A Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Mini-thesis submitted as course requirement for M Psych Clinical Psychology Degree

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ABSTRACT

This research project can be defined as an in-depth qualitative study. The research question was: How does social support affect women's psychological experiences during a pre-eclamptic high risk pregnancy? The main objectives were to explore, understand, and describe women's psychological state and perceived support during their past high risk pregnancy. For the purposes of this study, psychological experiences shall include emotions, feelings and thoughts and social support will be conceptualised as form of interpersonal interactions in which assistance is offered to another. The fieldwork was conducted at a public hospital in the Western Cape. Six women, who have previously experienced pre-eclampsia during pregnancy, were interviewed and asked to reflect retrospectively on their psychological and social support experiences during their high risk pregnancy. The interviews were recorded and transcribed verbatim. The theoretical framework that was used was phenomenological inquiry and the analytic tool was phenomenological analysis. The main themes that emerged were psychological distress, positive and negative experiences of social support. The subthemes encompassed the various emotions identified by the women, and the various social support experiences.

DECLARATION

I declare that *A Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Full Name: Lisa Tendai Sanders Date: February 2010

Signed: 

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Introduction

A Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Chapter One

Introduction

This research project can be defined as an in-depth qualitative study. The research topic that was focused on in this study is: how social support may affect women's psychological experiences of high risk pregnancy. More specifically, the psychological experiences and the received social support of women with the high risk condition of pre-eclampsia (a hypertensive disorder), at a public hospital in the Western Cape, were explored.

Worldwide, over half a million women die annually due to pregnancy related problems, 99% of these cases are reported in the developing world (including South Africa). The statistics indicate that pre-eclampsia complicates approximately 5-8% of pregnancies and is a major cause of maternal morbidity, perinatal death and premature delivery (James, Steer, Weiner & Gonik, 2006). In the United Kingdom, for example, pre-eclampsia accounts for one fifth of antenatal admissions and 10-15% of direct obstetric deaths, as it does in many developing countries (Duley, 2003). Pre-eclampsia is also one of the major causes of iatrogenic prematurity in new born babies (Page, 2002).

Firstly, it is of great importance to define and conceptualise the key terms and concepts that comprise this research project. A high risk pregnancy of any kind is defined as "a pregnancy in which there is an increased chance of poor maternal or perinatal outcome (maternal

mortality or morbidity, fetal and neonatal mortality and morbidity)" (Department of Obstetrics and Gynaecology, 2000, p.18). Pre-eclampsia is a hypertensive disorder, where hypertension is measured by: (i) a reading of diastolic pressure exceeding 110mmHg, or (ii) two consecutive diastolic arterial pressures of 90mmHg or greater at an interval of at least 4 hours (Moodley, 1997). Furthermore, the current clinical definition of pre-eclampsia is "hypertension normally occurring after the 20th week of gestation and accompanied by proteinuria (a urinary excretion of a least 0-3g protein in a 24h specimen)" (National Institutes of Health, 2000, as cited in Page, 2002, p.413). If there is an absence of proteinuria, pre-eclampsia is suspected and diagnosed if the hypertension is accompanied by abdominal pain, headaches, visual disturbances, rapid weight gain or abnormal laboratory results. In addition, women with severe cases of pre-eclampsia can develop seizures that cannot be explained by any other causes (Page, 2002). However, the exact cause of pre-eclampsia is unknown. It has been attributed to a number of causes, namely: genetic abnormalities, immunologic intolerance, dietary deficiencies, and maladaption to the cardiovascular and inflammatory changes in pregnancy (Black, 2007).

Due to pregnancies complicated by hypertension, pre-eclampsia in particular, being regarded as severe diseases that are potentially life-threatening, they also have an immense impact on the psychological state of the women who are experiencing it. The women's psychological well-being may further be affected by their perceived and received social support. Therefore, it is necessary to define what exactly is meant by emotional and/or psychological experiences; and the concept of social support.

For the purposes of this study, psychological experiences shall include emotions, feelings and thoughts experienced by women during a past pre-eclamptic high risk pregnancy. Another

key concept/theme explored in this research study is social support. Social support can be defined as "a form of interpersonal interaction in which one individual offers assistance to another" (Corbet-Owen, 2003, p.1). It is fundamental to explore these psychological effects as they are often profound and long-lasting.

1.1. Objective

The main objective is to explore and understand women's psychological state and perceived support during their past high risk pregnancy. More specifically, this study will explore the role social support plays on the psychological experiences of women during their pre-eclamptic pregnancy.

1.2. Aims

An aim of this study was to describe women's psychological experiences during a past pre-eclamptic pregnancy. This will entail describing the cognitive aspect (thought processing) and the emotional aspect (feelings and emotions), that both comprise the psychological experiences defined for this particular study. A further aim of this study is to explore and form a greater understanding of the role social support plays in terms of the psychological experiences of women during a past high risk pregnancy. This will involve gathering data about the perceived social support (community, family, personal, and institutional), as well as the psychological impact this may have had on the women.

1.3. Research Question

The research question, in this case, is: How does social support affect women's psychological experiences during a pre-eclamptic high risk pregnancy?

1.4. Rationale

The motivation and need for this study are twofold. Firstly, the rationale behind this research topic is to raise public discussion around the psychological experiences, including the cognitive, emotional, and social aspects, of women experiencing a high risk pregnancy. Thus, we are hoping to produce more knowledge about the topic, create a greater awareness of pre-eclampsia, and to inform the public of the emotional consequences of this condition. Furthermore, discussions arising from this research may help to identify the current gaps in social support structures for women with pre-eclampsia and thus inform future decisions regarding the provision of support resources for women during high-risk pregnancies.

Secondly, this research project aims to fill the large void in the local literature. Thus far literature on pre-eclampsia has been formed mainly from the biological and clinical perspective, with only a few studies exploring the psychological and social aspects of the disorder. In addition, these studies have all focused on developed countries. Therefore, it is necessary to conduct a local study, in the South African context, that explores women's emotional experiences during a past case of pre-eclampsia, a high risk pregnancy. Furthermore, it is important to attempt to broaden our knowledge and understanding of the affects social support (during a past high risk pregnancy) can/or may have on women's psychological well-being, as this may inform more effective mental health interventions.

1.5 Theoretical Framework

This research will be located in the theoretical framework of phenomenology and phenomenological analysis will be used as an analytic tool.

The remainder of this thesis will be structured as follows: Chapter two will consist of the literature review; Chapter three will discuss the methodological process followed during this research; Chapter four and five will be combined to form the findings and discussion section; and Chapter Six will conclude the paper and explore possible limitations of the study as well as proposing recommendations for future research.

Chapter Two

Literature Review

Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Chapter Two

Literature Review

It has been reported that approximately 25% of all pregnancies worldwide, are high risk (Lobel, DeVincent, Kaminer, & Meyer, 2002). Furthermore, pre-eclampsia is a disease that complicates 5 to 8% of all pregnancies (James et al., 2006). Thus, due to these significant differences in statistical prevalence there has been a larger amount of literature submitted on high-risk pregnancy as opposed to pre-eclampsia (Black, 2007). The literature on high risk pregnancies remains heavily focused on health care directives and on adherence to specific medical treatment plans, such as reduction in risk behaviours (smoking) and consistent monitoring of blood sugar and uterine activity (Brooten, Youngblut, Donahue, Hamilton, Hannan, & Neff, 2007).

Although there is a wider database of information of high risk pregnancy compared to pre-eclampsia, there still remains a very limited selection of literature focusing specifically on the psychological experiences of women during both high risk pregnancy and pre-eclamptic high risk pregnancy. Most of the literature lacks empirical data highlighting the common problems encountered during a high risk pregnancy from the women's perspective – it is often communicated from a more objective point of view (Brooten et al., 2007). Furthermore, the effect of social support on the women's emotional and cognitive experiences during a past

case of pre-eclampsia has been largely overlooked. In addition, there is a serious shortage of research conducted on this topic in South Africa. Therefore, this literature review will mainly focus on the psychological and social factors associated with high risk pregnancy in general, with a limited review of the available literature on pre-eclampsia. Furthermore, this literature review will be separated into the following themes identified during the research process: psychological distress and psychosocial support.

2.1. Psychological Distress

Several researchers have reported that emotional disturbances are not uncommon amongst pregnant women (Bernazzani, Saucier, David & Borgeat, 1997). Although, the transition into parenthood and the arrival of a new child in the family are both incredibly stressful phases, in some situations the stress may be heightened due to medical complications, as in the case of high risk pregnancies (Bernazzani et al., 1997). McCain and Deatrick (1994) found that heightened anxiety and vulnerability, often expressed as uncertainty over outcome of the pregnancy, to be the main themes in women's experiences in high risk pregnancies. Bernazzani et al. (1997) conducted a study that explored a multi-factorial model for the understanding of the factors related to the severity and intensity of prenatal emotional disturbances. Their research showed that stressful life events had direct and indirect relationships to prenatal symptomatology (Bernazzani et al., 1997). On the whole, their results indicated that interpersonal relationships, stressors, socio-demographics, locus of control, and psychiatric and family history are associated either directly or indirectly with prenatal emotional disturbances (Bernazzani et al., 1997). However, this research study was somewhat flawed as the prenatal variables were measured in the same time period as each other, and therefore casual inferences could not be drawn (Bernazzani et al., 1997).

Jomeen (2005) elaborates on the importance of exploring the psychological status of women during pregnancy. Jomeen (2005, p.144) emphasises that "the belief that emotions, behaviour, and the physical and social environment of the pregnant woman may influence the development of the fetus is widely held and cross cultural". Research thus far has traditionally characterised the psychological status of women during pregnancy by the emotions: anxiety and depression. However, this largely ignores the complex psychological interrelations that occur during pregnancy (Jomeen, 2005). Jomeen (2005) proposes that the psychological status in pregnancy cannot simply be defined within a unidimensional framework; instead it must include an in-depth assessment of all the dimensions that contribute to the mood and emotional status for women during pregnancy, childbirth and the postnatal period. These various dimensions include: anxiety and depression, worry, control, self-esteem, sleep and quality of life (Jomeen, 2005). This will enable healthcare professionals to identify and acknowledge normal and abnormal adjustment and offer interventions and support (Jomeen, 2005).

A descriptive study by Jones and Flaherty (1992) examined pre-eclamptic new mother's perceptions of the early postpartum period. They identified stressors described by the mothers and the care that they perceived to be useful in decreasing levels of stress. Three general themes emerged from the data analysis: "It's going to be OK"; "It was a bad experience"; and "Did this really happen to me?" (Jones & Flaherty, 1992). These themes encompass a variety of emotions that the women were experiencing, such as being: hopeful, grateful, reassured, scared, worried, detached, out of control, and guilty. Although the emotional states experienced by the women were in some instances contrasting there were two measures that all participants identified as being helpful in decreasing stress: firstly, clear and descriptive

information that explained step-by-step what was happening; and secondly, being able to have increased contact with their babies and direct support from family and the obstetrical health care team (Jones & Flaherty, 1992).

Dulude, Belanger, Wright and Sabourin (2002) investigated the effects of a high risk pregnancy on the psychological well-being and marital adjustment of parents. This focus on both the parents separates this research from previous studies. Dulude et al. (2002) hypothesised that because a high risk pregnancy is considered an unexpected negative event, parents confronted with a high risk pregnancy will experience more psychological distress than parents experiencing a low risk pregnancy. In contrast to this hypothesis, the findings indicated no difference in the psychological and marital adjustment of high and low risk pregnancy parents during the transition phase in parenthood (Dulude et al., 2002). Their data did, however, suggest that the actual experience of a high risk pregnancy does affect the process through which parents adjust and adapt to parenthood, especially when it is a first child (Dulude et al., 2002). The results further demonstrated that the transition to parenthood is an event that is significantly more demanding on women than it is for men. The study conducted by Brooten et al. (2007) emphasises that one of the main psychosocial stressors for women during and post high risk pregnancy is their parenting and caretaking abilities. This finding was supported by the higher ratings in depression amongst women and greater distress displayed by women as opposed to men (Dulude et al., 2002).

