were at.

By taking one of the participants' accounts it is possible to show how the changes to body size are variously interpreted by one individual. To this end if we look at the extracts taken from Pat's diaries (as presented in themes three and four), we can note the multiple interpretations she made at any one point in time, as well as over time. For example, in the early stages she reports that she is looking forward to getting bigger and enjoys close family

and friends noticing her 'lump'. For Pat the increase in size also represents reassurance (indicates the baby's presence). However, on the other hand she feels she has to explain her larger size to strangers in case they think she is fat, and she herself is very self-conscious about her increased size in terms of it being perceived as being unattractive. Here we can also see how cultural definitions of ideal body size are being internalised by Pat. Her feelings about the increase in size reflect her conformity to, and the influence of, the norms of society. The increase in size makes her feel self-conscious and feel a loss for the figure she previously had. This wanting and not wanting the increase in size is particularly noticeable in Extract 157 where seeing her sister in a swimsuit makes her reflect on the dual meaning that the increase in size has for her.

On a number of occasions Pat mentions the difficulties she is experiencing in terms of her increased size (especially in relation to finding suitable clothes to wear). In this instance it is the practical considerations (e.g. the expense of buying clothes which may only be worn for a few weeks) that are being referred to, rather than the meanings of the increase in size on a psychological level.

8.7 Summary

Overall, this chapter has aimed to show how the women come to construct the changes that are occurring to them in both positive and negative terms. The personal and social reactions to the changes occurring to the women are varied, and what the four themes show is that the level of satisfaction experienced is influenced by the social context and the norms of the society the women live within.

Chapter Nine: Images of pregnancy (part 2): Visualising and coming to know the baby

9.1 Introduction

This chapter builds on chapter eight in that it aims to explore a number of the positive experiences that the women constructed during the course of their pregnancies. In this instance, I have selected four themes which reflect particular images of the baby. The choice of themes came about as a result of the high frequency with which issues concerning the visualisation of the baby came up in the data. In addition, the examination of the ways in which women construct particular images of their baby at various stages of their pregnancy is an area that has been under-researched, and thus the analysis presented here aims to provide an insight into the ways in which the participants of this study have constructed particular images of the baby and the meanings that they hold.

Given the predominance of the discussions relating to the feelings that the women held in relation to perceiving the baby, I have chosen to outline the ways in which the women came to describe these experiences of 'identifying with' the baby. Each theme explores the different anticipations, preparations and experiences of the images the women constructed.

Theme one, 'pregnancy as transition: preparing for the arrival of the baby', is based on the women's preparations relating to the arrival of the baby. The extracts, taken from four of the participants' accounts, show how the women anticipated the arrival. The preparations made, and the fantasised images constructed of the baby (whilst making the preparations), are examined. The contradictions contained within accounts and the variations found across accounts are provided to show how the fantasies that the women hold about their baby are constructed in multiple ways.

Theme two, 'issues concerning the gender of the baby', examines the ways in which the women consider the gender of their baby using either medical or non-medical forms of identification. Four of the participants' accounts are used to highlight these considerations. The option to be able to

ask the gender of the baby during the routine ultrasound scan has meant that discourses concerning the decision to find out the gender of the baby now take place. These discourses in turn are explored within this theme. The extracts show that some of the women did not question whether they should ask, but instead were determined to find out, while others were more ambivalent (those women who chose not to ask are also briefly discussed).

In addition to the advent of being able to find out the gender of the baby, discussions about the likelihood of the baby being a boy or a girl (with friends and family) were also described by the participants. These discussions are explored in order to show how non-medical forms of knowledge were being used (e.g. the way the woman is carrying, or the amount of weight gained). This predicting and/or guessing of the gender is shown to be an enjoyable aspect of the pregnancy experience.

The level of knowledge about the gender of the baby had particular implications for the women (for example, type of decorating carried out in the baby's room). I have analysed this aspect of the data in relation to what it shows about gender-stereotyping. The gender-stereotyping which did take place during the pregnancy (by way of deciding on appropriate colours for boys and girls) shows that the women had prior expectations as to what would be most appropriate for their baby (based on the likely gender of the baby).

Theme three, 'the anticipation and experience of the baby moving', explores the images of the baby in relation to the meanings that the feeling of the movements held for the participants. The reasons why the women want to be able to feel the baby move are shown to be related to the reassurance they receive and the enjoyment experienced (by themselves, as well as with their partners once the movements of the baby can be felt externally).

Finally, Theme four, 'the significance of the ultrasound scan', explores the experiences that the women reported in relation to the uptake of the ultrasound scan. All of the participants had a 'routine' scan, and in addition a number of participants were offered, and subsequently had, further scans as a result of particular complications during their pregnancies. These differing experiences are highlighted. This theme contains four subsections, which

detail the issues related to the waiting period before the scan, the scan itself, the post-scan period (when the information they received is discussed with others, and is reflected upon by the women themselves), and finally the impact that the scan had on the women.

9.2 Theme one: Pregnancy as transition: preparing for the arrival of the baby

Preparations for the arrival of the baby often led to the women trying to imagine the baby post-pregnancy. The feelings that they experienced in relation to identifying with the baby were many and varied. To show the variation within person I have selected a number of quotes from one of the participant accounts (Doris). The extracts taken from Pat, Sandy and Jane's diary accounts have been included to show further examples of the types of preparations the women made.

In the following two extracts Doris explains how she attempts to imagine her baby in the clothes that she has gathered for it. In Extract 188 she explains how she felt 'broody' as a consequence of trying to imagine the baby, while in Extract 189 she explains that it feels 'strange' to be buying clothes before the arrival of the baby. Thus, at different points in time Doris experiences different feelings about having imagined her baby in the clothes that she has gathered.

Extract 188 (Doris - diary):

'Also my husband's Nan made some cardigans for us, for the baby. When I saw these clothes I started to imagine a little baby wearing them, and I went all broody.'

Extract 189 (Doris - diary):

'It felt strange buying baby clothes when the baby hasn't even been born yet. It also felt quite exciting to look at the baby clothes we bought and imagine our baby wearing them.'

In Extract 189 Doris also describes the contradictions she is experiencing. On the one hand, it feels 'strange' to be buying clothes for the baby whilst she is pregnant, while on the other she does find it 'quite exciting' to imagine the baby wearing them.

In Extract 190 Doris again shows concern about her fantasising about the baby in the early stages of her pregnancy. She now changes from thinking that it is 'strange' to be buying baby clothes prior to the baby's arrival, to thinking that 'something could happen', and hence refrains from continuing some of the preparations (decorating). In addition, in Extract 190 we can see how Doris experiences a mixture of emotions when she thinks about the baby. She feels excited about the prospect of having a baby, but is also nervous at the same time due to worries about the pregnancy not continuing.

Extract 190 (Doris - diary):

'We have put the first things in the baby's room today. We've put the wardrobe up and a chest of drawers. We will still not decorate the room until December because there's still a worry that something could happen. When I saw the wardrobe and chest of drawers in the baby room I felt excited but also a bit nervous.'

Pat shows how she too is preparing for the arrival of the baby by buying baby items, and how looking at the baby items is an enjoyable experience for her.

Extract 191 (Pat - diary):

'I went to Boots chemist and bought some breast pads for when I start feeding and some new-born nappies for the stock I am building up. I love to look in the drawers that I keep my baby bits and pieces in.'

Thinking about the baby with reference to the preparations that the women made was a common theme that was discussed both in the interviews and in the diaries. On many occasions during the interviews I was invited to go and look at the baby's room and the items the women had gathered. The women would often discuss where and how they acquired the items, and how

they felt whilst they were doing this. As the discussions took place while we were standing in the baby's room, the conversations were not recorded and thus I am only able to reflect on them and mention that they did take place.

One of the main discourses that they used during these conversations related to how excited they felt about the arrival of the baby (this was more so with the first-time mothers). They would also mention how they couldn't believe that this was happening to them, and thought about themselves as being lucky and/or fortunate. This discourse was often provided in conjunction with ones about people they knew who had been trying for years to have a baby. Their own position was being considered in light of other peoples' experiences of infertility (except in the case of Sandy, who considered herself lucky and fortunate as a result of previously experiencing infertility problems herself).

In Extract 192 Sandy shows how she began to fantasise about the baby and anticipate its arrival once she herself began to feel better. Sandy had suffered from morning sickness and tiredness in the early stages (see theme five in chapter five), and it was once these symptoms subsided that she began to describe how she was looking forward to the arrival of the baby.

Extract 192 (Sandy - diary):

'Feeling quite lively, more energetic and optimistic. I wish the baby was here because I want to cuddle him.'

Jane explains how she is making totally different preparations to the ones described by Doris and Sandy. Jane discusses her concerns about the welfare of her baby, and thus begins to make arrangements for the baby in case of adversity:

Extract 193 (Jane - diary):

'Went to Alan and Celia's for the afternoon and evening. They have agreed to be Christopher's godparents and guardians (god forbid that it should be necessary). So when he's born we will have to change our wills pronto.'

Returning back to Doris' account, the next two extracts show how she continues to experience contradictory feelings. She describes below how she visualises the baby during a dream, in which she is able to fulfil her curiosity about what the baby looks like. At the same time as finding the dreams funny, she also emphasises their impact.

Extract 194 (Doris - diary):

'I sometimes have funny dreams as well. One dream that I can remember is opening my stomach up and taking the baby out, and having a look at it, and then putting it back again. They're really funny dreams. They do seem so real when I'm dreaming them.'

In Extract 195 Doris explains how she continues to hold contradictory feelings even late on in the pregnancy, when there are a number of signs that acknowledge her pregnancy. Although she says that it is hard for her to believe that she will become a mother, she does say that she is excited by the prospect.

Extract 195 (Doris - diary):

'I still find it hard to believe that soon we will be parents. I don't suppose I will really believe that I'm having a baby until the baby's here. Even though I'm pregnant and I'm putting on a lot of weight, it still hasn't really sunk in that I'm going to be a mother. I'm getting excited and also nervous, especially about the birth.'

Overall, in this theme I have attempted to show how the women come to prepare for the arrival of the baby, and how during this process they imagine their babies. Buying baby items was an activity in which a number of the participants engaged, although not all of the women in this study did so. For example, Karen did not engage in such activities as she continually doubted the pregnancy being successful due to her previous history of miscarrying. Also, Rita did not refer to any visualisations of the baby during the interviews or in her diary. I myself did not prepare for the arrival of my own baby up until a day before I went into hospital. This was partly due to me

delaying such preparations until I was on maternity leave, but also to the fact that in the initial stages I experienced a number of problems and was unsure of the pregnancy continuing. The two threatened miscarriages that I experienced, and my health problems, led me to pay little attention to the arrival of the baby. It was only when I knew the labour was imminent (six weeks before the expected due date) that I went shopping. The differences between women, in terms of identifying with their babies via their preparations, shows the level of variation that occurs across accounts, just as variation occurs within accounts (as Doris' accounts show).

9.3 Theme two: Issues concerning the gender of the baby

Whilst analysing the data relating to issues concerning the gender of the baby, I found that the gender was referred to in three distinct ways: gender-stereotyping; debating the use of and/or identifying the gender via the ultrasound scan; guessing and predicting the likely gender of the baby. Each of these categories of usage will be highlighted in turn below.

The stereotyping of girls and boys by way of the appropriation of particular colours for each was seen to occur prior to the baby's arrival. For some of the participants, the lack of knowledge about the gender of the baby meant that colours which were perceived to be 'neutral' were chosen, so as not to have the wrong 'type' of decoration based on the gender of the baby. Extracts from Doris and Mary's accounts exemplify this:

Extract 196 (Doris - diary):

'We were discussing how to decorate the room. We've decided to decorate it in a neutral colour, so whatever I have, boy or girl, it would be appropriately colour matched.'

Extract 197 (Mary - diary):

'(friend) had made us a Moses basket and also bought us an outfit for the baby. The outfit is in pale blue, although she did say to me that "you can't put a boy in pink but you can put a girl in blue".'

Mary shows how it is her friend that is stereotyping and indicating that girls can wear the colours assigned to boys, but boys can't wear the colours assigned to girls.

Continuing with the appropriation of what is suitable for each gender, we can see that in Extract 198 dresses are seen to be only appropriate for girls to wear. This is a cultural stereotype and is specific to certain cultures at certain points in time (given that boys also wore dresses in this country in the past).

Within the Asian culture both boys and girls are placed in dresses whilst they are babies, and hence, in this country, if a Asian baby boy is wearing a dress he is likely to be labelled as a girl by those who are unaware of the unisex usage of dresses for babies in the Asian community. This comparison is provided to show how one's culture affects what is the norm, and shows how experiences are constructed in light of cultural ideologies of what is appropriate for each gender.

Extract 198 (Doris - diary):

'Saw my husband's parents and his mother had been making some little dresses. Both my husband and I think she may just be hoping for a grand-daughter.'

Here Doris also explains that one set of grandparents are hoping for the baby to be a girl. The preference for one gender over the other, not only by relations but also by the women themselves, was a common feature that was referred to. In many instances they would say what gender they preferred, but also that they didn't mind if it was the other (see, for example, Extract 208). Extract 205, however, shows how Ann particularly wanted her baby to be a boy and not a girl.

Concerns about being able to match the gender of the baby (via scans) with the women's (and/or significant others) desires has become a real issue now that the gender of the baby can be identified in the early stages of pregnancy. The reasons for this are highlighted in the discussion subsection of this chapter.

The second category of describing issues concerning the gender of the baby shows how the women describe their decision-making in relation to finding out the gender of the baby. A number of the participants did not want to know the gender of the baby (Pat, Doris, Jane, Rita, Sam and Mary), and thus the debates only relate to some of the participants. Those that did consider it (Sandy, Sue, Karen and Ann) constructed their desire to know in a variety of ways. In order to show the differences between accounts, extracts from two of the participants are presented below (Karen's, to show representations of experiencing the option in ambivalent ways, and Ann's, to show representations of definitely wanting to know).

In Extract 199 Karen constructs her dilemma about finding out the gender of the baby in the form of a debate. She shows how, to others, she has indicated that she would not want to know, although personally she is still undecided.

Extract 199 (Karen - diary):

'I have been debating whether to ask if it is a boy or a girl, even though throughout my pregnancy I have been saying to everybody that I didn't want to know the sex.'

As can be seen in Extract 200, Karen did decide to ask the gender of the baby and thus, although she was unsure about wanting to know, the option of being able to ask was taken. However, during the scan the gender of the baby was not easy to identify, and as a result Karen did not know if it was a boy or a girl. This result was not portrayed as a disappointment, and this is likely to be in the light of Karen's ambivalence toward wanting to know the gender in the first place. She emphasises that to her the health of the baby is more important, and that in light of this the gender is unimportant.

Extract 200 (Karen - diary):

'I did ask what the sex was. At first they thought it was a boy then the baby moved and it looked like a girl. I don't really care what it is so long as it is alright.'

In comparison to Karen, Ann shows below that she definitely wants to know the gender of the baby. Ann had a number of scans prior to the routine

scan, due to complications in her pregnancy. She asked if they would tell her the gender of the baby at each of these, but was not told:

Extract 201 (Ann - diary):

'Baby is fine. Scan confirmed that my loss of blood is still from the placenta/uterus. I asked if they could tell if it was a boy or girl, but they wouldn't tell me.'

The routine scan was Ann's seventh scan, and the anticipation for it was evident in her diary entry the day before. In Extract 202, Ann shows how she couldn't wait for the scan, and how waiting for it made time go by slowly. The desire to know the gender meant that she would not be able to sleep as she would be feeling excited.

Extract 202 (Ann - diary):

'Today has seemed so long and I'm not looking forward to tonight as I know I won't be able to sleep because my scan is tomorrow morning, and I will find out if it is a boy or a girl. I feel very excited.'

At the scan, the gender of the baby could not be identified. After being unable to find out the gender, Ann decided to mention her daughter's condition (Talipes), and asked if they could check her baby for the same condition. This request is likely to have been partly made in the hope of being able to have another scan so as to afford herself another opportunity to find out the gender of the baby. Her desire to know the gender of the baby, over the likelihood of her next baby also having Talipes, is one of the interpretations that can be made based on the order of her request of information.

Extract 203 (Ann - diary):

'Typical! Baby was laying facing down and therefore unable to find out sex of baby. However, I mentioned about my first baby having been born with Talipes and could they spot the condition at this stage (19 weeks). They could not see anything wrong but asked if I would like to make another

appointment for two weeks to check feet and also the face and 4 chamber heart. I can hopefully find out the sex.

I feel so disappointed.'

Ann makes clear her disappointment in not being able to find out the gender of the baby. However, as she is able to have another scan she again begins to anticipate its arrival (which would be scan number 8), as shown below.

Extract 204 (Ann - diary):

'Counting the days now to the next scan. I hope I can find out if it is a boy or a girl.'

One of the questions that Ann's account raised for me was whether she would have mentioned Talipes at all if she had been able to find out the gender of the baby. She may have mentioned it due to her wanting to have another scan so as to be able to find out the gender. If this is the case then we can see that Ann took active steps toward having more scans, and therefore she may have been taking control.

In the next extract Ann shows that she did find out the gender of the baby, and that the gender is the one she and her husband hoped for (a boy). Her preference for a particular gender, and its discovery, led to an extremely positive experience. To have had a girl would have been something she would have had to 'resign' herself to, and so if it had been a girl she would not have been as pleased.

Extract 205 (Ann - diary):

'It's going to be a boy! This is what my husband and I hoped for. I nearly fell off the bed as I had resigned myself to having a girl. I nearly cried. My husband is over the moon.'

Once Ann had received the news she began to share it with others, just as such news is normally shared after the birth of a baby. One of the implications of finding out that the baby was a boy related to Ann's preparations for his arrival. Choosing an appropriate name was one of these preparations:

Extract 206 (Ann - diary):

'Spent the day telephoning everyone that I was expecting a baby boy. Also spent the day going through boys names. Feel on top of the world.'

In the next set of extracts the third category of representing issues relating to the gender of the baby is discussed. These extracts are taken from those participants who did not know the gender of the baby. Here we can see that the interest in trying to predict the gender is a popular activity in which those who know the women come to engage in.

Doris' work colleagues base their decision of predicting the gender on chance. They take bets on which gender it will be, and show no utilisation of any other forms of knowledge on being able to tell the gender.

Extract 207 (Doris - diary):

'[Work colleagues] said they are going to take bets as to what I'm going to have, a girl or a boy.'

Others who also attempt to guess the gender of the baby use a number of cultural myths, such as the size and the shape of the woman whilst pregnant. Extract 208, from Mary's account, shows this in practice.

Extract 208 (Mary - diary):

'Some of the ladies at work are trying to guess what sex my baby will be.

I have only put on weight at the front and I am now quite large. They said that this means it could be a boy. My mom thinks that it will be a boy. But another lady said that she thinks it will be a girl. Personally I would prefer a boy but I don't mind what it is as long as its healthy.

I don't believe that anyone can tell what sex it will be by the way the baby lies and my shape.'

Mary shows that there are contradictions in the way in which people interpret the way she looks, as some of the individuals interpret her weight

gain to reflect her carrying a boy while others interpret it as carrying a girl. She states which gender she would prefer, but also says that it would not really matter. Her own interpretations of other people's guesses relating to the gender are far more sceptical, in that she says that she does not believe that the indicators they are using could predict the gender of the baby.

In the following extract, Karen attempts to guess the gender of the baby by comparing the types of desires she had for certain foods. Her desire for spicy foods in this pregnancy matches that which she had when she was pregnant with her son. As this was very different to the desires she had when she was pregnant with her daughter, she questions whether it means she is carrying a boy. Relating the desire for particular foods with a particular gender shows another non-medical means by which Karen seeks to establish the gender of the baby.

Extract 209 (Karen - interview):

Question: 'Do you think you will have a girl or a boy?'

'I'm wondering if the baby is a boy because I fancied spicy food when I was pregnant with my son. When I was pregnant with my daughter I only wanted things like oranges, cucumber, melon and ice-lollies.'

In Extract 210 Karen shifts from suspecting that it is a boy to believing that it is. She now begins to plan for the arrival of a boy, as she is only thinking about the baby as though it is a boy. Having said this, she does once again reiterate that she doesn't care which gender it is, and thus attempts to show that she does not have a preference for one gender over the other.

Extract 210 (Karen - diary):

'I am only thinking of boys names for the baby. I am convinced that it is a boy. I don't really care what it is just as long as its alright.'

Overall, in this theme I have attempted to show the variety of ways in which the gender of the baby is considered. The gender of the baby has particular implications for the women, such as choosing an appropriate name

or decorating the baby's room in particular gender relevant colours. The constructions of what is suitable for boys or girls are culturally specific, as is the point in time at which preparations are made for the arrival of the baby. Choosing a name prior to the birth is yet another example of where the Asian culture differs from the English culture. The choosing of the name of the baby normally only takes place once the baby has been born in some Asian cultures. In addition, many of the names that can be used are unisex, and thus thinking about which is the most suitable based on the gender of the baby rarely occurs. As mentioned previously, these comparisons show that cultural ideologies are used as frames of reference and contribute toward the different pregnancy experiences across women.

Predicting the gender of the baby is now more accurate as a result of the use of ultrasound scanning. However, it is not always possible for the ultrasonographers to detect the gender, and thus the women may not find out (as was the case for Karen). In addition, some hospitals have a policy which bars telling the women the gender of their baby, and thus the ability to find out may depend on which hospital you attend. The use of the ultrasound scan for the construction of the images of the baby occurs not only in relation to the gender of the baby, but also in a number of other ways. The variety of constructions made as a consequence of having had a scan are discussed in the fourth theme of this chapter.

Returning back to the current theme, the guessing of the gender carried out by some of the women, and certain others they know, shows that wanting to know the gender of the baby is an issue which is considered at various points in the pregnancy. In the next theme, different aspects of coming to know the baby are explored. The gender of the baby is one of many aspects relating to the identity of the baby that is considered by the women.

9.4 Theme three: The anticipation and experience of the baby moving

In this theme the women's reflections relating to particular sensations which are indicative of the baby are explored. The theme shows how the

women are anxious to start feeling the movements of the baby and how, once the movements do occur, they are interpreted. Some of the interpretations they make are similar to the ones made when the baby's heartbeat is heard during medical interventions (see chapter eight, theme two).

Extracts 211–214 show how the women anticipate the beginning of being able to feel the baby moving. Movements are expected to be able to be felt between 16 and 18 weeks of pregnancy by the women. This knowledge is gained via the pregnancy books that they have read.

Ann describes how she is anxious to feel the baby move, while Mary describes how she is worried about not having felt the baby move, as she is now 18 weeks pregnant.

Extract 211 (Ann - diary):

'Feeling fine although I have been anxious waiting to feel first movements of baby, which I hope will happen within next 2 weeks.'

Extract 212 (Mary - diary):

'Spoke to mum this morning, I haven't felt any movement from the baby yet. She said that it was probably too soon.

I am 18 weeks this week.'

Karen, like Ann and Mary, describes how she is waiting to feel the first movements.

Extract 213 (Karen - diary):

'Can't wait until I am sixteen and a half weeks, then I should be able to feel the baby kicking.'

Pat goes into detail as to why she wants to be able to feel the baby move. She states that being able to feel the baby move would be reassuring for her, especially as she sometimes feels that the size of her stomach seems less at times, and this leads to her wondering whether the baby is still there.

Extract 214 (Pat - diary):

'Woke up this morning and although it sounds silly my stomach appears flatter than usual. Sometimes when this happens I wonder if the baby is still there. I have read in one of my books that at 18 weeks you may start to feel the baby move. I find myself longing for that moment again I feel this would be reassuring for me.'

