Living Through Sickness In Pregnancy

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ABSTRACT

This thesis presents a study of the lived experiences of ten women who encountered symptoms of nausea, vomiting and / or retching during their pregnancies. These distressing and debilitating symptoms affect the quality of life of 50-75% of all pregnant women (Rhodes 1990). The thesis provides both a description and a beginning interpretation of the phenomenon of sickness in pregnancy. The four main lifeworld existentials of corporeality (the lived body), relationality (the lived other), spatiality (lived space) and temporality (lived time), as described by van Manen (1990), are used as a guide to reflect on the women's experiences.

Disruptive symptoms such as nausea and vomiting seriously affect a woman's experience of the functioning of her body - in particular, it can no longer be taken for granted. The women coped by maintaining control over those aspects of the experience that they could. All women felt that they had been changed by the experience. New meanings had been incorporated in their 'being in the world' not just for the present but for the future.

An inability on the part of health professionals to understand the significance of sickness in pregnancy and to comprehend the concerns of these women can result in ineffective care and support. The study offers recommendations for more effective professional care for these women.

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Part One

Background To The Study

Chapter One

INTRODUCTION AND OVERVIEW

Introduction

This thesis presents a study of the lived experiences of ten women who encountered symptoms of nausea, vomiting and/or retching during their pregnancies. It provides both a description and a beginning interpretation of the phenomenon of sickness in pregnancy. Although not regarded as life threatening, except in extreme forms, sickness in pregnancy remains a cause of much discomfort and concern both to the women experiencing the symptoms of this phenomenon and to their families.

The phenomenon of sickness in pregnancy is commonly referred to as 'morning sickness', however as detailed in chapter two, pregnant women experience symptoms of nausea, vomiting and retching over a wider time frame than that suggested by its common nomenclature. In this study, therefore, the term sickness in pregnancy is used to describe the overall phenomenon.

As a nurse I have come to realise that we (health professionals) can never fully understand how another individual is affected by their experience of symptoms and, from the recipient's perspective, the care we provide is often ineffectual. The examination of the lifeworld of the women who participated in this study provides rich descriptive data to broaden nurses' and other health professionals' knowledge of this lived experience and thereby provides guidance for the provision of more effective care.

Background to the study

Through my studies I have been introduced to the phenomenological work of Benner and Wrubel (1989), who stress the importance of nurses developing an understanding of lived experiences in order that they can care more effectively; and also the work of van Manen (1990), in turning to the nature of lived experience and researching experience as it is lived. The work of these authors have helped shape this study. Phenomenology provides a scientific method of exploration which is compatible with the humanistic concept that has been incorporated into the practice of nursing and midwifery. It enables the researcher to "uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalised" (Benner 1989, p. 6). As well as being a research method Kestenbaum (1982) indicates that phenomenology is a style of thought that;

> [A]dvances not only our knowledge of human nature but also our understanding of the awareness that a health professional needs if his or her practice is to convey more than simply an adequate technical comprehension of bodies and persons. To grasp the meaning of illness for humanity, the patient, and the humanity of the patient is more than simply to "identify" with the patient or to feel compassion. It is to appropriate at least one of the conditions necessary for professional judgement inspired by human wisdom (p. viii).

Human wisdom is more than problem solving and rational calculations, it includes what it is to be human, and what is significant to anyone at any particular time. Lived experience is according to van Manen (1990) the beginning point and end point of phenomenological research. He sees that the aim of phenomenology is

> [T]o transform lived experience into a textual expression of its essence - in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience (p. 36).

When studying the lived experience of others no researcher can ignore their own experience of the phenomenon under study. Van Manen (1990, p. 57) states "To be aware of the structure of one's own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all the other stages of phenomenological research". The research study presented in this thesis follows van Manen's approach and recognises that the researcher's own experiences of the phenomenon under study "are the possible experiences of others and that the experiences of others are the possible experiences of oneself." (van Manen ,1990, p. 58).

I experienced symptoms of nausea and vomiting during each of my own four pregnancies (my children range in age from four to thirteen years). Each of these pregnancies differed in the amount and length of time the sickness was experienced, as well the significance it had in relation to my life at the time. Although I had come into contact with women experiencing sickness in pregnancy during my nursing, it was not until my own experience of this phenomenon that I understood what it was like. My own experiences have given me valuable insights into the experiential accounts provided by the participants of this research study and have helped in the identification of the common themes and structures of the participants' experiences.

As an earlier part of my post graduate studies I undertook a preliminary fieldwork study on nausea and vomiting associated with pregnancy which involved single interviews with six pregnant women. This increased my knowledge relating to the impact of this phenomenon for other women. Although each woman's experience was uniquely her own there were many commonalities in their stories which demonstrated the distressing nature of the phenomenon for these women and their families. This present study sought to

confirm and to build on those preliminary findings exploring in more detail what it means to experience sickness in pregnancy. The respondents in this research do not include any of the women who were interviewed in the preliminary fieldwork exercise.

Significance of the study

Rhodes (1990) indicates that nausea, vomiting and retching are distressing and debilitating symptoms which affect the quality of life of 50-75% of all pregnant women. DiIorio and van Lier (1989) note that while it is well accepted that the symptoms of nausea and vomiting are commonly experienced by women in the first trimester of pregnancy, few studies have actually explored this phenomenon. The lack of nursing and midwifery research in this area is also raised by Cotanch (1989), Jenkins and Shelton (1989), Rhodes (1990) and Birks (1993).

