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Research Article

A Phenomenological Exploration of Women's Lived Experiences During their Pregnancy Lifecycle

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Abstract

When considering peri-and-post natal health, there are several biopsychosocial risk factors at play. Biological, psychological, and social health factors are significant in contributing to maternal wellbeing and influencing maternal morbidity/mortality [1]. The Covid-19 pandemic had significant impacts on general populations and on vulnerable groups such as pre-peri-and-post natal women [2]. In previous epidemics, pregnant women were reluctant to attend hospitals and doctors' appointments due to fear of infection [3]. Covid-19 has shown similar effects [2] and as such, risks associated with the pregnancy lifecycle have increased. A phenomenological investigation found themes of women experiencing negative healthcare, struggles with self-advocacy, heightened challenges for Women of Color, financial instability, increased anxiety, lower social support, lower physical wellbeing, and overall negative experiences related to being pregnant and/or in the pregnancy lifecycle during the COVID-19 Pandemic.

Keywords: Women's health; Pregnancy lifecycle; Biopsychosocial; Qualitative; Phenomenology; Perinatal health; COVID-19

Introduction

Pregnancy can be a crucial developmental period in the lives of women. When considering the health challenges during the pregnancy life cycle (i.e., pre, during, peri, and post-gestation), there are several biopsychosocial risk factors at play. Biological, psychological, and social health factors are significant in contributing to maternal wellbeing and influencing maternal morbidity/mortality [1]. The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely in the absence of disease or infirmity" [4] (p. 984). Often, the biological components associated with pregnancy and women's health are emphasized. However, pregnancy lifecycles include an array of unprecedented emotions and experiences, making psychological and social determinants of health integral during the pregnancy lifecycle [1]. Factors contributing to maternal morbidity and mortality point to the need for improved healthcare access, healthcare quality, and mitigation of women's adverse social conditions [1]. The biopsychosocial model of wellness [1, 5] however, is equipped to address the multifaceted risks faced by women in the pregnancy lifecycle. Not only is mental wellness amongst pregnant women a determinant for their health, but it is also a predictor for positive neonatal health outcomes [1-2, 5]. Thus, viewing women's health through a holistic and integrative lens allows healthcare professionals to account for the diversity of factors influencing

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Citation: Ashley J Blount, Charmayne R Adams, Kara M Schneider, Gurudutt Pendyala, Ann L Anderson-Berry, Corrine Hanson. A Phenomenological Exploration of Women's Lived Experiences During Their Pregnancy Lifecycle. Journal of Women's Health and Development 6 (2023): 89-101.

Received: October 20, 2023
Accepted: October 26, 2023
Published: November 22, 2023

fortune journals
Blount AJ, et al., J Women's Health Dev 2023
DOI:10.26502/fjwhd.2644-288400111

maternal wellbeing [1]. Biological, psychological, and social determinants of maternal health are highlighted below.

Biological Wellbeing

Biological components include factors related to physical health such as hormonal changes; sensory changes; hair, skin, and nail changes; circulatory system changes; and respiratory and metabolic changes [6-7]. Poor nutrition is considered another factor contributing to healthcare issues in women and their children distinctly displayed in vitamin level deficiencies [8]. Vitamin deficiencies associated with nutritional concerns, often correlate with poverty, diseases, and poor food accessibility [8-11]. Hansen et al. [8] conducted a study with 108 women in the U.S. at the time of delivery and found that race and insurance status were associated with vitamin A and E deficiencies. Additionally, the researchers reported that non-white women were at risk for deficiencies at higher rates than their white counterparts. Thus, women in wealthier countries (such as U.S.) can experience deleterious effects having a lack of access to health food options during the perinatal period [1, 9]. Neurobiological issues must also be included because pregnancy has been shown to change women's brain structure impacting the amount of gray matter, particularly in the prefrontal cortex [12]. Such changes are long-term and influence processes like decision making and a mother's ability to perceive their own emotional needs as well as their child's [13-14].