The studies conducted by Heaman and Gupton (1998), Leichtentritt, Blumethal, Elyassi and Rotmensch (2005), and Richter, Parkes and Chaw-Kent (2007) imply that bed rest and hospitalisation of women with pregnancy complications is a commonly prescribed treatment that elicit negative physical, psychosocial and psychological effects. Leichtentritt et al. (2005)

constructed a study that allowed hospitalised women to speak out and state their needs, feelings and concerns. Many of the themes raised and discussed by the women were similar to those discovered in previous research, (Curry, 1987; McCain & Deatrick, 1994; as cited in Leichtentritt et al., 2005) such as: separation from home and family, loss of control, feelings of helplessness and loneliness, and concerns for the health of the fetus. However, it departs from previous research as it offers a "detailed, comprehensive, and specific understanding of the experience as described by the women themselves" (Leichtentritt et al., 2005, p.46).

Heaman and Gupton (1998) found that bed rest had a major emotional and social impact on pregnant women and their families in both settings (home and hospital). Nevertheless, bed rest in hospital was associated with more sources of stress than at home. In hospital women had to cope with separation from home and family, hospital discomforts, lack of privacy, whereas women at home struggled with role reversal and the temptation to do more activity than was recommended (Heaman & Gupton, 1998). Some stressors were not unique to but were heightened by the hospital setting such as: concerns about children, boredom, depression, loneliness, sense of confinement, and negative impact on spousal relationships (Heaman & Gupton, 1998). Thus, it seems clear that home bed rest and/or hospitalisation are incredibly stressful events for pregnant women in differing ways.

Overall, these studies indicate that high risk pregnancies in general usually elicit psychological distress amongst both parents, but it is often more intense for the women compared to the man. Furthermore, the types of emotional distress experienced are varied and often affected by a number of factors.

2.2. Social Support

The theme of social support resonates throughout the literature surrounding high risk pregnancies. Social support is defined as "a form of interpersonal interaction in which one individual offers assistance to another" (Corbet-Owen, 2003, p.19). Hogan, Linden, and Najarian (2002) divided social support into the following categories: emotional support, informational support, and instrumental support. Emotional support encompasses the communication of caring and concern, which serves to reduce distress, permit the expression of feeling states, and improve self-esteem; information support (provision of information to advice/guide) enhances sense of control and ability to cope with otherwise confusing and distressing situations; and instrumental support also helps to decrease feelings of helplessness and powerlessness by the provision of material goods such as transportation, money, or physical assistance (Hogan et al., 2002). These various types of social support, although not always specifically categorised, have been identified in much of literature surrounding high risk pregnancies.

Studies have been done on the normative emotional states in pregnancy; and how women respond to a number of physical, emotional, and social changes (Stanton, Lobel, Sears & DeLuca, 2002). The provision of routine social and psychological support to pregnant women is considered to be a fundamental part of proper health care during pregnancy (Langer, Farnot, Garcia, Barros, Victora, Belizon & Villar, 1996). Several studies indicate that social support during pregnancy results in better psychological health of the women (Collins, Dunkel-Schetter, Lobel, & Schrimshaw, 1993; Corbet-Owen, 2003; Engelhard, Van Rij, Boullart, Ekhart, Spaardemaan, van der Hout, & Peeters, 2002; Heaman & Gupton, 1998; Jomeen, 2005; Leichtentritt et al., 2005).

According to Black (2007) a number of studies have shown that social support acts as a mediator between stress and its manifestations; has a positive correlation with adaption (Ford & Hodnett, 1990); and has a negative correlation with stress (Kemp & Hatmakar, 1989). Therefore, it seems that social support may greatly influence how women with high risk pregnancies adapt to their stressors. However, limited studies have been done focusing on whether there is an association between social support and the progression of pre-eclampsia (Black, 2007).

Partner support, stability, and the status of the relationship are viewed as major components in determining women's psychological experiences during pregnancy (Kroelinger & Oths, 2000). Corbet-Owen (2003) interviewed eight women regarding their perceptions of the support they felt they had or had not received. The findings showed that: some women could not turn to their partners for support due to existing relationship problems; and many were able to turn to their partners for support but it was not sustained (Corbet-Owen, 2003). Overall, the women expressed a want and need for emotional support from the partners, and when this was not provided they perceived their partners' support as lacking or negative (Corbet-Owen, 2003). However, a major limitation and complication of this study is the differences between the ways in which men and women cope with stress. This ambiguity often results in miscommunication between partners and leads to resentment, anger, and possible conflict (Corbet-Owen, 2003). Moraes and Reichenheim (2002) found that pregnant women suffering spousal abuse feel extremely depressed, isolated, and insecure. Furthermore, these women often began prenatal care late which hinders the identification of risk behaviours such as smoking and drug use. Besides these women being immediate victims, Moraes and Reichenheim (2002) argue that there will be negative effects on the child rearing process which will cause negative emotional consequences for their children.

The study by Collins, Dunkel-Schetter, Lobel, & Scrimshaw (1993) strongly supports the research discussed above. Collins et al. (1993) found that women who received more partner and social support had better labour progress, experienced less postpartum depression, and had babies of higher birth weight. Furthermore, Collins et al. (1993) discovered that the positive outcomes were more consistently predicted by instrumental (tangile goods or assistance with tasks) rather than emotional (expressions of caring and esteem) forms of support. This is further supported by Kroelinger and Oths' (2000) research which indicates that women felt the most useful forms of support were financial, child care support, and assistance with housework. Nevertheless, Besser, Priel, and Wiznitzer (2002) still advocate that close social bonds, particularly marriage and partnerships, were found to be extremely beneficial in reducing negative pregnancy outcomes in high risk pregnancies as the significant others were assumed to provide instrumental and emotional support. Thus, it seems that emotional support, although at times is seemingly less important than instrumental support, is still a fundamental factor affecting women's psychological experiences during high risk pregnancies.

Interesting to note, the majority of the literature on social support during pregnancy focused heavily on partner support with very limited literature on broader social supports, such as family, hospital staff, and friends. A few studies have alluded to the importance of these social supports during pregnancy by studying the effects of outreach programs for women during high risk pregnancies, such as bedrest helplines, support and education for family, home visiting, and nurse support (Richfield, 1993; Johns, 2006; Olds, Robinson, O'Brien, Luckey, Pettitt, Henderson, Rosanna, Sheff, Korfmacher, Hiatt, & Talmi, 2002; & Wallace,

2009). However, there has been minimal research exploring the actual experiences of lacking social support for women during high pregnancies.

2.3. Social Support Interventions

Although the presence of social support has often been linked to good long-term health outcomes, especially with regard to better immune system function, reduced mortality rates, and lower blood pressures, there has been limited empirical evidence to determine the efficacy of social support interventions (Hogan, Linden, & Najarian, 2002). For the purpose of review and evaluation, the following studies were included to highlight the different forms of social support interventions used for high risk pregnancies, as well as other medical conditions.

2.3.1. Bed rest helplines

The Bedrest Helpline is a program developed by the Childbirth Education Association of Greater Philadelphia. It is a telephonic support network for women suffering from high risk pregnancies necessitating bed rest. Women who have previously been on bed rest for at least one pregnancy are trained as lay counselors to provide emotional support and practical guidance/information to women currently going through the same experience (Richfield, 1993). Various topics and feelings are discussed, including: hopelessness, lack of control, concerns about premature delivery, marital strain, inactivity, and guilt. It has been a largely successful initiative illustrating how such support can enhance women's emotional well-being and compliance to the recommended treatment plan for women with high risk pregnancies (Richfield, 1993). However, it has been noted that some women have difficulty

utilising this support network as they feel unjustified to use such a service and uncomfortable trusting a stranger with their inner most conflicts (Richfield, 1993). In addition, the service needs to be expanded in order to educate and support a larger population.

2.3.2. Nurse support groups

Wallace (2009, p. 55) strongly advocated that "nurses are effective only if they care for themselves". She proposes that support groups enable nursing staff to dampen their emotional reactions to their patients and thus provide their patients with more emphatic care. It is important for nurses to feel empowered and confident that they can rely on colleagues for support through professional and educational training (Wallace, 2009). In essence, Wallace (2009) feels strongly that if nurses are cared for effectively, they will be more likely to derive fulfillment and satisfaction from caring for their patients.

2.3.3. Support and education throughout hospitalisation (family and patient):

Brooten et al (2007) conducted a study exploring what advanced practice nurse interventions were most commonly needed in order to address a variety of physiological and psychosocial problems during and post high risk pregnancies. It was discovered that health teaching; guidance; counseling (physiological, psychological, and social); education about effective interpersonal functioning; and advice on self-care management were the most fundamental knowledge and skills needed to improve maternal and infant outcomes, and ultimately reduce the psychological distress in women with high risk pregnancies (Brooten et al, 2007). This finding was supported by the study conducted by Seefat-van Teeffelen, Niuewenhuijze, and Korstjens (2009) which found that nearly all women wanted health care professional, nurses

in particular, to proactively support them in dealing with the psychological, physical, and social changes during pregnancy.

Furthermore, Martin-Arafeh, Watson, and McMurtry Baird (1999) advocate that incorporating family-centered care into the support policies for women during high risk pregnancies is crucial to individual and family functioning. It was noted that family-centered care for women with high risk pregnancies was best implemented by: providing information and education; validating and supporting the emotions of the patient and family; allowing the family and patient to share the experience of the illness; encourage family support; encourage family to provide care for the patient; and maintaining family rituals (Martin-Arafeh et al., 1999). In essence Martin-Arafeh et al (1999, p. 27) propose that "models that emphasise the family assist the health care team to shift from a plan focused on the medical aspects of care to one that is incorporated to include the woman's family, the base of her support".

2.3.4. Support groups for women during pregnancy

Hogan's et al. (2002) review of the surrounding literature found that both peer support, or "self help" groups, and organised support groups led by a professional (e.g. psychologist, psychiatrist, nurse, or social worker) were fundamental in providing patients with an opportunity to develop friendships, improve social networks, discuss emotional issues and personal experiences, and both receive and provide support. Eight out of 16 studies reviewed reported that there were favourable outcomes of social support group interventions, with improvements observed on both psychological and medical outcome measures (Andersson, 1985; Kelly et al., 1993; Rahe et al., 1979; Schmitt & Wooldridge, 1973; Spiegel & Bloom, 1983; Spiegel et al., 1981, 1989, 1999; as cited in Hogan et al., 2002).

Overall, the literature on the psychological experiences and social support factors of women during high risk pregnancy, especially with focus on pre-eclampsia, was limited but varied. Further longitudinal research needs to be conducted on this topic to expand on the existing theories, to discover new dimensions that affect the psychological well-being of women during high risk pregnancy, and to explore a larger variety of social support factors that may affect women. Furthermore, it would be interesting if future research focused on how different high risk pregnancy conditions, such as pre-eclampsia, elicit varied types and degrees of psychological distress.

2.4. Phenomenology

The theoretical framework of this study was, as mentioned earlier, based on phenomenological theory and analysis. Phenomenology can be best understood as both a qualitative research method and a philosophical movement. Phenomenology was first introduced as a philosophical method of enquiry in 1901 by the German philosopher Edmund Husserl (Colman, 2001). Husserl proposed that phenomenological research was aimed at studying phenomena as they appear in a rigorous and unbiased manner – this he believed would provide an essential understanding of human consciousness (awareness) and experience (Valle, 1997). According to Welman and Kruger (1999, p.189) "phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved".

The fundamental dynamic of phenomenology is to attempt to identify and explore the internal shape of experiential awareness – to understand how the individual makes meaning of their

experiences (Husserl, 1997). Phenomenology aims to construct meaning and understanding which are both characterized by intersubjectivity. Intersubjectivity draws upon one's experiences of the world as a source for which one's experiences are based within and through others (Parker, 2005). Thus, the women in this study were asked to reflect on their past psychological experiences of being diagnosed with a high risk pregnancy, namely pre-eclampsia. In addition the women drew on their understanding by reflecting on how they felt and how they were treated by others (hospital staff, friends and family). This provided the researcher with an understanding of the women's perception of psychosocial support received during their past high risk pregnancy. According to Creswell (1998) and Van Manen (1990) phenomenological reflection is retrospective as opposed to introspective, as person cannot reflect on a lived experience whilst living through the experience. Within the framework of phenomenology the way in which a person lives through, experiences, and reflects on a situation is often provided in a retrospective description (Giorgi, 2003).