It is through the body an individual assesses and experiences the world. One is normally not aware of one's body, however, in the presence of disruptive symptoms like nausea, vomiting and retching an individual becomes acutely aware of the functioning of the body. Madjar (1991, p.114) in a phenomenological study examining pain as an embodied experience discusses the change from a situation where one's body is taken for granted to "becoming aware of a body which is the source of unpleasant and worrying sensations, which does not behave in predictable ways". She stresses that the communication of such experiences can deepen our understanding of human life and our ability to cope with various situations, and advocates that phenomenological research has a major contribution to make to nursing with "descriptions, exemplars and paradigm cases that depict the reality of human

experience and nursing practice in a way that statistical manipulation of values assigned to operationally defined variables cannot do" (p. 66).

The need for nurses to develop an understanding of lived experiences in order that they can care more effectively is also stressed by Benner and Wrubel (1989) who state:

> Because personal concerns determine what is at stake for the person in any situation, the challenge for the health care provider is to interpret those concerns that influence the person's understanding of his or her own illness (p.88).

Toombs (1987), in examining her own relationship as a patient with her physician, reported that rather than there being a 'shared reality' of illness there were in fact two distinct realities. Her perspective on experiencing being ill was significantly and qualitatively different in meaning to that of her physician. This is equally relevant to nurse-patient relationships.

Benner and Wrubel (1989) discuss the difference nurses can make by being able to presence themselves in order to help others. "This ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the base of much of nursing"(p. 13). Presencing acknowledges a person's experience and involves making oneself available and accessible to another person in a way that they feel understood and supported. This requires an open mind and the use of one's knowledge surrounding various lived experiences.

Purpose of the study

The overall purpose of this study was

> To examine the lived experience of sickness in pregnancy and, its significance in the lives of women who are affected.

Overview of the thesis

This thesis is presented in two parts. Part One (Chapters One to Four) introduces and presents material pertaining to the background of the study, the research methodology and the procedure used in this study. Part Two (Chapters Five to Nine) presents the findings of the research study and discusses the implications of the study for health care professionals.

Chapter One has provided an introduction to the study topic and the background to this study. The lack of research into the lived experience of sickness in pregnancy is acknowledged. The significance for nurses and other health care professionals of developing an understanding of lived experiences has been outlined.

Chapter Two presents an overview of the literature pertaining to the symptoms of nausea, vomiting and retching associated with pregnancy. There is little New Zealand literature on this topic, and the published research from overseas is not prolific. The lack of a conclusive aetiology for sickness in pregnancy and the predominance of quantitative studies focused on symptomatology is demonstrated. The limited literature focusing on the lived experience of sickness in pregnancy is identified.

In **Chapter Three** the selection of a phenomenological method for this study is justified. Emphasis is given to hermeneutical phenomenology and the work of van Manen (1990) in researching lived experience as this is the approach that has been utilised in this research study.

The study design and methodology are outlined in **Chapter Four.** Ethical considerations of this study are discussed including the measures taken to protect the anonymity of the research participants.

Chapters Five, Six and Seven use the existential lifeworld themes of corporeality (lived body), relationality (lived other), temporality (lived time) and spatiality (lived space) to describe and reflect on the study participants' experiences of living through sickness in pregnancy. **Chapter Five** examines how the body is affected by the presence of the disruptive symptoms of nausea, vomiting, retching and fatigue. The impact of the women's lived experiences on their relationships with others is examined in **Chapter Six.** In **Chapter Seven** the impact of the phenomenon of sickness in pregnancy on the women's lived time and lived space is examined.

Chapter Eight integrates the study findings in a discussion of how the study participants have coped with the phenomenon. It tells of their 'being in the world'.

Chapter Nine discusses the study's limitations and presents a summary of the thesis findings. The implications of this study for health care professionals are addressed.

Chapter Two

LITERATURE REVIEW

Introduction

This chapter will provide a review of the literature relating to the phenomenon of sickness in pregnancy. While little has been published in New Zealand there is an increasing number of studies on this topic being carried out internationally; however, the literature to date has focused predominantly on the symptoms of nausea and vomiting. Key nursing and medical literature will be reviewed to discuss these symptoms, including the terminology currently used, a brief outline of the history surrounding sickness in pregnancy, and a consideration of the epidemiology, aetiology and management of this phenomenon. The limited literature relating to the lived experience of sickness in pregnancy is reviewed and its relevance for effective care is outlined.

Symptoms of nausea, vomiting and retching

Symptoms of nausea, vomiting and retching associated with pregnancy have been considered as either a discomfort, or a disease depending on whether or not specific interventions are required. The first category, discomfort, includes mild to moderate symptoms and is referred to as 'morning sickness' or more recently has been termed 'pregnancy sickness'. The second category, disease, includes more severe symptoms that mandate medical intervention and is referred to as 'hyperemesis gravidarium'. The need for hospitalisation is also a criterion frequently used for diagnosing hyperemesis gravidarium (O'Brien 1990, Gadsby 1994). Symptoms that are not serious enough to meet the diagnostic

criteria for hyperemesis gravidarium can still severely disrupt a pregnant woman's life (DiIorio 1988). An examination of hyperemesis gravidarium is beyond the scope of this study. This study is concerned with women's experiences of the ordinary symptoms of nausea, vomiting and retching that have classically been known as 'morning sickness'.