Psychological Wellbeing

Pregnancy is not just a biological experience, however. It is a psychological event in and of itself, with several complex changes occurring prior to gestation and especially during peri-and-post natal periods [15]. Thus, psychological wellness is an important factor for women in their pregnancy lifecycle. Risk factors in this category include exposure to trauma, changes in mood, anxiety, fatigue, depression, exhaustion, and excitement [1, 16]. Overlooking the impact of stress only leaves women more vulnerable to adverse experiences during the pregnancy and beyond. In previous qualitative investigations [17-20], researchers found women often receive pressure from their providers to follow certain birth plans (e.g., labor induction, cesarean delivery) contributing to their levels of stress. Furthermore, women with substance use disorders report experiencing their medical providers as scrutinizing, judgmental, and disparaging [18]. In addition, exposure to trauma such as previous traumatic birth or loss, history of medical or sexual trauma, and discriminatory or inequitable care are salient to women in their pregnancy lifecycle [16]. The counseling and mental health field recognize that these trauma exposures may not just be acute but can often be accumulative across a lifespan and generations [1]. This is relevant to women in their pregnancy lifecycle because it not only accounts for the psychological effect of past traumas, but it also considers the experiences that can influence present and future levels of wellbeing [1]. For helping professionals, understanding the potential effects trauma can have on a maternal population allows trauma-informed care to be provided contributing to their overall psychological well-being [1]. Women in their pregnancy lifecycle often experience varying levels of anxiety unrelated to trauma [21]. Enduring stress during this time is associated with an array of negative maternal and neonatal outcomes such as spontaneous abortion, preterm delivery, and delivery complications [21]. It is important to note the existing disparity amongst these complications. Mortality rates among Women of Color (WOC) are substantially higher for Black women (10.97 for every 1000 live births), than for their White and Hispanic counterparts [22]. These high mortality rates for Black women are directly linked with stress related pregnancy complications [22]. In addition, Black women have a higher chance of delivering their children pre-term [22-24]. Once delivered, their children have a higher probability of weight loss or low birth weight – both of which are variables correlated with maternal stress during the early stages of the pregnancy lifecycle [22-24]. Consequently, healthcare disparities among women during peri-and-post natal care exist and risks can be exacerbated for racial minority populations. It is well documented that women face a variety of mental health issues later in their pregnancy experience as well [1, 15, 20, 24]. Baby blues, or acute Postpartum symptoms such as difficulty sleeping, mood changes, and difficulty concentrating are found in three out of four women post-gestation [20]. Postpartum Depression (PPD), which is a more severe form of post-gestation distress and a clinical psychological diagnosis differentiated as an onset specifier for Major Depressive Disorder, affects approximately 13% to 20% of women [20, 25]. Many of these risks fall along different places in the pregnancy lifecycle and are unique to the individual. As such, learning about the experiences and assessing for these risk factors amongst women during the pregnancy lifecycle is vital. The inclusion of these factors should allow helping professionals to intervene earlier and reduce negative pregnancy lifespan issues and outcomes [1].

Social Wellbeing

Due to the holistic nature of the biopsychosocial model, social and psychological wellbeing often influence the other in interrelated ways. The Covid-19 pandemic exemplified this relationship [2]. In an effort to limit the transmission of the virus, social distancing strategies were implemented [26]. With that emerged a heightened sense of social isolation and loneliness for the general population leading to potential risk for mental and physical health consequences [26]. Evidence suggests that this was particularly true for pregnant women during this time due to the pandemic control measures (e.g., attending appointments alone) in addition to the already increased vulnerability that exists within the pregnancy lifecycle [2, 27-29]. For example, a study published in 2020

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DOI:10.26502/fjwhd.2644-288400111

showed that levels in both anxiety and depression symptoms of pregnant women significantly increased during the pandemic [2].

The concept of "it takes a village" in relation to maternal health and support is common. During the COVID 19 pandemic, however, many of the social supports generally available to women in their pregnancy lifecycles were removed [26, 30]. External supports such as friends and extended family were strained, as shutdowns and isolation related to the pandemic were enforced [26]. Additionally, many healthcare settings restricted the number of individuals allowed on site, forcing many women to attend appointments alone [30]. In some states, pregnant patients were not allowed to bring their partners to ultrasound appointments, general wellbeing checks, and other pregnancy-related appointments [30]. These restrictions on social support had deleterious effects on maternal wellbeing [30]. This is consistent with what previous epidemics have shown in that pregnant women are more reluctant to attend hospitals and doctors' appointments due to fear of infection [3]. The intensity of stress around fear of infection, the disruption of receiving healthcare services, and the loneliness paired with the lack of support were some of the contributors that negatively influenced peri-and-post natal wellbeing [3]. However, amongst the leading factors mitigating these levels of stress was the indication of a positive relationship with their partner and connection through virtual platforms (e.g., online groups) [2-3]. Even prior to the outbreak of Covid-19, relational support was considered a significant factor to wellbeing [1]. Relationships, satisfaction related to relationships (e.g., intimacy), and friendship are all related to maternal wellness [1]. Navigating the disruption to these support systems only further highlights the importance of the role they can play while contributing to the wellness of women in the pregnancy lifecycle.

Materials and Methods

Purpose of the Study

Risk factors can contribute to unwellness in women during their pregnancy lifecycles. There is a dearth of research about understanding women's lived experiences in their pregnancy lifecycles, especially during a global pandemic. Further, implications of why risk factors should be assessed and how they might be mitigated in the future are warranted. The purpose of this qualitative study was to explore the lived experiences of women within the pregnancy lifecycle and to determine what meaning they make of those experiences. Through gathering health experiences from a biopsychosocial perspective, themes that relate to associated risk factors were gleaned. Since women's healthcare is a biopsychosocial issue, a wellness philosophy is a fit for this population, as it allows for a holistic examination of factors influencing maternal functioning [1]. Additionally, knowing maternal risks within a biopsychosocial paradigm allows for accountability and enhanced quality of care for women during the pregnancy lifecycle [1].

Methodology

The purpose of this investigation was to examine the biopsychosocial risks of women during their pregnancy lifecycle. A qualitative methodology was employed, specifically a constructivist hermeneutic phenological approach [31]. See Appendix A for the interview protocol. Phenomenology was used to allow researchers to examine how women make meaning of their experiences across the pregnancy lifespan. The researchers aimed to allow the individual voices of the participants to stand alone in quotes throughout the results section, while also looking at the experiences collectively to understand themes across participants.