Husserl identified several constructs to aid in understanding and describing the human experience of the world. Husserl noted that intentionality was a fundamental feature of human consciousness – the notion of intentionality implies that object and subject do not exist independently. Instead Husserl proposed that "...the very meaning of subject implies a relationship to an object, and to be an object intrinsically implies being related to subjectivity" (Giorgi, 1997, p. 338). Thus, he believed that in this sense human consciousness is relational (there is an inseparable connection between the human and the world); and therefore phenomenology is not aimed at understanding an objective reality but rather concerned with how objects present to a person and how meaning is given to that object. According to Giorgi (1997) consciousness, from a phenomenological perspective, refers to a

person's directed awareness of objects/phenomena within their world, and in relation to others.

Husserl further argued that the distinction between subjects and objects should rather be understood as a correlation between noema (what is experienced) and noesis (the way it is experienced) (Langdridge, 2007). In essence the noesis of a phenomenon is the structure of what is experienced (perception, memory, judgment), and this is often revealed through reflection on how noematic (perceptual meaning) aspects of a phenomenon have come to be experienced by that person (Moustakas, 1994). Therefore, in relation to this study the women were asked to describe the lived psychological and social support experiences during their past high-risk pregnancy, and then reflect on the meanings they attributed to the appearances of the phenomena. In doing so the women were describing the essence of their lived experience during past high risk pregnancy.

Another key concept introduced into phenomenological research by Husserl is the notion of life-world. Life-world is understood to be the world as lived by the person, instead of viewing the world as an external construct separate to the person (Valle, 1997). To explain further, the life-world comprises of the lived experiences and meanings attached to these lived experiences by individual persons – this renders the life-world a convoluted and dynamic sphere in which we live. Therefore, the life-world cannot be experienced, described, and/or understood from a fixed perspective. Husserl further divided the life-world into four existential themes that guide phenomenological reflection, namely: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality) (Van Manen, 1990).

Space, from a phenomenological perspective, is not viewed in measurable or objective properties. Instead it is perceived subjectively lending importance to the meaning given to the experience of space (Benswanger, 1979). The above mentioned themes of space form the nature in which humans experience the life-world comprised of perceived objects and lived experiences of the self, body, and relationships (Finlay, 2008). These themes will be briefly described: spatiality is a description of how space is lived by a person; corporeality implies that we are always 'bodily' in the world and that our body reveals and conceals aspects of the self; temporality refers to the subjective perception of time that informs our temporal way of being in the world; and relationality signifies the lived relations we have with others in the shared interpersonal space (Van Manen, 1990). These concepts of the life-world are important for any study of the phenomenon of lived experiences as they encompass the assortment of concepts that constitute a lived experience.

Interpretative Phenomenological Analysis (IPA) is a phenomenological method of analysis used and is concerned with how people perceive an experience. There is no predetermined hypothesis but the researcher has general questions in mind to explore (Langdridge, 2007). A core premise of phenomenological research and analysis was coined in the term epoché, or as Husserl named it 'natural attitude'. Epoché effectively means the suspension of 'natural attitude', refraining from imposing preconceived notions of phenomena being investigated, this is also referred to as bracketing (Langdridge, 2007). This is meant to ensure that researcher approaches the phenomena with minimal bias as possible so that it can be accurately described from the perspective of the participant (Dowling, 2004). Related to this process is the concept of phenomenological reduction, which essentially involves treating data from each participant with equal relevance and value. According to Langdridge (2007) all perspectives should be described with no particular perception being privileged over

another. Thus, epoché and phenomenological reduction serve to ensure that the research findings are more precise, and thus helps to identify the essence of the phenomenon (Giorgi, 1997).

Identifying the essence of a phenomenon is the fundamental aim of phenomenological research – reducing the textural (what) and structural (how) of the lived experiences to a brief description that epitomises the experience of all the participants in a study (Moustakas, 1994). Thus, the term essence can therefore be understood as that which is common or universal to the phenomenon, the underlying quality without which it would not be what it is (Moustakas, 1994). In order to identify the essence of an experience or phenomenon it is important to rigorously examine and reflect on the consciousness and awareness of an experience among the participants and the researcher – both epoché and phenomenological reduction are methods for identifying such essences (Langdridge, 2007).

In summary, the theoretical framework of phenomenological research and analysis has both psychological and philosophical underpinnings; and aims to describe and understand the essence of a phenomenon from within the individual's life-world, consciousness, awareness, and lived space. The seeming lack of phenomenological research in the area of high risk pregnancies again motivates for the need to obtain information about the subjective/lived experiences of high risk pregnancies, the primary aim of this study. The method of analysis that will be employed in this research study is IPA, which will be discussed further in the following chapter.

Chapter Three

Methodology

Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Chapter Three

Methodology

This research study was conducted as an in-depth, qualitative, retrospective and descriptive study. This enabled me to gain rich data that provided me with better insight into the women's psychological experience of the high risk pregnancy, pre-eclampsia, and how social support may have impacted on their psychological well-being. According to Babbie and Mouton (2004) this research can be classified as inductive research, as it begins with a general purpose that in turn results in a theory (theory-building).

This research can be located in the category of ethnographic research, and more specifically, it is linked to phenomenology. My reason for choosing phenomenology is that it allowed me to identify, explore and describe the various themes I wished to research (emotions, thoughts, feelings, and level of social support) (Mouton, 2001). Furthermore, interpretative phenomenological analysis (IPA) was used as an analytic tool. Ethnographic research has been recognised as having high construct validity; in-depth insights; and establishing good rapport with research participants (Mouton, 2001). It is important to note, however, that limitations occur whilst conducting ethnographic research. These include: lack of generalisability of results; time-consuming data collection and analysis; and the non-standardisation of the measurement tool (Mouton, 2001).

3.1. Participants:

Purposive sampling was used, in which participants were chosen according to the needs of the study (Morse, 1989). The sample of participants consisted of women ranging from twenty years old to mid-forties. The primary criterion for their selection was a past experience of a pre-eclampsia high risk pregnancy. This was defined as blood pressure greater than 140mmHg systolic of 90mmHg diastolic and a urinary excretion of at least 0-3g protein in a 24-h specimen (Page, 2002). Furthermore, the participants were required to be aged mid-twenties to mid-forties in order to narrow down the target group to women in similar life phases. Past experiences were required, as, in my view, women were able to better reflect on their psychological experiences and received support retrospectively, than they would during the traumatic time of a high risk pregnancy. The past experience must, however, be more than one year and no longer than 2 years previous. The reason for this was that I did not want the women's emotions to be too fresh and raw; but I still required the memories to be intact so they could better reflect on their social support and psychological experiences during their pregnancy.

The research sample was reflective of the age, cultural, racial and ethnicity of South Africa as women from differing backgrounds and demographics were chosen. The public sector hospital, in which I conducted our research, caters for a variety of women when treating pre-eclamptic pregnancies – thus the sample was not homogenous. The reason for this being that lower, middle and upper class women of all races and cultures are referred to this hospital, as the obstetric unit and staff are very experienced in dealing with these specific high risk pregnancies. The six participants ranged between 20 years of age to 42 years of age; and the languages spoken amongst them were Xhosa, English and Afrikaans. The majority of the participants, five to be exact, were either married or in a relationship with a significant other;

whereas one of the participants was single at the time of the interview. The infant mortality rate amongst the participants was 67%, with four out of the six women having experienced an infant death as a direct result of a pre-eclamptic pregnancy. One of the participants experienced an infant death due to causes unrelated to pre-eclampsia. It is important to note that none of the women were aware of any underlying medical conditions before they were diagnosed with the condition pre-eclampsia during their pregnancy.

Table 1: Demographic Information

Participants	Age	Occupation	Education	Marital Status	Language	No. of Preg	Preg with PE	Live births	Infant Deaths
Participant A	22	Unemployed	Gr.9	Married	Xhosa/Eng	4	1	2	2
Participant B	40	Unemployed	Gr.8	Married	English	7	3	5	2
Participant C	42	Receptionist	Matric	Single	Xhosa	3	1	1	2
Participant D	40	Teacher	Diploma	Married	Afrikaans	1	1	1	0
Participant E	23	Unemployed	Gr.9	Rel 5yrs	English	2	1	1	1
Participant F	20	Unemployed	Matric	Rel 4yrs	English	2	1	1	0

3.2. Procedure and data collection tools:

Access was obtained with the assistance of the head of the maternity centre at the public sector hospital who gave support for this study to occur within the unit. Following the attainment of this support it was necessary to request ethical clearance from the University of Cape Town's Ethics Committee. Ethical approval was granted by the committee and I commenced the study. Furthermore, informants were asked whether they were willing to take part in the research. Given the obstacle that the researcher was unable to access confidential medical records, the participants were recruited through the senior administration of the

hospital. When the referral was given, the researcher did follow-up telephonic calls to recruit any women who were willing to participate in the study. The interviewer then travelled to meet the women who had agreed to partake in the study. Upon meeting face-to-face the informants were given an informed consent form in the language of their choice (translated by fellow psychology master students), once this was read and understood the informants were asked to sign the form. The interviews then commenced.

Six informants were recruited and interviewed in approximately one hour sessions, where various questions were asked concerning their psychological experiences during their pre-eclamptic high risk pregnancy. These interviews were semi-structured as they were guided by a schedule of themes that needed to be explored (emotions, thoughts and feelings) (See Appendix D). Although the phenomenological paradigm advocates for unstructured interviews as the preferred method of data collection, semi-structured interviews were employed in this study as the target group necessitated greater containment viz-a-viz a more structured interview schedule. The interviews had an explanation phase and the main aim was to get the respondents to talk about the topic. As an interviewer, I attempted to restrict my function to facilitator, clarify and probe contradictions. These interviews were recorded, with the permission of the participants, and subsequently transcribed. However, it is important to mention that in one case the interview did not record properly and thus the interview was transcribed from recall and interview notes within two hours.

3.3. Reflexivity

Parker (2005, p.25) argues that reflexivity is a "way of attending to the institutional location of historical and personal aspects of the research relationship". More specifically, reflexivity

refers to the process of watching how one's own thoughts and behaviours may bias and influence what one picks up on (Babbie & Mouton, 2004). This can introduce bias into the data and invalidate the findings. In this sense, researchers are also a major source of bias and error. I attempted to maintain reflexivity, and ensure that I did not impose my beliefs about certain phenomena upon the participants, by monitoring my own behaviour before, during and after the interviews. In addition, I monitored my effects on the participant and research setting, and the participant's and research setting's effects on me, the researcher.

3.4. Credibility and Trustworthiness

In qualitative analysis researchers speak about the credibility and trustworthiness of a study, as opposed to the more quantitative terms of reliability and validity. In order to establish the credibility and trustworthiness of a research study it is important that one has: had prolonged engagement in the field; provided a detailed and thick description of the phenomenon being explored; and shared a reasonably close interaction with the participants (Creswell, 1998). Thus, instead of striving to create a "valid" study qualitative research aims to understand and recognise the existing constructs/phenomena rather than imposing theories or constructs on the participants or context (Creswell, 1998). In order to ensure the credibility and trustworthiness of this study it was necessary to: triangulate the data methods and sources, and to ask different raters to assess the identified themes (Creswell, 1998). Triangulation of the data methods and sources was done by the researcher, and the supervisor assisted in assessing the identified themes.

3.5. Data analysis:

It is preferred in some qualitative social research (Boutton & Hammersley, 1993) to record everything that the informant tells the researcher, as well as body language, gesture and tone of voice. However, it is impossible to capture everything about the context of the interview. "The interviewer is an intermediary between the informant(s) and the audience of readers of the final report. The researcher therefore plays a critical role in the selection and presentation on material drawn from the interviews" (Head, 2001, p.35). Qualitative research is, in essence, shaped by the researcher. Thus, the analysis of the data collected in qualitative research is never completely neutral and/or objective. In this particular research project data was collected in the form of qualitative data. The aim was to develop rapport to enable the joint exploration of the participant's worldview concerning the research topic (Langdridge, 2007). Data was gained through tape recording, note-taking during the individual interviews and transcriptions of the interviews.

This research analysed data using the phenomenological approach. In this particular research study the data analysis was conducted through interpretative phenomenological analysis (IPA) which can be defined as "an attempt to unravel the meanings contained in accounts through a process of integrative engagement with the texts and transcripts" (Smith, 1999, p.189). The main aim of IPA is to gain an in-depth understanding of the individual's experience and to elucidate the essential meaning of the phenomenon being investigated (Willig, 2001). This form of data analysis is often selected above other qualitative methods as its fundamental purpose is to explicate the meanings in individual experiences in a systematic and meticulous manner (Smith, 1999).