Throughout nursing and medical literature the terms nausea, vomiting and retching, although they are separate concepts, are often used interchangeably (Rhodes 1990, Jablonski 1993). Rhodes (1990, p. 887) indicates that "this practice leads to confusion and inadequate understanding for practice, research and education." Clarity of the meaning of symptoms is stated to be essential for accurate assessment so nurses can plan patient care (Rhodes 1990, Hogan 1990).

Nausea is defined as the subjective unpleasant feeling of the need to vomit without actually making any expulsive effort to do so (Jablonski 1993). It is recognised as being largely an unobservable symptom which consists of an unpleasant sensation experienced in the back of the throat and in the abdomen that may, or may not, culminate in the autonomic nervous system response of vomiting. Nausea is often described as feeling 'sick', having 'the birdies', 'the collywobbles', 'the weewaws', 'the heaves', and 'feeling squeamish' (Norris 1982, Rhodes 1990). Signs of nausea include vasomotor changes with feelings of hot or cold, increased perspiration, and pallor. The pulse usually increases then decreases. Increased salivation is frequently present accompanied by increased swallowing. Nausea associated with pregnancy often persists for hours.

Nausea usually precedes vomiting and if one vomits the nausea may pass. However, when associated with pregnancy the nausea frequently persists after vomiting (Norris 1982). While nausea may not be a very visible symptom it can be very disconcerting and may be life threatening if ignored. Jablonski (1993, p. 65) stresses it "is a symptom of and by itself".

Retrospective studies including those by Brands (1967), Fairweather (1968), Jarnfelt-Samsioe, Samsioe and Velinder (1983) and Klebanoff, Koslowe, Kaslow and Rhodes (1985) confirm 50 - 80% of all pregnant woman suffer from nausea or vomiting during pregnancy. A more recent prospective study involving 363 pregnant women carried out by Gadsby, Barnie-Adshead and Jagger (1993) found 80% were affected by nausea. Their study indicated that 28% of women experienced nausea alone and 52% experienced nausea and vomiting. No one in their study experienced vomiting on its own.

Vomiting can be defined as "the forceful expulsion of the contents of the stomach, duodenum, or jejeunum through the oral cavity" (Rhodes 1990, p. 888). The act of vomiting is reflexive and involves the coordinated activity of both voluntary and involuntary muscles. The intrinsic neurophysiological mechanisms of vomiting are well documented (LeWitt 1986, Rhodes 1990, and Jablonski 1993). Rhodes (1990) warns that the pathogenesis of nausea, vomiting and retching associated with pregnancy may differ from the current understanding of the physiological mechanisms of these symptoms which has arisen from research into the drug induced nausea and vomiting associated with chemotherapy. Language used to describe vomiting includes to 'puke', 'upchuck', 'spew' or phrases such as 'throwing up' or 'feeding the fishes' (Norris 1982, Rhodes 1990).

Retching is defined as a failed attempt to vomit - the body undergoes the same physiological actions as vomiting but without expelling any gastric contents. It may be referred to as having the 'dry heaves', to 'gag' or to 'keck' (Rhodes 1990). Retching is often felt to be the worst of these three symptoms as many people report relief once their stomach contents are emptied after they vomit.

Various studies indicate that the experience of sickness in pregnancy is not limited to the morning as one would suppose from the commonly used terminology of 'morning sickness' (Jarnfelt-Samsioe et al 1983, Vellacott et al 1988, Jenkins & Shelton 1989, and DiIorio & van Lier 1989). Jarnfelt-Samsioe et al (1983) found that 50% of women experience peak symptoms of nausea in the morning and 36% felt sick throughout the day. Other studies have given similar results (Vellacott et al 1988, Jenkins & Shelton 1989). DiIorio and van Lier (1989) reported that the peak period (period of greatest intensity of nausea and vomiting) was identified by some women in the morning, others in the afternoon or evening and in some cases symptoms persisted throughout the day. Birks (1993) reported that 7% of the 248 New Zealand women sufferers in her survey had vomiting only in the morning, 10% vomited only in the afternoon but 78% vomited throughout the day.

Gadsby et al (1993) suggest a more appropriate description would be "episodic day-time pregnancy sickness" (p. 248). In some of the more recent literature the term 'pregnancy sickness' is being used rather than 'morning sickness' (Billett 1992, Anderson 1994, and Gadsby 1994). Many studies carried out in America such as those by DiIorio and van Lier (1989), Jenkins and Shelton (1989) and O'Brien (1992) use the term nausea and vomiting of pregnancy, which is abbreviated to NVP. Deuchar (1995, p. 6) indicates that the American nomenclature of NVP "is bland but holds several advantages: it is unbiased

towards any putative cause, it allows for a spectrum of severity, and it differentiates between the subjective symptom of nausea and the objective sign of vomiting". As previously stated, this study uses the terminology sickness in pregnancy when discussing this phenomenon.

History of sickness in pregnancy

Symptoms of nausea and vomiting have been associated with early pregnancy throughout the history of the civilised world. In Egypt a description of these symptoms was recorded on a papyrus dated 2000 B.C. and in the fourth century B.C. Hippocrates referred to nausea and vomiting induced by pregnancy as 'maux de coeur' or illness of the heart (Fairweather 1968).

Aristotle (384-322 B.C.) noted that most pregnant woman experienced a syndrome that included nausea, headaches, feelings of 'heaviness' in all parts of the body, sensations of darkness before the eyes, superfluous swellings, rapid mood changes and longings. He recorded that the symptoms were present as early as the tenth day and he associated the symptoms with the suppression of menses due to pregnancy. Aristotle observed that many experienced relief when menstruation did not occur and blood was channelled towards the breasts where it became milk (O'Brien 1990).