Participant Recruitment

Institutional Review Board (IRB) approval was granted prior to recruitment. Participants were recruited using a recruitment flier that was distributed via email, Instagram, and Facebook by the first author. Interested participants reached out to the first author by email to determine eligibility for participant and received information about the study. Eligible participants participated in an interview that is described in greater detail in the data collection selection of the article. 16 individuals initially expressed interest in participating in the study, 11 were interviewed.

Study Participants

Study participants were recruited using purposive sampling [32]. The inclusion criteria were: 1) Biological females 2) Currently in pre-gestation, gestation, or post-gestation. There were no exclusion criteria for this study. Participants consisted of 11 women across the United States. The participants ages ranged from 25 – 37 years old and all participants identified as married. Seven of the participants stated that they were employed full time (63.6%), two identified as self-employed (18.2%), and two identified as full-time students (18.2%). Participants identified the stage of the pregnancy life cycle they were in at the time of the interview. They had the option to choose post-gestation which is noted as after giving birth and no longer pregnant, currently in gestation which is noted as currently being pregnant, or pre-gestation which was note as prior to being pregnant. Six of our participants identified as being in the post-gestation stage of the pregnancy life cycle (54.5%), four participates identified as being in the gestation stage of the pregnancy life cycle (36.4%), and one participant identified as being in both the gestation and post-gestation stages of the pregnancy life cycle (9%). Participants were asked to self-identify their ethnicity. They were provided choices and a textbox if the way they identify was not listed. Three of our eleven participants self-identified as African American/

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DOI:10.26502/fjwhd.2644-288400111

Black (27.3%), one self-identified as Asian American (9%), two self-identified as Hispanic/Latina (18.2%), and five self-identified as Caucasian/White (45.5%). See Table 1 for demographic breakdown.

Data Collection

Data was collected through semi-structured interviews that ranged in length from 30-45 minutes. Prior to completing their interview, all participants reviewed an informed consent document, and completed demographic questionnaire, and Marlowe-Crowne social desirability scale [33].

Interviews. All interviews were conducted via Zoom and included 10 open ended questions that were split into 5 sections: 1. General introduction questions (example question: Tell me about your experience with your pregnancy lifecycle), 2. Biological questions (example question: Tell me about your physical health during your pregnancy lifecycle), 3. Psychological questions (example question: Tell me about mental health during your pregnancy lifecycle), 4. Social questions (example question: Tell me about your social wellness during your pregnancy lifecycle, this could include things like your friendships and romantic relationships), and 5. Ending questions (sample question: Is there anything you'd like to share with me about your pregnancy life cycle/ healthcare experience that I did not ask about during this interview?). The full I-guide for the inquiry can be found in appendix A.

Marlowe crown social desirable scale (MCSDS - X1). Participants completed the MCSDS–X1 [34], which is a 10-item shorter version of the Marlowe–Crowne Social Desirability Scale [33]. MCSDS–X1 item scoring is based on a 1 (items that are socially desirable) to 0 (items that are not socially desirable) range, with total scores on the assessment ranging from 0 to 10. Sample items from the MCSDS–X1 include "I like to gossip at times" and "I'm always willing to admit it when I make a mistake." Individuals scoring higher than 5 are viewed as answering in a socially desirable manner. The MCSDS–X1 has an internal consistency range of around .50 to .90 [35-36].

Table 1: Participant Demographics.

Participant	Age	High Level Education	Marital Status	Job Status	Hours Worked	*Primary Health Care Provider	**Stage in Pregnancy Life cycle	Ethnicity
MCIC	37	Master's Degree	Married	Self-employed	31- 40	Work-based	Post- gestation	African American/ Black
SAIC	31	Doctorate	Married	Employed Full-time	31 - 40	Private	Gestation	Asian American
LSIC	30	Bachelor's Degree	Married	Employed Full-time	40 +	Work-based	Post- gestation	Caucasian/ White
ADIC	26	Master's Degree	Married	Full time student	Nov-20	Work-based	Post-gestation	Caucasian/ White
ESIC	25	Master's Degree	Married	Full-time Student	31 - 40	Spouses work-based	Gestation	Caucasian/ White
CCIC	25	Bachelor's Degree	Married	Employed Full-time	40+	Work-based	Post- gestation	Caucasian/ White
ACIC	37	Master's Degree	Married	Self- employed	31-40	Work-based	Post-gestation	African American/ Black
CGIC	32	Master's Degree	Married	Employed Full-time	40+	Work-based	Gestation	Caucasian/ White
LMIC	26	Bachelor's Degree	Married	Employed Full-time	40+	Work-based	Post- gestation	Hispanic/Latina
JGVA	33	Doctorate	Married	Employed Full-time	21-30	Work-based	Gestation	Hispanic/Latina
OUIC	33	Doctorate	Married	Employed Full-time	40+	Work-based	Gestation and post- gestation	African American/ Black

Note: *Some participants indicated use of secondary insurance which is not included in this table. **Post-Gestation (e.g., after birth, no longer pregnant); Gestation (e.g., pregnant).