Doris, like Pat, describes how the baby's movements are interpreted as being reassuring. Doris states that the reason why she feels reassured is related to the movements indicating that the baby is 'alright'.

Extract 215 (Doris - diary):

'I felt the movement of the baby at work today. I've been feeling the baby moving a lot lately. It's quite reassuring when you feel the baby move because its letting you know that everything is alright.'

For Ann, being able to feel the movements means that she is more relaxed about the pregnancy since they have occurred.

Extract 216 (Ann - diary):

'Can actually see the baby kicking. I feel much more relaxed about things now.'

Even once the movements are more frequent and the baby has grown considerably, the movements continued to be interpreted positively. The extracts below show how Karen and Doris reflect on the images of their babies:

Extract 217 (Karen - diary):

'I really enjoy having a bath just so I can watch the baby moving, its hard to believe that there is a living thing growing inside you.'

Extract 218 (Doris - diary):

'I don't think it will be long before I see an actual foot or arm sticking out in my stomach. I'm quite looking forward to it.'

In Extract 219 Doris further emphasises how much she enjoys the baby's movements. Now the movements are being related to the baby's communication with her.

Extract 219 (Doris - diary):

'Tonight while I was relaxing, me and my husband noticed that my stomach was moving....My husband put his hand on my stomach and he could feel how strong it was on the outside as I could feel how strong it was on the inside. We both thought it was quite funny to watch and feel the baby moving. It felt nice as well. It was as if our baby was telling and showing us that its aware of the outside world. It is really lovely to feel and see the baby moving.'

In Extract 220 Doris again explains how she interprets the baby's movements as a means of the baby communicating with her. She indicates just how positive these experiences are for her, and how she thinks the baby is able to express its own feelings by way of movement.

Extract 220 (Doris - diary):

'Today at work I had that exciting feeling again where I wanted to squeal out aloud. It makes me laugh when I get that feeling. I'm sure the baby's feelings are coming out through me, its as if its trying to communicate with me and make me laugh at itself. When I get this excited feeling even though there's no reason for the feeling at the time, I always feel close to the baby and comforted by this excited feeling.'

In this theme the women's desire to know of the baby's presence by way of its movements have been shown. The accounts show how they look forward to these movements prior to experiencing them, although they also

feel anxious that this should happen at the 'right' time. Knowledge of when they should take place leads to worries if they are not experienced by this time. Once the movements are felt, the women interpret these in positive ways, and when the movements can be felt by placing the hand on the stomach the women also begin to share these sensations with their partners. The movements are interpreted as being reassuring and also lead to some women becoming more relaxed in the belief that it means the baby is still there and that it is alright.

In the next theme the desire to know of the baby's presence is shown to be indicated by way of the ultrasound scan. The different issues the scan raises are explored.

9.5 Theme four: Significance of the Ultrasound Scans

Being able to see visual images of the baby via the ultrasound scan was an experience that, again, was on the whole interpreted in positive ways by the women. The ways in which the ultrasound scan were considered, and the impact it had on the experience, will be highlighted.

In order to structure the issues, I have divided the analysis into four subsections. The first subsection examines the accounts provided prior to the scan, and shows how the women looked forward to it. The second details the women's experiences of having the scan, and the descriptions they provided relating to seeing the baby. The third subsection looks at the ways in which the women used the information that they obtained from the scan, and shows the significance that the photograph of the baby obtained from the scan held for them. Finally, the fourth subsection considers the impact of the scan on the women, and their subsequent constructions of their baby.

9.5.1

Prior to the scan

Knowledge of the availability of the scan, and its timing, meant that all of the women had time to reflect upon it. Examples from four of the participants' accounts are provided in order to highlight the constructions of the waiting time and reasons why the women were looking forward to the scan.

For Pat the interpretation of having the scan related to the medical use of it to detect abnormalities. This was in contrast to the accounts provided by the other participants of the study, who did not mention the reasons why the scan was being offered.

In Extract 221 we can see how Pat delays her preparations for the arrival of the baby in accordance with the date of the scan. She does not want to prepare the room for the baby until she knows that she will not need to terminate the pregnancy due to the detection of abnormalities.

Extract 221 (Pat - diary):

'We decided to just paint the room white and brighten it up with a border. Steve started the painting but I don't want to put the border up until after I have had my scan and perhaps the Barts test.'

In the following extracts the reasons that the women construct as to why they were looking forward to the scan are shown.

Extract 222 (Ann - diary):

'I feel very excited about my scan on 17th September. Firstly to actually see the baby in my womb and secondly to find out the sex of the baby.'

Here Ann points out that there are two reasons as to why she is excited about her forthcoming scan: to be able to see the baby and to find out its gender. Ann's determination to find out the gender has been shown in theme two above.

In Extract 223 Pat points out that one of the reasons why the scan is important relates to her partner's ability to be able to share in her experience. The scan is seen as a means of being able to allow the partner to become more involved. The partners were often seen to be just as excited about the scan as the women were (as Extracts 224 and 225, from Jane and Doris' accounts, also show).

Extract 223 (Pat - diary):

'Steve has booked the day off work so he can come to the hospital and be with me for the scan. He's very excited and I think he will feel more involved when he has seen the baby. So far it's only been me that's seen the baby and heard its heartbeat.'

Extract 224 (Jane - diary):

'Heard the foetal heart again today both of us are really looking forward to seeing the baby at the scan on Monday.'

Extract 225 (Doris - diary):

'I'm looking forward to my scan next week. Both my husband and I are quite excited about it. I was talking to some friends about it and they're looking forward to seeing the picture of the scan as well.'

The forthcoming scan is not only discussed with partners, but is also discussed with friends. In Extracts 225 and 226 Doris shows how she discussed it with her friends, and how they also reported looking forward to being able to see the picture. The sharing of aspects of the pregnancy experience has been discussed in chapter eight, and hence here I have kept the interpretation of this aspect to a minimum.

Extract 226 (Doris - diary):

'I was talking to one of the girls at work about my scan that I'm due to have in a couple of weeks. I was telling her that I'm really looking forward to it.'

Where the women were offered scans due to complications in the pregnancy, the anticipation of the scan took on a different meaning. Jane, in Extract 227, shows how she suffered from worry and poor sleep as a result of the waiting, while Ann, in Extract 228, reports how she was becoming extremely anxious, and as a result of this wanted to have a scan in order to put her 'mind at rest'.

Extract 227 (Jane - diary):

'Slept very badly not sure whether that's due to worry about the scan or about the house or just one of those things.'

Extract 228 (Ann - diary):

'I will be 18 weeks pregnant tomorrow. I am getting extremely anxious to feel the baby move, as I have read you should feel it by *eighteen weeks*. *I don't really feel pregnant* today and I am a bit worried. If I am still losing old blood next Monday I will see doctor again and ask for a scan to put my mind at rest.'

In this subsection the different interpretations that can be made about the purpose of the scan are mentioned (to detect abnormalities, to see the baby and to put one's mind at rest). These different interpretations show how the scan is conceptualised by the women, and this in turn depends on whether the scan is being offered in a 'routine' sense or whether it is due to perceived difficulties in the pregnancy. The context thus plays an important part in the construction of the meaning of having a scan.

In the next subsection descriptions relating to undergoing the scan are examined.

9.5.2

Having the scan

Whilst analysing the data for this subsection I was struck by the level of detail the women went into when they described the conduct of the scan. The descriptions they provided were lengthy, and included discourses relating to the procedure involved, the viewing of the various parts of the baby, and the emotions they experienced. Six of the participants' accounts are used to represent the types of constructions the women provided.

In Extract 229 Rita describes what happened when she had the scan. She describes the way in which the scan was carried out, and then goes on to say how she came to see the baby and that this was 'amazing'. Visualising the baby for the first time, and seeing that it was 'all there', made Rita feel very emotional and helped her further believe in the pregnancy being real, as the scan provided a 'double confirmation'.

Extract 229 (Rita - diary):

'Eventually I was called for my (dating) scan. A jelly substance was rubbed over my tummy and I watched the screen and saw my baby for the first time - amazing. It was all there a complete baby. I felt very emotional. All the time you know you are pregnant but when you see the baby for the first time it's just like a double confirmation.'

Pat also describes the preceding time up to having the scan, before she describes the scan taking place. Pat constructs her description as a shared experience, and writes her account with reference to how her partner experienced the event as much as her own experience of it.

The information that the ultrasonographer provided related to the identification of the various parts of the baby and the dating of the pregnancy. Pat thought that the information relating to the dating of the pregnancy was as expected, while, on occasions, other participants questioned the date of the pregnancy as the date they felt was the right one differed from that which was provided.

Extract 230 (Pat - diary):

'My scan was at 4.20 so I met Steve at 4.00 and off we went...The jelly substance was put on my belly and then we watched the screen. Steve was really amazed and we were taking it all in. The girl was pointing out the two arms, two legs, head, spine etc. She said everything was fine.

The baby was moving a lot and I thought how could it be resting on a nerve when it's moving about so much?

We saw the heart and the girl pointed out the four chambers in the heart. It was beating very quickly. She explained they were taking three lots of measurements and this would indicate how many weeks the baby is. They said it was just over 19 weeks which I knew was what they'd say.'

In Extracts 231 and 232 Doris and Mary, like Pat, describe the event as a shared experience, and again point out how they saw the various parts of their babies.

As shown in Extract 231, Doris and her partner perceived the picture of the baby on the screen to be clear, yet these images are often blurred and require interpretation in order to identify the various parts. The construction of the picture being clear is likely to have been based on prior expectations that it would be difficult to make out the baby. Seeing the baby led to Doris' partner describing the baby as 'sweet', which shows how the physical appearance is being interpreted in emotional ways. The baby is being given a personality based on the constructed image they have of it (which is beyond that which is visible on the screen).

Extract 231 (Doris - diary):

'I had my scan today, it was really fascinating. My husband was there too and when we saw the baby on the screen he held my hand and said 'oh that's really clear, isn't the baby sweet'. We saw the heart beating and the spine, the little hands and legs, it was all so clear. It took a while to sink in that, that was our baby, it was really wonderful. We

were given a photo of the scan and I was really impressed at how clear it was. It showed the baby with a little turned up nose and the mouth was open slightly. The girl at work had a scan photo and hers wasn't as clear. She drank a pint of water before her scan because apparently you're suppose to. I forgot to drink anything before the scan and my scan was really clear.'

In Extract 232 Mary describes how the scan showed her something different to what she had expected in relation to the way the baby was lying. She also shows her active decision not to ask the gender of the baby. In the description of the scan Mary also mentions how viewing the baby had a particular purpose (checking that everything is okay), and thus, although this was not mentioned prior to the scan, she shows knowledge of the reasons why they are offered, and also uses the knowledge gained to construct an image of the baby being 'ok'.

Extract 232 (Mary - diary):

'Went for my scan today at the hospital. Paul came with me, he really wanted to see it as well.....

It was wonderful to actually see the baby moving. The baby was quite stretched out which was strange as I thought that they were curled up more.

We asked for a picture

She looked at all the major organs in the baby and said that they were ok. She also looked at the spine and the heart valves/arteries. Everything seemed ok with the baby. We didn't want to know the sex so we didn't say anything.'

In Extracts 230–232 the participants also show how they came to take on board medical discourses relating to the workings of, for example, the heart. The information provided by the ultrasonographer was being remembered and detailed in the diary entries. This active approach relating to the communication of what is being examined, and allowing the woman to share in the examination, is a recent event, and Campbell et al's (1982) work

is seen to be the turning point in the medical profession's move to sharing such information.

The constructed image is partly based on the information the ultrasonographer provides, although the extent to which the constructed image is taken on board also depends on what the woman is expecting. In Extract 203 Ann shows how the most important aspect of the scan for her is identification of the gender of the baby. Ann does not describe anything else about the scan, and this may be due to her disappointment in not having gained what to her is the most important information.

Extract 203 (Ann - diary) (repeated):

'Typical! Baby was laying facing down and therefore unable to find out sex of baby. However, I mentioned about my first baby having been born with Talipes and could they spot the condition at this stage (19 weeks). They could not see anything wrong but asked if I would like to make another appointment for two weeks to check feet and also the face and 4 chamber heart. I can hopefully find out the sex.

I feel so disappointed.'

In Extract 205 Ann shows that once she does obtain the knowledge of her baby's gender, she concentrates on this. The other information she may have received is likely to be much less significant, as she does not mention anything else in relation to the scan.

Extract 205 (Ann - diary) (repeated):

'It's going to be a boy! This is what my husband and I hoped for. I nearly fell off the bed as I had resigned myself to having a girl. I nearly cried. My husband is over the moon.'

Jane shows how she came to construct an image of her baby from various readings of the scan. She is told that the baby is the 'right size', and rather than interpreting the information as relating to the health of the baby, she interprets it as indicative of the baby seeming to be 'normally formed'. This is likely to be as a result of Jane's own medical background, and hence

her knowledge that the scan can only detect a number of abnormalities, and even then that they may not always be picked up.

Extract 233 (Jane - diary):

‘Scan today. All is well, the baby is the right size and seems to be normally formed.

It's a boy - Christopher James !

We asked if we could know and the radiographer scanned its genitalia without any objections. It's lovely to know - we both feel we can really start to develop a relationship with a known identity rather than an 'it'.

We have two pictures to record the event too. He's very sweet, playing with his toes and feet a lot of the time.’

In Extract 233 Jane also shows how coming to identify the gender of the baby allows her and her partner to begin to develop a stronger relationship with their baby, and that the baby now has an identity. Like Doris in Extract 231, the baby is perceived to be ‘sweet’, and hence the parents begin to build up a particular image of the baby as a result of having the scan (in this case with their own constructed projections being used).

Overall, in this subsection the participants are shown to take on board the medical constructions of the baby. In addition, they interpret the baby's movements and looks in ways that indicate a particular personality. These constructions are beyond that which are evident on the scan, and so the images of the baby are also self-constructed. The positive constructions presented are also likely to have occurred as a result of abnormalities not being detected, and as a result of the preconceived ideas that the women had of being able to see and identify the baby via the scan.

9.5.3

Post scan: (with special reference to the significance of the ultrasound photograph)

In this subsection I will explore the ways in which the women came to share the information that they gained from the scan with others, and how they interpreted the event and the subsequent photo they bought. The showing of the photograph to others shows how the women use the photograph in their discussions about the pregnancy.

Pat describes how she and her partner discussed the scan, and construct its occurrence as 'amazing'. She also points out that the photograph 'does not look much', but that with the interpretation that they can provide it will be meaningful to others.

Extract 234 (Pat - diary):

'Steve and I discussed the scan which he thought was amazing he was really glad he had been there So was I. We had our photo which doesn't look much but we can explain it to everyone.'

Here Pat implies that they have been educated and now know how to interpret the photo. They acknowledge that the photo needs interpretation but feel they can do this.

Below Doris constructs the picture of her scan as one that does not require much interpretation because of the 'cleanness of it' and 'how clear it was'. These descriptions show how she perceives the pictures to be of good quality. The terminology she uses is very interesting.

Extract 235 (Doris - diary):

'Showed some more friends the picture of the scan. They were impressed by the cleanness of it.'

Extract 236 (Doris - diary):

'I showed her (a friend) the scan photo and she agreed at how clear it was.'

Extract 237 shows how Pat and her partner use the knowledge they have gained to point out to others what they know about the baby. The photograph itself (like in the case of Doris) is seen as something that is relevant to show others:

Extract 237 (Pat - diary):

'We got home and I was exhausted and had an hours sleep. I heard the phone ringing it was Kate my colleague from work seeing how I had got on. I heard Steve proudly telling her the details of my scan. It was nice of her to ring. Steve's mum rang and I went through it all again and then again later on when my sister rang. I like telling people it's really nice to share the experience. I'll take the photo to work tomorrow and I know Steve will want to show it off at work the day after.'

In Extracts 238 and 239 Mary and Pat mention the people who they will show the photograph to. The photograph seems to be treated in the same way as the first photographs after the birth are normally treated, i.e. to show what the baby looks like:

Extract 238 (Mary - diary):

'At work I photocopied the scan pictures and sent a copy to my mum and to my sister.

I showed the people I work with who thought that it was great to be able to see a picture.'

Extract 239 (Pat - diary):

'I took the photo of the baby into work and Kate was the first to ask to see it. I didn't need to explain which bits were which she could already tell. She was really interested and so was Sarah Jane our temp who had been with us for about two months.'

Here Pat also emphasises her friend's ability to be able to interpret the scan photograph. Her friend's experience in interpreting the photograph shows that such sharing of the scan photo is not a rare occurrence.

In Extract 240 Pat again says that people are interested in the photograph. However, any negative comments made are seen to be upsetting. The interest that others are shown to have is a further construct that the women make. Of course, while people may say that the photograph is interesting because they find it so, it is also possible that they may be saying it out of politeness as the photograph itself is a blurred picture.

Extract 240 (Pat - diary):

'Steve showed my scan picture to everyone they were really interested although my sister said she thought it was expensive and commented that it was a waste of money. I felt a little upset by that comment as to me and Steve it's a wonderful picture and we will keep it safe as a momento. I know my sister only said this comment in a light-hearted way so I have to try and not be too sensitive.'

Doris shows how the scan has made her want to hold the baby, and how the waiting period for its arrival will require her to be patient.

Extract 241 (Doris - diary):

'We showed both our parents the photo and they were impressed and pleased that everything's alright. It was really great to see our baby, I just want to hold the baby, but I suppose I'll have to be patient and wait for the baby to arrive when its ready.'

Overall, in this subsection the women show that the experience of the scan is shared, and that the photograph plays a major role. The photograph means a lot to the women, and the visual image of the baby helps them to further identify with it.

9.5.4

Impact of the scan

In this subsection some of the consequences of having the scan are explored. A number of the different types of consequences which relate to the individuality of the experience are detailed in order to show the variation that exists.

In Extract 242 Doris explains that the excitement, as well as the anxiety, that she experienced whilst she was waiting for the scan may have led to the pain that she experienced in the upper half of her body the day after the scan. Feeling both excited and anxious is thus considered to have had a negative impact (although the scan itself was seen as a positive experience).

Extract 242 (Doris - diary):

'Today I had an aching neck, shoulders and top half of my back. It was even giving me a bit of a headache. Every time I moved my head my neck hurt. I went to see the doctor and he gave me some cream, he said the problem was muscular which could have been caused by tension. I knew I was excited and anxious about the scan and I'm wondering if I may have got a bit tense about it all and that could have caused my neck problem.'

In Extracts 243 and 244 Karen and Ann show how having multiple scans is helpful to them, as they have particular worries about the progress of their pregnancies. The use of scans to 'put one's mind at rest' has also been described in the subsection on issues 'prior to the scan' (see Extract 41, from Ann's account).

Extract 243 (Karen - diary):

'I am over my danger period, it has helped having had five scans already but I don't want to get excited and then lose yet another baby.'

Extract 244 (Ann - diary):

'I had my sixth scan and saw the baby move, I nearly cried with relief.'

In Extract 245 Mary, who also began to experience problems, shows how she, too, underwent a further ultrasound examination. The information that she received was positive in relation to the progress of her baby and thus, once again, the scan provided a diagnosis that was perceived to be helpful.

Extract 245 (Mary - diary):

'I had a scan this morning which showed that the baby is in the correct position still and is a good size. The scan showed that the baby weighs approx. 5 1/2 lbs which is very good.'

They tell me at the hospital that if the baby was born it would stand a good chance of survival even though I am only 31 weeks.'

In the next set of extracts the relationship that Jane forms with the baby after the scan, and over time, is shown. This constructed relationship shows how profound the knowledge of the gender of the baby can be. In the first of this set of extracts Jane indicates the reasons as to why the identification of the gender is wanted to be known/requested.

Extract 246 (Jane - diary):

'We asked if we could know and the radiographer scanned its genitalia without any objections. It's lovely to know - we both feel we can really start to develop a relationship with a known identity rather than an 'it.'

Following on from the identification of the gender, the baby is named prior to its birth, and is referred to with reference to the name.

Extract 247 (Jane - diary):

'Bought Christopher James a musical show.'

The relationship with the baby is seen to further develop with Jane now abbreviating the baby's name to its initials. This getting to know the baby is unlikely to have occurred if Jane had not visualised the baby via the scan.

Extract 248 (Jane - diary):

'Went to Watford and Harrow looking for wallpaper for CJ's room.'

Overall, in this subsection examples of the variety of uses of the information gained at the scan are provided. What can be seen is that although there are a number of commonalities across the women's accounts in relation to the discourses of the imagery of the baby, there are still individual differences in some areas.

9.6 Discussion

In this chapter I have aimed to show the variety of ways in which the women constructed particular images of their baby. In theme one we can see how during the process of preparing the physical environment for the arrival of the baby the women also imagine (fantasise) about the baby at the same time. In Doris' account we can see that although she enjoys thinking about the baby, she still has difficulties in seeing herself as a mother. The reality of the pregnancy does not seem to be an aid to the reality of motherhood.

The psychological adjustments made during the course of pregnancy, in terms of preparing for motherhood, is a subject matter that has previously been explored in depth by a number of qualitative researchers (see for example, Oakley, 1979; Smith, 1990; Phoenix, 1991; Kaplan, 1992), and thus in this theme I have only presented a few quotes which directly refer to how the participants in my study perceive their baby whilst preparing for the arrival of the baby, in order to build on their work.

In theme two, concerning the issues relating to the gender of the baby, the advent of being able to ask the gender of the baby shows that this option is taken by some of the participants and is rejected by others. Some of the participants were unsure, and for these the decision was not as straight

forward. Coming to know the gender of the baby has particular implications, and these are explored in detail by Rothman (1988).

Within theme two I have shown how the gender of the baby is related to preparing for the arrival of the baby in terms of selecting names and decorating the baby's room. Where the gender of the baby is not known, neutral colours are chosen, and boys' as well as girls' names may be considered. Not having the knowledge also leads to a number of discourses relating to lay predictions of what it will be. For some, the size and the shape of the pregnant woman is used as a basis for predicting, while others simply gamble on it being a particular gender.

In theme three the perceptions of the baby during pregnancy are shown to be linked to the experience of movements as felt by the women. The movements of the baby are also linked to the well-being and development of the baby, in so far as they are interpreted as being indicative of everything being alright, and thus reassuring. These experiences are, above all, constructed in positive terms.

Theme four explores one of the main ways in which the women came to 'know' their baby (via the ultrasound scan). By visualising the baby, some of the women are able to construct a personality for it, and can also build up their own relationship with the constructed image. The ultrasound scan is shown to have a major impact on the women (and often on their partners). The interpretation of the scan experience in positive ways has been demonstrated to be the case for the participants of this study. This positive interpretation has also been shown to be the case in a small number of other studies (see for example, Campbell et al, 1982; Hyde, 1986). However, Price (1996) points out that when anomalies are found, the ultrasonographer is unable to relay this information to the woman, and as a consequence the women experience the scan in negative ways. Thus, the experience of the scan as being positive or negative is likely to be affected by the communication process, which in turn is influenced by 'what' the ultrasonographer 'sees'.

Overall, in this chapter the similarities within and across accounts are shown to be numerous, while a number of differences also occur. The main area where differences were found related to asking the gender of the baby. Further individual differences in the interpretation of the scan, which show variation across accounts, have also been provided in the last subsection of theme four. However, the first three subsections of theme four show that there are also a number of similarities in the women's interpretations of the scan taking place. Many of the women provided detailed accounts of this aspect of their experience, and showed that they enjoyed the experience.

In this chapter, the knowledge of the baby that is obtained (by various means), and the thoughts that the women have about the baby, are shown to be, by and large, very positive experiences for the women. This may well be due to the participants' desire to have a baby, and therefore a wanted baby is being identified with.