Soranus of Ephesus (98-138 A.D.), a Greek physician specialising in women's and children's illness, included nausea and vomiting of pregnancy in his definition of a condition called 'pica' which occurred in most pregnant women. This began around the fortieth day and lasted four months but could last the entire pregnancy. He viewed this as normal but not healthful, noting that "many inconveniences beset the pregnant woman who is heavily burdened and suffers

from pica" (Temkin 1956, p. 41). Temkin also details Soranus's description of women experiencing pica as follows;

> [T]hose with this condition are affected with the following: a stomach which is upset, indeed full of fluid, nausea and want of appetite sometimes for all, sometimes for certain foods; appetite for things not customary like earth, charcoal, tendrils of the vine, unripe and acid fruit; excessive flow of saliva, malaise, acid erucation, slowness of digestion, and a rapid decomposition of food. Some women are affected with vomiting at intervals or at each meal, with a feeling of heaviness, dizziness, headache, discomfort together with an abundance of raw pallor, the appearance of undernourishment, constipation; some also have gastric distension, or pain in the thorax" (p. 41).

Soranus' definition is still considered accurate and much of his suggested management (which included a day's fast in order to rest the stomach) is still regarded as appropriate (O'Brien 1990). Comprehensive reviews of the history of nausea and vomiting associated with pregnancy and the debates that have occurred in relation to this throughout history are detailed by Fairweather (1968) and O'Brien and Newton (1991).

During the early part of the 20th century researchers focused on seeking a cause and a cure for those most severely affected, those with hyperemesis gravidarium. Vellacott et al (1988) indicate that this is probably because these women are more easily identifiable and are also the group most accessible to hospital researchers. They warn that "extrapolation of the results from these patients to those with ordinary 'morning sickness' [is] highly questionable" (p. 58). Only in the last ten years has the more typical form of sickness in pregnancy become an area of interest.

Dilorio and van Lier (1989) suggest that the historical lack of interest may be traced to the fact that women and health care professionals have "viewed these symptoms as mild and so short lived as not to be of any great importance for

study" (p.259). Cotanch (1989) indicates that until recently the sensation of nausea was frequently dismissed because it is self limiting in that it passes with time; is never life-threatening in itself; is considered psychogenic to some degree; and, being subjective, is very difficult to measure.

This attitude has now been eroded by a changing society and women's changing expectations in relation to health care (Dilorio & van Lier, 1989). More pregnant women now work outside the home and demands for work and home duties leave little time for illness. These women seek some means to reduce their distress and discomfort and to cope with the changes in their lives at this time. Jarnfelt-Samsioe et al (1983) calculated that 12% of women suffering nausea and vomiting found ordinary work during pregnancy impossible. In the study by Vellacott et al (1988) 243 out of 500 women were employed. Of these 75% complained of symptoms and 47% felt their job efficiency was reduced with one in four requiring time off work. Gadsby et al (1993) found a strong positive association between the time lost to both paid employment and housework and the severity of pregnancy sickness symptoms in that the more severe the symptoms, the greater the time lost.

Epidemiology of sickness in pregnancy

Although it is commonly accepted that a large proportion of pregnant women experience sickness in pregnancy (70-80%) no one has identified why certain women experience it or why some multiparious women experience it in some pregnancies and not in others.

One of the largest studies looking at the epidemiology was reported by Klebanoff et al (1985). This was a prospective study carried out between 1959 and 1966 by the National Institute of Health (USA). A sample of 9098 healthy

pregnant women with no predisposing factors was investigated. Vomiting was found to be more common among primigravidas, teenagers, women of less than 12 years education, non-smokers and women weighing 77.1 kg or more. Several factors that had previously been considered important such as a twin pregnancy, being 'black', smoking, known intolerance to oral contraceptives, degree of weight gain and unplanned or planned pregnancy were found to be of no significance.

Gadsby et al (1993) could not determine why some women experience nausea and vomiting while others did not. In their study, for 72% of the women symptoms started between 29-49 days from the last menstrual period and for 80% of the women all symptoms ceased by the 99th day. Their results showed that a third of women will have different symptoms in successive pregnancies. A surprising finding in their study was a sudden cessation of symptoms in 39% of women. This cessation of symptoms occurred at approximately the same day from the last menstrual period whether symptoms began early or late or if the symptoms were severe or mild (Day 84 was the mean).

O'Brien and Zhou (1995), in a study of 126 women, noted that "independent variables contributed little to predicting or explaining the presence and severity of nausea and vomiting during pregnancy" (p. 99). Their study supported some of the associations found in other studies including that older women experience less severe symptoms than younger women, primagravidas experience more vomiting than multiparious women, and smokers experience less nausea than non-smokers.

Aetiology of sickness in pregnancy

The aetiology remains unclear despite many theories being proposed over the last several hundred years. One early theory suggested that vomiting resulted from pressure of engorged blood vessels on the diaphragm. Other early suggestions included displacement, distension or inflammation of the uterus, cervical erosions, constipation and neurosis (Fairweather 1968).

Further studies need to be conducted to provide a clearer picture of the aetiology. At present there are several competing hypotheses which can be separated into those implicating 1. physiological, 2. psychological, and 3. genetic and cultural factors.