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DOI:10.26502/fjwhd.2644-288400111

Analysis

As previously stated, the participant data was analyzed using a constructivist hermeneutic phenomenological approach [31]. This approach is focused on capturing the essential meaning of the phenomenon. The first and third authors immersed themselves in the data by reading and rereading the digital transcripts. Then the two authors independently utilized a line-by-line approach to first round coding [37] which required a complete review of the 11 transcripts noting words or phrases that captured the essence of the participants pregnancy life cycle experience. After the first round of coding, the authors independently conducted a second round of coding looking specifically for patterns of interaction with the healthcare system [37]. The first and third author independently created preliminary themes, and then came together to discuss their codes and themes. They collapsed their preliminary themes into the eight themes presented later in this manuscript.

As with other counseling manuscripts that use this method [38-39] we hoped to capture both the individual and holistic experiences in our analysis and in our writing. In an aim to honor the unique differences of the participants, the demographic data above is presented by participant and aggregate. Additionally, in the results the themes represent the aggregate experience, and the individual quotes honor the individual experiences of the participants.

Methodological Integrity

Researchers engaged with each other throughout the process of data collection and analysis which led to a deeper understanding of the participants lived experiences [31]. The first author randomly selected three participants (JGVA, OUIC, and ADIC) to engage in member checking. The three participants were sent the transcript of the interview and were asked to provide feedback on if the transcript accurately represented the interview and their pregnancy experience. The three participants were provided 4 weeks to respond, and they all responded within 3 days stating that the information was an accurate representation of the interview and their pregnancy experience. Additionally, during data analysis the researchers noted their reactions to the participate data and discussed that in their data analysis meetings.

Research Team Positionality

The first author is a cis gender female with three children. She identifies as a Greek/Italian/White American with varying experiences in the healthcare system. Her three birth experiences shape the way she views women's health and the healthcare system along with the data in this investigation. The second author is a cis gender childless female. She identifies as Black/African American and has had a variety of experiences with the American health care system ranging from exceptional to traumatic. Those personal experiences, and the experience of engaging with the health care system specifically regarding reproductive health shape her worldview and how she engages with this participant data. The third author is a cis gender childless female. She identifies as a White American with varying experiences with the healthcare system, particularly regarding reproductive health care, that shapes how she engages with this investigation's data. The fourth author is a cis gender male with two children. He identifies as an Asian with extensive experience in preclinical models of drug abuse and neurodevelopment. The Fifth author is a cis gender female with two adolescent children. She identifies as a White American with extensive experience in healthcare delivering care as a provider to newborns with critical medical needs at birth and supporting their families. The sixth author is a cis gender female with two adult children. She identifies as a White American with extensive experience in the role nutrition plays in early life development and outcomes.

Results

Marlow crown social desirable scale (MCSDS – X1)

All 11 participants responded to the Marlowe Crown Social Desirability Scale (MCSDS - X1) which was embedded in their demographic questionnaire. All questions were asked in true/false format and results indicated participants were not answering in a socially desirable way. The data is displayed in a Table 2 below.

Table 2: MCSDS-X1 Results

	TRUE	FALSE
I'm always willing to admit it when I make a mistake	4	7
I always try to practice what I preach	9	2
I never resent being asked to return a favor	5	6
I have never been irked when people expressed ideas very different from my own		11
I have never deliberately said something that hurt someone's feelings	2	9
I like to gossip at times	8	3
There have been occasions when I took advantage of someone	4	7
I sometimes try to get even rather than forgive and forget	4	7
At times I have really insisted on having things my own way	11	
There have been occasions when I felt like smashing things	11	

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DOI:10.26502/fjwhd.2644-288400111

Qualitative Interview Findings

The investigation resulted in eight major themes from the data: (1) Covid influences on wellness, (2) Negative Healthcare Experiences, (3) Pregnancy experience of Women of Color in Healthcare System, (4) Self-Advocacy, (4) Financial Wellness (access to quality care), (6) Mental Wellness (anxiety), (7) Social Wellness as important to wellbeing, and (8) Physical Wellness (awareness/effort to get or stay physically well).

Theme 1: Covid influences on wellness

Among the eleven women interviewed, eight of them, unprompted, spoke directly to the impact of Covid-19 had on their pregnancy experience. Whether they were already pregnant when the pandemic emerged or were planning to be, the overall influence on their wellness was evident.

MCIC: "…I feared that even if we did survive, we will probably catch Covid and then die that way.…I didn't do a lot of things that I would have traditionally done when I, you know, was pregnant. So, I didn't go around people at all. That's a big thing."

CCIC: "…It was very emotional and very tough, and I felt like a lot of things were taken away from me so like I couldn't really see my mom during this time. And like [partner] could no longer come to appointments and so he doesn't talk about it very much but I just know that that was hard on him, it's hard on me... I think I have anger toward the pandemic because of how much it's taken away."

LMIC: "…And then my second pregnancy, pandemic kind of hit. So, it was just a weird time… I think it was more mentally exhausting for me just because I felt like I was stuck at home all the time and I couldn't do anything is what I thought."

Theme 2: Negative Healthcare Experiences

The experience these mothers reported having with the healthcare system varied according to their particular situations. However, whether it came to their personal requests, birthing plans, or experiencing complications, many of the women reported feeling unheard by their medical providers.