The constructed images, as created by the medical profession, together with the other images the women also construct using socio-cultural frameworks and fantasies, show the variety of ways in which images of the baby are constructed.

Chapter Ten: The research process and reflexivity

10.1 Introduction

Reporting on the realities of carrying out research by way of taking a reflexive approach 'is perhaps *the* most distinctive feature of qualitative research. It is an attempt to make explicit the process by which the material and the analysis are produced. It is a concept integral to...feminist research...in which both the researcher and researched are seen as collaborators in the construction of knowledge' (Banister et al, 1994: 145).

Bannister et al's description of the use of reflexivity is but one of many different descriptions which are now available. The term reflexivity has become complex over the years in so far as it has acquired many and varied usages (Pidgeon and Henwood, 1997). For example, Bhavnani (1993) argues that one of the uses of reflexivity relates to the way in which it can help prevent researchers from engaging with dominant representations that may reinscribe inequality. Additionally, its use can address power relations between the researcher and researched. Fonow and Cook (1991) see its use as providing 'an insight into the assumptions about gender relations underlying the conduct of inquiry. This is often accomplished by a thorough-going review of the research setting and its participants, including an exploration of the investigator's reactions to doing the research' (p 1).

The many varied uses of the term mean that only global, broad definitions can encompass the basic elements of the different reflexive approaches. To this end Wilkinson (1988) defines reflexivity as 'at its simplest, ...to be disciplined self reflection' (p 493). In developing the concept Wilkinson identifies three uses of the term: personal, functional and disciplinary.

In this chapter I will be highlighting my personal reflexivity, which acknowledges who you are, and your individuality as a researcher, in line with Wilkinson's 'personal reflexivity' use. This is in order to show some of the ways in which I experienced the process of research from conception to completion. My review of the research process will include Fonow and Cook's (1991) emphasis on the exploration of the researchers' reactions and

Bhavnani's (1993) point about the need to consider power relations in the research setting.

This position of taking a reflexive approach contrasts sharply with that taken by traditional social scientists who view reflexivity as a contamination of data and hence a problem for objectivity (Reinharz, 1983). On the other hand, social constructionists emphasise the need to be reflexive, as the representation and interpretation of the participants' experiences needs to be considered in light of their mediated construction (mediated by the researcher and socio-cultural frameworks as described by Duelli Klein, 1983; Henwood and Pigeon 1995b). How we come to *represent the other, as well as the self* and the research process, is at present a topical debate for many feminist psychologists (see, for example, the two special issues of Feminism and Psychology, 1996, Volume 6, and Bola et al 1998).

The research process, as Roberts (1992) describes it, is 'never as simple as it looks. While traditional textbooks of research methods may seem to give a clear indication of 'how to do it', there are many questions which remain unanswered by both the textbook, and the polished accounts resulting from completed research' (Roberts, 1992:1). In order to address some of these unanswered questions, and to contribute to feminist debates on the representation of the self and the other, I will detail some of the issues I encountered whilst doing my research. One of the ways in which I will do this is to highlight some of the problems and obstacles I found during the course of my research. This exposition of the problems and obstacles researchers can encounter is one area on which I found a lack of information on in traditional methodology text books, which fits in with what Roberts (1992) describes as, 'a wide gap between the apparently problem-free research trajectory as described in textbooks, however well written, and the realities of carrying out research' (p 1).

The problems and obstacles I will highlight in this chapter are primarily based on the role and impact of 'differences' as I came to experience them during the conduct of this study. For me, the impact of perceptual (which are also positional) differences (as explained below) first came into play whilst negotiating access to potential participants, and thus an account of this phase

will be provided before examining the dynamics of difference during contact with participants. Following on from this I will aim to explore the role of perceptual differences in the shaping of my interpretation of the data. In addition, I will also detail some of the participants' own reflections and interpretations of me as a researcher and the research project.

To begin with, and at various points throughout this chapter, I will refer to some of the available feminist literature that also conceptualises and comments upon the personal experience of difference, in order to contextualise my own account and to show how other researchers also perceive the research process to be influenced by the actions, perceptions and circumstances of the researcher and researched.

10.2 The construction of difference

In terms of how difference may be seen to be constructed, black feminists such as Hooks (1984) point out that there are certain methods of representation and thinking, such as dichotomies (e.g. either/or), which are 'the central ideological component of all systems of domination in western society' (p 29). Collins (1991) calls this 'the construct of dichotomous oppositional difference' (p 42), and sees this categorisation of people in terms of their difference from one another. She suggests that the formation of the meaning that difference may have is characteristically constructed in relation to it being seen in terms of its oppositional status (e.g. male/female, black/white). The oppositional status, however, has not been complementary and the relationships between terms have not been stable. This has led to unequal relationships being resolved by subordination of one by the dominance of the other. Thus, oppression is experienced in many instances by those in a subordinate status position, which itself has resulted from the pervasive dualistic categorisation systems in western society.

10.3 Why examine difference?

The historical, cultural and material conditions in which oppressions are shaped, as well as the differing experiences of oppression based on differential characteristics such as age, social class, and point in time, need to be addressed as these shed light on the differential experiences of oppression (Collins 1991).

Phoenix (1994) describes the ways in which the gender, 'race', and social class positions of respondents and researchers can intersect. She argues that the way in which these positions enter into the interview situation are complex and thus cannot easily be predicted. Therefore, how we study difference and how we manage it in research settings is likely to require a great deal of consideration. In light of the complexities involved, Phoenix argues that putting forward prescriptions for matching the 'race' and gender of respondents and researchers would be too simplistic. One mechanism by which these complexities can be explored is the use of reflexive analysis. Detailed reflexive accounts of the experiences and negotiations that take place during the research process in which complex relationships are formed help to highlight the differential experiences of all those involved in the research process.

The exploration of differences in, for example, age, gender, social class, 'race' and disability within research settings is important as each of these characteristics can affect various aspects of the research process. A reflexive examination of the influence of difference on the elicitation of accounts and subsequent interpretations of the accounts allows the reader to form a picture of the processes involved in the construction of accounts. For example, how one sees the self as the researcher, in terms of what is taken into the research, as well as how the researched are seen, will affect the data collection phase. In the same way, the researched will also presumably consider their role in the research process, and will act according to how they perceive the researcher and the topic of research. The accounts that are provided will inevitably be shaped by the perceptions and feelings one has, not only of the work being undertaken, but also the intersections between the

similarities and differences which are constructed between the researcher and researched.

10.4 Questions of legitimacy? The fit between the researcher, researched and research topic.

In this subsection of the chapter the very early stages of the research process will be discussed. The first subsection provides a brief account of the available literature on previous researchers' personal experiences of the stage of trying to gain access. This is followed by a brief account of my own personal experience at the stage of trying to gain access (see also Bola, 1995).

10.4.1

Accounts of the early stages of the research process

Within feminist research there are now a number of accounts available which describe the early stages of the research process. This is especially evident in the stage of interviewing participants (see Oakley, 1981; Mishler, 1986; King, 1996). There is, however, a lack of description of the personal experiences encountered by feminist researchers whilst trying to gain access to the participants. This is especially the case when access is negotiated via a third party (e.g. doctors to recruit patients; head teachers to recruit school children).

The gatekeepers to access often have their own interests to consider as well as those of the potential participants, and it is therefore not unusual to find them scrutinising the proposed research project. In the broader social science literature there are a few texts which explain some of the problems which can be encountered whilst trying to gain access. For example, both Burgess (1984) and Shaffir et al (1980) describe in some detail the problems often encountered when negotiating access, suggesting that it is a common experience to find a number of obstacles present before interviewing takes place. Even in these texts, the questioning of the legitimacy of the proposed

research is often connected with its validity, practicability, ethical considerations and the methodology to be employed. What remains only briefly described is the compatibility between the researcher, researched and research topic. To address this imbalance, a description will now follow of my personal experience in gaining access to women in their early stages of pregnancy. This is in line with Stanley and Wise's (1993) suggestion: 'at least a few researchers are not male, white, heterosexual or middle class in origin. Those who aren't should make good use of this by examining, as research, our experiences as female, black, lesbian, working class and so on. Few such accounts find their way into research of any kind...Members of such groups have a unique opportunity to represent directly the experiences and understandings of oppressed people of various kinds, and this opportunity should not be passed up because we are too busy trying to fit ourselves into the social sciences as they are, too concerned with respectability and conformity' (p 169).

The dimensions of difference (as I perceived them) which permeated relations between myself, the researched and research topic were 3 fold:

1. Race: I am Black (of Asian origin), the participants White.
2. Appearance: I have vitiligo (white patches of skin).
3. Experience: I had no personal experience of pregnancy during the data collection phase.

10.4.2

Personal experience of gaining access

In this research project the gatekeepers to access were medical practitioners of various kinds (consultants, GP's midwives and nurses). Negotiating access was seen at the outset as a matter of persuasion. I was prepared with some standard responses to the sorts of questions I thought I would be asked (e.g. 'what is the purpose of this research?', and 'how will you go about its conduct?').

The process of gaining access was lengthy (one year), and began with the presentation of a paper on 'The uptake of amniocentesis amongst women of advanced maternal age' to an audience of medical practitioners in the local District Hospital. This was a way of introducing myself and my research interests. At the end of the presentation I informed the audience that I was looking to undertake a project on women's experiences of pregnancy and would like to discuss its feasibility and participant recruitment possibilities. I subsequently wrote to a number of people in the hospital and finally gained permission for the study after many lengthy discussions.

After gaining permission from the hospital I received a telephone call from one of the doctors informing me that an obstetrician with whom I had not spoken objected to the study as she had not been consulted, and that the women who would potentially take part in the study would be her patients. I went to meet this obstetrician to explain my oversight and to apologise for not having consulted her directly. At the meeting she was quick to point out (by using an example) that Asians did not know how to follow procedures. She remarked that she was on a committee looking into complaints about GPs and asked if I was aware that all of the complaints and the wrong doings were related solely to Asian GPs. A racist element was inherent in this encounter and I felt unable to reply. However, having made her point she was quick to take up an active role in helping to recruit women for the study. As I wanted to follow women from the early stages of pregnancy she pointed out that recruitment would best be achieved via GP practices. She phoned a number of GP's on my behalf and asked them to co-operate.

In trying to gain access, what I was wholly unprepared for was the subsequent questioning I received concerning my own suitability to conduct this piece of research, and the development of my own doubts with regards to this matter. The gatekeepers wanted to know why I (an Asian woman) wanted to carry out research on white middle class women, and not women from an ethnic minority background. For some, the 'race' of the researcher was not the primary question of legitimacy but rather the mis-match between what I was interested in as a topic of research (pregnancy) and what they thought I should be interested in based on my appearance (vitiligo). These issues of difference

will be outlined and discussed to highlight the dilemmas faced and the use of criteria for granting access, beyond those one would expect when trying to gain access, to demonstrate how they affect the differential experiences of black researchers.

10.4.3

Difference in appearance, race and experience

In my case I have visible white patches of skin on the face and hands. Vitiligo is a condition in which, for often unknown reasons, colour is lost in certain parts of the skin. Deciding not to wear camouflage creams to render the condition invisible, a number of remarks are often made to me. Curiosity is natural, and thus I was prepared to talk about the condition should I be asked by participants. Much to my surprise none of the participants asked and so no explanations were provided.

The vitiligo was of major concern for one gatekeeper in particular. Whilst I was explaining the proposed research project, I was interrupted by the gatekeeper, a doctor, with the remark 'it must be awful for you'. As this remark was out of the blue and did not relate in any way to what I was saying, I replied by saying 'I'm sorry but I don't know what you mean'. He replied by saying 'well everybody must look at you twice and wonder what it is. I mean it must be difficult for people to listen and talk to you'. I became aware (as he had pointed out) that I had not been listened to by him, but did not know how to respond. In fact I did not acknowledge his comments verbally and continued to describe the proposed study, asking if he would distribute the leaflets I had produced to any patients who came to him in their early stages of pregnancy.

After I left his office, I began to question my suitability to interview women in the light of what I had just experienced. Would the participants be able to listen and talk to me about their pregnancy if at the forefront of their minds was this curiosity with what I looked like? Could I make a suitable interviewer given that I do look different? These feelings were carried into each of the interviews I undertook with the participants.

One week after this encounter I received a call from a midwife who had been asked to help recruit. She asked me to meet up with her for a talk about the proposed research project. In the meeting the midwife (who was Asian) wanted to know why I was not investigating the experiences of ethnic minorities. She had come along with some fairly detailed information and offered to provide me with a participant pool. However, I pointed out to her that, although her ideas were extremely interesting and research in the area was needed, I had already invested much time and effort in setting up my research and would therefore like to pursue this before taking on another project which was markedly different. The midwife then went on to ask me how long I had had the vitiligo, and I informed her that it had been over four years. She then went on to ask me why I was not doing research *in that area* given that I had personal experience and interest well before the conceptualisation of the project on women's experiences of pregnancy. These issues are discussed in the next subsection.

10.4.4

To what extent do perceptions of 'lack of fit between researcher and researched' contribute to the dilemmas of black researchers?

The above comments placed me in a dilemma. Given that research is lacking in areas such as the experiences of ethnic minorities in a variety of situations and the perceived lack of congruity between myself, the researched and research topic, was I justified in carrying on? It had been clearly pointed out to me that, given I had no personal experience in pregnancy, and given the difference in my appearance, I should research people with similar 'problems' instead (or at least match the 'race' and gender). These points are of debatable concern. There is, of course, the need to examine the experiences of ethnic minorities on the one hand by black researchers, but on the other hand it could also be an exercise in marginalisation, in which black researchers are deemed only to be able to research black participants. This

can be a no win situation: if one examines non-race matters then one is being treacherous, but if one does then it might be seen as 'typical' and the research be granted with lower status. These statements are intensely political and served to make me feel uneasy when undertaking my research. I felt my position as a researcher was being undermined, with resulting consequences in terms of my self esteem.

10.5 Difference in methodology to be applied

Remarks were made about carrying out a qualitative study and how this would only provide anecdotal accounts. Comments such as: 'what's the point, why don't you develop a questionnaire and carry out a scientific investigation?' and 'we advise you to reconsider the design of the study' were made by a group of General Practitioners whom I approached to help in the recruitment. These comments I was prepared for and was able to respond with text book style answers from the reading I had done on feminist research methods. My own methodological and epistemological shifts from quantitative to qualitative methods were occurring at this same point in time. In chapter eleven I detail the difficulties I experienced whilst engaging in this shift.

10.6 Effect of the experience with the gatekeepers on the interviews with the participants

Having spent so much time and effort gaining access, it was a relief to be making contact with potential participants. However, my encounters with the gatekeepers had left me feeling self conscious about my suitability as an interviewer based on people's perceptions of my difference. What perceptions would the participants have of me? Would the women be comfortable with someone whose only similarity with them was gender? This was further compounded when I read Oakley's (1981) account of interviewing pregnant women, in which she highlighted the value of her similarity with the participants in the study. Oakley's similarity between self and respondents was based not only on gender but also on past experience. Her participants were

able to engage in conversations in which the personal experience of the researcher could be brought in to elicit personal opinions. In terms of how far my personal differences from the women I was interviewing were concerned, my worries remained unspoken, and were not raised either by myself or the women (see Phoenix, 1994, for a contrasting detailed account of the effects of 'difference' during the interview situation). The women seemed to accept my reasons for carrying out the research, and one woman even remarked that the project was my 'baby'.

In line with Oakley's suggestion, interviewing women was 'a strategy for documenting women's own accounts of their lives' (1981:48). However, the possible lines of structural/perceptual differences between the interviewer and interviewees, and the relative power in the interview situation, is more complex and thought provoking than Oakley suggests. The notion that power lies with the researcher rather than the researched in interviews did not tie in with how I felt: that my acceptance, and their continued participation in the research, was in their hands and not mine. It was only at the end of the data collection phase that I was able to reflect on the interview situation as having been successful, although my personal opinion is still one in which I see myself as powerless in the interview situation. This may of course, have been due to the disempowerment that I had already experienced from the gatekeepers to access. The sense of powerlessness experienced in the interviews could be seen to be one of the major impacts of 'difference'.

The construction of fit between the researcher and the researched, in terms of the perceived similarities and differences, is therefore an important element which can affect the research in complex ways. However, previous researchers (see for example Oakley, 1981) tend to only provide details relating to their similarities with the participants in order to make the case for shared experience on the grounds of, for example, gender and past experience. These are often used and discussed in research papers as a source of empathy for, and a means of building rapport with, participants.

As can be seen from the above account, in my case perceptual difference was paramount in the early stages of the research process. While ready acceptance of legitimacy is often related to the similarities one has with

the researched, my lack of similarity led to questions of suitability and self doubts for which I was unprepared. To use the traditional language of psychology, the 'experimenter effect' on the pre-interview stage of the research process is important for consideration in feminist research methodology. Identification with the researched can be, and was in my case, partly shaped by the opinions of the gatekeepers to access. They had an influential role in placing doubts about my suitability to conduct the research and could have led to the abandonment of this particular piece of research. I would argue that perceived researcher characteristics are vital in the shaping of many research projects and should therefore be paid more serious attention. Outlining the differences one has from the subject matter can be as informative as the similarities that are seen to exist.

10.7 Dynamics of difference in relation to participants

On the first meeting with participants, Phoenix (1994) found a minority of white interviewees visibly shocked to see a black researcher on their doorstep. This assumption was made on the basis that although an interviewer was expected, was known to them only by name, and was wearing nothing unusual, it was reasonable to assume it was her colour that led to the shocked reaction. This initial reaction was seen to have little impact on the actual interviews as rapport was found to be fairly easily established. However, Phoenix argues that establishing rapport can not be taken to indicate that there was no impact on how forthcoming the participants were, or whether the impact was inhibitory, given the possibility that it may have been the first time a black woman was in the participant's home. Whether 'race', social class, gender, age and any other differential positionings (or for that matter which of the social positionings) had an impact on the interview situation is difficult to tell due to the simultaneity of many of the positionings.

In my own research project, I did not find any reactions of shock on the part of the participants. This may of course have been due to their expectations of the interviewer to be Asian given the Indian name which appeared on the consent form and the use of my name as an introduction to

who I was when I first phoned them to make the appointment. However, as was the case for Phoenix (1994), the possibility that it was the first time a black woman was in their home could not be ruled out, or the relative impact that this may have had on the production of accounts. In the next subsection an account of my own feelings and experiences during the interviews has been provided in order to outline the way in which I came to interpret the impact my perceptual differences may have had on the participants.

10.7.1

Presenting the self to participants in light of the experience of difference

In subsection 10.4, 'questions of legitimacy', it can be seen that before meeting the participants I had begun to consider the perceptions the participants may have of me based on 'race', appearance, and lack of personal experience of pregnancy. I addressed the latter in the first meeting by pointing out that I had no experience, however I turned this around from something that could be negatively construed to something which was hopefully positive by saying that it was their personal experience which I was interested in and that they were the experts who could inform me and could discuss what may appear as commonsense or obvious, as this would still be interesting and novel for me to hear (in line with the standard ethnographic technique). Putting myself forward as naïve, and acknowledging the lack of shared positioning I held with the participants (in terms of experience), as well as making explicit that control of what should or could be said lay with the participants, meant that I initially saw the participants as the ones with power rather than myself (in subsection 10.10.2 I discuss the way in which the researcher can both be the one with and without power). My 'race' and appearance were not raised either by myself or the participants, and thus were taken as unproblematic in terms of impact on the research during this stage.

A number of participants did raise questions related to my credibility as a researcher on the grounds that they thought I appeared very young to be

holding a research post. They asked me how old I was and once I had replied with a smile, I asked them why they were interested, and found out that it was related to credibility issues. I went on to assert my credibility for fear of them rejecting the worthiness of their participation if they saw me as likely being incompetent with research. I mentioned how the idea for this particular piece of research came from the work I had done on a similar project examining 'Women's uptake of prenatal diagnosis'.

The ease with which rapport was established, with the consequential effect that continued participation and detailed accounts were provided by the participants, showed that the realist epistemology of *matching the 'race' of the interviewer to interviewees to gain 'better' data* was not necessary for this particular research project. In line with Phoenix's (1994) critique of prescriptions for matching 'race' and gender, I too would argue that simply matching would have been too *simplistic given that the differential positioning of 'race' between interviewer and interviewee in my case was not of any great importance (as far as I could judge)*. Had I been white or the respondents black, the influence of one on the other may have been different and yet the other differential positionings still may have outweighed any problematic influence of 'race'.

The notion of matching differential positionings, as Phoenix points out, is 'sometimes rooted in a realist epistemology, the central tenet of which is that there is a 'unitary truth' about respondents and their lives which the interviewers need to obtain. Black interviewers are considered to 'blend in' better with black interviewees and thus to be more likely than white interviewers to get data which is 'good' because it captures 'the truth' (1994.66).

If we are to take accounts as constructed, and take on board constructivist theories of knowledge (as is the case in this research project), then we must recognise that different accounts may be constructed in any given situation and there is no unitary truth. Accounts may be constructed based on perceptual differences, although the level of influence would be difficult to gauge. One must also remember that situational factors and timing of interviews, as well as the other daily experiences of the researched and

researcher, may influence the type of account elicited. It is therefore necessary to examine the context in which the account was produced, and see the account as a product of that context (e.g. the interview situation).

This also ties in with what we take as knowledge, together with issues of reality and the meanings associated with them. These points have been discussed in chapter three. Here, I would argue that the way in which we position and represent ourselves (the researchers) and the other (the researched) is extremely important if we want to further our understanding of the influences present in the construction of accounts. To this end feminists in more recent times continue to debate the usefulness of presenting unitary social structural categories as a means of representing the self and other (see for example the journal: Feminism and Psychology special features on 'representing the other', 1996, and Bola et al, 1998). Simple listings of category membership (e.g. race, age, social class) can be limited in their usefulness, as they neglect the complex differential lived experiences within such categories, and as such can lead to superficial identifications with or distinctions from the other (Bola et al, 1998).

10.8 Reflections on self as the interviewer

Within Black feminist thought there is now a growing body of literature which examines issues of marginality and its influence on the research process. Issues of power and control are discussed to show how shared differential positioning may, or may not, be of importance and the variability of the effects of these in the research process. Collins (1991) examines the 'outsider within' status of black feminists (Harding, 1991, has also examined the outsider-within status, although she relates this to strong and weak objectivity). In summary, Collins argues that black feminists' marginality in academic settings can tap into this marginal status of outsider-within to 'produce distinctive analyses of race, class, and gender' (p 35). Collins suggests that despite the obstacles outsiders-within may face, they can benefit from this status by exploring what the links are amongst the multiple interlocking systems of oppression. As a useful starting point for a black

feminist standpoint, Collins cites Simmel's (1921) essay on the 'stranger'. She quotes the potential benefits as being '(1) Simmel's definition of 'objectivity' as 'a peculiar composition of nearness and remoteness, concern and indifference' (2) the tendency for people to confide in a 'stranger' in ways they never would with each other; and (3) the ability of the 'stranger' to see patterns that may be more difficult for those immersed in the situation to see' (p 36). Taking Simmel's points and applying them to the research I undertook, we can see the first point, on the issue of nearness and remoteness, surfacing in my lack of personal experience and my 'stranger' status based, if not on 'race', then at least in terms of past experience and of no prior knowledge of each other (participants and interviewer). In relation to the second point, the participants in my study can be seen to have confided in my 'stranger' status, by the level of depth they went into in their personal accounts, and at times their sharing of very sensitive aspects of their experiences. The third point outlined by Simmel of being able to identify patterns which may have been more difficult if I was further immersed in the situation (e.g. had previous experience or knew the participants beforehand) would hopefully serve fruitful in the analysis, and in some ways must have operated in terms of which themes I extracted from the data.