1. Physiological factors

a) Vitamin B deficiency: A study by Schuster, Baily, Dimperio and Mahan (1985) did not support the theory of vitamin B deficiency in women who experience nausea and vomiting in pregnancy, however during the 1940 s several uncontrolled studies suggested efficacy from the use of vitamin B and vitamin B6 (Willis, Winn, Morris, Newsom and Massey 1942, Weinstein, Mitchell and Sustendal 1943, and Dorsey 1949). These studies were challenged when the American Medical Association (1979) stated that there was no solid evidence that Vitamin B6 was effective. A randomised, double-blind placebo-controlled study by Sahakian, Rouse, Sipes, Rose and Niebyl (1991) found that the use of oral vitamin B6 at a dosage of 25 mg every eight hours had an effect on reducing nausea for some women but did significantly reduce vomiting for all women.

b) Gastric function: DiIorio (1988) indicates that pregnancy significantly affects the functioning of the stomach and intestinal tract resulting in gastric

hypofunction. Experimental research by Riezzo, Pezzolla, Darconza and Giorgio (1992) in this area has shown various alterations in gastric motility in pregnant women, such as the reduction of lower oesophageal sphincter pressure, with an increased prevalence of gastroesophageal reflux and delayed gastrointestinal transit. Their study indicated that "there is a persistent chronic alteration in gastric electrical activity correlated to early pregnancy" (p. 706), but little difference between those who experience nausea and vomiting and those that do not. These researchers advocate further studies in this area.

c) Biochemical: Voda and Randall (1982) suggested that nausea and vomiting in pregnancy may be associated with changes in the biochemical milieu of the body. According to their model during the first trimester of pregnancy total body water increases, expanding plasma volume, lowering sodium concentrations and decreasing serum osmolality from a normal level of 290mOsm/kg to 280mOsm/kg. Since it takes several weeks for the osmoreceptors to reset to the lower value women may experience symptoms associated with hyponatremia which include nausea, vomiting and fatigue.

d) Endocrine: The most popular theories proposed are those that involve an endocrine aetiology. Nausea and vomiting were commonly thought to occur in the first trimester of pregnancy due to elevated progesterone levels and elevated levels of human chorionic gonadotrophin (hCG). hCG rises rapidly in the first trimester and peaks at 12 weeks. However controlled studies testing this relationship have also yielded conflicting findings. Soules, Hughes, Garcia, Livengood, Prystowsky and Alexander (1980) could not find any evidence of a relationship between the levels of these hormones and the incidence or severity of nausea and / or vomiting in women. A study by Mori, Amino, Tamaki, Miyai and Tanizawa (1988) indicated that there is a relationship and in addition they

found a high correlation between hCG and free thyroxine in early pregnancy. It has been hypothesized that elevations in hCG may promote nausea and vomiting by stimulating secretion of thyroid hormone, however de Swiet (1989) regards this to be unproven and controversial.

e) Allergenic: Fairweather (1968) noted that Hoffbauer in 1926 contended that some women had nausea and vomiting due to 'histamine poisoning' but this has not been substantiated. Jarnfelt-Samsioe et al (1983) found that women with gastritis, gall bladder and allergy problems tend to have more frequent and intense nausea and vomiting in pregnancy.

The only proven physiological factors that have been identified are associated with hCG levels and those that affect the gastrointestinal tract. Medical research continues to be carried out in these areas.

2. Psychological factors

DiIorio (1985) indicates that hypotheses relating to psychological factors include Higgin's assertion in 1887 that nausea and vomiting was a response to the pregnant woman's aversion to sexual intercourse, and Deutsch arguing in 1945 that vomiting and craving for food during pregnancy are expressions of conflicting wishes - vomiting is an unconscious wish to expel the child whereas craving food is an unconscious wish to keep and nourish the baby. An experimental study carried out by Uddenberg, Nilsson and Almbren (1971) found that women without nausea and vomiting were generally more prone to psychological difficulties during pregnancy and had more difficulties with adjustment in the postpartum period. Wolkind and Zajicek (1978) carried out a follow up study but this did not support Uddenberg et al's findings. However they did find that the women who experienced nausea and vomiting reported

feeling closer to their own mothers and closer to their husbands after the pregnancy began. Psychological factors such as unwanted pregnancy, unresolved conflict, and identification with the female role have also been implicated as possible causes for the symptoms of nausea and vomiting (DiIorio 1985), however research is inconclusive.

3. Genetic and cultural factors

Studies by Walker, Walker, Jones, Verardi and Walker (1985) and DiIorio (1985) indicate that the incidence of nausea and vomiting is lower in groups of 'black' people compared to their 'white' counterparts. Such studies suggest that there may be a genetic aetiology.

Miniturn and Weiher (1984) in a cross cultural study involving thirty-one societies found that those societies whose women did not experience nausea and vomiting in pregnancy included more green vegetables, higher levels of fat intake and a substantial amount of maize in their diets. Such results may indicate dietary considerations for nausea and vomiting of pregnancy rather than a cultural aetiology.

Although several studies have been carried out over the last two decades to determine the aetiological factors it is consistently reported that many of the results have been inconclusive and the underlying mechanisms are not understood (de Swiet 1989, Rhodes 1990, Anderson 1994). Currently no specific aetiology is confirmed.

Management of sickness in pregnancy

To date, despite the increase in the number of studies being undertaken, there are still insufficient conclusions to lead to any commonly accepted simple, and

effective treatments. Management has revolved around pharmacological or non-pharmacological measures to relieve symptoms.