SAIC: "I tried to see a new provider. I asked her both about, you know, my cramps, which she just told me, if you get pregnant, you won't have cramps. And then I was like, but I just told you, I'm getting pregnant next year, not this year, I have cramps now. And he said, well, but if you did get pregnant, you wouldn't have your period for nine to 10 months. So, and I was like, OK, you're not hearing me. It's just -- I felt so unheard"

MCIC: "And so I just -- I think I went ballistic, honestly. I have bruises on me that I don't know where they came from. And I don't think I was tied down. But some -- you know, I can't remember everything. I do remember, like, trying to get up. And I remember telling them, like, I need to push right now. And they were like, don't push because you're not faralong. I remember going to the bathroom. And I remember nearly falling because I was just so out of it and in so much pain. And then I remember like being in the bed and not being able to move."

ADIC: "But I don't want the Cytotec. And they're like, nope, we only offer Cytotec. Like you're just going to have to do it and had a panic attack. Ended up pulling a muscle on my back during my panic attack, which was great because all of my pain throughout labor and delivery was just from the pulled muscle and not from contraction…And nobody believed when I said that my body was pushing."

Theme 3: Pregnancy experience of Women of Color in Healthcare System

The healthcare experiences of Women of Color with the healthcare system, in particular, was noteworthy. As you will read below, one woman mentioned how she benefited from having a WOC who was her primary care physician. While the majority of others voiced how they experienced discrimination.

SAIC: "…I have a primary care physician that I love who listens to me, who's a woman of color. And probably because she knew me before, she spends like a good hour with me when I go in for a physical, you know. So, I realized that's an outlier situation."

MCIC: "…Being Black, I have a different experience with the healthcare system because of the color of my skin…And I think for me, when I'm interacting with the healthcare system, it's so important for me to be, like, a good patient, you know, because I don't want to be seen as, like, noncompliant or, like, angry or whatever… There were a few times that basically, I know they put in my chart that I was a noncompliant patient. And that really bothers me, being Black, because it kind of makes it look like you're not trying to take care of yourself. I wish they had to put something in there like, you know, I had a fear of COVID and refusing hospitalization as a result."

LMIC: "…they marked down a different race on my son's papers? And he's -- my husband is half Black. So, she did it just based on looking at me."

Theme 4: Self-Advocacy

The pregnancy experience amongst our sample brought forth a theme where several of the participants spoke of the need to advocate for themselves or wishing they had when they didn't feel like they were being given best care.

SAIC: "And I just told her that I loved her work and I know that they are full right now, but if there's any -- do they have any sort of like waitlist type concept because maybe I can start with someone else and transition over to her or

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DOI:10.26502/fjwhd.2644-288400111

something like that. And she took me in right away. I was so surprised. And I was really excited about it. It's still probably one of my more proud moments in pregnancy, because I really felt like I advocated for myself, and I really feel like I made the right decision."

MCIC: "…But what I hate that she did that I didn't speak up or advocate for myself, she did not work gloves. And she -- you know, where she punctured me, she literally put her hand right there without gloves in an open space in my arm, you know, to stop the bleeding before she taped it down. And so I was really like -- I don't know. I was kind of just, like, shocked that this happened. But I also was, like, questioning myself, like, why am I not saying anything?"

CCIC: "Long story short with that basically they didn't tell me what was going on and there was a lot of like talk behind the scenes and I got admitted to the hospital that day to have him. And I definitely let them know how to do their jobs because I was like, "You can't just expect -- I mean, forget the first time or whatever you can't expect someone to go into an appointment for their health and not understand fully like what they're being tested on because like expectations are important…but being an advocate for myself, dissipated honestly."

Theme 5: Financial Wellness

Financial wellness for expectant mothers is critical. Access to care and obtaining the quality of care one receives is often determined by the type of insurance one holds. Our participants made note of this.

CGIC: "…I have great insurance and like what it does not cover during pregnancy is amazing."

CCIC: "…I'm very blessed I have insurance."

MCIC: "I had to take special tests that my insurance didn't cover all the time. And so, insurance was an issue at times. For my doctor's office, for example, I had to pay $1,700 upfront for her to deliver the baby. And she ended up not delivering the baby because she was delivering somebody else's baby when I actually had the baby. But, you know, I had pay for my doctor's appointments and stuff out of the pool of money, too."

Theme 6: Mental Wellness

The strongest theme that emerged from our data pertains to the area of mental wellness, particularly the high levels of anxiety that was experienced during pregnancy. All but one of our participants endorsed experiencing some level of anxiety.

LSIC: "…the beginning of the pregnancy lifecycle six months prior to conception was probably the most mentally unhealthy I've ever been. Home from the hospital after that delivery with severe, severe anxiety. Like startled to loud noises, wasn't able to leave and drive for several weeks because of anxiety. And wasn't able to sleep. And then anxiety that was complicated by grief. And I think those two things, kind of go hand in hand."

ADIC: "I was extremely anxious probably my entire pregnancy… a lot of like checking like, okay, what's my risk today? Like what's the risk that I'm going to miscarry? A lot of fear like anytime I'd have to go to the bathroom like, and I'd never experienced a miscarriage before."

ACIC: "…I do have some anxiety, for the longest time in my life I had no idea I had anxiety, I just thought I was this, you know, perfectionist control freak…I realized I was kind of like self-medicating in a way like trying to prevent panic attacks."