10.9 Interpretation of accounts: The value of being the 'outsider-within'

The interpretations were structured according to the most salient issues which I perceived to have been documented by the women in their diaries. I began by reading the diary entries from each of the participants and then moved on to coding the themes which appeared in chronological order for each of the participants. In the first instance, note was taken of recurrent themes, from where I began to question what they showed and the possible meanings that could be attached to them. Taking, for example, chapter five on pregnancy identification, I picked up on the stark contradiction between what the women described as their symptoms of pregnancy (e.g. tiredness and nausea), and how they thought about the pregnancy (questioning the reality).

This dichotomy did not make sense to me and came as a surprise, thus I paid it closer attention to gain a level of understanding. It appeared to be a complex relationship between the women's thoughts and behaviour.

Having at the outset of the project been interested in examining women's experiences of pregnancy, particularly in relation to being defined as high or low risk, I decided to examine the women's accounts for their use of these terms and their interpretations of them (as presented in chapters six and seven). I was aware of my predefined interest in this aspect of the pregnancy, and thus paid particular attention to the way in which I was reading the accounts for 'evidence' of a distinction. I paid close attention to the data and carried out line by line coding (in line with grounded theorists) in order to attempt to minimise my own imposition of categories for which evidence was required. This is not to say that I have been impartial and objective in my interpretation, but to suggest that as far as possible I attempted to work from the data up and produced the themes/categories as a result of paying close attention to the data.

Indeed, by questioning and acknowledging my own suppositions (mainly based on a rather unitary medical model) and by staying close to the data I found that the women did not interpret risk in a way I had previously thought that they might. I found that some of the women changed in their views as to whether they were at risk, and that often the reasons for seeing the self to be at risk varied.

The selectivity in which I engaged was shaped by my particular readings of the accounts. Where something seemed commonsensical and was put forward as non problematic, I began to question why this was the case. Where the accounts seemed to contradict the commonsense view, close attention was paid to see what was being said.

In terms of imposing a structure on the analysis, I initially considered using a progression model in which different themes relating to each stage of the pregnancy could be highlighted, the stages being those defined medically as the first, second and third trimesters. In practice, after having analysed the data, I found that identifying themes for each of the three trimesters was

somewhat superficial in that after the initial stage (first trimester) the women were not, for the most part, using the stage model, and the issues they were raising spanned across the various stages. Thus, the first chapter in my analysis subsection (chapter five of the thesis) is the only chapter which specifically deals with one particular stage (the first trimester). In the subsequent chapters I have presented material which deals with the most salient issues in the women's accounts across the length of their pregnancy.

My initial thoughts about using a progression/stage model to formulate a structure to the analysis related to my interest in using and presenting as much of the longitudinal data as was possible, given that the women had participated in the study for the duration of their pregnancy and had continued to provide detailed information throughout. Thus, it was not so much a question of taking on the medical model to formulate a structure to the analysis, but rather my concerns about doing justice to the amount of work put in by the participants over a lengthy time span. In other words, this provided a framework to help start organise my data for analysis. Chapters six to nine have used the longitudinal data and thus my concerns about not making use of the data provided in the later stages of the pregnancy were allayed.

10.10

Participants' reflections on the researcher and the research topic

During the course of the research project a number of the participants discussed their feelings about taking part in the research as well as reflecting upon me as the researcher (for example, in terms of me ultimately being in a position to judge their contributions and experiences, and thus perceiving me to hold a position of power not powerlessness). In addition, I found that during a number of the one-to-one interviews the participants perceived me to be capable of playing a dualistic role, one of researcher/counsellor or researcher/'expert'. In subsections 10.10.1-10.10.3 I will highlight each of the above points and my interpretations of their implications.

The information that the participants offered in relation to taking part in the research and about me as the researcher had not been asked for, either in the diaries or in the one-to-one interviews I conducted with them. It was only when I was carrying out the initial analysis of the data that I came across the data presented below. Not all of the participants reflected on the issues and so I am only able to present the views of those who had provided the information.

10.10.1

Taking part in the research project

The following extracts are taken from Sam's diary accounts, and show how she moved from a position of being unsure about taking part to really enjoying keeping her diary account of the pregnancy.

Extract 249 (Sam - diary):

'Asked to join Research project - not sure of feelings about this yet - a little bit new.'

Extract 250 (Sam - diary):

'[GP] asked re: the research. I think I am beginning to enjoy keeping this diary. I just hope my writing can be read.'

A few weeks after Sam had reported enjoying keeping the diary, she observed another one of the participants taking part in the study writing her diary at a hospital visit. Her observation led her to feel 'guilty' and 'shocked' as can be seen in the following extract:

Extract 251 (Sam - diary):

'I felt so guilty today, at the clinic there was a pregnant woman with her diary - she sat there in the waiting room, recording all her thoughts and feelings, I was very impressed but also somewhat shocked, that I haven't been so diligent as her!!'

With reference to the amount of work each woman put into the research project (including Sam's contribution), I found that they all certainly did provide me with an overwhelming amount of data, and each of them remained motivated and committed to the research project until the end (around one month after the birth). However, as Sandy's comments below show, there were times when the women did not have anything to say or did not make diary entries:

Extract 252 (Sandy - diary):

'nothing to report'

Extract 253 (Sandy - diary):

'Feeling lazy about keeping this diary.

But there really is nothing much to say. I'm feeling okay, getting lots of rest...'

Extract 251 shows that some of the participants came into contact with each other and that such encounters led them to consider their own role in light of the encounters. In Sam's case we can see that she began to evaluate her own contribution as a result of the encounter. The extract below not only shows that such encounters continued, but also that they developed as time went on. One of the possible outcomes of the unplanned meetings between the participants is that they had the opportunity to discuss their contributions toward the research project, although as to whether this did occur was not asked by me, and thus it remains only a possibility.

Extract 254 (Sam - diary):

'Spoke to a nice woman in the clinic, who is also doing this research - not about the research, but about births etc. She gave us some good advice about the hospital admission, which I really appreciated.'

In the next extract Sam mentions her concerns about what she said during the interview. This could be interpreted in two ways: firstly, as a concern for the relevance of what she said in relation to the research, and

secondly, as a concern about the way she may be interpreted by me as the researcher.

Extract 255 (Sam - diary):

'Meeting with Manjit - did I talk too much and sound silly?'

Extract 256 (Sue - diary):

'When I was in my 7th month last pregnancy, I was so full of energy and really enjoying being pregnant. I was also hungrier. This time I'm feeling bulky and tired - my feet ache a lot and I'm feeling more like I did in my last month last time. I feel like all I've done is complain about how I feel in this diary, but I've not been very energetic or really enjoyed this pregnancy.'

The above extracts show how some of the participants attempted to evaluate themselves in light of the contributions they were making, and as such we need to acknowledge not only our own evaluations of how the research is going, but also those the participants hold. To this end the diary became a useful tool in self evaluation for the participants, and as such the potential usefulness of diaries as a means of meta analysis should be acknowledged.

Furthermore the feelings that participants may have about various aspects of the research process are all too often ignored in the final write-up of research reports and is an area that needs to be addressed.

10.10.2

Participants' reactions of meetings with the researcher

In the following extracts we can see that some of the participants had mixed reactions about the interviews I conducted with them. In the case of Sam these reactions were expressed in the following way:

Extract 257 (Sam - diary):

'Met Manjit. Funny but I don't think I have ever opened up like that so openly before, not even to Steve. I felt incredibly vulnerable afterwards and quite tearful for the rest of the day.'

Extract 258 (Sam - diary):

'Nothing from researcher, for several weeks, I hope her father is OK. I expect she read the first edition of this and thought it the complete ramblings of a mad women - I know I would!!'

In the above extract Sam is referring to my inability to meet up with her for an interview for just over a month. I had phoned to let her know that my father had deteriorated in his condition (he suffers from Motor Neurone disease), and that his chances of survival were slim and therefore I was in Derby at my parents' house. However, as can be seen from Sam's extract, the lack of contact I had with her on this particular occasion led her to suspect that the meeting may have been postponed because of my evaluation of her previous diary entries. She even went as far as to assert that she would have thought her data was just 'ramblings' in an effort to assert her acceptance of such an interpretation. I would like to point out that I found Sam's diaries very interesting, and had I known about her doubts about the contribution she was making to the research project I would have informed her that her contributions were invaluable. Unfortunately, given that she had recorded this extract in the second of her diaries, I did not come across it until the end of the project and as such had not reassured her whilst the data collection phase was going on. However, at our next meeting Sam had inquired as to how my father was doing and was very sympathetic toward my situation as a carer for him and the need to cancel the appointment. She showed no doubts about believing the reason why I had to delay the interview.

As I mentioned previously, the notion of power resting with the researcher and not the researched was highlighted to me when I read extracts such as the one presented above. This acknowledgement of my power

position was late in coming, as it was only when I was analysing the data that I became aware of it. During the data collection phase I felt powerless (see subsections 10.6 and 10.7.1), and disagreed with previous researchers' notions of power lying with the researcher and not the researched. In light of my experience of feeling powerless during the data collection phase and then coming to recognise the power I did hold whilst analysing the data, I would like to argue that power relations work in complex and dynamic ways. In my case I would argue that I was both powerless and powerful simultaneously. This was due to the differential interpretations that I and the participants held in relation to my positioning. In subsection 10.10.3 there is further evidence that I was perceived as the one to hold the power in the relationship, given that some of the participants looked to me for advice.

10.10.3

Participants' interpretations of the researcher as counsellor/expert

On a number of occasions I was asked for my advice about certain symptoms and/or feelings the women were experiencing whilst I was carrying out the interviews. This was interpreted as indicative of how disempowering the pregnancy experience can be. They were aware that I was undertaking a psychology project, and believed that psychologists know or have the answers to why particular feelings occur. Their questioning of me for information made clear that they did not perceive me to be as naive as I had said I was to them about my knowledge on the experience of pregnancy. In addition, a number of participants asked me about whether other participants saw me as someone to 'pour their hearts out to' and thus feel counselled.

My responses were mixed. On occasions I would say that I have no training in counselling and so doubted that other participants saw me as a counsellor, while at other times I would acknowledge that although I wasn't a counsellor I did feel as though some of the women perceived me to be one and reported finding the interviews rather therapeutic. In the second of the two

responses I used there was (I felt on my part) more of an acknowledgement of the way the participant was perceiving me, and that this was not so unusual.

There were times when I was asked for advice for which I was not qualified or ethically able to give, but yet to simply say this would have been very difficult for me and the participant. For example, on one occasion Sam (a diabetic) asked me if she was at high risk and whether I knew anyone else who was diabetic and at high risk like herself. She had been crying for the previous twenty minutes and I had switched the tape recorder off so as not to be putting the research first when she asked me these questions. There was another diabetic woman in my sample of participants and so I would have been able to give this information if it was not ethically wrong to do so. I replied by saying that although there was another participant who was diabetic I had to remain confidential, but I would try and find out if there were any support groups or information on pregnancy and diabetes for her.

After the interview I was left unsure as to whether it was appropriate for me to offer help in locating support groups and information on pregnancy and whether, if it were, I should ask the other diabetic woman for such information. I spoke to my supervisor about this dilemma, and we felt that it would be appropriate, as long as I acknowledged that the book which contained information on diabetes and pregnancy together with addresses of support agencies was simply a book that I had heard of, and did not know much about its usefulness.

10.10.4

Afterthoughts about the reflections made about the self and the participants

The reflections of the participants, and the reflections that I have provided about myself in relation to their comments, have meant that an indirect means of reflecting upon each other has been attempted above. Ideally (speaking from hindsight), a direct attempt would have been made to assess the acceptability of my interpretations of the participants and the

participants' interpretations of me. This would have meant that feedback on each of our representations of the other could have been incorporated in the write up of the research and the reader would have received a fuller picture of how we had come to negotiate our constructions of each other.

10.11

Discussion

Within this chapter particular reference has been paid to Black feminists' accounts of the impact of difference. Their experiences provided valuable insights into my own experiences and spurred me on to write about my own experiences, and to think about the construction of difference in everyday life. Taking a reflexive approach seems now to be firmly rooted in feminist research practice, as can be seen by the number of reviews and accounts of representing the self and other. Take for example, the special features in the journal of Feminism and Psychology (1996) and the review paper by Bowes and Domokos (1996) on muted voices, which looks at issues of matching researcher and researched; empowerment; power negotiation; the interview process and analysis of accounts.

In the next subsection I have outlined some of the concerns that might be raised when examining the concept of 'difference'. This is in order to keep in mind the importance of examining the concept within its local contextual use and to consider the theoretical implications of its construction in light of the different forms in which it comes into play within the research setting.

Following on from this, a short review of the ways in which my own experiences can be considered in relation to the available literature in feminist psychology is provided.

10.11.1

Representing difference: A word of caution

There are two broad ways in which we can consider the legitimacy issues related to aspects of 'difference' during the research process: the macro and micro levels of analysis. At the macro level we can examine the socially constructed nature of 'difference' in terms of its conceptualisation and usage at a societal level, as well as the related political issues. At the macro political level we often see the advocacy of particular stances that are either in effect, or are being put forward as preferable to the contemporary stance. Feminist theory and research practice has proposed the need to see the macro level of analysis at the micro level. This can be done by seeing the personal as political and being reflexive, allowing the researcher, in part, to examine the impingement of the macro on the micro level. Thus, at this level, the personal relationship between the researcher and the participant can be examined reflexively in terms of the wider political context, as well as the inherent issues of similarity and difference between the researcher and the researched. To this end we can now find a number of feminist accounts which detail the similarities and/or differences between the researcher and the researched, or at least the importance of addressing relations along certain dimensions, such as, race, social class and gender (Bola et al, 1998; Phoenix, 1994, 1995; Hill Collins, 1991; Griffin, 1989; Burman, 1990). These dimensions have been explored *in terms of their impact in the interview situation*, especially in terms of the dynamics of power (Bhavnani, 1991, 1993).

The need for further discussion of the issues related to the impact of difference between the researcher and researched lies in the complex nature of such inter-personal relationships. There can be very few clear indicators at the outset of the research process which indicate whether the impact will be problematic or non-problematic, advantageous or disadvantageous. Much probably depends on the structural as well as the perceptual differences at the researcher-researched interface, and the complex interaction between them. The concerns we might have at the outset may be better addressed if there is

available literature which highlights previous researchers' experiences. In addition, such accounts could draw attention to factors that we may be unaware of at the outset.

Having outlined the potential importance of such accounts, we must also be aware of the dangers in making strong assertions about the appropriateness of particular researchers to particular research groups. The dangers lie in the likely scenario where difference is equated with incompatibility, which in itself could lead to marginalisation. Certain groups in society (especially those that already face discrimination) are more likely to be left out, as compatible researchers in the current climate are rare. From the researcher point of view, marginalisation would occur in terms of who you are deemed suitable to research.

The application of what might be termed 'in group' - 'out group' criteria would lead to a further reduction in research which examines the already under-researched populations in society. Such a stance would also lead to researchers having to justify why they chose a particular research project in terms which would exclude valuable reasons that relate to their own curiosity and interest. Knowledge for its own sake would become under-valued, and feminists argue that this should not be so.

Given the potential dangers in codifying the difference(s) between researcher and researched, as feminists we need to have open discussions about the very nature of, and the role played by, the concept of difference. First, we need to see how the concept of difference has been used and explained in feminist theory and practice, and second we need to bear in mind why its dichotomous counterpart (similarity) seems to be given either positive attention, or little attention, in terms of its possible detrimental contributions in the research process.

Difference has been a central element in feminist theory and practice. It has not only been explored in terms of differences between certain categories, most notably the categories of 'women' and 'men', but also in terms of differences within a category along certain dimensions such as social class and race. Barrett (1987) discusses the concept of difference within feminist

theory and practice and points out the distinct ways in which it has been used and the meanings attributed to it, as well as outlining the tensions it has produced. Barrett suggests that one of the uses of difference in modern feminism is in terms of experiential diversity, where diversity occurs along a wide variety of dimensions such as age, ethnicity, disability and religion. It is this category of usage that has been outlined in this chapter.

As the aims of the research were to examine women's experiences of pregnancy, and not cultural comparisons of the pregnancy experience, my own race (the first dimension of difference, as discussed earlier) was seen as incidental, and apparently played no part in the questions the participants asked me, or the questions I asked them. Thus, in this particular research project, the difference in race did not warrant detailed explanation as it was not perceived to be a barrier. This is not to deny the relevance of race in differing research projects where its impact may be substantial, in which case it would be appropriate to see it as a central analytical concept. The questioning of the appropriateness of a member from an ethnic minority group researching members drawn from a majority group, or vice-versa, may not always be relevant or be a problem that requires legitimisation, although it may be unjustly seen as such (as was my experience whilst initially attempting to gain access to participants). Relevance, instead, may depend on the nature and the purpose of the research which must be kept in sight when examining identifiable dimensions of difference.

The second dimension of difference: lack of personal experience (as discussed earlier), was raised by myself and addressed to the participants. I informed them that I had no personal experience of pregnancy and tried to turn this into a positive advantage, in that anything they may have to report would be of interest to me and would deepen my understanding. The women did provide me with elaborated accounts, which may partly be attributed to this role of them teaching/informing me, rather than me knowing and questioning them. The dynamics of power in this instance may be construed as having shifted from the traditional sense of it lying with the researcher to the researched. During the interviews I felt uneasy with this lack of power, although this was not expressed to the participants. The sense of

powerlessness was not only generated by myself in terms of having attributed a powerful role to the participants based on my lack of experience, but also in the sense that it had been generated for me prior to the interviews taking place by the gate keepers. Whether or not I was justified or correct in seeing myself as the one with a lack of power in the interview situation, I nevertheless felt this to be the case. Again, as mentioned previously, the older feminist literature I had read up to this point indicated the advantages of similarity whilst interviewing, thus further compounding my unease in the interview situation.

Given my unease with regards to my suitability as a researcher for this particular piece of research, there is likely to have been some impact on the accounts that had been produced. The influences of this dimension of difference on the construction of the relationship, accounts produced, and therefore the analysis performed, does in this instance (unlike the dimension of race) require explanation. The interpretations that are made need to be seen in the light of the influences which existed in the construction of the data, which takes us back to the importance of reflexivity in report writing.

The two dimensions of difference briefly highlighted here serve to show that codification may or may not be appropriate, and the decision is dependent on the nature of the research project. I would argue that as feminists we should continue to investigate the personal experiences of researchers in different research contexts, so that we are aware of the potential effects of the concept of difference, in terms of the role that it may or may not play in the research process, however difficult this may be. However, we must be cautious about advocating particular stances along dimensions of difference, which would serve to codify and thus regulate the type of research conducted. We must remain aware of the concept of difference and the complex role it plays in the research process, and see this usage and reporting of the concept as distinct (as far as is possible) from its evaluation as a concept on a macro level of analysis, otherwise we may end up producing generalised accounts of appropriateness, which would undoubtedly ignore the micro level of analysis that is also required to highlight the positive and negative aspects of difference and diversity. This is especially important when we attempt to describe the

independent, dependent, and interdependent relationships that exist between the macro and micro levels of analysis in relation to understanding the nature and consequences of personal experience. Our personal experiences can emphasise the significance of diversity and universality without inhibiting research practice if we can adopt a pluralistic approach to carrying out research.

10.11.2

Relating past feminist writings and my own experience

Oakley (1981) described in detail the process of interviewing women. She suggested that to gain knowledge of participants' subjective experiences it is best achieved when there is a non-hierarchical relationship between the interviewer and interviewee, and where the interviewer invests their own personal identity in the relationship. This I felt was partially achieved: the interviews were informal and, to some extent due to the unstructured procedure that was adopted in the meetings, there was a level of ease in the friendly communicative environment. As Oakley found, the interviewees took the initiative in defining the relationship which existed, and the meetings were not only a source of data gathering but also a time in which personal matters unrelated to the pregnancy were discussed and friendships formed over a period of time.

The level of interest that was maintained by the participants in this longitudinal study took me by surprise. Not only did they participate in a number of interviews, they were also keeping in-depth accounts of their pregnancy in diaries which I had provided. It was in many ways a collaborative exercise. At the outset of the interview stage I was concerned that the lack of personal experience on my part may lead to a question-answer style interview in which it would be more difficult to form and sustain a non-hierarchical relationship. In addition, I was aware of the fact that I may be too far removed from the women's experiences, given the comments that were made by the gatekeepers to access. However, in practice my lack of experience served to enhance the level of power the participants held. They felt able and did go into

detail in explaining their feelings and developments in such a way that someone without their experience could be informed.

Stanley and Wise (1973) suggest that the researcher should locate herself in the research situation, to be reflexive and give her personal account. They point out that 'As women, as lesbians, as black, as working class, as disabled, as otherwise 'deviant', we see the world in a different way, different experiences happen to us, people relate to us differently, we relate to them differently' (p 169). This statement can be seen in practice in the differential experience outlined here. As relationships are different, based on who we are and the situation we are in, each piece of research needs to include a reflexive element if we are to better understand the research process. Henwood and Pidgeon (1993) also point out that the writing of personal experiences encountered during the research process is important for a number of reasons, for example 'as a strategy for debunking the myth of total objectivity in scientific research...to explain and justify the basis for her interpretations to all concerned (as part of making the research process and its objectives open to public view) the qualitative researcher becomes accountable for her interpretations and their social and political consequences to herself, her participants and her community' (p 11).

In summary, in my own attempt to make the self visible I have outlined and discussed issues of 'difference' as I came to perceive them during the research process. In addition, some of the participants' perceptions of me as the researcher, and of their involvement in the research project, have been outlined. The theorisation of difference, and Black feminists' reflections on the 'outsider-within', have been detailed in order to provide a commentary on previous conceptualisations of difference. My own reflections build on this literature and extend the available knowledge base by providing my individual experiences of it.

Chapter Eleven: Discussion and Conclusion

11.1 Introduction

This thesis began by outlining the previous research which had been conducted on the psychological aspects of pregnancy. During the literature review it became apparent that there was very little research which had been carried out on the experience of pregnancy itself. Instead, the majority of previous research focused on various discrete aspects of pregnancy, such as levels of stress, anxiety and depression (which are of particular interest to the medical profession), or alternately discussed pregnancy in terms of its relation to the transition to motherhood. In the latter research area, qualitative research methods had been employed by a number of researchers, and the theorisation of pregnancy did not involve the pathologisation of the state (as was the case with some of the quantitative studies). Previous quantitative based research studies were shown to be largely based on the complicated and problematic aspects of the pregnancy experience. Those using qualitative methods were shown to be in the minority.

In contrast to much of the research outlined in chapter two, my own research is located within the minority qualitative methodology camp, as I have used a feminist post-structuralist approach. However, instead of examining pregnancy in light of the transition to motherhood using qualitative methods, I have examined certain aspects of the pregnancy experience, to see how ten women came to construct and experience their pregnancies.

In chapter three I explored a number of the epistemological and methodological issues involved in the conduct of research and outlined and described the developments which have occurred over time, both within psychology and feminist based research endeavours. The epistemological and methodological stance that I have taken is based on Stanley and Wise's (1993) approach, and this was detailed at the end of chapter three.

Following this, I outlined the conduct of my own study. The participants' details and the design of the study were presented in chapter four, while chapters five to nine contained the main empirical analysis. These chapters

form the substantive component of this thesis, and are considered in more detail in this final chapter.

As a feminist researcher who takes reflexivity and 'difference' seriously, I have attempted to highlight a number of the often ignored aspects of the research process in chapter ten. This chapter mainly deals with the structural and perceptual images I experienced as a researcher whilst in the field, and examines the contributions my study and experiences have made to feminist analysis.