Pharmacological interventions

Early studies investigating the relief of the symptoms of nausea and vomiting in pregnancy indicated a fairly high use of medication which was prescribed without research on the effectiveness as well as the side effects of the medications (DiIorio 1988). Diggory and Tomkinson (1962) reported 83% of subjects used medication to relieve the symptoms. The main medications which have been used are thalidomide, bendectin, and pyrodoxine.

In 1962 thalidomide, a widely prescribed sedative and anti-nausea medication, was implicated in the birth of infants without limbs and was subsequently withdrawn from the market. Subsequent studies by Biggs (1975) reported 50% utilising medication, and the study by Vellacott et al (1988) showed only 10% using medication. DiIorio and van Lier (1989) reported only one person from their research sample utilising medication to control nausea. The decreasing percentages reporting the use of pharmacological means since 1962 may be largely due to the increasing awareness of the potentially harmful side effects of medication on the foetus.

LeWitt (1986) indicated that until the early 1980 s 10% to 25% of pregnant women in the United States were prescribed bendectin, a combination of the antihistamine doxylamine succinate and pyridoxine, for the relief of nausea and vomiting. It was formulated as a delayed release tablet so that when taken at bedtime the active ingredients would be utilised early in the morning before the onset of morning sickness. Although the occurrence of birth defects after the use of bendectin was rare, it led to a number of litigations in 1983 causing it to

be withdrawn from the market by the manufacturers. There is some debate that the birth defects leading to these lawsuits were in fact coincidental and not directly related to Bendectin (LeWitt 1986, de Swiet 1989, Newman, Fullerton & Anderson 1993).

Pyridoxine has been indicated in the treatment in nausea and vomiting of pregnancy. The antihistamine component of pyridoxine has been shown to have a direct effect on the emetic centre (DiIorio 1988). Although historically controversial, the recent study by Sahakian et al (1991) indicates that pyridoxine (Vitamin B6) is beneficial for those women who experience severe nausea and for all women who experience vomiting.

De Swiet (1989) stresses that the majority of cases can be managed without recourse to drug therapy because of the concern over the safety of anti-emetics. Birks (1993) notes that some women have tried various homeopathic medications, such as Cocculus 30, Kreosote 30 and Verat Alb 30 with varying success. No formal research studies on these preparations were identified.

Non-pharmacological interventions

Professional and lay literature suggests many non-pharmacological remedies for 'morning sickness'. Traditionally these have been limited to psychological support and dietary modification. Suggestions in relation to diet include: fasting, avoidance of specific foods, a bland diet, eating low-fat protein foods and easily digested carbohydrates, eating crackers and toast, and having small frequent meals. A common intervention suggested to women has been to have a cup of tea and a piece of toast prior to rising in the morning. The drinking of herbal teas such as spearmint, raspberry leaf, peppermint, chamomile and ginger root have also been advocated (Newman et al 1993). Only limited research has been

done to assess the effectiveness of such interventions (Voda & Randall 1982, DiIorio 1985, and Birks 1993). The effectiveness of self-care actions in reducing 'morning sickness' was the subject of a retrospective survey of 55 pregnant women undertaken by Jenkins and Shelton (1989). In this study self-care actions fell into three broad categories: manipulating diet, adjusting behaviour and seeking emotional support. The most effective self care actions are listed in ranked order in table 1.

Table 1 Effective Self-Care Actions to Reduce Morning Sickness
(Jenkins & Shelton 1989, p. 270)

RANK	SELF-CARE ACTIONS
1.	Getting more rest
2.	Several small meals rather than three big ones
3.	Avoiding bad smells
4.	Avoiding greasy or fried foods
5.	Avoiding cooking
6.	Receiving extra attention from partner
7.	Avoiding spicy foods
8.	Eating whenever I felt nauseous
9.	Keeping myself busy
10.	Sharing experiences with another mother
11.	Eating bland foods
12.	Eating dry toast or crackers before getting out of bed
13.	Cutting down on drinks with caffeine
14.	Getting more exercise
15.	Cutting down on alcoholic drinks
16.	Eating a midnight snack
17.	Taking a prescribed medication
18.	Having someone tell me that the morning sickness was normal and would go away soon
19.	Eating hard candy
20.	Avoiding certain other foods
21.	Drinking herbal tea
22.	Taking vitamins at bedtime
23	Cutting down on smoking
24.	Avoiding riding in the car
25.	Taking extra B vitamins
26.	Eating more acid foods
27.	Avoiding vitamins with iron
28.	Avoiding liquids with meals
29.	Taking 'over the counter' medication

Over 50 % of the women in the Jenkins and Shelton study reported trial and error as the way they found successful remedies to relieve their symptoms. They reported that other sources of advice for dealing with these symptoms included the woman's mother or an experienced friend (13.5%); doctor (10%); nurse practitioner (8%); nurse (5.5%); and midwife (3%). Although this study was carried out in USA, it is significant that nurses and midwives are so poorly represented, and leads one to question their educative role in relation to a woman's symptom experience. Newman et al (1993) reported that "emotional support and patient education often are the only nursing interventions necessary for the nausea and vomiting of early pregnancy" (p. 484).

The studies by DiIorio and van Lier (1989) and Jenkins and Shelton (1989), indicated that nurses and midwives can assist women to adopt self-care behaviours that enable them to cope more effectively with the distressing symptoms of nausea, vomiting and retching associated with pregnancy.

In her book 'Coping with Morning Sickness' Birks (1993) presents many suggestions based on a combination of anecdotal evidence and research which may help women to manage their symptoms. She stresses the need for emotional as well as physical support.