CGIC: "…I worry about, you know, going back to like a 60-hour week workweek. Having to pump on the job, having to -- all of that stuff. It makes me wonder, you know, this lifestyle like really conducive to with the family, which I'm sure is most women's worry like once they have a newborn at home."

Theme 7: Social Wellness

The need for a strong social support during pregnancy is established. Our participants underscored that need by describing how grateful they were for the people in their lives understanding that they were in large part why they were able to make it through their pregnancies.

ESIC: "…the support system and social support has been, you know, extremely important for me, pre and during… Being able to kind of get out and still socialize, you know, in healthy and safe ways, has definitely been really important for that human connection too for me."

CCIC: "My husband is he's the best…My family is the best like I think I get emotional thinking about it because I know that not everybody has that…I mean I have really great friends…I had a co-worker actually who was pregnant at the same time and like exact same period. So, we spoke often about what was going on."

ACIC: "…my mom was there, emotionally for me through all of them [appointments]. All but this last one because of COVID. I had her as essentially a doula kind of, she's not licensed, but I had her for all of my births and that was very emotionally helpful, and it kept me centered and she was there to help me through everything."

Theme 8: Physical Wellness

Lastly, there was a high awareness amongst our participants of the importance of their physical health. Several of them mentioned the effort they made to stay physically well even if they were less active during their pregnancy.

LSIC: "…We have one who's still in school online, and one who's back in the classroom and just balancing their

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DOI:10.26502/fjwhd.2644-288400111

social wellness with their physical wellness. And all of our physical wellness has been challenging."

ESIC: "…I'm not super active as much as I probably should be…It's certainly not as active as I would like it to be, or that as it has been in the past."

CGIC: "…I used to work out pretty avidly pre-pandemic…I wasn't in the best shape when I got pregnant or when I was leading up to getting pregnant. Since I've become pregnant, I really been trying to make extra efforts for like walking and just some like strength, really basic strength training."

Discussion

Results from this investigation supported eight themes (1) Covid influences on wellness, (2) Negative Healthcare Experiences, (3) Pregnancy Experience of Women of Color in Healthcare System, (4) Self-Advocacy, (5) Financial Wellness, (6) Mental Wellness (anxiety), (7) Social Wellness as important to wellbeing, and (8) Physical Wellness (awareness/effort to get or stay physically well). Theme (1) covid Influences on wellness, highlighted the effects of the pandemic on the sample. Participants discussed feeling scared, how they worried about the effects of contracting COVID-19 on themselves and for their fetuses. They also discussed post-partum COVID concerns with family not being able to visit/support them and worries of contracting COVID after the birthing process as well as concern with trying to get pregnant during a pandemic. Further, our sample discussed the challenges during their pregnancies directly related to COVID protocols. For example, one participant discussed how her partner was unable to attend their baby's ultrasound and another said "I felt like a lot of things were taken away from me so like I couldn't really see my mom during this time" when discussing how her family was unable to visit during her pregnancy because of the COVID travel restrictions in place. These findings are similar to what recent research has demonstrated in that the heightened control measures implemented in order to prevent the spread of infection were associated with fear, anxiety, and a sense of uncertainty for pregnant women during an unprecedented time [26, 30].

For theme (2) Negative Healthcare Experiences, participants discussed having generally poor experiences with the healthcare system during their pregnancies. Many participants felt unheard when discussing personal health with their medical providers and almost all participants talked about at least one negative experience during their pregnancy lifecycle, directly related to either their pregnancy, trying to conceive, or post-partum issues. For example, one woman summarized her birthing experience by stating "I tried to tell them what I needed, but nobody believed me" and another response "I wish I could do it all over again and have a more positive experience." These negative healthcare experiences are not uncommon, as about half (46%) of women encounter issues with healthcare yearly within the United States [40]. These findings parallel previous investigations where participants perceived healthcare providers in a negative light and describe being pressured to follow traditional birthing plans [17] whereas others felt unheard or scrutinized by their medical provider [18]. Further, these negative healthcare experiences in the U.S. may be exacerbated by stress related complications contributing to the poor maternal health outcomes reported across the country [21-24].

The majority of participants who identified as women of color (WOC) discussed experiencing either some form of discrimination, a desire for providers who looked like them, or simply being misunderstood particularly as it related to their race. These reports constructed Theme (3) Pregnancy experiences for WOC. One participant stated "you know, like that's what stands out for me is like, I have a primary care physician that I love who listens to me, who's a woman of color. And probably because she knew me before, she spends like a good hour with me when I go in for a physical you know. So, I realized that's an outlier situation". Another participant described, "Being Black, I have a different experience with the healthcare system because of the color of my skin." Acknowledging the differential experiences distinct to WOC within the healthcare system is key to the findings of this investigation. Previous literature supports these findings as well in that WOC have repeatedly shared experiences of being overlooked and their concerns ignored [41-42]. Further WOC have voiced the need for more providers of color as well as person-centered care where their individual health were more valued, not just their fetus' wellbeing [42]. Not receiving such care only compounds the stress that these women are experiencing and can limit access to necessary services [41-43].