Turning to the structure and specific contents of this chapter, the first subsection provides an insight into the journey I made as part of being a research student. This reflexive account sheds light on the behind the scenes events I experienced, and is a continuation of the reflexive approach outlined in chapter ten. In contrast to chapter ten, in which I examined issues related to fieldwork, in this subsection I will detail the shifts I made whilst considering the theoretical and methodological issues that related to the conduct of the study.

In this first subsection I have also disclosed aspects of my own positionings which impinged on the research process (most notably my own researcher developments and the gaps in its write-up and hence completion). The reason why I have presented a reflexive account prior to the discussion of the empirical chapters relates to the impact and recognition I have of the effects my own social locations and interpretations of the research process have on the construction of the analysis and main findings which have come to make up the empirical chapters.

The second subsection, which discusses the empirical analysis is the largest of the subsections. A summary of the main contents of the empirical chapters, and a discussion of the findings and novel contributions made, are presented in this subsection. However, a discussion appears at the end of each empirical chapter and thus it requires the reader to also pay attention to these discussions as well as the synopsis of discussions which appear here. This subsection also aims to contextualise the findings of my research within feminist interests concerning the oppressed social locations of women and the possible emancipatory goals which would benefit women by raising

awareness and fighting for change. In doing this, I am aware of the tension between the poststructuralist notions of plurality (the main position I have taken in analysing the accounts) and the structuralist notions of fixed (essentialist) unitary explanations (a position that I have occasionally used to relate some of my own interpretations of the construction of experience to traditional feminist explanations).

The third subsection contextualises the research findings by looking at the relations between my own research and that of previous researchers. The similarities and differences between the studies are outlined.

Building on from this, the fourth subsection of this chapter contains suggestions for future research. These suggestions are based on the experience and findings obtained as a result of having carried out the present study, and look at the potential usefulness of carrying out relational studies to further our understanding of the experiences of pregnancy.

The fifth and final subsection which appears before the discussion of the chapter, contains the criteria I used to evaluate my research study.

11.2 Reflections on the development and completion of the study

My interest in examining the pregnancy experience as a continually changing state came about at an early stage of my research endeavour. As mentioned in chapter one, this was as a result of having worked on a questionnaire based study on the uptake of prenatal diagnosis which allowed me to become aware of the numerous weaknesses associated with particular styles of research.

However, my final choice of a particular qualitative approach was a long time in coming. I had chosen two forms of data collection which would be conducive to both discourse analysis (my first choice at the early stages) and grounded theory (my second choice). It was the lack of time to carry out the initial analysis upon which subsequent data collection could be based for

category saturation (a requirement of the grounded theory approach) that led me to abandon grounded theory during the second data collection phase.

I had at this same stage (of trying to choose an appropriate epistemological and methodological framework) become interested in feminism, after having discovered for the first time that there were many feminisms. Joining a feminist group fuelled my interest in feminist practice and my long journey to attempt to understand feminist theory and research practice began. My late discovery of feminist academic work (the reasons for which are explained below) delayed my analysis and write up of the research, as I found an array of terms and forms of feminisms which required a great deal of reading and rereading.

Each form of feminism that I came across had a special appeal, and seemed to fit my interests until I read elsewhere the criticisms that could be made of the approach taken (e.g. use of realist epistemologies). In addition, the alternatives to certain approaches came to have their own appeal (e.g. social constructionist epistemologies, to which I was already aligned). The arguments against taking a realist stance also influenced my decision not to use the grounded theory approach, as at the time of learning about this approach I had only come across the use of grounded theory within a realist perspective. Since this time I have become aware of the constructionist revisions of the grounded theory approach, and thus its rejection on that basis would no longer be relevant.

My interest in feminist approaches led me to also reflect on, and critically examine, the use of discourse analysis as an appropriate social constructionist tool, for the analysis of my data. I decided to reject its use due to its lack of consideration of the individual as the producer of the text. Instead I found using an interpretative style of analysis more conducive to my interest of keeping the individual central within the analysis. To this end I adopted Stanley and Wise's (1993) approach (as described in chapter three).

As a psychology undergraduate and postgraduate student I had received very little formal training in the history, philosophy and conduct of qualitative research (including feminist based analysis). This meant that unlike

the psychology students who remained with the methods they were taught, I, like the other qualitative research methods students from psychology backgrounds, had taken on a dual role of learning new methods and of applying them without the benefit of practice or taught guidance beforehand.

As a result of the substantial shift in the epistemological position I had taken from my undergraduate training, I found that trying to disengage with the prior ways of thinking I had developed (as an undergraduate) very difficult to separate from and leave behind. This is evident in my empirical analysis chapters where, although I have attempted to employ only constructionist ideas to the interpretation of the data, I have at times explained my findings using a rather unitary bio-medical model. This reversion to the rather singular forms of explaining particular occurrences occurred for a number of reasons. Firstly, what you have previously learnt and applied for a number of years takes on the role of being common-sense, a system of operation that we take for granted in our everyday lives. This common-sense view leads us to put into practice, and accept, the way in which we are operating without giving consideration to the way in which we have come to operate in such a manner. Secondly, the ease and familiarity of old positivistic styles of explaining research findings is not always easy to ignore, and despite your best efforts to recognise and break away from these styles of thinking, there is a basic appeal that they carry because of their simplicity. This simplicity provides a starting point from which the researcher can gain a foothold into a subject matter and can come to make sense of the data in ways that are previously known to them. Thirdly, even when I came to recognise where I was reverting back to singular routine modes of explaining the data, I found that it was often difficult to put into practice the different way of thinking that is required when a constructionist approach is taken. Looking for the multiplicity of realities or the multifaceted use of particular concepts (e.g. risk) was at times easier to recognise in the data than in my write up (re-representation) of it. Thus, at times the constructionist position I was taking did not appear to be constructionist in the final versions of the analysis chapters.

The imposition of particular themes and categories also reduces the data to unitary explanations, which is at odds with a full constructionist

approach. For example, in the pregnancy identification chapter I used particular styles of explaining the data which were rather unitary rather than constructivist e.g. referring to 'stages', 'new status'. These ways of thinking show that the researcher uses her own interpretations (gained from past and present experiences) to explain the data. Recognising your own strengths and weaknesses allows for a better understanding of the basis upon which the research findings have been constructed, and the ways in which they can be interpreted. From this it is possible to see that the sanitised version of coming to choose and implement a feminist research methodology (as presented in chapter three) is deceptive in the way in which I experienced it.

Additionally, the need to present a coherent argument and show a clear understanding of the issues involved for the purposes of assessment require that the final write-up be a coherent story. My own write-up therefore follows a fairly traditional route.

Although feminist researchers attempt to move away from 'the mythology of hygienic research', the presentation of the findings (in the format currently used) still leads to a sanitisation of the process. By taking a reflexive stance, certain aspects of knowledge production have been brought into the open (see chapter ten, where the relations between researcher, researched and research topic have been outlined), however we are still operating in limited systems of disseminating information in novel ways (Gill, 1998), which means that feminists have a long way to go before they can break away from patriarchal, institutionally based forms of representing their research.

By highlighting the above shifts in my own positionings I am attempting to bring to the fore the learning curve which I experienced prior to the development, conduct and write-up of the present study. However, what I have not attempted to do in this thesis is present the information using a novel format, as this would again require another shift in moving away from my prior training which would require further time consuming efforts, and hence be beyond that which I could cover in this thesis.

In the remainder of this subsection I will highlight some of the personal reasons which led to the delays in the completion of this thesis. Each

individual researcher goes into the research process with particular difficulties. For many (as well as myself) the difficulties experienced relate to issues such as resources, access to participants and completing within a particular time frame. I have discussed at length my personal experience of gaining access in chapter ten, and thus here I will concentrate on other aspects of my experience. Certain aspects of my experience are likely to be similar to the ones a number of other researchers may experience, however other aspects relate to the individuality of experience. I will briefly outline the reasons why there have been substantial gaps in the time spent in completing the research and writing up of this thesis, the reason being that as a feminist who takes difference seriously I would like to make explicit the ways in which my own social identities/locations have impacted upon my role as a researcher, as these provide an insight to the differential experiences of researchers.

Firstly, my personal and family members' experiences of health related problems resulted in me having to rearrange a number of the interviews. This resulted in some of the participants questioning why I was unable to attend at the pre-arranged times (see, for example, Sam's account provided in chapter ten). At each of the subsequent meetings the participants would ask me how my own health and that of my parents was. They often said that compared to what I was going through their problems seemed minor. Such considerations may have meant they were not as forthcoming with the problems they were experiencing during their pregnancy.

At the end of the data collection phase I became seriously ill which meant that I was unable to work on the thesis for over a year. This long delay made it very difficult for me to motivate myself to return back to the study.

Secondly, my relationship with my partner was disclosed to my parents during the write up of the study. This resulted in difficult negotiations with my community, as the relationship fell outside of the accepted cultural norms of the Indian community. The emotional upheaval I went through affected my ability to concentrate on the thesis.

Thirdly, I became pregnant whilst in my final year of registration for the PhD. My expected date of delivery and the date for the submission of the

thesis coincided. The difficulties I experienced with the pregnancy meant that once again I was unable to work on the PhD adequately. I decided to take six weeks off prior to the expected date of delivery so that I could work on the thesis full-time, instead of part-time due to work commitments, but two days into my maternity leave I went into hospital and my baby arrived prematurely. This meant that once again I was unable to complete the thesis, and resulted in me having to ask for yet another extension (which was granted).

Now in the final stages I have completed this thesis whilst combining motherhood with working and writing a substantial amount of the thesis. This has been an enormous task for me, and has meant that I have had to skirt over some of the issues I would have liked to have covered as part of the thesis (e.g. exploring the management of employment whilst pregnant) due to time constraints.

By providing these very personal details I am attempting to make myself as the researcher visible and therefore accountable. This, again, is in line with feminists' arguments about the need to be open in terms of describing the self in the same way we are with the descriptions of our participants. The background of the researcher affects the research in many and varied ways, and it is only by disclosing aspects of the self that readers can make their own interpretations. One of the major effects that the gaps in the conduct of the study had was on my ability to immerse myself in the data for the purposes of analysis. The stops and starts led to the immersion process being disjointed and as a consequence I spent a considerable length of time doing the same thing on a number of occasions, as without familiarising myself with what I had already done I could not move forward.

11.3 Summary of the research findings and their contributions to feminist psychology

The empirical section of this thesis provides a fractured account of the women's phenomenological descriptions of their pregnancy. No attempt has been made to provide an in-depth look at the whole pregnancy experience due to the enormity of the issues that come to make up each experience.

Instead, a certain number of the issues discussed by a number of participants have been outlined contextually in order to show how they have come to construct certain aspects of their experiences.

As has been described at the start of the above subsection, the analysis has been carried out at the level of the text, although the individuals' use of the text to construct and explain their experience has been kept central. By remaining close to the level of the individual I do not wish to imply that each individual experience is indicative of a single reality. The analysis of the accounts from any one individual have been shown to contain multiple realities (multiple ways of seeing) the same event. Take, for example, the contradictions present in seeing the pregnancy as real and unreal, or the case study of one participants' experience of risk in which risk is perceived to be her fault at one point in time and others' construction at others.

One of the major debates within feminism relates to the acceptance or rejection of remaining purely at the level of the individuals' accounts of experience. A number of feminists (for example, Currie, 1988) argue that the socio-structural locations which come to shape women's experiences can only be analysed if we move beyond the level of the individual and examine the structural roots which come to make up the micro experience.

Whether one accepts or rejects the potential usefulness of remaining at the micro level, feminists still agree on the importance and centrality of women's experience. It is the level of analysis and forms of explanations used that have led to the differences within feminist based endeavours. In the analytical chapters I have turned to the women's descriptions of their pregnancy experience and have shown the ways in which their accounts can be interpreted in light of post structuralist theories, of the ways in which multiple (and often competing) realities are constructed. This is in line with Stanley and Wise's (1993) approach, and accordingly examines the personal (micro level) of experience in greater detail than the structural (macro level) explanations which come to make up the personal experiences. However, in a number of places within the empirical chapters (see especially chapter eight) I have also provided structuralist notions of gender oppression as I came to identify them from the reading of the accounts. In addition, within the

discussion of the findings as presented below I have highlighted some of the socio-structural roots which can be applied to the understanding of the basis of the women's experiences. However, as mentioned above, this is at odds with the poststructuralist stance of seeing the multiple ways in which experience is constructed, and therefore is also at odds with the main focus of my study. My use of structural explanations means that I am applying a rather fixed and unitary form of interpretation/explanation when the participants themselves are shown to provide multiple and often competing understandings and constructions of their experience. The privileging of my own voice over those of the participants has arisen where I have interpreted certain aspects of the women's experiences as being the result of them being 'victims of oppression', when the women themselves do not report this to be the case.

Turning to the specifics of each of the empirical chapters, in chapter five, on the early stages of pregnancy, a number of themes were explored to show how reality was made up of a number of different and sometimes competing factors. For example, identifying with the pregnancy at the early stages seemed to occur at certain levels (by confirming the pregnancy via personal use of pregnancy test kits, changing dietary habits and preparing the physical environment for the arrival of the baby), whilst at other levels (psychological acceptance and belief in the pregnancy being real) was shown not to be very easily accepted. The degree of physical symptoms experienced (e.g. tiredness and nausea) was not seen to be related to the belief in the pregnancy being real, and this led me to question why there may be a lack of relation between the physical symptoms and the psychological identification of the pregnancy. I concluded that such dualistic (contrary) modes of thinking are common and, as Billig (1988) points out, there are many instances which are also subject to dual (competing) interpretations in our everyday lives. One clear example of this that I have experienced relates to finding out about exam results, where you have passed but can't believe this to be so.

In terms of the contributions that the chapter on pregnancy identification can make to feminist endeavours, these are shown in relation to the detrimental effects of labelling pregnancy as either health or illness. In

chapter five it was shown that feminists' preoccupation with countering the negative labelling of pregnancy as pathological led them to argue that indeed pregnancy is representative of health and not illness (which is not only a generalisation, but it also ignores the way in which the pregnancy state may be experienced as both or neither).

By turning to the women's accounts of the early stages of pregnancy we can see that their experience of a number of physical symptoms (characteristic of many pregnancies) led them to experience a great deal of difficulties in terms of them having to cope with the physical changes to their bodies at the same time as continuing to carry out their day-to-day activities (work and household duties). These difficulties were not seen as indicative of illness (or health) but instead as part of the pregnancy experience.

One of the contributions of my data analysis is to show how these women are expected to manage the demands that pregnancy places upon them, in addition to their normal day to day activities. This occurs with no recognition of the negative consequences which may arise as a result of the pregnancy having to be managed without any acknowledgement of, or disruption to, the other activities that are undertaken prior to the pregnancy.

Public acknowledgement of the pregnancy is not openly sought by the women in the early stages of the pregnancy, as the fourth theme of the chapter showed. This accepted pattern of not disclosing the pregnancy at first glance appears to be commonsense, given that the risk of miscarriage is relatively high in the first three months. However, as feminists argue (see Matlin, 1992), we need to take the commonsense aspects of our culture and see what produces and reproduces them. In taking this line of inquiry, we can begin to see how the privatisation of the early stages of pregnancy carries with it both positive and negative effects. On the positive side, should the woman miscarry she does not have to make others aware of her loss, and so the tentative period in which she knows she is pregnant but is uncertain of its continuation can be come to terms with, without the additional pressures of having to inform others. On the negative side, we can see that this privatisation requires the woman to suffer or mourn the loss in silence. If she does miscarry she will mourn her loss without the support or understanding

she may have received from her wider community. The issues involved are complex and no easy answers can be found.

On the other hand, if the pregnancy continues, she may suffer from a number of physical symptoms which accompany the biological changes that are occurring to her. Here again, with the pregnancy being kept private, she may receive little support or understanding of what she is going through. What becomes evident is that the cultural norm of not disclosing the pregnancy at an early stage means that the woman is effectively being silenced. Furthermore, where the silence may be broken the woman may still be required to cope with the changes in her body at the same time as continuing to operate in her usual duties on a day-to-day basis. This again may be difficult for the woman (although not for all women), however she may resist putting herself or her pregnancy first, as she may risk being labelled negatively (for example, not being able to cope, or being feeble).

The possible need to take time off at the beginning of a pregnancy may outweigh the needs accorded in law toward the end. One of the suggestions put forward by a midwife was the desirability to have the time off split across the pregnancy according to the needs of individual women. This legitimisation of the need to take time out from other duties whilst carrying out the task of growing a baby in the early stages could reduce the negative feelings women may suffer in the early stages when they are more likely to find it difficult to cope (e.g. feeling guilty about not being able to carry out household chores due to morning sickness). For this change in maternity leave to occur there would not only need to be legislative changes, but also changes in the cultural viewing of a pregnancy as necessarily being one that goes to full term. This would mean that the pregnancies that are miscarried would need to be acknowledged publicly as having occurred and their loss be seen as a possible outcome, one in which the woman by virtue of its disclosure does not become labelled as a failure or made to feel unsuccessful in her attempt.

In chapter eight, the positive reactions they encountered when they shared their news about the pregnancy were reflected upon by the women, and the help and support they received was often acknowledged and valued. This shows that, for the women of this study, disclosure carries with it a

number of advantages and therefore if the disclosure occurred earlier on in the pregnancy they may well have these advantages brought forward. although this would be at the expense of allowing privacy and reflection which the women also see as necessary.

Chapters six and seven show how risk is variously constructed in complex ways. The women use both medically and non-medically based forms of knowledge to construct the likelihood of considering the self to be at risk and move between considering the self to be and not to be at risk simultaneously and over time.

The movement between using different, and at times overlapping, discourses which originate from medical and lay socio/cultural sources in constructing risk, and the movement between perceiving the self to be and not to be at risk, demonstrates clearly the weaknesses of applying dualistic categorisations and interpretations of the concept and experience of risk (as occurs in quantitative studies). Within the discipline of psychology the majority of the past quantitative research on the experience of risk during pregnancy has used dualistic categories (e.g. high and low risk) to identify differences between groups of pregnant women. The research has tended to concentrate on measuring the levels of anxiety associated with being medically defined to be at high risk, especially in relation to the subsequent uptake of prenatal testing. The interest in examining the links between risk and anxiety is in part due to the relevance that this has for the medical management of pregnancy, where measuring clinical outcomes allows further medical interventions for particular sets of women. However, as the research findings presented in chapter six show, women do not experience risk or anxiety in either/or categories with linear relationships. In addition, risk is not solely constructed in medical terms.

Chapter six shows how some of those medically categorised to be at high risk, as well as those categorised to be at low risk, accept and reject the labels assigned to them. This means that those who are labelled at low risk, but consider themselves to be at high risk (and vice-versa) at different points in time, would not be accounted for in quantitative based studies. Thus, in these studies the differences within categories (in terms of perceiving the self

to be at risk) would not be highlighted, nor would the reasons as to when and why they occasionally feel anxious become visible (except where the participants' feelings match the predefined categories presented in the questionnaire).

The search for generalisations in quantitative based studies means that little insight is gained into the lived experiences of pregnant women, and the reasons for the differences found within and between categories of women would be abstract ones. In my own research the use of a qualitative approach has allowed for a greater understanding of the ways in which, firstly, risk is variously constructed both within and across individuals and, secondly, how it is experienced. One of the notable advantages of seeing how risk is experienced using qualitative methods relates to its ability to pick up on the changes across short and long spaces of time and the contradictions in the explanations of the experiences. Take, for example, Sandy's experience of anxiety when she experienced complications and was at high risk of losing the baby. Sandy found that she was not at all anxious about the potential loss of the baby when she was admitted to hospital due to blood loss. In fact she felt that rather than feeling anxious, she was more reassured as a consequence of the information and care she had received. However, later on she did become anxious when she again experienced the same symptoms. These differing feelings across time relating to a similar occurrence are not likely to be picked up in quantitative studies.

The main aim of the analysis in chapter six was not to explore what type of risk is being considered (although these are presented, e.g. miscarriage, abnormalities) but rather to explore the consequences of considering the self to be at risk and the actions taken based on this perception. In this chapter a number of similarities in the construction of risk are highlighted (especially in relation to the uptake of prenatal diagnosis and the decision to terminate if abnormalities are found). Also, where variations across accounts were evidenced, they have been included to show the individual lived experiences of considering the self to be at risk. For example, in theme two of subsection two, Sue and Jane's differing decisions relating to the consumption of alcohol are highlighted, together with the reasons they

provide for their different courses of action (Sue justifying her continued consumption of alcohol whilst pregnant and Jane's abstinence during pregnancy).

The consideration of the baby's welfare led many women to change a number of their prior forms of behaviour (smoking and drinking). In addition they often faced a number of dilemmas which related to the conflict of interest between what was best for them and what was best for their baby. This was most clearly evidenced when the women were suffering from minor ailments, such as a cold, for which they would previously have taken certain forms of medication without question. During their pregnancy they only took medication if their symptoms were ones that they could no longer cope with, and thus on taking the medication they attempted to justify their decision as a result of the dilemma experienced. Again, quantitative studies would be unable to pick up on the many dilemmas the women experienced during the course of their pregnancy.

In chapter seven a more detailed examination is made of the shifts one participant made in terms of constructing her potential risk and her identifications with the label. The participant (Sam) is shown to consider her own role in taking the decision to become pregnant in light of the consequences it may hold (e.g. personal blame if the baby has abnormalities). The negative impact that being at risk held for Sam was shown, and thus in this chapter we can see how the medicalisation of pregnancy carries with it particular negative consequences (believing the self to be at fault and blameworthy for possibly producing a baby with abnormalities). This chapter provides a clear example of within-account differences of the way in which risk is experienced, and therefore builds on chapter six in terms of providing an in-depth examination of the consequences of risk. The case study analysis presented in this chapter particularly stood out when I was carrying out a thematic analysis on risk, the reason being that Sam's construction of risk contained far more details on the effect that being at risk had on her emotionally, and also contained a number of different constructions relating to her role and positions in being at risk. By taking a case study approach in this chapter I have been able to show the multiple ways in which risk is related to

by a given individual. The shifts in her account (for example, blaming herself, and then blaming others for perceiving her to be at risk) are provided to show the differences that occur over time.

Sam's account particularly shows the negative impact that the construction of risk from a medical perspective can have on certain women. Thus, although the medical management of pregnancies may contain certain advantages, there are also a number of disadvantages that are associated with it.

Overall, the two chapters on risk contribute to the understanding of certain aspects of the pregnancy experience by looking at the knowledge gained about the many and varied ways in which risk is experienced. In comparison to quantitative studies, this qualitative in-depth study allows a more detailed understanding of the way in which risk is constructed and experienced in different ways and over time. Anxiety is shown to be a small part of the consequence of being at risk for the majority of the participants (as presented in chapter six), although it plays a major role for one participant, Sam, as a result of her risk being qualitatively different from the others (as presented in chapter seven). It is thus important to examine particular concepts and their impact in an individual and contextualised way. To this end chapters six and seven help highlight some of the more negative aspects of the pregnancy experience, and show how a significant part of the experience involves considerations about the welfare of the baby.