A newer therapeutic approach being investigated is the use of sensory afferent stimulation (SAS). Evans, Samuels, Marshall and Bertolucci (1993), following on from the use of SAS for the treatment of nausea and vomiting associated with cancer chemotherapy, investigated the use of SAS for the suppression of pregnancy related nausea and vomiting. In a randomised, cross-over study comparing an active SAS device with an inactive placebo device, the results

indicated an 87% improvement in symptoms with the SAS device and a 43% improvement with the placebo device.

More recently alternative health approaches such as acupuncture and acupressure have been suggested as being beneficial (Newman et al 1993). Stainton and Neff (1994) identified an acupressure wristband known as 'SeaBands' [1] to be effective for 50% of the women in their study for the control of nausea and vomiting in pregnancy. 'SeaBands' were found to be more effective if applied early in the symptom experience but less effective if applied late. The authors commented that the 'SeaBands' have a high potential for "enabling and restoring a sense of control and alliance with the body during pregnancy" (p. 574).

The effectiveness of digital accupressure was evaluated by Belluomini, Litt, Lee and Katz (1994) in a study involving 60 women. Women were assigned using a randomised block design to one of two accupressure groups: a control group using an accupressure point (PC-6) [2] and a sham control group using a placebo point. The results indicated that accupressure at PC-6 is effective in reducing symptoms of nausea but not the frequency of vomiting. "Accupressure is convenient to use, does not cause discomfort, avoids the cost of wristbands and can be easily taught to patients" (Belluomini et al 1994, p. 247). Such interventions are looked forward to by both sufferers and health care professionals alike. Finding reliable ways to provide relief from nausea and vomiting in pregnancy will remain a challenge for health professionals into the future. The literature indicates that therapies controlled, at least partly by the

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1 SeaBands are elasticised circular bands with a plastic button incorporated in them which are worn around the wrists. When worn on the wrists the plastic button exerts even pressure on the Neiguan (P6) pressure point on the anterior surface of the forearm proximal to the wrist crease. SeaBands were originally developed to control nausea and vomiting associated with seasickness.

2 PC-6 is the accupressure point specifically designated in traditional Chinese medicine for the treatment of nausea and vomiting.

women are the most effective for managing the nausea and vomiting associated with pregnancy.

Developing an understanding of the lived experience

Although several research studies have considered various aspects of sickness in pregnancy only a few have looked at what the symptoms mean to those women experiencing them. One such study (DiIorio & van Lier 1989) acknowledged the distressing nature of nausea and its multidimensional impact on the women's life styles. It was noteworthy that most women in their first pregnancy indicated that the experience of nausea was worse than they had anticipated but those who had been pregnant before were divided in opinion. A range of lifestyle changes for many women were necessary due to their nausea and / or vomiting. These included "changing eating habits, reducing physical and outside activities, sleeping more, avoiding food or shopping, changing work schedules, and being less productive" (DiIorio & van Lier 1989, p. 265).

The need for nurses to develop an understanding of lived experience in order that they will care more effectively is stressed by Gadow (1985) and Benner and Wrubel (1989). Gadow (1985), in examining the caring relationship between a nurse and a patient, notes how patients are often removed from the centre of their experience. In health care the body is often viewed as a machine which Gadow indicates occurs because

> [R]egard for the body exclusively as a scientific object negates the validity of subjective meanings of the person's experience. Those meanings are categorically nonexistent in the scientific object. Thus clinical decisions are based upon external interpretations, not upon the meanings and coherence of the body as constituted by the patient. (p. 36)

Zanter (1985), in examining what it is to be a patient and what it is to be ill, stresses the need to "reconsider this business of being ill from the patient's actual

perspective, not from that of the health care provider's .../.../... To attain this perspective, there is nothing to do but consult patients themselves" (p. 83) According to Morse and Johnson (1991, p. 341) health professionals are beginning to "listen more attentively and to give credence to the patient's perspective". In examining the clients perspective of 'morning sickness' Alley (1984) stressed that the "nurse must listen when the client describes how the problem is affecting her and what the client thinks helps or hinders the nausea. Only then can the nurse offer counsel and guidance"(p. 188). It is this perspective that is the focus of the phenomenological study reported in this thesis.

The phenomenological approach is concerned to show "not simply that the patient's experience should be taken into account as a subjective accounting of an abstract 'objective' reality, but that the patient's experiencing must be taken into account because such lived experience represents the reality of the patient's illness" (Toombs 1987, p. 236). According to Benner and Wrubel (1989):

> [T]he best nursing practitioners .../.../... seek the patient's story in formal and informal nursing histories, because they know every illness has a story - plans are threatened or thwarted, relationships are disturbed, and symptoms become laden with meaning depending on what else is happening in the person's life. Understanding the meaning of the illness can facilitate treatment and cure. Even when no treatment is available and no cure is possible, understanding the meaning of the illness for the person and for that person's life is a form of healing, in that such understanding can overcome the sense of alienation, loss of self-understanding, and loss of social integration that accompany illness (p. 9).

O'Brien and Naber (1992, p. 138) stipulate that "Since pregnant women's qualitative experiences with nausea and vomiting have not been adequately documented, health caregivers may be unable to advise and support them appropriately". This study examines the stories of the individual women who

agreed to participate and describes their experiences of living through the phenomenon of sickness in pregnancy.