Theme (4) Self-Advocacy emerged as some participants stated positive experiences related to advocacy, elaborating on how proud they were that they had advocated for themselves during pregnancy, labor and delivery, and/or post-partum. They discussed how these moments contributed to an overall more positive pregnancy lifecycle experience as it allowed them to receive the care that they were seeking. On the other hand, some participants wished they had advocated more for themselves describing that they regret not speaking up for their wants and needs throughout the pregnancy lifecycle. One participant described "being an advocate for myself, dissipated honestly," when she was describing the impact of rushed decisions that were made by her doctors as she was entering labor. When considering the results from the MCSDS-X1 in table 2, every participant selected false in reference to, "I have never been irked when people expressed ideas very different from my own." Within the context of self-advocacy and healthcare, this could be related to one's desires and needs being overlooked. In addition, each participant

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marked true in reference to, "At times I have really insisted on having things my own way." Again, within the given context, this could be related to past experiences participants have had in standing up for themselves. Furthermore, experiencing pride in advocating for oneself as well as the emotion of regret for failing to do so connect to these results through the lens of self-advocacy. This self-advocacy concept isn't new in the healthcare literature, specifically as it applies to women's health [44]. There have been numerous studies [42-45] on women's abilities to advocate for themselves and their healthcare experiences, with many reporting that women often struggle to be assertive in medical situations, find it difficult to advocate for their needs with doctors and other medical personnel, and often wish they would have spoken up after the fact. As such, it's crucial we support women in their pregnancy lifecycles and specifically create space for them to voice their unique needs and desires.

Theme (5) Financial Wellness is integral to positive maternal outcomes. In this investigation, many participants talked about financial health in relation to health insurance and how it was a blessing to have a good insurance plan. Other participants emphasized the difficulties associated with having poor insurance or a plan that did not cover certain pregnancy-related tests. Some participants voiced concern over access to good healthcare providers, as their insurance only covered certain locations or doctors. The relationship between health insurance and quality of care has been longstanding [46]. It is known that pregnant women who have less insurance coverage receive less preventative care, treatment options, attend fewer prenatal and postpartum appointments, thus contributing to increased rates of adverse health outcomes [1, 46]. From a holistic, biopsychosocial lens, it is critical to consider components such as health insurance coverage as a factor that influences overall wellbeing, not just in access to care but on psychological level as well [46]. To elucidate this point, participants within this study voiced concern regarding overall financial stability and its impact on their levels of anxiety. One participant summarized it being costly to have a baby, "even a normal pregnancy," and another stated, "I started really worrying about, you know, the financial health of my family" and expressed concern over what they would do if something happened to her as the primary provider. Current literature supports this notion in that women often consider financial stability as a factor that is outside of their control which may play a role in the timing of when they would like to start a family or the anxiety associated with the experience when they do [47].

Theme (6) Mental Wellness was an important area for participants within the investigation with all 11 participants speaking directly to some form of mental duress at some point during their pregnancy lifecycle. Some participants discussed high levels of anxiety related to the pregnancy lifecycle and many voiced concerns about being mentally unhealthy, struggling with anxiety and worrying about pregnancy complications. One participant stated, "So much of my pregnancy with him [her unborn baby] like I was terrified of telling anyone that I was pregnant and so that made me feel very anxious and very isolated." Another stated she was an anxious person but that her anxiety only worsened as pregnancy-specific concerns only compounded her worry. It is well supported in literature [15, 20-21] that anxiety is associated with negative maternal outcomes and there is a clear trend of women experiencing increased anxiety in their pregnancy lifecycles. For example, in recent years, up to 59% of pregnant women reported clinically significant symptoms of anxiety [48]. The role that Covid-19 played in this increase was certainly significant [48] and was validated by the participants within this study as well. Findings such as these only further highlights the need for women's psychological wellbeing to be supported alongside biological factors within healthcare settings.

For theme (7) Social Wellness, it was clear that participants valued the concept of social support but struggled with a lack of that support due to COVID-19 restrictions. Many participants talked about losing the idea of "it takes a village" because their family and friends couldn't travel to support them during their pregnancies and post-partum. A few of the participants expressed sadness that their mothers or other significant people could not visit them or their babies. Further, many of the women discussed challenges with their partners because of healthcare restrictions (not allowing partners to be present for appointments etc.) and the induced anxiety that emerged because of the realities of experiencing pregnancy during a pandemic. Our study included all participants who identified as "married" and therefore, the idea of social support would undoubtedly be different than someone going through a pregnancy lifecycle alone or as a single parent. Social support has been shown to be a critical determinant of wellbeing during pregnancy as it is associated with increased physical health and decreased levels of anxiety and depression [48-49]. During pregnancy, individuals often take on new roles and have new responsibilities, highlighting how helpful support from significant people can be often acting as a buffer to the stress that contributes to negative health outcomes [48-50].

Theme (8) Physical Wellness was the final theme to emerge from the data. All participants discussed physical wellness to some extent, with a majority stating that they attempted to enhance their physical well-being at some point during their pregnancy lifecycles. They all expressed an awareness of the positive benefits that physical activity can bring. On top of the already existent physical factors that come with pregnancy such as fatigue, exhaustion, and nausea, some participants discussed how the Covid-19 pandemic added another layer of challenge to this aspect of wellness. One participant expressed how she and her family

Citation: Ashley J Blount, Charmayne R Adams, Kara M Schneider, Gurudutt Pendyala, Ann L Anderson-Berry, Corrine Hanson. A Phenomenological Exploration of Women's Lived Experiences During Their Pregnancy Lifecycle. Journal of Women's Health and Development 6 (2023): 89-101.