In chapter eight it was shown that in many ways the pregnancy experience was a disempowering experience for the women (which was in part due to the enormous physical and psychological changes that took place). The social structural positioning of the women meant that they experienced the changes to be difficult to handle at times. The ways in which certain people reacted toward their pregnancy meant that they felt they had to explain their level of weight gain and/or had to adjust to the differing ways in which people responded to them, as a result of them being pregnant. For example, some of the women found that certain others were not very accommodating of the needs they had (e.g. whilst out shopping), while other women found that they were being treated differently when they wished for

this not to happen. In addition, due to the social construction of what women should look like, the physical changes that occurred to them led to them feeling uncomfortable with their pregnancies, while at the same time as having negative feelings relating to the changes to their body (experienced predominantly in the later stages of pregnancy), the women also enjoyed some of these changes. To a certain degree the increases in body size were seen as positive, as they were markers of the pregnancy. When the women thought about the pregnancy in terms of the baby they accepted and enjoyed the changes that were occurring. It was when they were in certain social environments and were heavily pregnant that they felt a loss of their own identity and wished to be able to go back to their pre-pregnancy state.

My mode of presenting the analysis as representing the positive and negative aspects of the pregnancy experience (particularly in chapter eight) came about as a result of my recognition of the dual methods used by the participants when discussing their pregnancy experience. As outlined in the introduction to the thesis, psychologists have neglected to explore the positive aspects of the pregnancy experience and therefore one of the aims of my research was to examine the accounts to see if, and how, pregnant women came to construct their experiences in ways which could be labelled positive or negative (which are contextually dependent categorisations). As the analysis of the accounts show in chapter eight, the women often interpreted certain aspects of their experience in both formats, and thus seeing the experience in either positive or negative terms is inappropriate. The use of the two terms helps to identify both aspects and helps to show how the two are experienced. However, the experience is not based on an either/or approach and the two do occur simultaneously without them necessarily being identified as contradictory by the participants.

From the analysis of the accounts provided in chapter eight, the issues which can be taken up relate to the social construction of ideal body image. As was shown in chapter eight, in western society the pressures on women to conform to the constructed ideal body shape need to be addressed. Pregnancy is a state in which a 'loss' of the women's figure occurs, and thus it serves as a good example for considering the effects of being 'big' has on

women. Previous research which has looked at images of the body has concentrated on examining the impact that the social construction of it has on women with eating disorders. In light of my research findings, pregnancy is another area which can be considered for the analysis of the impact that social constructions of the ideal body have. In this chapter the impact of the social construction of the ideal body is shown to be responsible for a number of the negative emotions the women experience.

In chapter nine the different visual images that the women construct of the baby are highlighted. The ways in which the images are constructed reflect both cultural and medical ideologies of reproduction. The interpretations that the women make of the visual images are positively constructed, and show that during pregnancy the women try to identify with and build up a relationship with their baby prior to its arrival. Amongst the more recent ways of visualising the baby is the use of the ultrasound scan. The participants' interpretations and experiences of this routine antenatal practice have also been shown to be positive. However, this may partly be a result of the apparent satisfaction with the communication process reported between the ultrasonographer and the women (plus partner for some of the participants). The study by Price (1996) on the experience of visual imaging found contrasting results. In her study, the participants had not been provided with the information they wanted as a result of the ultrasonographers not being in the position to be able to relay news about potential problems/risks that were detected. Her findings further emphasise the need to consider the individuality of experience and the need to avoid generalisations.

What all of the empirical chapters have in common is the exploration of the ways in which the women relate to particular aspects of their pregnancy, on a personal level as well as within their social context. For example, chapter five looks at how the women relate to the news of being pregnant and the implications of this on a personal level (e.g. belief in the pregnancy) as well as on a more social level (disclosing the pregnancy to others). Chapters six and seven look at the impact of risk in terms of the personal consequences this would hold as well as the reactions they would likely receive from others. Chapter eight explores the personal and social reactions experienced during

the course of the pregnancy (particularly in terms of the level of support received and perceptions of the changes to the body). Chapter nine not only shows how particular images of the baby are constructed but also shows how the women look forward to being able to share the images of their baby with others (particularly partners). Here the movements of the baby, and the ultrasound scan, are perceived to be useful in involving the partners in the experience.

There are a number of interrelated issues that appear in the different themes across the chapters. For example, the consideration and consequences of the possibility of miscarrying have been discussed in each chapter in terms of its various lived experiences. Although there are a number of issues which appear across the different chapters (such as miscarriage and the medical management of pregnancy), I have aimed to present a rich and diverse set of issues which come to make up various parts of the pregnancy experience. To this end the empirical chapters contain 28 themes which all highlight different aspects of the experiences and show the dynamic, changing ways in which pregnancy is experienced over its duration. The contradictions contained within their accounts show how the women have multiple ways of seeing and relating to various aspects of their pregnancy. Pregnancy is perceived to be a process involving numerous physical and psychological changes. The women continually attempt to identify with the pregnancy and show how this state is interpreted in numerous ways.

11.4 Relation of the literature review to the present study

The early psychological studies which addressed the experience of pregnancy predominantly used psychodynamic models in which psychoanalytic concepts such as libido, introjection in coitus and object relations are used to explain a women's identification with her pregnancy. This form of analysis differs from that which is appropriate when trying to describe women's phenomenological accounts of their pregnancy experience, which are constructed contextually with the use of available discourses. There is a need to consider how the women themselves come to conceptualise, give

meaning to and understand the pregnancy experience rather than exploring the inter and intra psychic factors which may have led up to the shaping of their experience. In more recent years there has been a small number of researchers that have explored this aspect of the pregnancy experience. One important example is Phoenix et al's (1991) research on motherhood. Here the social constructionist approach is utilised to show how 'good mothers' and hence 'deviant mothers' are socially constructed' (p 2). Phoenix et al examine women's accounts of motherhood and contrasts these with current ideologies (take for example, the appropriation of the 'right' age at which childbearing should take place).

In addition to the psychological studies on the experience of pregnancy being reviewed in this thesis, the influential work which has originated from sociologists has been discussed and related to the present study. Both Oakley's and Rothman's approaches provided me with a framework and a distinct conceptualisation of the pregnancy experience (the reasons why I included a review of their work is detailed below). In addition, their work, together with the later work of Gregg (1994), helped me to recognise the importance of gaining a contextualised understanding of the subject matter from a feminist perspective.

This study differs from the majority of previous research studies outlined in the literature review (including the feminist approaches to pregnancy) due to its degree of emphasis in examining the self constructed pregnancy experience. This thesis reflects on and explores the meanings of the experience at the various stages of pregnancy, in and of itself, rather than seeing the pregnancy as a purely transitional stage to motherhood. Feminist researchers have neglected to explore the pregnancy experience in spheres such as personal identity, as their main emphasis has been on the structural aspects that shape the women's experiences. While research studies which explore the structural factors (e.g. patriarchy and medicalisation) that affect and to a large extent shape the experience of pregnancy are valuable, they do not inform us on matters such as individual differences within and between women's experiences, or women's personal conceptualisations and identifications with their pregnancy. Smith's (1990) and Gregg's (1994) studies

on aspects of personal identity have explored these issues using qualitative approaches, and their findings together with my own study show the benefits of exploring the personal domain of individual experience at the micro level.

The multitude of factors that have been examined by a number of qualitative researchers shows not only the complexity and the individuality of the experience, but also the socially constructed nature of the data gathering process, in which different aspects of the same state can and are reported and analysed differently.

My own research attempts to mainly deal with the neglected areas of study using a feminist perspective with recognition of the narrowing down of focus from the macro level down to the micro level. The subsections on the institution of motherhood and the medical and technological impact of pregnancy, in chapter two, have been included to show the relevance of keeping in mind the macro level of impact on the individual experience of pregnancy, and indeed two of my analytical chapters (six and seven) attempt to explore the similarity and differences between medical and personal perceptions and conceptualisations of risk during pregnancy. In addition, during the discussion of the findings presented in chapters five and eight I have discussed the most prominent macro issues which account for the micro level of experience (e.g. in chapter five the discussions about pregnancy as health or illness and in chapter eight the discussions about the women's body size and their (dis)satisfaction with it).

Within the literature review chapter, equal emphasis has been given to the qualitative research conducted from a sociological perspective as to that from a psychological perspective. The reason for the prominence placed on the sociological perspective relates to the slower progress made by psychologists to accept the value of qualitative approaches to the study of human behaviour as compared to sociologists. Hence, studies based on the pregnancy experience have appeared sooner in the discipline of sociology. This is not to say that one perspective or method should, or can, be valued/prioritised over another, but to argue that where a differing perspective and/or method (e.g. sociological/qualitative approach as opposed to for example psychological/quantitative approach) can yield fruitful data and is a

more appropriate approach/method of investigation given the particular aims of the study, then it should be considered, without raising questions about the validity of such an approach/method. It is for these reasons that I have chosen to include the research that I reviewed from the sociological perspective.

Coyner (1983) discusses the advantages and disadvantages of remaining within particular disciplines, as well as the problems of researching in an interdisciplinary framework. In her advocacy of making women's study a discipline in itself, rather than an adherence to an interdisciplinary approach, she highlights the issues involved when one considers the output of researchers working in different disciplines. Indeed this raises a number of questions in relation to my own research. For example, one of the questions relates to whether I should place my own research within the discipline of psychology or, given my allegiance to feminism, would it be better placed within women's studies? In relation to my own position the answer has been straight forward, in that at the time of registering for my studies I had not considered the use of feminism and feminist analysis for my research. I had registered as a psychology student, and thus remained within that discipline. In addition, the University did not have a women's study department to which I could later transfer had I so desired. A second question relates to my use and review of sociological literature given my registration and commitment to a psychological study of the pregnancy experience. My reply would be that the research reviewed and highlighted which is sociological in nature, still relates significantly to the research approach I have undertaken, and helped to contribute to my understanding of the topic area, and thus should not be ignored in the write up of my research. My own research is not interdisciplinary in that although sociological research has been reported, an examination of the discipline of sociology has not been carried out in this thesis. In the main it is the similarity in the methods used by the sociological researchers and myself that I feel has warranted the level of emphasis I have placed in describing their work. Although the issues Coyner raises are very important in terms of furthering feminist work, her emphasis is on the structural issues which may help or hinder the progress of women's studies.

In summary, qualitative methods have been employed by psychoanalytic researchers in order to examine women's experiences of pregnancy (in terms of their adjustment and adaptation to motherhood during pregnancy), as well as by a small number of postempiricists (examining the changes in identity as preparations for the transition to motherhood). However, few studies have employed qualitative methods to explore the differential identifications women hold in relation to their pregnancies and the meanings they hold for them (whilst pregnant rather than in terms of motherhood). The present study therefore substantially differs from much of the work carried out on the experience of pregnancy by past researchers.

11.5 Future developments and possible improvements to the conduct of the study.

With hindsight and based on the experiential learning curve, if I was to begin the study again I would use a number of different approaches. Firstly, the method of data collection used, although fruitful, could have been replaced with other alternative styles of data collection which could have provided much more information on negotiated meanings as they occur within particular social contexts. Wilkinson (1998) argues the case for using focus group discussions, as they provide feminists the opportunity to address 'feminist ethical concerns about power and the imposition of meaning; generating high quality, interactive data; and offering the possibility of theoretical advances regarding the co-construction of meaning between people'. She argues that 'it is still the case that when qualitative research *is* undertaken, the individual interview is probably the most widely used method' (1998:111). One of the reasons why Wilkinson is critical of the individual interview relates to the way in which this method of data collection dislocates the individual from their social context, while feminist psychology aims to understand the person within their social world.

Secondly, If I had a longer time span or was able to conduct the research on a full time basis I would have taken my research findings back to the participants in order to partially validate my findings, although I recognise

and fully accept the difficulties which may be present as a result of the power imbalance between the researcher and researched which may prevent the participants from voicing their disagreements with my interpretations of their accounts (Henwood and Pidgeon, 1995b; Smith, 1996).

Thirdly, the exploration of a number of different qualitative approaches meant that I spent a long time in coming to identify an approach I was happy with. It would have been more fruitful to have chosen one and then dedicated my time to applying that approach to the data, as this would have saved time and hence reduce the anxiety I experienced in trying to complete the PhD in the set time span. My use of a social constructionist approach has allowed me to explore the complexities of the pregnancy experiences, and hence further consideration of the ways in which this approach can help in the struggle against oppression would be undertaken.

Fourthly, turning to the empirical analysis of the accounts, my future research interests lie in the examination of the ways in which the women come to construct the role of their partners in coming to identify with the pregnancy. In chapter eight I have touched upon the ways in which the partners were perceived to be supportive and more accommodating of the changes to the woman's body than the women themselves, however a more in-depth analysis of the partners' involvement in the pregnancy experience could shed light on the ways in which pregnancy is experienced in a social context. In a number of the one-to-one interviews the women often referred to the role of their partners and at times asked me if they could come and join in the interview later on. I agreed with their requests, and thus this data would be available for analysis.

Another area which could be further investigated relates to the women's discussions about disclosing and discussing their pregnancy with friends and relations who are experiencing difficulties in conceiving. The unease that this caused could shed light on the problems infertile couples face as a consequence of other peoples' reactions and perceptions of them.

The data that were collected were by no means analysed fully, and thus further time could be spent on the analysis and presentation of a number

of other issues that the women felt influenced their current pregnancy experience (for example, employers' reactions and work pressures; the experience of vivid dreams; awaiting the arrival of labour and their specific ideas of the type of birth plan they would desire).

Overall, there are very few studies which have explored in depth women's constructions of their pregnancy experience. Fewer still have explored different groups of women's experiences (most noticeably those from ethnic minorities, see for example, Woollett et al, 1995, for a relevant study in this field). Further research in this field is much needed, and thus future research in this area would be a step forward.

11.6 Evaluating qualitative research

One of the central questions in social science research relates to the validity of the findings presented. There are a number of different criteria that have been forward for the evaluation of qualitative research. The criterion that I have found most helpful and have kept in mind whilst competing this thesis is the one put forward by Marshall (1986). Her criterion, as presented by Bannister et al (1994: 152), is detailed below as I have attempted to cover the issues she raised in my reflective checklist.

'How the research was conducted

Were the researcher(s) aware of their own perspective and its influence?

Were they aware of their own process?

How did they handle themselves?

Did they challenge themselves and accept challenges from others?

Were they open in their encounters?

Did they tolerate and work on the chaos and confusion? (If there is no confusion, I become suspicious that deeper levels of meaning were neglected.)

Have the researcher(s) grown personally through the research?

Relationship to the data

Is the level of theorising appropriate to the study and its data?

Is the theorising of sufficient complexity to portray the phenomena studied?

Are alternative interpretations explored?

Is the process of sense-making sufficiently supported?

Contextual validity

How do the conclusions relate to other work in the area?

Are the researcher(s) aware of relevant contexts for the phenomena studied?

Is the research account recognisable – particularly by people within the area studied?

Is the material useful?

‘Good’ research addresses most of these issues – it does not do so ‘perfectly’ (whatever that means); rather, the researcher(s) develop their capabilities for knowing.’

11.7 Conclusion

This thesis has aimed to present a fractured account of different pregnancy experiences. It is necessarily fractured as both the participants and myself have been unable to detail all of the issues involved and experienced during the course of any one pregnancy. There are a number of interrelated issues which have been presented, and thus what has been presented aims to show how the participants of this study came to construct particular fragmentary aspects of their pregnancy experiences (in light of medical/social and cultural ideologies). Of the different ideologies which come to form the individual construction of pregnancy as experience, medical discourses have been shown to have played a significant role for the participants of this study in so far as many of the quotes taken from the women’s accounts have been constructed using various medical terms.

The use of a prospective longitudinal approach has allowed pregnancy to be shown to be a complex event (by virtue of the number of dilemmas and contradictions that are experienced and expressed). In line with Stanley and Wise (1993), lived experience is shown to be constructed in multiple ways, with multiple realities coinciding. The women are shown to shift in their perceptions and beliefs about the progress of their pregnancy, and are shown to be continually seeking to identify with the changes that occur over the course of the pregnancy.

The use of a poststructuralist feminist approach has allowed the complex, multiple, non essentialist aspects of the experience to be portrayed. Experience has been considered to be constructed through language, and language is seen to represent experience (although it cannot be taken at face value as experience is mediated, see, Duelli Klein, 1983; Hollway, 1989; Griffin, 1995; Henwood and Pidgeon, 1995a). The analysis of the language used by the participants has been analysed to show the various constructions that have been put forward with particular regard to the personal conceptualisations and identifications that the women construct. As variability within and between accounts is evident, the results of this study should not be generalised, but instead need to be considered in light of what they show about the individuality of experience.

The main contribution of the analysis is its portrayal of the many similarities and differences within and between accounts which show that pregnancy experiences need to be considered within their social context and that generalisations of many aspects of the pregnancy experience fail to capture the diverse and changing personal conceptualisations and identifications women experience. Thus, qualitative studies such as the one presented here provide us with rich data that helps us further understand women's experiences in their social world.

In terms of the contributions that this thesis makes to feminist psychology, the differences in experience as constructed within person show that essentialist notions of oppression and sexism need to be unpacked. As shown in chapter eight, the dynamic ways in which sexist behaviour is interpreted depends on the way it is perceived (positively or negatively) by the

women. Although particular behaviours of others toward pregnant women can be seen to be oppressive and/or sexist using traditional forms of feminist analysis (as I have also presented on a few occasions), the women's own interpretations of this may be significantly different. If we are to value and understand the women's own constructions then we must take seriously their interpretations and not our own predefined interpretations. This is a difficult task for feminist researchers as essentialist notions of what constitutes oppression are the bedrock upon which the fight for social change can be based. My own allegiance with the feminist movement and acceptance of certain essential differences and labelling of forms of oppression has meant that I have experienced a number of tensions in holding back from being critical of some of the women's own interpretations and providing more of my own essentialist analysis of the accounts. The tension between poststructuralist interpretations (which have a lot to offer) and traditional essentialist forms of analysis (that also have a lot to offer for the emancipation of women) is difficult to resolve. However, as I take the impact of difference seriously I have argued that poststructuralist forms of analysis that unpack notions of similarity and difference as lived experience are essential, despite their inability to reflect the need for social change to improve women's positions in society.

My own analysis of the personal accounts of pregnancy shows that taking a poststructuralist stance (with its inherent problems of excluding subject matter centred inquiry and insensitivity toward gender) allows a greater understanding of the fractured and dynamic aspects of experience. This style of analysis, which looks at experience as constructed with multiple contradictions, differs significantly from essentialist forms of analysis where single realities are perceived to exist and subsequently can be used to fight for change for all women.

In addition, I have also shown in this thesis that the differences within category are multiple and dynamic with reference to my own experiences as a black researcher investigating white women's experiences. I have shown that feminist prescriptions for matching and therefore making use of one's similarity along certain structural dimensions (e.g. race) is a disempowering

experience. Not only that, but colluding with the idea of sameness provides a false sense of security and deters from the examination of within category differences in terms of the impact it has on lived experience and its interpretation.

The ways in which one's own perceptual differences are experienced varies, for example my race appeared to matter to the gatekeepers of access but not to the participants. Discovering such variations in one's own experience helps to better understand diversity.

The main aim of my thesis has been to examine the diversity of experience (the participants and my own) and its major contribution to feminist psychology is to show how difference within category is constructed. This has subsequent critical implications for traditional (essentialist) forms of feminist analysis which uses uni-vocal pre-determined orthodoxy. Traditional feminism skirts over within category differences and promotes similarity by way of arguing that essential differences exist along certain dimensions and that these differences are experienced in the same way. This line of analysis claims a uniquely privileged voice despite the personal understandings and constructions of women which show variation and contradiction (as portrayed in this thesis). My predominant line of analysis (which takes on board notions of contradictory, changing, discursively and contextually shaped discourses) values women's own constructions and interpretations and I believe this to be more important than imposing pre-determined feminist orthodoxy. The challenge then for contemporary feminism is to see how we can build upon the experience of women (in all its contradictions) with the wider feminist concerns about the place of women in society. I would argue that feminist analysis has a lot to gain from the understanding of the multiple experiences of women in the changing conditions of social life, and that contemporary feminists need to open up and further the debate about how this approach can be integrated with the continued need for a fight for change.

REFERENCES

Ballou J.W. (1978) **The Psychology of Pregnancy**. Toronto: Lexington Books.

Banister, P., Burman, E., Parker, I., Taylor, M. and Tindall, C. (1994) **Qualitative Methods in Psychology**. Buckingham: Open University Press.

Baron, R .A. (1992) **Psychology** (2ed) USA: Allyn & Baconork

Barrett, M. (1987) The concept of 'Difference'. **Feminist Review**, 26, July, 29-41.

Bhavnani, K-K. (1991) **Talking politics: a psychological framing for views from youth in Britain**. Cambridge: Cambridge University Press.

Bhavnani, K-K. (1993) Talking Racism and the Editing of Women's Studies. In D. Richardson and V. Robinson (Eds.) **Introducing Women's Studies. Feminist Theory and Practice**. London: Macmillan.

Bibring, G.L. (1959) Some considerstions of the Psychological Processes in Pregnancy. **The Psychoanalytic Study of the Child**, 14. New York: International University Press.

Bibring, G.L. (1961) A study of the psychological processes in pregnancy and of the earliest mother-child relationship. I. Some propositions and comments. **The psychoanalytic study of the child. Vol. XVI**. New York: International Universities Press.

Bibring, G.L., Dwyer, T.F., Huntington, D.S., and Valenstein, A.F. (1961) A Study of the Psychological Processes in Pregnancy and of the Earliest Mother-Child Relationship. 1: Some propositions and comments. **The Psychoanalytic Study of the Child**, 16, 9-24.

Billig, M. (1988) Social Representation, Objectification and Anchoring: a Rhetorical Analysis. **Social Behaviour**, 3, p1-16.

- Bohan, J.S. (1993) Regarding gender: essentialism, constructionism, and feminist psychology. **Psychology of women quarterly**, 17, 5-21.
- Bola, M. (1991) Qualitative data collection: A comparison between diary/diary interview and unstructured interview methods. Discourse analysis conference Manchester Metropolitan University.
- Bola, M. (1995) Questions of legitimacy? The fit between the researcher and the researched. **Feminism and Psychology**, 5(2), 354-357.
- Bola, M., Drew, C., Gill, R., Harding, S., King, E., and SEU, B. (1998) I. Representing ourselves and representing others: A response. **Feminism & psychology**, Vol. 8 (1): 105-110.
- Bowes, A.M. and Domokos, T.M. (1996) Pakistani women and maternity care – raising muted voices. **Sociology of Health and Illness** 18(1) 45-65.
- Bowles and Klein. (1983) **Theories of women's studies**. Routledge & Kegan Paul.
- Breen, D. (1975) **The Birth of the First Child: Towards an Understanding of Femininity**. London: Tavistock.
- Brown, G W and Harris, T (1978) **Social Origins of depression: A study of psychiatric disorder in women**. London: Tavistock.
- Bryman, A. (1988) **Quality and Quantity in Social Research**. London: Unwin Hyman.
- Burgess, R.G. (1984) **In the field: An Introduction to field research**. London: Allen and Unwin.
- Burman, E. (ed.) (1990) **Feminists and Psychological Practice**. London: Sage.

Campbell, S., Reading, A.E., Cox, D.N., Sledmore, C.M., Mooney, R., Chudleigh, P., Beedle, J., Rudduck, H. (1982) Ultrasound scanning in pregnancy: the short-term psychological effects of early real time scans. **Journal of Psychosomatic Obstetric Gynaecology** 1, 57-61.

Chalmers, A.F. (1982) **What is this thing called Science?** Milton Keynes: Open University Press.

Chodorow, N. (1971) Being and doing: A cross-cultural examination of the socialisation of males and females. In Gornick, V. (ed.), **Women in sexist society: Studies in power and powerlessness**. New York: Basic Books.

Chodorow, N. (1974) Family structure and feminine personality. In Rosaldo, M.Z. and Lamphere, L. (eds). **Women, culture and society**. Stanford: Stanford University Press.

Chodorow, N. (1978) **The reproduction of mothering: Psychoanalysis and the sociology of gender**. Berkeley: University of California press.