The phenomenological analytic approach of IPA contains three essential steps: (1) preparing a phenomenological description; (2) identifying meaning units and clustering these units into themes; and (3) integrating the themes into an articulate understanding through an essential theme (Giorgi, 1997). This form of thematic analysis is essentially concerned with how people seem to understand the meanings of the words and phrases they use (Parker, 2005). Data analysis begins by categorising the material from ones interviews into certain themes or concepts. It is important to integrate and embed the themes and concepts within a theoretical framework (Rubin & Rubin, 1995). The process of coding is often used to group interviewees' responses into categories that reflect similar ideas or themes discovered through the analysis process (Rubin & Rubin, 1995).

3.6. Ethics:

Ethical questions are of great importance, especially in situations where information can be used by those in positions of power to gain some advantage over the less powerful and/or where information can be used against people. It is of great importance to treat the informants as if they are essentially the same as us in order to diminish possible unequal power relations (Parker, 2005). This study involved in-depth interviewing of six informants at a public sector hospital. Ethical clearance needed to be obtained from the head of obstetric services at the hospital. In addition, participants needed to be informed about the nature and purpose of the study, given the right to withdraw at any stage, and give their voluntary consent via signing an informed consent form. The informed consent forms were provided in English, Afrikaans, and Xhosa (see Appendices A, B, and C). Translators were also made available so interviews could be conducted in the participants preferred language. Furthermore, informants were assured anonymity and confidentiality. The tapes and transcripts of the interviews were kept

in a safe place, only accessible to the researcher, supervisor and participants. Tapes and transcripts were destroyed or returned to the participants, as requested by them, on completion of this particular study.

Participants were given the contact details of a registered psychiatrist working at Groote Schuur whom they can contact in the event of secondary trauma arising during the interview process. This subject is very sensitive and I was not adequately trained to assist participants in dealing with powerful emotions they may have experienced whilst disclosing information during the interview. A major ethical consideration, however, in this research project was how I, as the researcher, would deal with the information collected from the informants. This could potentially be very problematic with regard to the ethics of this research. I, as the researcher, must be very careful not to distort any information obtained from informants and/or exploit their position with regard to their medical history.

3.7. Significance of study:

This research project is important and necessary in order to fill the large void in the local literature, as most studies have focused on developed countries. Therefore, it was necessary to conduct a local study, in the South African context, that explored women's emotional experiences during a past case of pre-eclampsia, a high risk pregnancy. It was also hoped that many women will have access to this study and thus may find it useful in helping through their own psychological experiences of high risk pregnancy. Furthermore, it was anticipated that women may in future feel empowered to ask for social support when needed and lacking. Lastly this study may provide information around more effective interventions to help women cope during pre-eclamptic pregnancies.

Chapter Four and Five

Findings and Discussion

Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Chapter Four and Five

Findings and Discussion

Phenomenological analysis was employed to describe the essential meanings attached to the women's experience of a past high risk pregnancy. The following box summarises the essence of the phenomenon being studied.

Box 1: Essence of Phenomenon

In essence, the key meanings attached to the women's experiences were that their high risk pregnancy was psychologically distressing, with social support (negative and positive experiences) playing a significant role in mediating their psychological experiences. The findings obtained through this research process show that the psychological experiences of women during a high risk pregnancy, such as pre-eclampsia, is a highly in-depth and complex topic. The interviews demonstrated that women experience both similar and contrasting psychological experiences (emotions and cognitions) during a high risk pre-eclamptic pregnancy. However, all the women did report having experienced some form of psychological impact, to varying degrees, during their high risk pregnancy. Furthermore, all the women expressed that social support played a fundamental role in their psychological experiences and emotional well-being during their high risk pregnancy. It was reported that any form of social support (partner, family, hospital staff, friends, and/or community) positively influenced their psychological experience, whilst lack of social support adversely affected them. These essential meanings of the phenomenon under investigation will be more systematically and comprehensively explored throughout this chapter.

The material obtained through the six in-depth and exploratory interviews will be subject to interpretative phenomenological analysis and a discussion of the key themes will follow. The main themes focused on for this study and observed throughout the interviews were: psychological experiences and social support (positive and negative experiences). The theme of psychological experiences was divided into number of subthemes, including: fear, anxiety, loss, confusion, anger, isolation/loneliness, and guilt. The theme of social support was divided into positive experiences (community, partner, family, spirituality, medical staff) and negative experiences (lack of emotional support, lack of informative support, lack of instrumental support, and lack of follow-up care)

These themes and subthemes will be linked to the literature surrounding the issue of pre-eclamptic high risk pregnancies. Thus, the data will be embedded within a theoretical framework, which will hopefully result in a better understanding and interpretation of the themes. It is important to note that the themes and subthemes are not mutually exclusive, but rather they are linked and interrelated. There will be a discussion at the end of the chapter making connections between the themes and subthemes that were identified in this research study.

4.1. Psychological Experiences

The literature surrounding psychological experiences and high risk pregnancy has shown that emotional disturbances are common amongst pregnant women (Bernazzani, Saucier, David & Borgeat, 1997). The theme of psychological distress found in the literature is emphasised throughout the six interviews. This theme of psychological distress is prominent and recurring throughout the interviews. The following extracts taken from some of the interview

transcripts explicitly demonstrate how this theme occurs and operates in situations of high risk pregnancy, specifically pre-eclamptic pregnancies.

Participant A: *"I just needed my child at that time, but I didn't get it. I was worried... mmmm... I was worried all the time. I am sitting on my own and crying, all the time. It's sore, so sore..."*

Participant B: *"I'm not alright when I'm there [Groote Schuur], I'm feeling very very bad... I'm worried because all I think of is the baby. When I'm so sick I'm thinking I'm dying and my baby is dying..."*

Participant C: *"I was so depressed, I was crying my lungs out, but at the back of my mind I knew there was nothing more I could do because I was really sick – my back was sore, it was like there was something there that was pulling me in my back, I couldn't walk and my feet were big! I was really swollen, everything, even in my face. So I could see myself that I was really like, really getting sick now..."*

Participant D: *"At the time I didn't think it was that serious, I thought maybe I was gonna come back, gonna leave the morning, go to Groote Schuur and then they gonna send me back home, but by then my blood pressure was too high. They said you must get admitted because they want to remove the baby, they wanted to do a C-section. I was about 7/8 months and the other problem was she was underweight, you see and they wanted to take her out immediately and I tried to fight against it. I mean because I was thinking now, what survival chances*

is she going to have? Throughout my whole experience, that was my only problem – this blood pressure... the whole experience I was so worried – how was she going to survive?

Participant E: *"I was fine that whole year, but when I went to day clinic for my check-up the doctors they tell me something. When I go there, I was nine months already, and they told me that my baby is not moving so I go there in Mowbray Maternity and then they took me to Groote Schuur Hospital. And then Groote Schuur they say that my baby died, so ... [crying] It was bad, it was very very bad and I was sick after that. They told me that... they told me that I will die, but I didn't die. It was very bad, I was crying all the time... I didn't know what to feel, I don't know what to say... [crying]"*

Participant F: *"I went to the day hospital because my legs were swollen. I found out there, at the day hospital that something was wrong and they sent me to Groote Schuur Hospital – they told me I had high blood pressure. I was so worried I would lose my baby again... I lost my first baby at four months... it's very painful to think about [crying]"*

These extracts demonstrate that not only is the transition into parenthood and the arrival of a new child in the family both immensely stressful processes; but that one's level of stress may be dramatically increased when medical complications occur, as in the case of high risk pregnancies (Bernazzani et al., 1997). Research thus far has traditionally characterized the psychological status of women during pregnancy by the emotions: anxiety and depression. However, Jomeen (2005) proposes that the psychological status in pregnancy cannot simply

be defined within a unidimensional framework; instead it must account for the complexity of all the dimensions that contribute to the psychological status for women during pregnancy, childbirth and the postnatal period. These various modalities include: anxiety and depression, worry, control, self-esteem, sleep and quality of life (Jomeen, 2005). This multidimensional perspective of women's psychological experiences during high risk pregnancy, and especially in the case of pre-eclamptic pregnancies, is fundamental if one is to gain an accurate and complete understanding of the women's psychological state. This in-depth understanding and assessment of women's psychological experiences during their high risk pregnancy will enable healthcare professionals to identify and acknowledge normal and abnormal adjustment and hence offer interventions and support accordingly (Jomeen, 2005).

Overall, the literature surrounding the theme of psychological distress indicates that high risk pregnancies in general usually elicit psychological distress amongst both parents, but it is often more intense for the women compared to the man. The research data gained throughout the interview process supports and emphasises the literature of psychological distress during a high risk pregnancy.

When in engaging in the analysis of the theme psychological distress it became apparent that there were many contrasting, similar, and interrelated emotions and cognitions experienced by all the women during their past high risk pregnancy. Thus, it seemed fundamental to expand and explore these subthemes as a method of further enriching our phenomenological understanding of women's psychological distress during a past pre-eclamptic pregnancy. The following emotions were the most recurring and prominent throughout the interviews, and thus the discussion will be limited to these: fear, anxiety, anger, isolation/loneliness, loss, guilt, and confusion.

4.1.1. Fear

The emotion of fear was prevalent throughout all the interviews that were conducted, with every woman stating that at some stage during their experience they had felt the emotion of fear. The fear that they experienced was often related to multiple dimensions of their experiences ranging from: fear of loss of their own life; fear of loss of the baby's life; and fear of the unknown or unexpected.

Participant A: *"Yah, so I get a lot of pains, and the, and the headache, and the high blood pressure... so they say I have to sleep in there, in the Groote Schuur room. I was only six months at that time and I didn't want to stay in hospital... I didn't want to be a sick person. It was very scary ... I didn't know what was going to happen to me or baby."*

Participant B: *"When they take me to hospital I was scared... I was not okay... I was scared that I was going to get sick again and then lose my baby again."*

Participant C: *"It was very scary... they stabilized me, put me on oxygen and told me that I'm waiting for a bed in ICU because I'm very sick, and then when the time is good they take me and put me in ICU. They forgot the only thing I'm losing is my breathing, my brain was still there, my mind was there, my ears was there. And then the professor himself, when he comes, he just look at me and tells the other doctors they don't think this pregnancy is going to survive. So he instructed the other doctors just to come within a few hours and tell her she*

must terminate the baby. Sho, I didn't know what to think then... but I'm scared now that my baby is going to die."

Participant D: *"I was very ill. So they put me on a drip and I don't know what other kind of medication but I was very ill. I was in ICU so only my husband could visit and no other family members. It was quite a traumatic experience because it was my first time in hospital, I was never before in hospital. They [medical staff] were all worried about medical stuff, they were thinking about my blood pressure and protein in the urine that it's also going to affect the baby and the survival chances will be much lower. So they were thinking about that and obviously the weight and if she's gonna survive and about the lungs that aren't really developed. So they were concerned, which made me very scared... because if they were concerned then I must be very concerned too."*

Participant E: *"Mmmmmm... both of that... I was scared and I was worried because that was my first child. So, I was very scared. I was scared for me, my baby, my boyfriend, and my family."*

Participant F: *"Yes, I was terrified... I didn't know what this was happening and I was so worried about my baby, not so much me but more my baby. So they had to cut me open and take baby out, I felt better but my baby was early [premature] and had to go into an... incubator for a week. I went home and she stayed in hospital, I was scared... but I had to come every to give her the breast milk."*

These extracts clearly show that the women suffered from the emotion of fear for most of their high risk pregnancies, as well as postnatally especially if the infant was premature and hospitalized for long periods of time. They were often afraid because they were not exactly sure as to what was going on, or what their exact condition was. A descriptive study by Jones and Flaherty (1992) found that two measures were identified by women as being helpful in decreasing stress and fear during pregnancy, namely: clear and descriptive information that explained step-by-step what was happening; and secondly, being able to have increased contact with their babies and direct support from family and the obstetrical health care team. It became apparent throughout the interviews that the lack of these two measures often served to heighten the women's levels of fear and thus increased their psychological distress.