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DOI:10.26502/fjwhd.2644-288400111

were all impacted stating that "all of our physical wellness has been challenging." However, another participant stated her physical wellness actually increased because of the COVID-19 pandemic given her ability to devote more time to working out and focusing on her nutrition. She also noted how she believes this contributed to her success in managing her symptoms of anxiety. This is consistent with current literature as physical activity has been shown to lower levels of depression and anxiety in multiple populations, including those in the pregnancy lifecycle [48, 51-53].

Limitations

All research has limitations. As this investigation is qualitative in nature, generalizations from the data should be used with caution. The sample was achieved through purposive sampling, as such, a more diverse representation might have been achieved with randomized sampling methods. Finally, data was self-reported in nature and as such might be highly personalized in nature and respondents may have answered in socially desirable way.

Recommendations for Practice and Future Research

Future research on the influences of risk factors on maternal wellness is warranted. Additionally, preventative factors supporting maternal wellness should be explored to meet the needs of women in their pregnancy lifecycles and mitigate risks. Biopsychosocial risk associated with maternal pre-during-and-post natal care could also be explored to support wellbeing in women and their babies.

Conclusion

Since women's healthcare is a biopsychosocial issue [1], gathering the lived experiences of women during their pregnancy lifecycles through this lens provided themes related to the associated risks and protective factors. It is evident that the COVID-19 pandemic placed an unprecedented pressure on pregnant women that extended into many domains of wellness. Participants in this investigation experienced concerns directly related to being pregnant during a pandemic, had anxiety surrounding their health, their fetus's health, and experienced overall uncertainty regarding their financial stability. In addition, participants experienced numerous negative experiences with the healthcare system, particularly for WOC as it related to being misunderstood, dismissed, or unheard. Finally, although the role of social support and physical wellness was challenged during the time of the pandemic, these two factors emerged as potential protective factors to mitigate risks associated with maternal health. Gaining a deeper understanding of maternal risks within a biopsychosocial framework allows for accountability among helping professionals and opportunities to provide improved quality of care to women during the pregnancy lifecycle [1].

Author Contributions

Conceptualization, A.J.B., C.R.A., and K.S.; methodology, C.R.A. and A.J.B.; formal analysis, A.J.B., K.S., C.R.A..; writing-original draft preparation, A.J.B., C.R.A., and K.S; writing-review and editing, A.J.B., C.R.A., and K.S. G.P., A.L.A.-B, and C.H. All authors have read and agreed to the published version of the manuscript.

Funding

This research was funded by the University of Nebraska System Collaboration Initiative, under grant number NU 27034.

Institutional Review Board Statement

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Review Board of the University of Nebraska (protocol code 0674-20-EX, 02/22/2021).

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Conflicts of Interest

The authors declare no conflict of interest.

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Appendix A. Interview Protocol

I-Guide

Hello, my name is [name] and I am a Counselor Educator in the Counseling Department at the University of Nebraska Omaha. I really appreciate you talking to me about your experiences during your pregnancy lifecycle (pre-gestation, gestation, post-gestation). This interview is being conducted as part of a research study and will take 45-60 min. If at any time you are uncomfortable or wish to stop, please let me know, and I will terminate the interview immediately. I want to remind you that I am recording the interview for transcription purposes, but your identity will remain confidential. This means that I will remove all identifying information such as names, places, or overly specific details that may be traced back to a specific participant. Please feel to be as candid as you would like, you will have an opportunity to check the transcript after it has been de-identified.

During the interview I will refer to the term "pregnancy life cycle" this means 6 months prior to gestation, the roughly 10 months of gestation, and 6 months post-gestation. This interview is broken into 5 sections, and each section has two questions. It is okay if you feel like you are getting off topic or moving on to a different section, the whole point is to learn about your experience. If any of the questions are confusing, please feel free to ask for clarification and I will rephrase it. Are you ready to begin?

Section 1: General

1. Tell me about your experience with your pregnancy lifecycle
2. Tell me about your experience with the healthcare system during your pregnancy lifecycle

Section 2: Biological

3. Tell me about your physical health during your pregnancy lifecycle
4. Tell me about your nutritional health during your pregnancy lifecycle

Section 3: Psychological

5. Tell me about mental health during your pregnancy lifecycle
6. Tell me about any Post-Partum concerns you have for your pregnancy lifecycle

Section 4: Social

7. Tell me about your social wellness during your pregnancy lifecycle, this could include things like your friendships and romantic relationships.
8. Tell me about any social issues that have influenced your healthcare experience during your pregnancy lifecycle. This could include things like discrimination or inequity.

Ending questions

9. What would you like your pseudonym to be?
10. Is there anything you'd like to share with me about your pregnancy life cycle/healthcare experience that I did not ask about during this interview?

Thank you so much for your time. What will happen next is your interview will be transcribed and all identifying information will be taken out of it. When all of our interviews have been transcribed, we will send them to the participant so that you can amend any aspects that you don't feel like properly represent your experience. Then we will analyze the data. Once that is complete every participant will receive a copy of the finished manuscript. Do you have any questions before we end?