Chodorow, N. (1979) Feminism and difference: Gender, relation, and difference in psychoanalytic perspective. **Socialist Review**, 46, 51-69.

Chodorow, N. (1981) On the reproduction of mothering: A methodological debate. Reply by N. Chodorow. **Signs**, 6(3), 500-14.

Chodorow, N. (1989) **Feminism and Psychoanalytic Theory**. New Haven: Yale University Press.

Collins, P.H. (1991) 'Learning From The Outsider Within: The Sociological Significance of Black Feminist Thought. In M.M. Fonow and J.A. Cook (eds) **Beyond Methodology: Feminist Scholarship As Lived Research**. Bloomington & Indianapolis: Indiana University Press.

Cook, J.A., and Fonow, M.M. (1986) Knowledge and women's interests: Issues of epistemology and methodology in feminist sociological research. **Sociological inquiry**, 56, 2-29.

- Cornwell, J. (1984) **Hard-earned lives: Accounts of health and illness from East London**. London: Tavistock.
- Coulter, J. (1977) Transparencies of mind. **Philosophy of the Social Sciences**, 7 321-350.
- Cox, M. J. (Ed.). (1985) The transition to parenthood [special issue]. **Journal of Family issues**. Beverly Hills, CA: Sage.
- Coyner, S. (1983) Women's studies as an academic discipline. In Bowles, G. and Klein, R.D (eds), **Theories of women's studies**. London. Routledge.
- Currie, D. (1988) Rethinking what we do and how we do it: a study of reproductive decisions. **Canadian Review of Sociology and Anthropology**, 25(2), 231-253.
- Denzin, N.K. and Lincoln, Y.S. (1994) Introduction to: **Handbook of Qualitative Research**. Thousand Oaks, California: Sage.
- Deutsch, H. (1945) **Psychology Of Women New York**. Grune and Stratton
- Donnison, J. (1977) **Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights**. London: Heinemann.
- Duelli-Klein (1983) 'How to do what we want to do: Thoughts about Feminist Methodology'. In Bowles, G. and Duelli-Klein, R. (Eds.), **Theories of Women's Studies**. London: Routledge and Kegan Paul.
- Elliott, S.A. (1984) Pregnancy and after. In Rachman, S. (ed.), **Contributions to medical psychology (vol 3)**. New York: Pergamon Press.
- Elliott, S.A., Rugg, A.J., Watson, J.P. and Brough, D.I. (1983) Mood changes during pregnancy and after the birth of a child. **British Journal of Clinical Psychology**, 22, 295-308.
- Espin, O.M. (1995) 'Race', Racism, and Sexuality in the Life Narratives of Immigrant Women. **Feminism and Psychology**, 5(2), 223-238.

Fedele, N.M., Golding, E.R., Grossman, F.K. and Pollack, W.S. (1988) Psychological Issues in Adjustment to First Parenthood. In Michaels, G.Y. and goldberg, W.A. (Eds) **The Transition to Parenthood: Current Theory and Research**. Cambridge: Cambridge University Press.

Ferguson-Smith, M.A. (1983) Prenatal Chromosome Analysis and its Impact on the British Incidence of Chromosome Disorder. **British Medical Bulletin**, 39, 355-364.

Finkelstein, J. (1990) Women, Pregnancy and Childbirth In Scutt, J.A. (ed) **The baby Machine: Reproductive technology and the commercialisation of motherhood**. London:Green Print.

Fonow, M.M., and Cook, J.A. (editors) (1991) **Beyond Methodology: feminist Scholarship as lived Research**. USA: Indiana University press.

Frost, K. (1980) On the Variety of the Forms of Self Knowledge: Some Thoughts on Women's Perceptions of Themselves. In Salmon, P. (ed.), **Coming to Know**. London: Routledge & Kegan Paul.

Gill, R. (1996) Discourse analysis: practical implementation. In Richardson, J.T.E. (Ed) **Handbook of Qualitative Research Methods for Psychology and the Social Sciences**. Leicester: British Psychological Society.

Gill, R. (1998) Dialogues and differences: writing, reflexivity and the crisis of representation. In Griffin, C & Phoenix, A. **Standpoints and differences: writings on the practice of feminist psychology**. London: Sage.

Glaser, B.G., and Strauss, A.L. (1967) **The Discovery of Grounded Theory: Strategies for Qualitative Research**. Chicago, Illinois: Aldine.

Glenn, E.N. (1994) Social Constructions of Mothering: A Thematic Overview. In Glenn, E.N., Chang, G.C. and Forcey, L.R. (Eds) **Mothering: Ideology, Experience and Agency**. New York: Routledge.

- Goldberg, W. A. (1988) Introduction. Perspectives on the transition to parenthood In Michaels, G. Y. and Goldberg, W. A. (Eds) **The transition to parenthood: Current Theory and Research**. Cambridge: Cambridge University Press.
- Gorsuch, R.L., and Key, M.K. (1974) Abnormalities of pregnancy as a function of anxiety and life stress. **Psychosomatic Medicine**, **36**, 352-362.
- Graham, H. and Oakley, A. (1986) Competing ideologies of reproduction: medical and maternal perspectives on pregnancy. In Curren, C and Stacey, M (ED) **Concepts of health, illness and disease. A comparative perspective**. U.K. Berg Publishers LTD.
- Green, J. M. (1990) **Calming or Harming? A Critical review of Psychological Effects of Fetal Diagnosis on Pregnant Women**. Occasional Papers, Second Series No 2, Galton Institute.
- Green, J.M., Coupland, V.A. and Kitzinger, J.V. (1990) Expectations, experiences and psychological outcomes of childbirth. A prospective study of 825 women. **Birth**, **17**, 15-24.
- Gregg, R. (1994) Explorations of pregnancy and choice in a High-Tech Age. In Kohler, C. (ed.), **Qualitative Studies In Social Work Research**. London: Sage.
- Griffin, C. (1986) Qualitative Methods and Female Experience. In Wilkinson, S. (Ed.) **Feminist Social Psychology: Developing Theory and Practice**. Milton Keynes: Open University Press.
- Griffin, C. (1989) "I'm not a women's libber, but ...". Feminist consciousness and gender identity. In Skevington, S. and Baker, D. (eds.) **The Social Identity of Women**. London:Sage
- Griffin, C. (1995) 'Feminism, Social Psychology and Qualitative Research', **The Psychologist**, **8(3)**, 119-121.

- Griffin, C. and Phoenix, A. (1994) The relationship between qualitative and quantitative research: Lessons from feminist psychology. Special issue: Qualitative social psychology. **Journal of community and applied social psychology vol 4 (4) 287-298.**
- Grimm, E. (1961) Psychological tension in pregnancy. **Psychosomatic Medicine, 23, 520-527.**
- Grimm, E.R. (1967) Psychological and social factors in pregnancy, delivery and outcome. In Richardson, S.A., Guttmacher, A.F., Baltimore: Williams and Wilkins Co (Ed.) : **Childbearing- its social and psychological aspects.**
- Grossman F.K., Eichler L.S., Winickoff S.A., Anzalone M.K., Gofseyeff M.H. and Sargent S.P. (1980) **Pregnancy Birth and Parenthood.** London: Jossey-Bass Publishers.
- Harding, S. (1986) **The Science Question in Feminism.** Ithaca: Cornell University Press.
- Harding, S. (1991) **Whose Science? Whose Knowledge? Thinking From Women's Lives.** Milton Keynes: Open University Press.
- Harre, R. (1983) **Personal Being.** Oxford: Basil Blackwell.
- Harre, R. and Gillett, G. (1994) **The Discursive Mind.** U.S.A.:Sage.
- Harre, R. and Secord, P.F. (1972) **The Explanation of Social Behaviour.** Oxford: Blackwell.
- Henwood, K.L. (1996) Qualitative Inquiry: Perspectives, Methods and Psychology. In Richardson, J.T.E. (Ed.), **Handbook of Qualitative Research Methods for Psychology and the Social Sciences.** Leicester: B.P.S. Books.
- Henwood, K.L. and Pidgeon, N. (1992) Qualitative research and psychological theorising. **British Journal of psychology, 83, 83-111.**

- Henwood, K.L. and Pidgeon, N. (1993) Qualitative research and psychological theorising In Hammersley, M. (ed.) **Social Researching: Philosophy, Politics and Practice**. London: Sage
- Henwood, K.L. and Pidgeon, N. (1995a) Grounded Theory and Psychological Research, **The Psychologist**, **8(3)**, 115-118.
- Henwood, K.L. and Pidgeon, N. (1995b) Remaking the link: Qualitative research and feminist standpoint theory. **Feminism and psychology**, **5**, 7-30.
- Hill Collins, P. (1991) Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought. In Fonow, M. M. and Cook, J.A. (eds) **Beyond Methodology: Feminist Scholarship as Lived Research**. USA: Indiana University Press.
- Hoffman, L.W. and Hoffman, M. (1973) The value of children to parents. In Fawcett, J.T. (Ed.), **Psychological perspectives on population**. New York: Basic Books.
- Hollway, W. (1989) **Subjectivity and Method in Psychology**. London: Sage Publications.
- Holt, L.H., and Weber, M. (1982) **The American Medical Association book of womancare**. New York: Random House.
- Hooks, B. (1984) **Yearning race, gender, and cultural politics**. Turnaround.
- Hubbard, R. (1982) Some Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy. **Women's Rights Law Reporter**, **7(3)**, 210.
- Hubbard, R. (1990) **The politics of women's biology**. New Brunswick, NJ: Rutgers University Press.
- Hyde, B. (1986) An interview study of pregnant women's attitudes to ultrasound scanning. **Social Science and Medicine** **22**, 586-592

Istvan, J. (1986) Stress, Anxiety, and Birth Outcomes – A critical review of the evidence. **Psychological Bulletin** 100(3) 331-348

Janis, I.L. and Mann, L. (1977) **Decision Making: A Psychological Analysis of Conflict, Choice and Commitment**. New York: Free Press.

Johnston, M. (1993) Reproductive Issues: Decisions and Distress. In Niven, C. and Carroll, D. (Eds.) **The Health Psychology Of Women**. Switzerland: Harwood Academic Publishers.

Kaback, M.M. (1984) The Utility of Prenatal Diagnosis. In Rodeck, C.H. and Nicolaides, K.H. (Eds) **Prenatal Diagnosis**. London: Royal College of Obstetricians and Gynaecologists.

Kaplan, M. M. (1992) **Mothers' Images of Motherhood**. London: Routledge.

Kaschak, E. (1992) **Engendered Lives**. New York: Basic Books.

Keller, E.F. (1985) **Reflections on gender & Science**. New Haven, Conn.: Yale University Press.

Kimball, M.M. (1994) The world we live in: Gender similarities and differences. **Canadian psychology/psychologie canadienne**, 35, 388-404.

King, E. (1996) The use of the self in qualitative research. In **handbook of qualitative research for psychology and methods the social sciences**. BPS books.

Kyle, D., Cummins, C. Evans, S. (1988) Factors Affecting the Uptake of Screening for Neural Tube Defect. **British Journal of Obstetrics and Gynaecology**, 95, 560-564.

Levin, J.S. and DeFrank, R. S. (1988) Maternal stress and pregnancy outcomes: a review of the psychological literature, **Review of psychosomatic obstetrics and gynaecology**, 9, 3-16.

Lincoln, Y.S. and Guba, E.G. (1985) **Naturalistic Inquiry**. Newbury Park, California: Sage.

- Lipman-Hand, A. and Cohen, D.I. (1980) Influence of Obstetricians' Attitudes on Their Use of Prenatal Diagnosis for the Detection of Down's Syndrome. **Canadian Medical Association Journal**, **122**, 1381-1386.
- Lubin, B., Gardner, S.H. and Roth, A. (1975). Mood and somatic symptoms during pregnancy. **Psychosomatic Medicine**, **37**, 136-146.
- Macfarlane, A (1990) Official statistics and womens health and illness. In Roberts, H. (ed.) **Women's Health Counts**. London: Routledge
- MacIntyre, S. (1981) **Expectations and Experiences of First Pregnancy: Report on a prospective interview study of married primigravidae in Aberdeen**, Aberdeen, Occasional paper no5, Institute of Medical Sociology
- Mackey, M., and Brouse, S. (1988) Childbearing. In Lipka, C.J. and Miller, C. (Eds.), **Women's health perspectives: An annual review, vol. 1**. Phoenix, AZ: The Oryx Press.
- Marshall, H. And Wetherell, W. (1989) Talking about Career and Gender Identities: A Discourse Analysis Perspective. In Skevington, S. and Baker, D. (ed.) **The Social Identity Of Women**. London: Sage.
- Marshall, J. (1986) Exploring the experiences of women managers: towards rigour in qualitative method. In Wilkinson, S (ed.) **Feminist Social Psychology: Developing Theory and Practice**. Milton Keynes: Open University Press
- Marteau, T.M. (1994) Psychology and screening: Narrowing the gap between efficacy and effectiveness. **British Journal of Clinical Psychology** **33(1)** 1-10.
- Marteau, T.M., Johnston, M., Plenicar, M., Shaw, R.W., Slack, J. (1988) Development of a Self - Administered Questionnaire to Measure Women's Knowledge of Prenatal Screening and Diagnostic Tests. **Journal of Psychosomatic Research**, **32**, 403-408.

- Marteau, T.M., Johnston, M., Shaw, R.W., Slack, J. (1989) Factors Influencing the Uptake of Screening for Open-Neural Tube Defects and Amniocentesis to Detect Down's Syndrome. **British Journal of Obstetrics and Gynaecology**, **96**, 739-741.
- Marteau, T.M., Kidd, J., Cook, R., Michie, S., Johnston, M. Slack, J. Shaw, R.W. (1991) Percieved Risk Not Actual Risk Predicts Uptake of Amniocentesis. **British Journal of Obstetrics and Gynaecology**, **98**, 282-286.
- Martin, E. (1992) **The Woman in the Body: A Cultural Analysis of Reproduction**. Boston: Beacon Press.
- Matlin, M. W. (1996) **The psychology of women**. USA, Harcourt Brace College.
- Maudsley, H. (1874) Sex in mind and in education. **Fortnightly review**, **15**, 466- 83.
- Mead, G.H. (1934) **Mind, Self and society**. Chicago: University of Chicago Press.
- Melges, F.T. (1968) Post-partum psychiatric syndromes. **Psychosomatic Medicine**, **30**, 95-106.
- Michaels, G.Y., and Goldberg, W.A. (Ed.). (1988) **The transition to parenthood: Current Theory and Research**. Cambridge: Cambridge University Press.
- Miller, W.B., and Newman, L.F. (Eds.). (1978) **The first child and family formation**. Chapil Hill: University of North Carolina, Carolina Population Center.
- Mishler, E.G. (1986) **Research interviewing, context and narrative**. Cambridge, Mass.:Harvard University Press.
- Murai, N. and Murai, N. (1975) The study of moods in pregnant women. **Tohoku Psychologia Folia**, **34**, 10-16.

Myers, S.T; and Grasmick, H.G. (1990) The social rights and responsibilities of pregnant women: An application of Parson's sick role model. **Journal of applied behavioral science**, **26**, 157-172.

Naylor, E.W. (1975) Genetic Screening and Genetic Counselling: Knowledge, Attitudes and Practices in Two Groups of Family Planning Professionals. **Social Biology**, **22(4)**, 304-314.

Newton, R.W; and Hunt, L.P. (1984) Psychosocial stress in pregnancy and its relation to low birthweight. **British medical journal**, **288**: 1191-3.

Nicolson, P. (1986) Developing a Feminist Approach to Depression following Childbirth. In Wilkinson, S. (ed.), **Feminist Social Psychology**. Milton Keynes: Open University press.

Nicolson, P. (1989) Counselling women with Postnatal Depression: Implications From Recent Qualitative Research, **Counselling Psychology Quarterly**, **2**, 123- 132.

Nicolson, P. (1990) A brief report of women's expectstions of men's behaviour in the transition to parenthood: Contradictions and conflicts for counselling psychology practice. **Counselling Psychology Quarterly**, **3**, 353-361.

Nielsen, J. M. (1990) **Feminist Research Methods**. U.S.A.: Westview Press.

Norman, P. (1995) Applying the health belief model to the prediction of attendance at health checks in general practice. **British Journal of Clinical Psychology** **34(3)** 461-470.

Notman, M.T. and Nadelson, C.C. (1978) **The woman patient: Medical and psychological interfaces**. New York: Plenum.

Oakley, A. (1974) **The sociology of housework**. London, Martin Robertson.

Oakley, A. (1979) **Becoming A Mother**. Oxford: Martin Robertson.

Oakley, A. (1980) **Women Confined: Towards a Sociology of Childbirth**. Oxford: Martin Robertson.

Oakley, A. (1981) Interviewing Women: A contradiction in terms. In Roberts, H. (Ed.), **Doing Feminist research**. London: Routledge and Kegan Paul.

Oakley, A. (1992) **Social support and motherhood**. Oxford, Blackwell.

Oakley, A. and Rajan, L. (1991) Social class and social support – the same or different? **Sociology**, 25 (1): 31-59.

Oakley, A., Macfarlane, J.A., and Chambers, I. (1982) Social class, stress and reproduction. In Rees, A.R. and Purcell, H. (eds), **Disease and the environment**, chichester, John Wiley.

O'Hara, M.W., Neunaber, D.J., and Zekoski, E.M. (1984) Prospective Study of Postpartum Depression: Prevalence, Course, and Predictive factors. **Journal of Abnormal Psychology**, 93(2), 158-171.

Pagel, M.D., Smilkstein, G., Regen, H., Montano, D. (1990) Psychological influences on newborn outcomes – a controlled prospective study. **Social Science and Medicine** 30(5) 597-604.

Parker, I. (1989) **The Crisis in Modern Social Psychology and How to End it**. London: Routledge.

Parlee, M. B. (1986) Feminism and the 'New Psychology'. **paper presented at the center for the study of women and society, CUNY Graduate Center, New York, May 1.**

Peplau, L. A. (1994) Men and women in love. In D.L Sollie & L.A. Leslie (Eds), **Gender, families, and close relationships: Feminist research journeys** (pp. 19-49). Thousand oaks, CA: Sage.

Phoenix, A. (1991) **Young Mothers?** Cambridge: Polity press.

Phoenix, A. (1994) Practising Feminist Research: The Intersection of Gender and 'Race' in the research process. In Maynard, M. and Purvis, J. (eds) **Researching Women's Lives from a Feminist Perspective**. London: Falmer.

Phoenix, A. (1995) Positioned Differently? The Impact of 'Race', Gender and Social Class on Identities and Research, **unpublished paper available from the author.**

Phoenix, A., and Woollett, A, (1991) Motherhood: Social construction, politics and psychology. In Phoenix, A., Woollett, A., Lloyd, E, (Eds) **Motherhood: meanings, practices and ideologies.** London, Sage.

Phoenix, A., Woollett, A. and Lloyd, E. (Eds) (1991) **Motherhood: Meanings, Practices and Ideologies.** London: Sage.

Pidgeon, N. and Henwood, K.L. (1997) Using grounded theory in psychological research. In Hayes, N (ed.) **Doing qualitative analysis in psychology.** Hove: Taylor and Francis

Potter, J. and Wetherell, M. (1987) **Discourse and Social Psychology: Beyond Attitudes and Behaviour.** London: Sage.

Price, F. (1989) **The parents study: Final report to the Department of Health** (London, Department of Health Library).

Price, F. (1996) Now you see it, now you don't: mediating science and managing uncertainty in reproductive medicine. In Irwin, A. and Wynne, B. **Misunderstanding science? The public reconstruction of science and technology.** Cambridge: Cambridge university press.

Price, J. (1988) **Motherhood: What It Does To Your Mind.** London: Pandora

Radcliffe, W. (1967) **Milestones in Midwifery.** Bristol: Wright and Sons.

Reading, A. (1983) **Psychological aspects of pregnancy.** New York: Longman.

Reason, P. and Rowan, J. (1981)(Eds.) **Human Inquiry: a Sourcebook of New Paradigm Research.** Chichester: Wiley.

- Reinharz, S. (1983) *Experiential Analysis: a Contribution to Feminist Research*. In Bowles, G. and Klein, R.D. (Eds.), **Theories of Women's Studies**. London: Routledge and Kegan Paul.
- Reinharz, S. (1985) *Feminist distrust: problems of content and context in sociological research*. In Berg, D.N. and Smith, K.K. (eds), **The Self in Social Inquiry**. London: Sage,
- Reinharz, S. (1992) **Feminist methods in social research**. Oxford: Oxford University Press.
- Roberts, H. (1992) **Women's health counts**. London: Routledge.
- Rollins, J.H. (1996) **Women's Minds, Women's Bodies: The Psychology of Women in a Biosocial Context**. New Jersey: Prentice Hall.
- Rosen, S. (1951) Emotional factors in nausea and vomiting in pregnancy. **Psychiatric Quarterly**, 1951, 29, 621-633.
- Rothman, B.K. (1986) Reflections On Hard Work, **Qualitative Sociology**, 9, 48-53.
- Rothman, B.K. (1988) **The Tentative Pregnancy: Prenatal Diagnosis And The Future Of Motherhood**. London: Pandora Press.
- Rothman, B.K. (1994) *Beyond Mothers and Fathers: Ideology in a Patriarchal Society*. In Glenn, E.N., Chang, G.C. and Forcey, L.R. (Eds) **Mothering: Ideology, Experience and Agency**. New York: Routledge.
- Rutter, D.R., Quine, L., Chesham, D.J. (1993) **Social Psychological Approaches to Health**. Hertfordshire: Harvester Wheatsheaf
- Sauwakon, A., Chalerm Sri, R., Pansak, S. (1988) Knowledge, Attitudes and Acceptances of Pregnant Women Towards Prenatal Diagnosis. **Journal of the Medical Association of Thai**, (March), 9-12.

Seals, B.F., Ekwo, E.E., Williamson, R.A., Hanson, J.W. (1985) Moral and Religious Influences on the Amniocentesis Decision. **Social Biology**, 32, 13-30.

Shaffir, W.B., Stebbins, R.A. and Turowetz, A. (1980) (Eds) **Fieldwork Experience: Qualitative Approaches to Social Research**. New York: St. Martins Press.

Shereshesky P.M. and Yarrow L.J. (1973) **Psychological aspects of a first pregnancy and early postnatal adaptation**. New York Raven Press.

Sherr, L. (1989) Obstetrics. In Broome, A.K. (Ed) **Health Psychology: Processes and applications**. London: Chapman and Hall.

Shields, S.A., and Crowley, J.J. (1996) Appropriating questionnaires and rating scales for a feminist psychology: A multi-method approach to gender and emotion. In: **Feminist social psychologies**. Wilkinson, S. Buckingham, Open university Press.

Shiloh, S. and Saxe, L. (1989) Perception of Risk in Genetic Counselling. **Psychology and Health**, 3, 45-61.

Simmel, G. (1921) The sociological significance of the 'stranger'. In Park, R.E. and Burgess, E.W. (eds), **Introduction to the Science of Sociology**. Chicago: University of Chicago Press.

Skevington, S. and Baker, D. (ed.)(1989) **The Social Identity Of Women**. London: Sage.

Smith, D. (1974) Women's perspective as a radical critique of sociology, **Quarterly**, 44: 7-13.

Smith, J.A. (1990) Self-construction: Longitudanal Studies in the psychology of personal identity and life transitions. **Unpublished Dphil thesis**, University of Oxford.