Furthermore, the women were extremely afraid that either they or their babies would die. In addition, some women reported being fearful of their family or partner's reactions to their illness and the possible loss of their baby. This impact upon the parent's relationship is well supported by the literature which suggests that the actual experience of a high risk pregnancy does affect the process through which parents adjust and adapt to parenthood, especially when it is a first child (Dulude et al., 2002). Another form of fear was identified which was the fear of a future pregnancy that would also be a negative and traumatic experience.

4.1.2. Anxiety

The women in this study all reported experiencing some level of anxiety during their pre-eclamptic pregnancy. The anxiety felt by the women was largely related to their fear of the situation; their lack of control over the situation; and their lack of information about the situation.

Participant A: *"I was worried all the time, I'm sitting on my own, crying and worrying... all the time. I was worried cause I love that child, you see, and I knew there was something wrong... but I was also worried because I don't supposed to worry for my blood pressure."*

Participant B: *"I'm worried because I think the baby is dying when I'm sick and that's not alright. I was worried about me also and my other children at home."*

Participant C: *"It even, what makes me more anxious, they said there was a woman who came in in the early hours of the morning and that the woman just arrived and I think after two hours the woman was dead. So when they were talking to me about this termination thing they did even mention that he did see that woman who died this morning, that it was because of the same thing."*

Participant D: *"Ja it was making me more stressed. And the doctor also, he told me oh my baby is going to die, my breasts are not giving milk so my baby is not getting milk, so you see that was also very stressful. You see the only thing was that I had to give milk and I didn't have milk and that also made my blood pressure high, it stressed me out also. Mmmmh and I think that that... that... I think that was the reason probably what I got such high blood pressure because people were pressurizing me."*

Participant E: *"Ja, they didn't tell me what happened. Ja they only told me that I must to Mowbray and then from Mowbray they take me to Groote Schuur and then*

from Groote Schuur they tell me that my baby is not okay... I was worried cause I didn't know what was bad with my baby. I was thinking about it, I didn't want a person to talk to me that day, and I was worried so I didn't listen..."

Participant F: *"I was there for 3 weeks, it was terrible... I was very worried about my baby. I understood what was happening but they kept coming to ask me questions and do tests every hour which made me feel worse, I was very anxious. It made me feel like I was very ill also... not just my baby."*

Research conducted by Leichtentritt, Blumethal, Elyassi and Rotmensch (2005) demonstrated that bed rest and hospitalization of women with high risk pregnancies resulted in various negative physical, psychosocial and psychological effects. Leichtentritt et al. (2005) listed these negative effects as: separation from home and family, loss of control, feelings of helplessness and loneliness, and concerns for the health of the fetus. The above extracts further highlight and emphasise that the emotion of anxiety took on many forms and dimensions amongst the various women.

The main factors that were reported as precipitating factors for the women's anxiety were: concern for the baby's well-being as well as their own; lack of information and communication about their situation; seeing distressing outcomes for other women; and the uncertainty surrounding the outcome of their situation. Interestingly, it was also noted by some of the women that their perceived pressure from medical staff to make certain decisions (termination) or engage in certain acts (breastfeeding) was felt to be oppressive and served to increase their anxiety levels to a point that they felt affected them both physically and

psychologically. Thus, it seems that although all the women in the study reported feeling anxiety – the reasons were varied and complex, often being interrelated and based on individual perceptions and meanings.

4.1.3. Anger

The emotion of anger was prevalent throughout some of women's experiences during their past high risk pregnancies. The women reported feeling anger towards themselves for their situation, and towards the medical staff for treating them in a way that they felt to be disrespectful. It seems that many of the women were unable to vocalise and express their anger during their pregnancies instead tending to suppress and internalise these feelings. Thus, much of this anger was externalised during the interviews and in some cases proved to be a cathartic process. The following extracts help to demonstrate the anger some of the women were left feeling:

Participant A: *"I was angry, I was cross all the time... and I don't want to speak with anyone. Mmmmm... but on that time I didn't have a choice, I had to stay. I was angry with myself, I didn't get angry with the nurse or doctor, na, just myself. I don't want to speak to anyone."*

Participant B: *"I was angry with me... why did this happen to my baby?"*

Participant C: *They forgot the only thing I'm losing is my breathing, my brain was still there, my mind was there, my ears was there. And then the professor himself, when he comes, he just look at me and tells the other doctors they don't think this*

pregnancy is going to survive. So he instructed the other doctors just to come within a few hours and tell her she must terminate the baby. Sho, I didn't know what to think then... but I'm scared now that my baby is going to die. I was crying, I cry a lot because I didn't have someone to talk to, and I couldn't answer them back, and I was angry. I didn't mind the termination because of my life, but I still believe I shouldn't hear it like that. Like they were not talking to me, they were talking to each other about me whilst I was lying there. If they were speaking to me it will be more different, but the way I hear it, it was like, it hurts, and I ask myself: "What kind of help did the hospital give if they can do that?" Then I go back to the same thing, like if they saw you are black, then they don't take it as if you got brain."

Interesting to note, the emotion of anger was largely absent from the literature surrounding women's psychological experiences during high risk pregnancies. This may be due to reluctance on the women's part to express anger which is often viewed with negative connotations, or it may have been an emotion unrecognised by previous studies as being a pivotal feeling state for these women.

Nevertheless, from the interviews conducted it became apparent that this was an intense and important emotion that tainted the women's psychological experience during their past pre-eclamptic pregnancy. Furthermore, this was an emotion that tended to linger on in the postnatal period and cause the women continued distress. It also became evident that these women lacked a forum in which to express this anger and thus harbored this feeling state for up to a year after giving birth. It seemed to be a cathartic process to simply acknowledge and validate this emotion of anger that was so often ignored.

4.1.4. Loneliness/Isolation

Many of the women in the study reported feelings of loneliness at some point throughout their ordeal. The loneliness that they experienced was due to a range of factors, and the feelings of loneliness took on variety of forms. Some of the women reported feeling lonely as a result of their hospitalisation and thus separation from their family and friends; whereas other women reported feelings of loneliness and isolation as a result of inadequate support from the medical staff, friends, family and/or partners. Furthermore, some of the women felt lonely because of the lack of communication between the other women in their wards.

Participant A: *"Sho, I didn't feel okay and I hate the hospital now.... I just want to see anybody, but I don't know how to..."*

Participant B: *"That time I'm in hospital for a month, I worried about my other children, and I miss them... I didn't see them. It must feel very bad."*

Participant D: *"You know sometime, yah, you are looking out to the day when they would come again, but it's very dragging, the day's very dragging. Especially Sundays, weekends, ooh it was terrible, when you want to be at home, you want to go to family to visit family members, I don't know but somehow I coped, somehow I coped."*

Participant E: *"Yoh, I don't know... maybe I was dying that day, maybe I was dying that day when they did not visit me..."*

Participant F: *"Being away from my boyfriend and family... that was the worst part... I felt so lonely, and I was so scared. I also felt bad for being away from home because my mom died in 2006 and I was looking after my father and my younger brother, he's 13 years old."*

The emotion of loneliness was most prominent amongst the women who were hospitalised for long periods of time, as they felt isolated from and missed their friends and family. Furthermore, it was identified that women also felt isolated from the other women sharing their wards even though they were experiencing parallel processes. This seemed due to a lack of spontaneous communication amongst them and/or the provision of a structured space and time to encourage this form of interpersonal communication and support. This sense of loneliness was a recurring theme noted in the research conducted by Leichtentritt et. al. (2005) and Heaman and Gupton (1998). Thus, it seems clear that the interview data in this study yielded similar findings to those in previous research studies surrounding high risk pregnancies.

4.1.5. Guilt

The emotion of guilt was a fairly prominent emotion experienced by the women I interviewed, with a few women reporting feelings of guilt at some stage of their high risk pregnancy. This feeling of guilt is largely linked to an underlying sense of self blame experienced by some of the women. Some of the women felt guilty as they believed that they could have done something differently to ensure a positive outcome; whereas others felt guilty about not realising the seriousness of their symptoms and thus not taking appropriate action. Furthermore, some women reported feeling guilty during hospitalisation as they were

unable to care for their families and dependents at home, a common role assumed by these women. In addition, some of the women reported feeling guilty in the postnatal period when seeing other women with children similar in age to the age their lost babies would have been – this seemed to enhance their feelings that they had somehow been responsible for the loss of their babies, or that they were unfit mother's compared to those women who had healthy live infants.

Participant A: *"Even when people, whey they are like "where's the child?" ... you get so, you feel so guilty. I don't know how to call it, you just get worried and you say "yes it was my baby that died"... it's like it's your fault or something."*

Participant C: *"Yah, it's still painful sometimes, and more like my neighbor was pregnant before me, and my daughter neighbor was pregnant almost the same time as me and all the time when I first came out I couldn't see their babies, I couldn't stand them, I couldn't even touch them, I couldn't do anything with them. But I decide it was not their fault, I felt like it was my fault, but even still sometimes I'm still not feel happy when I saw them cause I think my baby could be the same age with them."*

Participant D: *" I went to the day clinic, ja, so um after a month or two I spoke to them there and they told me that the body was a bit swollen and that if you experience these symptoms you must come into the day clinic, but I didn't take note of it... I didn't think it was that serious... but then I found out I was very sick, that was traumatic for me..."*

Participant E: *"I also felt bad being away from home because my mom died in 2006 and I was looking after my father and my younger brother, he's 13 years old. Now there was no one to look after them..."*

The above extracts from the interview data show that some of the women experienced feelings of guilt, but that their reasons for feeling guilty differed between each women. Thus, it seems that the feeling of guilty is a very subjective and individual perception or experience – this is supported by Jones and Flaherty's (1992) research which emphasised that various emotions, including guilt, were experienced differently by women during high risk pregnancies.

4.1.6. Loss

The theme of loss, although not explicitly explored in many of the research studies in this area, was found to be present throughout the interviews conducted. However, interesting to note, these feelings of loss were not always linked to the actual death of a baby, but also to loss of quality of life and a desired future life with their deceased baby. The extracts to follow highlight how loss was experienced differently by the women as they attached different meanings to what they felt they had lost.

Participant A: *"I just need my child at that time, but I didn't get it... I was sitting on my own and crying all the time. Yah, it's sore, it's so sore. So I decided to get another child that year, and last year I get the child... that helps."*

Participant B: *"My baby was in hospital from 1st October till December... I felt bad that I had to leave him. I went everyday to give him milk, but my health was not the same... my blood pressure was high. Since that time my blood is high."*

Participant C: *"My baby came out dead... but I ask them if I can see the baby and she a girl... she had everything and so it was a big baby, but the only thing it couldn't do was breath, the lungs weren't strong... but it was more painful because even when they induced me my baby was still kicking inside..."*

Participant D: *"Even though after the hospital I had my baby... I went for a check-up that was in December, yah... but then I couldn't sleep at night and I was like shivering the whole time and then the medical doctor, he picked it up and he sent me, he gave me a letter at Groote Schuur the same day and then he sent me to a psychologist... she said I had post-natal depression. I didn't have any problems with the baby, but I didn't feel like I thought I'd feel... I knew there was something wrong."*

Participant E: *"When I go there, I was nine months already, and they told me that my baby is not moving so I go there in Mowbray Maternity and then they took me to Groote Schuur Hospital. And then Groote Schuur they say that my baby died, so ... [crying] It was bad, it was very very bad and I was sick after that. They told me that... they told me that I will die, but I didn't die. It was very bad, I was crying all the time... I didn't know what to feel, I don't know what to say... [crying]"*

Of all the distressing emotions identified during this research, it seems that the emotion of loss is the most subjective in terms of meanings attached and the actual individual experience. Many of the women had formed their own understanding of why they felt a sense of loss, even if they had experienced a live birth. It seems that the loss of physical and psychological health in the post natal period had significant impact on some of the women; and often led to a sense of confusion at why they were experiencing these feelings of loss despite a positive pregnancy result. The manner in which some of the women attempted to deal with their feelings of loss differed and in some cases seemed to make sense only to the individual women, for example, one of the woman dealt with the loss of her previous pregnancy by becoming pregnant again and having a healthy live infant. It seems that the sense of loss and the attempts to alleviate this emotion is often extremely complex and is attributed and understood only within individuals' different internal working models.

4.1.7. Confusion

The sense of confusion was not only an emotional experience for women, but often formed part of a cognitive process in which they struggled to understand and make sense of their experiences from their personal perspectives. Thus the feeling of confusion often remained in the women's cognitive scheme for longer periods after giving birth than compared to some of the more emotional aspects to their experiences.

Participant A: *"I was so confused... it made me feel... I don't know how to say... um... it made me feel like I'm helpless, there's nothing I can do."*

Participant B: *"I don't understood what is high blood... all they tell me is high blood is dangerous... so now I worry whenever my blood is high, cause maybe the same thing will happen."*

Participant D: *"I couldn't understand it... why was this happening to me and not to someone else... I needed to answer that question. They said it happens... it could happen to anyone and I couldn't understand that. So the thing is I don't know if it depends on your age or what but I think there must be therapists in the hospital for women with premature babies so they can speak to them and ask them these things."*

Participant F: *"No nobody told me stuff like that... or asked me questions like that... I was very confused – I didn't know what did this happened to me, my pregnancy was fine until then and I was very happy, not stressed at all..."*

McCain and Deatrick (1994) found that heightened anxiety and vulnerability, often expressed as uncertainty over outcome of the pregnancy, to be the main themes in women's experiences in high risk pregnancies. This state of uncertainty and confusion seemed to render many of the women helpless as they felt their locus of control was externalised and placed in the hands of those medical professionals caring for them. This sense of powerlessness seemed to, for some of the women, continued on into the postnatal period where they at times felt lingering confusion as to why they had been subject to that specific experience of a pre-eclamptic pregnancy. It seemed like, from their perspective, if this confusion had been somewhat alleviated by having a greater understanding of this phenomenon then maybe their ability to let go and gain closure would be increased. It seems

that this lack of understanding in some way kept women in a state of limbo between accepting their experience and thus being allowed to move on with their lives.

4.2. Social Support:

The theme of social support was a prominent theme throughout the literature surrounding high risk pregnancies; and it proved to be an immensely important theme identified in the interviews. The women strongly regarded social support as a fundamental form of coping with their traumatic experience of pre-eclampsia. Social support was demonstrated by spouses, families, medical staff, friends, and community networks. These various types of social support served as a means of assisting the women in gaining some degree of insight and understanding into their situations; encouraging a sense of hopefulness, as well as helping them accept and cope with their situations.

Several studies indicate that social support during pregnancy results in better psychological health of the women; and this notion is further supported by the subthemes noted in the interview data. However, it is also important to note that women reported being adversely affected by a lack of social support (emotional, informative, and instrumental) during their past pre-eclamptic pregnancies. Thus, for the purposes of this data analysis the theme of social support will be divided into the subthemes of positive and negative experiences of social support, with each being further divided into the most noted components affecting women's psychological experiences during their past high risk pregnancies.

4.2.1. Positive experiences of Social Support

Throughout the interviews, from the women's perspective, it has become apparent that social support served to lessen their experience of psychological distress. This is not to imply that being afforded more social support eradicates all psychological distress from this experience, but rather to enforce that incurring social support during a high risk pregnancy may simply act as buffer that helps to decrease levels of emotional distress throughout this period. The following forms of social support were noted as most important in buffering the women's stress levels, and enabling their ability to cope during their high risk pregnancies.

4.2.1.1. Community Support

Social support received from community networks, such as church members, priests, or colleague support, was not often reported throughout the interviews. However, when these forms of social support were received the women expressed that they served to boost their sense of hope and improve their optimistic dispositions regarding their situations. A few studies have been conducted that suggest that optimistic women experience less distress in high-risk pregnancy than non-optimistic women (Lobel & DeVincent, 2002; Lobel et al., 2000). Furthermore, one woman identified that the hospital community, consisting of the other women patients, was also perceived as a positive form of social support. The following extracts highlight how these forms of social support were positively experienced and valued.

Participant B: *"The priest from my church... he came to visit me in Groote Schuur... he must tell me that I've got a hope, and I felt a bit stronger."*

"I talk a little bit with the other women who were also sick... we talk about going home and the baby. They helped a little bit."

Participant C: *"... my members of the church they were always there for me... it helped me a lot because there's my elder and his wife, they like mother to me, so they were always there for me, to support me, emotionally and physically."*

Participant D: *"I was sitting there and then the staff of my school sent me flowers that particular day, man I was just looking at the flowers and smiled... I knew they were thinking about me and the baby."*

Participant E: *"Ehe, yes, they phone me... only my neighbour phone me. She would phone me when I'm in Groote Schuur, she could visit me in Groote Schuur, she also there. That was good."*

Although this form of social support was not evident in the empirical research found surrounding management plans for women during high risk pregnancies (specifically focused on pre-eclamptic pregnancies) it was apparent that from the women interviewed those who did receive this form of informal support found that it aided in decreasing their psychological distress and improving their sense of inner strength and resolve.

4.2.1.2. Family Support

Many of the women interviewed in this research study communicated that the support they received from their family, both immediate and extended, was regarded as essential to their

psychological well-being. It is noted in the literature that family-centered care and support is fundamental to women's holistic treatment during high risk pregnancies, as her family is often her base of support (Martin-Arafeh, Watson, & McMurtry Baird, 1999). Almost all the interviewees noted having received, at some point, during their hospitalisation and pregnancies some form of family social support (emotional, informative, and instrumental).

Participant B: *"My mother she did come visit me... this made it okay. She did not come everyday to the hospital, but when she did come this was good."*

Participant C: *"My sisters were also there to support me, emotionally and physically, although sometimes they couldn't take it also because they are also young, they look up to me... so when I'm falling apart, it seems they are also falling apart, but they were there for me. They would bring food and clothes, also they sit and talk with me."*

Participant D: *"My mom and husband, they visited almost everyday, also my sister would come, she and my brother and my brother's daughter would come, also my husband's family, his would come, his auntie would come, his sister would come with the whole family group so that was very very supportive for me. Because you know when you are in hospital you are like cut off from the rest of the world.... So when they came it made my day easier, but then when they went I was sad again."*

Participant E: *"Yah, my mother and father came everyday, if they come to me in the Groote Schuur I feel better because they come and talk to me and give me hope... so*

everyday I'm feeling better when they come, if they cannot come I was dying on that day."

Participant F: *"Also my father came, my younger brother, and my boyfriend's parents, but not as often as my boyfriend... they would bring me some foods and we would laugh sometimes... it helped me to be in better mood."*

Thus, it seems that not only was family support one of the most prevalent forms of social support received by these women it was also one of the most crucial forms of support in affecting their psychological experiences during that period. It seems that when family members visited the women they felt more psychologically contained and supported, however, when the time came for their families to leave it was experienced as another distressing loss. This serves to highlight the value and significance attributed to this form of social support by the women experiencing a high risk pregnancy. Furthermore, the importance of this form of support reinforces the need for family-centered care to be incorporated into the management plans for these women (Martin-Arafeh et al., 1999).

4.2.1.3. Partner Support

Partner support, stability, and the status of the relationship are viewed as major components in determining women's psychological experiences during pregnancy (Kroelinger & Oths, 2000). This theme resonated throughout the interviews with almost all the women expressing a want and need for emotional support from the partners, and reporting when this was received it affected their psychological well-being positively whereas when this was not provided they perceived their partners' support as lacking or negative (Corbet-Owen, 2003).

The study by Collins, Dunkel-Schetter, Lobel, & Scrimshaw (1993) strongly supports the research discussed above. Collins et al. (1993) found that women who received more partner and social support had better labour progress, experienced less postpartum depression, and had babies of higher birth weight. The following extracts lend further support for the above mentioned views, as they highlight the impact of partner support during a high risk pregnancy.

Participant A: *"He was, even on that time I was on the hospital they go all the time, everyday, he came and see me, and bring me the food. So I was happy when he come, after he go, the time, when the time, they said the time is over now, they must go I just kept crying because I'm going to be alone."*

Participant B: *"In the hospital, my husband he did visit all the time, he came everyday. He did talk to me about how I was feeling, and he gave me hope..."*

Participant D: *"You see my husband is a joker, he likes to joke, try to make fun and try to cheer me up a little bit... it made a big difference to my day. He supported me the whole time, he would come every day even though he didn't have a car, so he must come to the hospital then he must go late home, take a taxi, public transport..."*

Participant E: *"Yah, everyday I had visitors, especially my boyfriend... and he gave me hope that I can have another child. What helped the most was to talk about it... I like to talk to my boyfriend about it because I don't have friends, I don't trust*

friends all the time, but I trust and I talk to my boyfriend all the time. He says I must still have hope and that it is not the last baby."

Participant F: *"My boyfriend would visit every day and ask me how I'm feeling and bring me food and gifts. He cared a lot, I looked forward to his visits... I would get very excited. It was very good. My boyfriend and my family... the support they gave me... I would not have made it without them, they kept me strong and gave me faith."*

Almost all the women reported a positive psychological experience when they received support from their partners, mostly in the form of emotional and instrumental support. Furthermore, when this form of social support was taken away, for example when their partners had to leave at the end of visiting hours, they would feel an increase in their psychological distress levels again reinforcing the impact this support had on their psychological experience during their high risk pregnancy.

4.2.1.4. Spiritual Support

Spiritual support was also a form of support that appeared to be an uncommon form of support reviewed in the literature surrounding high risk pregnancies; and was also infrequently noted in the interviews. Nevertheless, it felt important to mention this form of support as some of the women did report that this was significant in offering themselves containment and helped to soothe their distress. Thus, spiritual support is perhaps a slightly different form of social support as it is sourced internally to self-soothe as opposed to being experienced by external sources.

Participant A: *"I talked a lot to my priest... and go to church every Sunday, I just pray that's all I can do..."*

Participant D: *"So, I think for me as a religious person, I think that God was there and took me through that whole experience. During that time I also prayed a lot, you know sometimes it's also dark inside of me, so then I had to pray and ask God to help me, everyday he did that... he helped."*

Participant E: *"I go to church a lot, and it was very helpful... I don't have another thing to believe in. It is only God. I only believe in God. So, I pray all the time so that God can help me..."*

In trying to understand this experience from the women's perspective it seems that their ability to cling onto an internal and external belief system helped to instill a sense of hope and acceptance, thus proving to be an invaluable form of social support. Furthermore, it seems that when the women reported having this underlying belief system it helped to frame their understanding and make meaning of their otherwise confusing and traumatic experiences.

4.2.1.5. Medical Staff Support

Interesting to note, the majority of the literature on social support during pregnancy focused heavily on partner support with very limited literature on broader social supports, such as family, hospital staff, and friends. A few studies have alluded to the importance of these

social supports during pregnancy by studying the effects of outreach programs for women during high risk pregnancies, such as bedrest helplines, support and education for family, home visiting, and nurse support (Richfield, 1993; Johns, 2006; Olds et. al., 2002; & Wallace, 2009). When positive experiences of social support from the medical staff were reported it appeared to have a major impact on the women's psychological experiences during their high risk pregnancies. The forms of support most appreciated from obstetrical staff were emotional support and informative support, as emphasised in the following extracts.

Participant A: *"There's this other nurse there, she was lovely to me. The time I was in hospital, she was, she give me the power. She said "I know you're going to be alright, you're going to get another child so don't worry. It's only her, she gave me a lot of power."*

Participant B: *"In the hospital the doctors and nurses sometimes did ask how I was feeling... I also spoke with social worker once, that was good."*

Participant D: *"There are some nurses who are... they were very very good, you know, treat the patients good... One nurse spoke to me about high blood pressure during pregnancy and she tried to explain to me the reason why my blood pressure was so high so from that time I could understand why, why I went from low blood pressure to high blood pressure because of my pregnancy."*

Participant E: *"It was horrible [crying]... all I wanted to do was to take my baby home, or to stay with baby, but the doctors said I must go home and sleep, I needed rest*

they said. So I was worried about baby, but nurse and doctors were very nice and let me visit and stay with baby long.

Throughout the interviews it became evident that the women greatly desired support from the health care professionals that was somewhat outside of their medical requirements. It seems most of the women wanted the medical staff to show concern and curiosity into their emotional state; offer acknowledgment and normalise these feelings; simply be available to listen to them if so desired; and to provide them with information about the medical condition that was communicated in a caring and understandable way. These above mentioned forms of social support given by the medical staff appeared to have considerable impact upon the women's psychological distress during their pre-eclamptic pregnancy – with received support serving to alleviate some emotional stress and providing much needed reassurance.