- Smith, J.A. (1991) Conceiving selves: A case study of changing identities during the transition to motherhood. **Journal of Language and Social Psychology**, **10**, 225-243.
- Smith, J.A. (1992) Pregnancy and the Transition to Motherhood. In Nicholson, P. and Ussher, J. (Eds) **The Psychology of Women's Health and Health Care**. London: Macmillan.
- Smith, J.A. (1993) The case study. In Bayne, R; and Nicolson, P. (Eds) **Counselling and psychology for health professionals** . London: Chapman and Hall.
- Smith, J.A. (1994) Reconstructing Selves: An analysis of discrepancies between women's contemporaneous and retrospective accounts of the transition to motherhood. **British Journal of Psychology**, **85**, 371-392.
- Smith, J.A. (1996) Evolving Issues for Qualitative Psychology. In Richardson, J.T.E. (Ed) **Handbook of Qualitative Research Methods for Psychology and the Social Sciences**. Leicester: British Psychological Society.
- Spencer, H. (1896) **The Principles of Biology**. New York: Appleton.
- Stabile, C.A. (1994) **Feminism and the Technological Fix**. Manchester: manchester University Press.
- Stacey, M. (1988) **The Sociology of Health and Healing**. London: Routledge.
- Stanley, L. and Wise, S. (1983) **Breaking Out: Feminist Consciousness and Feminist Research**. London: Routledge & Kegan Paul.
- Stanley, L., and Wise, S. (1993) **Breaking Out Again: Feminist Ontology and Epistemology**. London: Routledge.
- Ussher, J.M. (1989) **The Psychology of the Female Body**. London: Routledge.

- Weedon, C, (1987) **Feminist Practice and Poststructuralist Theory**. Oxford: Blackwell Publishers.
- Wertz, R.W. and Wertz, D.C. (1977) **Lying - In: A history of Childbirth in America**. New Haven, CT: Yale University Press.
- Wiles, R. (1994) 'I'm not Fat, I'm pregnant': The impact of pregnancy on fat women's body image. In: **Women and Health Feminist perspectives**. London: Taylor and Francis.
- Wilkinson, S. (ed.)(1986) **Feminist Social Psychology**. Milton Keynes: Open University Press.
- Wilkinson, S. (1988) The role of reflexivity in feminist psychology. **Women's Studies International Forum**, 11(5), 493-502
- Wilkinson, S. (1996) (Ed.) **Feminism and Psychology, Special Issues on Representing the Other**, 6, (Double issue).
- Wilkinson, S. (1998) Focus groups in feminist research: Power, interaction and the co-construction of meaning. **Womens Studies International Forum**, 21(1), 111-125
- Woollett, A., Marshall, H., Nicholson, P. and Dosanjh, N. (1994) Asian Women's Ethnic Identity: The Impact of Gender and Context in the accounts of Women Briniging up Children in East London. **Feminism and Psychology**, 4(1), 119-132.
- Woollett, A., Dosanjh, N., Nicolson, P., and Marshall, H. (1995) The ideas and experiences of pregnancy and childbirth of asian and non-asian women in East London. **British journal of medical psychology**. Vol.68 (1) 65-84.
- Zajicek, E. (1979) Self Perceptions during Pregnancy and Early Motherhood. In Harnett, O., Boden, G. and Fuller M. (eds.), London: Tavistock.
- Zajicek, E. (1981) The Experience of Being Pregnant. In Wolkind, S. and Zajicek, E. (Eds) **Pregnancy: A Psychological and Social Study**. London: Academic Press.

APPENDIX 1

Project Information and Form of Consent

During your pregnancy you will be offered a number of services by the medical staff and midwives at Hillingdon Hospital (for example, antenatal classes and ultrasound scans). You may have mixed feelings about the different services offered to you and the way in which they are delivered. We are trying to record women's experiences of pregnancy both in relation to their care programme offered by Hillingdon Hospital as well as their experiences outside the medical setting (the social context). By recording women's experiences of pregnancy we hope to gain a better understanding of women's experiences of pregnancy in the 1990s.

This study involves asking women such as yourself to keep diaries (or if this is not a viable option to you, partake in a series of interviews) during your pregnancy and up to one month after the birth. The diary will contain some instructions to give you some guidance. If you are selected to take part in the study, you will be asked to write down anything you feel is relevant in your present experience of pregnancy. This may include for example, questions you have in your mind, whether you seek answers for these questions, how you think others feel about your pregnancy, and decisions you make about accepting or rejecting tests offered to you by doctors. While you will be open to write as much or as little as you like, please do bear in mind that the more you are willing to tell us, the fuller our picture will be of how women experience pregnancy in today's society.

The diaries and tapes will be entirely confidential and kept separately from your medical notes. The diaries/interviews on tape will only be read/heard by the researcher (Manjit Bola). Your name, address and personal details will not be revealed to anyone else. Your decision to either decline or take part in this study will not affect your medical treatment in any way whatsoever.

If you have any questions about the study please do not hesitate to contact me at the following address:

Manjit Bola,

Centre for the Study of Health, Sickness and Disablement,

Brunel University,

Uxbridge,

Middlesex UB8 3PH.

tel: 0895 274000 ext 3464.

If you are willing to take part in the study, please complete the following patient consent form.

I look forward to meeting you soon.

Yours sincerely,

Miss Manjit Bola.

Form of consent

I, _____

of, _____

tel, _____

give my consent for participation in the study examining women's experiences of pregnancy, should I be one of the women selected to take part in the study.

Signed _____ Date _____

APPENDIX 2

DIARY SCHEDULE INFORMATION

-A GUIDE TO COMPLETION-

Here are some examples of the types of things we would like you to note in your diary. Please remember that you are more likely to remember what was said or how you felt about a particular visit or conversation soon after it has taken place. Thus the sooner you are able to write it down the more you are likely to tell us. You may wish to set some time aside each day, for example just before you go to bed. We would like to know everything you wish to tell us that is related to your pregnancy (good and bad). Please start on a new page for each day and enter the date for each day in the top right hand corner. You may write as many pages as you like. If you have nothing to report on a particular day it will be useful if you could enter 'nothing to report' with the date in the right hand corner. We hope you find the reporting an enjoyable experience!

- 'Please detail any visits to places relevant to your pregnancy, for example, attendance at ante-natal classes and visits to doctors. Also include visits to friends and relatives. This may be to have a chat in which you talk about how your pregnancy is getting on, to express any fears you may have, or to ask for some help/information. Please include the time and day of the visit/conversation.'

- 'How do you see your see your family's views about your pregnancy? For example are there any changes in their attitudes and behaviour over time? Are you happy with their views or do you differ in your opinions? Does your partner/close relative normally accompany you to

your ante-natal classes or hospital appointments? How is your family involved with the pregnancy.'

- 'How do you feel your pregnancy is getting along? What are the types of things you think about and do you keep these thoughts to yourself or normally tell someone? Are there any past experiences that you keep remembering while you are pregnant? What would you like during your pregnancy? Have you been given any information or read something in a magazine that you did not know or are thinking about? Are you worried about anything?'

Above are some examples of topics that you can write about. You may want to write about some or all of the above topics. There may be plenty more things you wish to write about. Please feel free to do so. The way you experience the pregnancy and the decisions you have to make that are related to the pregnancy will provide valuable information with regards to the similarities and differences women face during pregnancy. One last thing, don't worry about spelling mistakes or writing in a certain way, anything goes!

The diary you return will be treated strictly confidentially, the material will only be read by the researcher. No names and addresses will be published or forwarded to any other organisations.

Thank you for your time and co-operation in this research project.

APPENDIX 3

**QUALITATIVE DATA COLLECTION: A COMPARISON
BETWEEN DIARY/DIARY INTERVIEW AND
UNSTRUCTURED INTERVIEW METHODS**

**DISCOURSE ANALYSIS CONFERENCE
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Abstract

A current investigation into women's decision making processes and experiences in relation to the uptake of prenatal diagnostic testing (amniocentesis) will be used to illustrate the comparative strengths and weaknesses of the diary/diary interview and the unstructured interview methods of data collection.

Of particular interest is the extent to which these two methods of data collection can capture and record in analysable form the objective and subjective experiences which precede and follow prenatal decisions (take-up/non take-up of prenatal testing) made by the sample of women studied during their pregnancy.

1. Introduction to the area of prenatal diagnosis

The biomedical sciences have seen a phenomenal utilisation of technological developments in the past two decades. One area in which this is extremely noticeable is that of human (medical) genetics. Technological development has made possible a far greater ability to detect many genetic disorders during the antenatal/perinatal period. The overall term used to describe this detection is 'prenatal diagnosis'.

The use of prenatal diagnosis (for example amniocentesis) as a means for detecting certain hereditary diseases and congenital defects has increased dramatically world-wide, and in this country there is a growing number of genetic centres offering prenatal diagnostic services. The services are offered to families at increased risk of having children with hereditary diseases or congenital defects. There are a number of reasons why provision of such services is considered important in the medical world, ranging from psychosocial considerations to reducing the number of incidence of infant mortality and morbidity due to congenital malformations, gene defects and chromosomal anomalies. There is also the support gained from cost-benefit analysis, which contrasts the economic costs of offering such services (where termination is an option), with those of care for those individuals suffering from the various physical and/or mental conditions during their life-span.

The relatively new option of prenatal detection of certain disorders in the foetus has profound implications for society as a whole. Many ethical and moral questions are raised, such as a person's attitudes and beliefs about reproductive matters and the birth of healthy children may alter over time in the light of the prenatal services being offered to them.

Families/individuals who know themselves to be at increased risk are likely to have to make decisions about a number of issues which may be central to, or contradictory to, their presently held beliefs and attitudes about matters of reproduction. There is, of course, a set of related and very important issues which must always be kept in mind: those relating to the quality of life of the infant itself, patients, family members and the community as a whole.

In the light of prenatal detection of abnormalities becoming a more familiar sight in many countries, a study shall be conducted to investigate the decision-making processes and women's experiences of taking part in prenatal testing. A brief outline of the study follows.

2. Case Study

2.1 Subject Group & Reasons for Choice

Women aged 35 years and over will be selected to take part in the study. This age range is considered medically to be one of the main risk populations, making them eligible for prenatal diagnosis.

2.2 Prenatal Diagnostic Technique to be Investigated

Amniocentesis is one of the techniques used for prenatal diagnosis, and is performed on women aged 35 years and over in order to detect chromosomal abnormalities. The procedure is relatively safe and is carried out on an out-patient basis.

2.3 Study

The study will involve an examination of:

1. the women's experiences of prenatal diagnosis. The women will be followed right through their pregnancy, from the time they first enter the services, until the first week after delivery. Using this format, it should be possible to establish the patterns of experiences women have, in terms of similarities and differences. It is hypothesised that women attending genetic centres will be offered a higher percentage of prenatal diagnostic tests and counselling than will those women attending non-genetic centres. If more women are indeed offered amniocentesis in genetic centres, we can investigate how this increased testing effects their experiences.
2. the decision making process, as to whether a woman should/should not take up the offer (presuming an offer has been made) of having an amniocentesis test to detect chromosomal abnormalities. This process shall be investigated by looking at the various factors (e.g. religion, partnerships, etc) which are considered when making the decision. An examination can also be made as to whether the women remain happy/unhappy with their choice, or whether they change their mind in the time they have available to make their decision.
3. women's attitudes and beliefs about the purpose of the test, which are naturally linked to the decision making process discussed above. These attitudes and beliefs may change according to the information made available to the women, the advice given to them by the medical profession (or others), and the perceived general 'acceptability' of the test itself. Attitudes towards the possible termination of the pregnancy if the test proves to be positive in it's detection of chromosomal anomalies may also alter during the course of the test, and one interesting avenue of investigation would be to see which factors play an important role in these changing attitudes and beliefs.

By addressing the above areas of research, it is hoped that a greater knowledge and understanding of the impact of having prenatal diagnosis offered as an option, with or without appropriate counselling, will help us improve the prenatal services offered. We will be able to address the value of genetic counselling for women during their pregnancy, as well as bringing to the fore the experiences that women have of the services offered to them.

To summarise, the study will be investigating the psychosocial impact of prenatal diagnosis on women aged 35 years and over, who are one of the groups considered to be at high risk from prenatal abnormalities. The study will also be evaluative in nature, in order to gain a greater understanding of the antenatal/prenatal care offered to women in this country.

The methodology to be employed to elicit this information for qualitative analysis will be either diary/diary interview or unstructured interviews with the women. A pilot study will be conducted in order to examine the possible advantages and disadvantages of each of these methods of data collection.

I will now outline some of the features of each of these methods before describing their applications in relation to this particular study.

3. Methods of data collection

3.1 Diary/diary interview

Ken Plummer, in his book 'Documents of Life' (1983), points out that the use of personal documents in social science research has had a long history. One notable example is the use of such documents by W. Thomas and F. Znaniecki in their research entitled 'The Polish Peasant in Europe and America' (1920). Personal documents were also extensively used by the 'Chicago School' of sociology in the 1920's and 1930's. However, after this period, Plummer reports that for various reasons the method fell into general disuse. In recent years there has been a modest revival in various fields of social enquiry.

Allport (1942) has classified diaries and diary interviews in terms of intimate journals (where individuals record thoughts, events and feelings that may be central to them), memoirs (similar to career biographies) and logs (records of events, meetings and visits).

3.1.1 Features of diaries

Diaries which are solicited for research purposes may take a number of forms. They can be highly structured, where pages are divided into particular sections for recording particular types of events occurring at specific times. Alternatively, an unstructured diary approach may be employed with only a note guiding the respondent as to what the researcher is looking for, thus allowing the respondent to take more control over what is entered.

3.1.2 Advantages of diary/diary interviews

The diary will be produced by the respondents themselves, without the conversational interaction which occurs in interviews. Although the respondent has the researcher in mind when making entries, the researcher does not have the same level of control, and thus experimenter effects which may be strongly felt in a standard interview situation are not as predominant in the diary/diary interview techniques.

The diary interview will be guided by what the respondent has entered in the original diary, and thus the interviewer comes in to the interview situation with some knowledge of the context and importance of various issues. The respondent affects the direction that the interviewer takes.

The diary interview forms only a supplement to the diary for the purposes of research. This interaction allows the researcher to test out her/his interpretations at the same time as clarifying and investigating deeper particular points. The diary, aided by diary interviews, has the potential to produce far more detailed accounts of the subject matter under investigation.

The subject can be perceived as being both the observer and informant of her/his situation and experiences, thus giving more power to the subject.

3.1.3 Disadvantages of diary/diary interviews

Diaries can only represent particular sections of the population, as only the reasonably literate will be able to satisfactorily produce them. This could lead to the omission of particular social groups. The diarist will also be selective in what s/he records, which may not be in line with the hypotheses that the researcher is attempting to investigate.

Finally, there is a (very real) problem of deciphering handwriting.

3.2 Unstructured interview

The most basic feature of unstructured interviews is that it is a speech activity, produced by two or more persons speaking to each other. It is a collaborative relationship between people (the interviewer(s) and interviewee(s)). In social science studies the unstructured interview can be perceived as a search procedure with the questions of the interviewer being guided by the set of themes or topics s/he wishes to explore during the course of conversation with the interviewee. The unstructured interview may be employed in order to capture how the interviewee organises, perceives and gives meaning to their experiences and understandings of themselves and their environment. This in turn means that a level of context exists in which the interviewee can express her/himself. The interview creates its own content, shaped by the questions asked/not asked and the many turns at talk which occur during the conversation.

The unstructured interview is characterised by its lack of standardised questions, where the very nature of the interview constrains the answers that a respondent can give. Thus there are no straight forward question and answer sequences. By taking an unstructured approach, the researcher can maintain the subject matter in context.

3.2.1 The role of the interviewer

The interviewer sets the scene in which the conversation will take place. This may involve explaining why they wish to interview the subject, what will happen to the interview material, and what they would like to talk about. As stated previously, the interview, by its very nature, is a collaborative exercise. The interviewer plays a part in the construction of the 'data' in terms of what s/he asks, how s/he asks the questions, the length of time given to listening to the replies/answers that the respondent makes, and the level of probing employed for gaining answers during the conversation. The style of interviewing employed will influence what the respondent talks about.

The personal characteristics of the interviewer need to be acknowledged. For example, age, sex and status can place limits on her/his role as an interviewer.

3.2.2 Power and role of questions

Questions are powerful units of discourse. They should not be perceived as neutral or objective, as they contain the interviewer's interest and involvement. The questions may have an anchoring effect which creates a

different context to that which the subject may have perceived in another setting. Questions are in themselves expressive and can influence the range and depth of the reply. It is for these reasons that the level of interviewing experience may influence the effectiveness of the technique.

3.2.3 Advantages of in-depth interviewing

The subject matter is preserved in the situational context. The interview can capture how people organise, perceive and give meaning to their experiences and environment. The subjects are encouraged to develop their answers, which in turn provides us with a greater understanding their experience.

3.2.4 Disadvantages of in-depth interviewing

Transcribing the interviews is a complex, tedious and time consuming activity. There are many ways to prepare a transcript (various transcription notation systems have been developed), but in transcribing the interview some aspects of the conversation are lost, for example, pitch, stress and conversational dynamics.

4. Case study implications

The particular subject matter, and the respondent characteristics (white, middle class women), both suggest the use of diaries to be the most effective method of data collection. The respondents are likely to be educated and thus capable of expressing themselves in written accounts. To test this hypothesis, a pilot study will be conducted in the near future to determine whether this method is a feasible alternative to the unstructured interview. The pilot study will be necessary because of the previous scarcity of the diary interview method being employed in social science research. Of course, some of the disadvantages associated with the diary as a method of data collection cannot be avoided. For example, the problems of deciphering handwriting, and selectivity and typicality of reports given by the participants.

The method of data collection employed needs to acknowledge the likely response effects and levels of distortion. In order to do this, it is important to emphasise the need to examine the effects of a variety of administrative procedures and related aspects of their construction when attempting to capture data.

There are a variety of techniques that a researcher may administer in order to collect the data. Interviews are only one such technique. Although this approach is now widely being administered for qualitative research, its relative advantages seem to be obscuring those of other techniques.

The researchers aim should be to match the data gathering method with the conditions of their particular study, in other words look at the particular advantages and disadvantages of the various methods of data collection available and the related comparative advantages and disadvantages gained from employing them in the research context. This may best be achieved by conducting a pilot study to examine the comparative strengths and weaknesses of the various methodologies. Other influences on the choice of methodology employed may include problems of access to subjects, ease of administration and cost.

In conclusion, the unstructured interview is increasingly being adopted by researchers carrying out qualitative research. Indeed, a number of books have recently been published dealing with research interviews. However, in contrast, in my own brief literature review, I have only found a very small number of books dedicated to examining personal documents, such as the diary/diary interview methods.

REFERENCES AND SELECTED BIBLIOGRAPHY

- Burgess, R.G. (1984), 'In the Field. An Introduction to Field Research', London: Unwin Hyman.
- Bryman, A. (1988), 'Quantity and Quality in Social Research', London: Unwyn Hyman.
- Feyerabend, P. (1975), 'Against Method', London: NLB.
- Gilbert, G.N. and Mulkay, H. (1984), 'Opening Pandora's Box: A Sociological Analysis of Scientist's Discourse', Cambridge: U.P.
- Janis, I.L. and Mann, L. (1977), 'Decision Making: A Psychological Analysis of Conflict, Choice and Commitment', New York: The Free Press.
- Johnston, M. and Marteau, T. (1991), 'Prenatal Screening', The Psychologist, 14, 3, p110-111.
- Kahneman, D., Solvic, P. and Tversky, A. (1982), 'Judgement under Uncertainty: Heuristics and Biases', Cambridge: Cambridge University Press.
- Keeney, R.L. and Raiffa, H. (1976), 'Decisions with Multiple Objectives: Preferences and Value Trade Offs', New York: Wiley.
- Kolker, A. and Burke, B.M. (1987), 'Amniocentesis and the Social Construction of Pregnancy', Marriage and Family Review, 11, 3-4, p95-116.
- Kyle, D., Cummins, C. and Evans, S. (1988), 'Factors Affecting the Uptake of Screening for Neural Tube Defect', British Journal of Obstetrics Gynaecology, 95, 6, p560-564.
- Mishler, E.G. (1986), 'Research Interviewing. Context and Narrative', London: Harvard University Press.
- Paget, M.A. (1983), 'Experience and Knowledge', Human Studies, 6, p67-90.

Pauker, S.P. and Pauker, S.G. (1977), 'Prenatal Diagnosis: A Directive Approach to Genetic Counselling using Decision Analysis', Yale Journal of Biological Medicine, 50, p275-289.

Pitz, G.F. (1987), 'Evaluating Decision Aiding Technologies for Genetic Counselling', Birth Defects: Original Article Series, 23, 2.

Plummer, P. (1983), 'Documents of Life. An Introduction to the Problems and Literature of a Humanistic Method', London: Unwin Hyman.

Popper, K. (1972), 'The Logic of Scientific Discovery', London: Hutchinson.

Silverman, D. (1985), 'Qualitative Methodology and Sociology', Aldershot: Gower.

Sjoren, B. and Marsk, L. (1989), 'Information on Prenatal Diagnosis at the Antenatal Clinic', Acta Obstet. Gynecol. Scand., 68, 1, p35-40.

Viek, C. (1987), 'Risk Assessment, Risk Perception and Decision Making about Courses of Action Involving Genetic Risk: And Overview of Concepts and Methods', Birth Defects: Original Article Series, 23, 2, p171-207.

Zimmerman, D.H. and Wieder, D.L. (1977), 'The Diary. Diary-Interview Method', Urban Life, 5, 4, p479-498.

APPENDIX 4

Medical Glossary

Abnormality: A physical deformity or malformation, a behavioural or mental problem, or a variation from normal in the structure or function of a cell, tissue or organ.

Amniocentesis: An operation to remove a small quantity of amniotic fluid.

Anti D Immunoglobulin: The special rhesus antibody that destroys rhesus positive red blood cells, especially in the baby.

Braxton Hicks Contractions: (Usually) painless uterine contractions which occur about every 20 minutes throughout pregnancy.

Cervix: The lower part of the uterus.

Congenital: Deformities or diseases that are either present at birth or, being transmitted directly from the parents, show themselves sometime after birth.

Down's Syndrome: A genetic abnormality, also known as Trisomy 21 or Mongolism.

Embryo: The unborn child from conception until the 8th week.

Fetal Alcohol Syndrome: A combination of congenital defects resulting from high alcohol consumption by the mother during pregnancy.

Fetal Heart Monitoring: Use of an instrument to record and/or listen to an unborn baby's heartbeat during pregnancy and labour.

Fetus: The unborn child from the end of the 8th week after conception until birth.

Hypertension: Another term for high blood pressure.

Listeria: Rare infection that may affect the fetus in utero.

Miscarriage: Loss of the fetus before the 28th week of pregnancy or before viability (the ability to survive outside the uterus without artificial support).

Multigravida: A woman during her second or subsequent pregnancy.

Nausea: A feeling that vomiting is about to take place.

Placenta: The afterbirth. It is responsible for transferring the baby's vital requirements from the mother to the baby in the uterus, and for transferring the baby's waste products to the mother.

Postnatal: After delivery

Primagravida: A woman during her first pregnancy

Spinabifida: A congenital defect in which part of one or more vertebrae fails to develop completely, leaving a portion of the spinal cord exposed. Can occur anywhere on the spine, but is more common on the lower back. The severity of the condition depends on how much nerve tissue is exposed.

Talipes: A birth defect in which the foot is twisted out of shape or position. Commonly known as club-foot.

Trimester: One third of pregnancy. 1st trimester = 1-14 weeks, 2nd trimester = 14-28 weeks, 3rd trimester = 28 weeks to term.

Ultrasound: Very short wavelength radiation which is used to detect, for example, fetal movement, fetal heartbeat, etc.