Overall, it is apparent that although all the above mentioned forms of social support are fundamental in providing the women with hope, an increased sense of being able to cope, and a buffer against stress, certain forms of social support were more fundamental to the women's psychological experiences than others may have been. For example, it seems that in particular partner support and support from one's immediate family were the most prevalent and cherished forms of social support received. It seems that when support from the medical staff was received, it was hugely appreciated and served to decrease the women's levels of psychological distress. Throughout the interviews a recurring subtheme of spirituality was noted as being perceived as an important form of social support. Although spirituality was individually identified as been fundamental to lessening some of the women's distress it was often a form of social support that was sourced internally, as opposed to being received

externally. Lastly, support from the women's friends and community networks were noted as being important and valued they were probably the least common forms of social support received, and thus seemed to be less prevalent than partner, family, and medical staff support.

4.2.2. Negative experiences of Social Support

When analysing the interview data it became apparent that in the women's understanding of their psychological experiences during their past high risk pregnancy, a lack of social support (emotional, informative, instrumental, and follow-up care) was directly related to them feeling increased levels of psychological distress. It seems that the negative experiences of social support during their pregnancy were more readily recollected and communicated than those experiences deemed positive. This may allude to a perception that the lack of social support affected these women's psychological experiences more so than did the positive experiences of social support. Thus, although positive experiences of social support are much appreciated and result in decreased levels of stress, negative experiences of social support are more vividly experienced and remembered as damaging in the long run. These negative experiences of social support are divided into the following categories: lack of emotional support; lack of informative support; lack of instrumental support; and lack of follow-up care/support.

4.2.2.1. Lack of Emotional Social Support

This negative experience of social support, or lack thereof, was most commonly expressed amongst the women interviewed. Most of the women reported feeling that there was a lack of empathic understanding and respect demonstrated towards them during their hospitalisation –

they identified that this lack of emotional support was mostly absent from the medical staff as well as the other patients with whom they shared wards. Furthermore, one of the women also noted that this form of support was missing from the father of her baby due to existing relationship problems (Corbet-Owen, 2003). Regardless from whom this emotional support was lacking, this deficiency seemed to have similar affects on the women's psychological experiences.

Participant A: *"No they didn't ask why or how do you feel because just on that time I was crying all the time so they, I think they decided to not talk or ask how do you feel cause I was crying."*

Participant C: *"The father of the baby was there but he had a problem because when he comes, he always comes with friends, and sometimes when they come drunk, then I said I don't need that at the moment..."*

"They {medical staff} didn't care. They only start caring after they understand my ability and the type of person I am... the quality of emotional care is very poor, I'm not scared to say that because although the medical care might be good, or you know the other kind of care might be good, they're not actually caring about you as a human, as a person. If feels like they treat you as thought you're not there, and you're not a human being, and actually you are a human being whose got lots of feelings."

Participant D: *"Also some of the nurses, I felt like they didn't really care... I felt the nurses were rude to patients, man, and they don't care about patients. Sometimes*

patients are rude, but you must be decent to patients, you can't be rude. Some of the nurses didn't treat you with respect or decency... So there was no support from the nurses, like they would say 'come come there's no madams here' and you know that type of thing and they didn't consider that these women had had c-sections the previous evening. So for me that was unprofessional, very unprofessional. Also they were only concerned about the medical condition and not what affects does it and how it is going to affect the women... they don't consider what is going on in this woman's mind or how does she feel. They don't consider that. You know it's just medical, they are just attending to medical conditions."

Participant E: *"They did not talk to me about how I feel. They just come and give me some medicines and pills and then they go."*

Participant F: *"I don't really talk to people about things like that... we spoke about normal everyday things, but not about how we were feeling. I felt like I was much worse than the women in may ward... so it felt like maybe they wouldn't understand."*

As evident from the women's perspective the lack of emotional support offered to them, left them feeling anxious, fearful, angry, and isolated – serving to heighten their psychological distress during their high risk pregnancy. Although nearly all the women reported receiving excellent medical care from the health care professionals attending to them, it seems that not enough effort and attention was given to proving them with the communication of caring and

concern, which serves to reduce distress, permit the expression of feeling states, and improve self-esteem (Hogan et al., 2002).

4.2.2.2. Lack of Informative Social Support

Research has shown that informative support – the provision of information to advice and guide – enhances ones sense of control and ability to cope with otherwise confusing and distressing situations (Hogan et al., 2002). Thus, when this support is perceived to be lacking, it can affect women's sense of control and resolve during their high risk pregnancies. Many of the women reported that this form of support was also found to be lacking in the care provided to them by the medical staff, with one woman noting that informative support was absent during her interactions with the other patients – something she found disturbing considering they were experiencing similar ordeals. The following extracts demonstrate that this was a common theme identified throughout the interview data.

Participant A: *"They said that the baby's not alright and they told me I'm going to do the abortion, so that's all. They didn't say they think, like, or what we are doing this and that, you?"*

Participant B: *"No we {other patients} didn't speak about it... I don't know if it was going to help or not..."*

Participant C: *"Nobody {staff} was talking to me, nobody was interested of what I'm going to say...Also what could have made better for me, first of all, if they could explain to me what is the cause of why I am sick, what is the cause of it, and*

after that they could tell me the consequences of it. Because you might be sick, very sick but your ears and your mind is still there."

Participant F: *"No, nobody {staff} asked me questions like that ... I was very confused – I didn't know why did this happen to me, my pregnancy was fine until then and I was very happy, not stressed at all..."*

Brooten et al. (2007) discovered that health teaching; guidance; education about effective interpersonal functioning; and advice on self-care management were the most fundamental knowledge and skills needed to improve maternal and infant outcomes, and ultimately reduce the psychological distress of women with high risk pregnancies. Thus, one can assume that when this form of support is lacking it would serve to increase the women's level of psychological distress. It seems that the above mentioned extracts support this previous research finding as the women reported feeling increasingly anxious, fearful, and confused when they were not offered education, guidance, and advice by either the medical staff or their fellow patients.

4.2.2.3. Lack of Instrumental Social Support

This theme of negative experiences of social support was the least prevalent amongst the analysed interview data, with none of the women reporting that they felt this was a major deficiency affecting their psychological state. The literature identifies instrumental support as helping to decrease feelings of helplessness and powerlessness by the provision of material goods such as transportation, money, or physical assistance (Hogan et al., 2002); and the provision of this form of support was identified by the women in this study as being

significant in improving their psychological experiences during their pre-eclamptic high risk pregnancies. However, there was virtually no data collected from this research to specifically indicate that when this form of social support was not received it had adverse affects. Nonetheless, one can assume that if the provision of instrumental support is positive then, in turn, the absence of this support denies one a positive experience and thus could be understood to have a negative or at least neutral effect. It seems that more research directed at focusing on this relationship is needed.

4.2.2.4. Lack of Follow-up Care/Social Support

Although social support provided in the form of follow-up care is not routinely offered or expected, it does seem that when there is a deficiency of this support it has a perceived negative effect on the women's psychological experiences during their high risk pregnancies. The following extracts show that some of the women keenly felt the absence of this support, with many of them advocating for an improvement in this sphere of offered treatment.

Participant B: *"No, nobody did speak to me when I'm out of this place, I'd like that because it is still sore now to talk about..."*

Participant D: *"I tried to suppress it when I was in hospital, but when I came home all those feelings came out...I couldn't sleep at night, I was like shivering the whole time, and a nerve in my face was twitching the whole time... I knew something was wrong, I just couldn't pinpoint it, couldn't say what it was...I think I that it was lucky in my case that I told the doctors when I went for a check-up, in most cases I don't know if they pick it up..."*

Participant E: *"When I leave Groote Schuur they don't phone me, they don't come to visit. I just sit with my parents, they tell me to pray."*

Participant F: *"No nobody called after I left hospital... oh yes, that would be nice, but nobody called. I never talked to anybody about this."*

Although follow-up care/social support was not a prevalent theme throughout the literature reviewed, it does seem that from the women's perspectives found in this study it is a form of support that would serve to lessen anxiety levels in the postnatal period; assist in identifying any psychiatric disorders such as postnatal depression; and thus ensure prompt and adequate provision of treatment. Therefore, although it may not be realistic to expect the provision of this form of support, it seems that when it is lacking it is perceived to be detrimental to the women's psychological experiences of their high risk pregnancies.

4.3. Summary of the Lived Psychological and Social Support Experiences

Overall, the theme of psychological experiences, distress, and the subthemes of emotions do seem to overlap and intersect one another showing that they are not mutually exclusive categories. The theme of psychological distress incorporated all of the emotions of fear, anxiety, guilt, confusion, anger, loss, and isolation/loneliness. The level of social support received by the women was directly linked to their feelings of fear, anger, isolation/loneliness, confusion and anxiety. Thus, it seems clear that one needs to consider all the emotions and themes as interrelated and interacting concepts; as it seems highly detrimental to only consider them individually and exclusively.

In summary, social support in its various forms (emotional, informative, instrumental, and follow-up) from various sources (community, partner, family, spirituality, and medical staff) surfaced as a very key theme in helping the women to cope with their highly stressful pregnancies. Although most of the women experienced and described a lack of support during their ordeal with a subsequent negative effect on their psychological well-being; several of the women in our study did receive social support in various forms and this support was greatly appreciated by those women who received it.

Chapter Six

Conclusion

Phenomenological Study Exploring the Lived Psychological and Social Support Experiences of Women during a Past High Risk Pregnancy (Pre-eclampsia) at a Public Hospital in the Western Cape

Chapter Six

6.1. Conclusion

In conclusion, the findings obtained from the interview data supported the existing literature surrounding the psychological experiences of women during a high risk pregnancy, and more specifically a pre-eclamptic pregnancy. Common themes of psychological distress, positive social support experiences, and negative social support experiences were identified in both the interview material collected and in the related literature. Furthermore, the common subthemes were located in the interview data and also supported by the existing literature and were embedded within the identified themes.

Overall, the findings indicated that women are subjected to stressful and traumatic experiences, to a varying degree, during a high risk pre-eclamptic pregnancy. The emotions and themes identified show that women experienced a range of difficult emotions and cognitions when going through this trying psychological and physical experience. It was also highly significant throughout this research study that social support played a fundamental role in forming the psychological experiences of women during their past high risk pregnancies, with positive experiences being more beneficial whilst negative experiences were more detrimental.

6.2. Limitations

This research study did, however, fall prey to various limitations. Firstly, analysing and interpreting qualitative data is a very subjective process which decreases the objectivity and generalisability of the findings. Secondly, due to the fact that there was significant amount of information and the focused nature of the research question, I was unable to incorporate all of it into our analysis. Thirdly, a bigger interview sample may help to elicit new themes and emotions; and/or more strongly support and emphasise the themes and subthemes already identified. Fourthly, phenomenological research usually employs unstructured interviews as a standard method of data collection; however for reasons stated in the methodology section semi-structured interviews were used in this study. Thus, there are several limitations identified in this research study.

It is also important to explore the more theoretical limitations of this research study. The findings in a phenomenological study are essences of a phenomenon, in the case of this phenomenological study, of psychological experiences and social support. It is imperative to be cognisant that these findings have to be read critically and with an appreciation of what the meaning of psychological experiences and social support was to the researcher, as well as the socio-economic context in which they emerged. Thus, I acknowledge that my own perceptions and views may have influenced some of the data analysis. However, this interpretative stance of the researcher is accepted as an inevitable part of the research process and thus not viewed as a limitation.

6.3. Recommendations

It is important to note and acknowledge the lack of research and literature surrounding this topic of the psychological and social support experiences of women during a high risk pregnancy, and more specifically surrounding pre-eclamptic pregnancies. Thus, future research needs to be conducted in order to more fully explore and understand this area of psychology. Such research is needed to raise public discussion about the psychological and social support experiences of women during high risk pregnancy, with particular focus on pre-eclampsia. More knowledge about this topic needs to be produced to help create a greater awareness of pre-eclampsia and inform the public of the emotional and cognitive consequences of this condition. Future research could also assist women with pre-eclamptic pregnancies by helping them to understand and cope with their own psychological experiences of high risk pregnancy. Furthermore, research in this area will also allow women a space to make their voices heard. In addition, and possibly most importantly, future research on this topic will help health professionals to increase available social support resources and be more acknowledging of women's emotions during high risk pregnancies; and thus to deal more effectively and sympathetically with patients. Therefore, it is imperative that the large gap in the research surrounding this area of psychology is filled and given the attention it so needs.

6.3.1. Development of Staff Support Groups

Throughout the literature reviewed the development of support groups for health care professionals seemed to facilitate better care provided to their patients. It seems that the experience of treating patients, such as those with high risk pregnancies, may also be an emotionally challenging experience for the medical staff caring for them. Thus, it makes

sense that in order for the health care professionals to be able to provide adequate emotional containment for their patients they to need a space were their feelings are acknowledged, validated, and they are offered support. It is recommended that a staff support group be formed in the obstetrical department at Groote Schuur Hospital, held on a monthly basis by a trained professional, in order to help facilitate this form of social support which will affect not only the staff but also the patients being treated.

6.3.2. Development of Support Groups for Women

It was evident in the literature reviewed that support groups, either conducted by a professional or held as self-help groups, were very beneficial in providing women with a sense of containment and understanding. Interestingly, this was a theme also noted throughout the interview data where many of the women reported that having a formal forum in which they could access the emotional and informative support of their fellow patients would have been extremely appreciated. It seems that this form of interpersonal support was greatly desired by the women interviewed in this study, but was found to be lacking in many of their experiences. Thus, it is highly recommended that there be a weekly support group held in the obstetric unit at Groote Schuur Hospital. This support group should be conducted by a trained professional, either a social worker or psychologist, in a contained and private room for approximately one hour a week. This may serve to decrease the level of psychological distress experienced by these women whilst they are in hospital, and also provide them with the tools to access more interpersonal support on discharge.

6.3.3. Increased Mindfulness amongst Medical Staff

Possibly one of the most informal and simple ways of attempting to help alleviate women's psychological distress during their high risk pregnancies is to appeal to medical staff to be more mindful of psychological distress during pregnancy. It may be important for a forum to be created where women can express their emotions, particularly those of anger, in order to give feedback to the health care professionals treating them. This could possibly be employed by devising a short feedback form which women could complete before they are formally discharged from the hospital.

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Appendix A

INFORMED CONSENT FORM

This form details the purpose of this study which will take place between October and September 2009. After a description of the involvement required and your rights as a participant you may decide whether or not you are willing to participate in the study.

The purpose of this study is:

- To explore and assess your psychological state and level of support during your past high risk pregnancy. In other words, this study will explore the role social support plays on your psychological experiences during your pre-eclamptic pregnancy.

The benefits of the research will be:

- Creating a better knowledge and understanding of the affects social support (during a past high risk pregnancy) can/or may have on women's psychological well-being, as this may help in the future development of treatment for women diagnosed with pre-eclampsia.

Criteria for suitability for study:

- Aged between mid-twenties and mid-forties
- Past experience of a pre-eclampsia high risk pregnancy (more than one year and no longer than two years previous).

The methods that will be used to meet this purpose include:

- A one-on-one interview with you, the participant. The researcher will travel to conduct these interviews at a place most conveniant to you, and translators will be provided so you may express yourself in the language with which you are most comfortable.

Our discussion will be audio taped to help me accurately capture your insights in your own words. The tapes will only be heard by me and my supervisor for the purpose of this study. If you feel uncomfortable with the recorder, you may ask that it be turned off at any time. On completion of the study you may request that the tapes and transcripts be/not be destroyed, or returned to you.

You also have the right to withdraw from the study at any time. In the event that you choose to withdraw from the study all information you provide (including tapes) will be destroyed and omitted from the final paper.

Insights gathered by you and the other participants will be used in the writing of a qualitative research report, which will be read by me and my supervisor. Though direct quotes from you will be used in the paper, your name and other identifying information will be kept anonymous.

You are encouraged to ask questions or raise concerns at any time about the nature of the study or the methods I am using. Results from the study should be available by December 2009. If you are interested in learning more about the results, do not hesitate to contact myself, my supervisor, or the UCT Ethics Committee. .

Researcher's contact details: Lisa Sanders on 072 586 5946 (mobile)
Supervisor's contact details: Michelle Andipatin on 021 959 2283 (Psychology Department University of the Western Cape)
UCT Faculty of Health Sciences Research Ethics Committee: 021 406 6338

By signing this consent form I certify that I _____ agree to the terms of this agreement.
(Print full name here)

_____
(Signature - Participant)

_____
(Date)

_____
(Signature – Researcher)
Affiliated to the University of the Western Cape

_____
(Date)

Appendix B

INLIGTINGS EN TOESTEMMING VORM

Hierdie vorm bevat besonderhde oor die doel van hierdie studie wat sal plaasvind tussen Oktober 2008 and September 2009. Agter 'n beskrywind van die betrokkenheid wat did van u sall vereis en jou regte as 'n deelnemer u mag besluit of u bereidwillig is om aan hierdie studie deel te neem.

Die doel van hierdie studie is om:

- Navorsing te doe nom vroue se sielkundige toestand en vlak van ondersteuning gedurende hul verlede hoe risiko swangerskap te ondersoek. Met ander woorde, hierdie studies al die impak wat maatskaplike ondersteuning het op die sielkundige ervaring van vroue gedurende hul vooraf-eclamptic swangerskap navors.

Die voordele van die navorsing sal wees:

- Om beter kennis en begrip van die effek van maatskaplike ondersteuning (gedurende 'n verlede hoe risiko swangerskap) kan/of mag het op sielkundige wellsyn van vroue, omdat hierdie kennis toekomstige behandeling vie vroue gediagnoseer met pre-eclampsia mag hulp.

Krieteria vir studie:

- Ouderdom tussen middle-twintigs en middle-veertigs.
- Redelike ontlangse ervaring van vooraf pre-eclampsia hoe risiko swangerskap (meet as een jaar en minder as twee jaar)

Die metodes wat gebruik sal work om hierdie doel te bereik sluit in:

- Een-tot-een (individuele) onderhoude met u die deelneemer. Die navorser sal reis om die onderhoude te voor op 'n plek meer geskik vir u. Verstalers sal beskibaar gestel word so dat u, uself mag uitdruk in 'n taal waarmeer u gemaklik is.

Ons bespreking sal opgeneem work op oudio band om te hulp om jou insigte in jou eie woorde, akkuraat op te vang. Die bande sal allenlike deur my en my toesighouer gehoor word vir die doel van hierdie studie. Indien u ongemaklik voel met die opnemer, mag u my enige tyd vra om dit af te skakel. By voltooing van die studie mag u versoek dat die bande en transkripses gehou word, vernietig word af dan u besorg word.

U het ook die reg om enige tyd van die studie te onttrek. In die geval dat u verkies om te onttrek van die studies al al die informasie wat u voorsien het (insluitende die bande) vernietig word en van die finale papier uitgehou word.

Insigte bekom uit hierdie studie met u en die ander deelnemers sal gebruik word in die opskryf van 'n kwalitaflewe verslag wat deur my en my toesighouer gelees sal word. Alhoewel direkte kwotasies gebruik sal word in die verslag, sal u naam en ander indetifiseerbane informasie anoniem gehou word.

U aangemoedig om enige tyd vrae te vra of bekommernisse omtrent die studie of die metodes wat deur my gebruik word. Die resultate van hierdie studie behoort beskrebaarte wees teen

Desember 2009. Sal u belangstel om meer inligting te kry oor die resultate van die studie kan u vir my, my toesighouer of die UCT Etiek Kommitee skakel/kontak.

Researcher's contact details: Lisa Sanders on 072 586 5946 (mobile)
Supervisor's contact details: Michelle Andipatin on 021 959 2283 (Psychology Department University of the Western Cape)
UCT Faculty of Health Sciences Research Ethics Committee: 021 406 6338

Deur hierdie toestemming vorm te teken Sotisfeer ek, dat ek met voorwaardes van hierdie ooreenkoms saamstem.

_____
(druk vol naam hier)

_____
(Handtekening - Deelnemer)

_____
(Datum)

_____
(Handtekening – Navorser)
Affiliated to the University of the Western Cape

_____
(Datum)

Appendix C

INFORMED CONSENT FORM IN isiXHOSA

Lencwadi iquka injongo zophando oluyakuqala ngo September no October 2009. Emva kwencazelo yento ezizakufunwa kuwe kunye namalungelo akho njengomthathi nxaxheba ungakhetha ukuba uyafuna uthabatha inxaxheba kolu phando okanye hhayi.

Injongo yoluphando:

- Ukujonga nokuvavanya imeko yengqondo yabantu abangomama kunye nenxaso abantu abangomama abathi bayifumane xa ukukhulelwa kwabo kunobungozi (high risk pregnancy).

Inzuzo zophando zezi:

- Zidala ulwazi olungcono kunye nengcazelo malunga ngokukhulelwa okusesichengeni nendlela inxaso ichaphazela ngayo abantu abangomama nabancedakala ngayo ngezengqondo. Iyakunceda uphuhliso malunga nokufumana unyango xa abomama befumaniseke benesigulo se pre-eclampsia.

Ukhetho lokungenela oluphando

- Iminyaka ephakathi kwi twenties kuya kwiminyaka ephakathi kwi fourties

- Ube unawo amava e pre-eclampsia (adlulile enyakeni kodwa angadlulanga iminyaka emibini)

Indlela eyakusetyenziswa ukufikelelal kulenjongo:

- Iyaba yintethathethwano phakathi kwakho noMphandi. Umphandi uyakyhamba eze kwindawo okuyo.
- Kuya kubakho itoliki ukuze ukwazi ukuthetha ngolwimi lwakho xa ufuna ukwenjenjalo

Intetho phakathi kwakho noMphandi iyakushicilelwa kwi (audio tape) ukuze umphandi afumanise incukacha zakho ngokufanelekileyo ngamazwi akho. Lemishicilelo iyakumanyelwa ngumphandi kunye nomkhokheli wakhe (supervisor) kuphela ngenjongo zoluphando.

Ukuba awuziva ukhululekile ngolu shicilelo, ungacela ukuba icinywe nangaliphi na ixesha. Unalo nelungelo loku rhoxa koluphando nangaliphi na ixesha. Ukuba kuthe kwenzeka warhoxa koluphando, zonke incukacha ezifunyanwe kuwe kuquka I tape eshicilelweyo ziyakutshatyalaliswa, kwaye aziyukupapashwa. Ekupheleni kolu phando unako ukucela uba lutshatyalaliswe olushicilelo okanye ulunikwe.

Izimvo eziqokelelwe nguwe kunye nabanye bathathi nxaxheba ziyakusetyenziselwa ukubhalwa kwingxelo yoluphando eyakuthi ifundwe ngumphandi kunye nomkhokheli wophando. Nangona intetho ezicatshulwe kuwe ziyakuthi zipapashwe kwingxelo yoluphando, igama lakho, nesazisi sakho aziyikuvezwa, ziyakugcinwa ziyimfihlo.

Uyakhuthazwa ukuba ubuze imibuzo uqonde ngayo yonke into ongayiqondiyo okanye engakucacelanga equkwe kuloluphando. Iziphumo zophando zizakuphuma ngo December ka 2009. ukuba unomdla wokwazi ezinye izinto ngeziphumo, ungathandabuzi uqhagamshelane nam, okanye umphathi wam okanye i UCT ethics committee.

Ngokutyikitya lencwadi yesivumelwano ndiqinisekisa ukuba Mna..... ndivumelana nazo zonke incukacha zoluphando. (Igama elipheleleyo)

Tyikitya (umthathi nxaxheba) Usuku

Tyikitya (Umphandi) Usuku
Nonxwemelano ne University of the Western Cape

Appendix D

Interview Schedule:

Psychological Distress

- What were your thoughts and feelings during your pregnancy?
- How did you experience your pregnancy?
- If you were distressed during your pregnancy, how did it impact on yourself and others?
- How is it different from how you feel now?

Social Support

- Did you get any type/form of support during your pregnancy?
- If so, what was it like (hospital, partner, family, friends, etc.)?
- How did this impact on your mental and emotional state?
- Would a different experience of support have improved/worsened situation?

Reflections

- What factor affected your emotional/mental well-being the most?
- What would have helped the most?