Summary

The literature reviewed in this chapter is predominately of a quantitative nature and is focused on the symptoms rather than the overall experience of sickness in pregnancy. No clear understanding of aetiology currently exists. The lack of a conclusive aetiology continues to affect the management of sickness in pregnancy.

The vast majority of literature reviewed is written from the perspective of the health professional. Little has been researched about what it is like to live with this phenomenon and its effect on women's lives. The importance of developing an understanding of the lived experience in order that nurses can give more effective care was identified.

The following chapter identifies the selection of phenomenology as the most appropriate research methodology to examine lived experience.

Chapter Three

PHENOMENOLOGICAL ENQUIRY

Introduction

This chapter focuses on the nature of phenomenological enquiry and its appropriateness to this study. The chapter begins by examining the three research paradigms utilised in nursing research in order to highlight the value of the interpretive paradigm for examining lived experience. This is followed by a more detailed consideration of phenomenological enquiry, including its historical development and the relationship between phenomenology and nursing. An examination of researching lived experience using hermeneutic phenomenology is given, including outlining the assumptions and methodology associated with this research approach. The chapter concludes by outlining the use of lifeworld existentials as constructs to reflect on lived experience.

Research paradigms utilised in nursing research

The three major paradigms utilised in nursing research are the positivist or empirico-analytical, the interpretive, and the critical theory approaches (Allen, Benner & Diekelmann 1986).

The empirico-analytical paradigm dominates research in the broader scientific community and assumes structure, universality and order. The world is seen as being structured by law-like regularities which can be identified and manipulated. This applies to the study of human behaviour as well as to that of objects. It is seen that there is a body of facts and principles that are universal

and therefore are not bound to any specific context, be it social, political, economic or historical. Research within this paradigm is often guided by hypothesis testing and a structured design that is imposed prior to data collection. By confirming or disproving hypotheses in which objects and events are manipulated as dependent or independent variables regularities are identified that give the researcher the ability to describe events of the world through explanation and prediction. Knowledge generated within this paradigm is seen as being factual, observable, verifiable and generalisable. (Munhall 1981; Allen, Benner & Diekelmann 1986).

The major criticism of this paradigm is that there may be multiple subjective truths experienced by different individuals and that these may not necessarily be fully generalisable. Swanson and Chenitz (1982, p. 241) indicate that such research has limited meaning for nursing practice as "this approach, in which each variable is given a single dimension and isolated to give a direct relationship between phenomena, yields findings that belie what nurses know to be the exceedingly complex and diversified nature of their professional domain". This view is supported by Munhall (1981), Meleis (1985), Barnum Stevens (1990), Bartjes (1991) and Wilkes (1991).

The interpretive paradigm developed due to dissatisfaction with the positivist approach in the study of humanism. It's philosophy has given rise to various qualitative research methodologies which include grounded theory, ethnography and phenomenology (Wilkes 1991). Wilkes states these research approaches are directed "towards providing 'interpretive' accounts of phenomena rather than law-like generalisations" (p. 231). The interpretive paradigm is concerned with studying individuals, their views and everyday experiences within their natural context (Cohen 1987). This approach has gained favour in recent years.

Meaning in the interpretive paradigm is viewed as being somewhere between within the individual and within the situation. Knowledge in this model is socially constructed with language, culture, life experiences, ideology, social, economic and political conditions shaping what is 'truth' and how we come to know the world in which we live. Research data is generated by direct contact with the participant using interviews and / or observation and is presented by description and interpretation of the phenomena or experience being researched rather than relying on explanation and analysis. Presentation of the research data is concerned with the entirety of the experience.

Nursing is now seen as an applied discipline with nursing knowledge directed towards practice, many components of which are not amenable to the reductionistic techniques of empirico-analytic research (Barnum Stevens 1990). The techniques of the interpretive paradigm are appropriate for an examination of the lived experience of sickness in pregnancy, because they reflect the complex nature of the phenomenon through the interweaving of perceptions, values and beliefs that constitute an individual's lived experience.

The critical theory approach goes beyond the interpretive and positivist approaches. "It seeks to identify and criticise disjunctions, incongruities, and contradictions in people's life experiences. It focuses on critical self-reflection coupled with action and change" (Wilkes 1991, p. 232). An assumption of this paradigm is that social life is structured by meanings, rules, conventions and habits to which individuals adhere. The central interest of critical social theory is in emancipating individuals "from conscious or unconscious constraints in the hope of making community life more rational" (Allen, Benner & Diekelmann 1986, p. 33). It is therefore political and is directed at personal and social transformation rather than scientific description (Wilkes 1991).

Wilkes (1991, p. 228) states "If nursing is considered holistic, caring, involving human beings experiencing and interacting, the interpretive approach to research will help nurses to grasp the totality of events, situations, and experiences and fit them together for themselves and others". Although she recognises that nursing can be seen from many perspectives and as such a variety of research methods should be utilised, she believes phenomenology is a 'window to the nursing world'. Wilkes (1991) notes that phenomenology:

> [P]rovides a baseline to provide ways of elevating nurses to new levels of understanding; for setting parameters for future research in the empirical paradigm; and especially in opening doors to the critical theory paradigm where critical self-awareness is coupled with action, and change. In order to instigate change through action the phenomena need to be understood and have meaning to the human involved in the experience (p. 244).

Spiegelberg (1976) believes the phenomenological approach is best suited to examine lived experience, as this approach is an inductive, exploratory method that seeks to provide understandings of the meanings of a given lived experience.

Historical perspective on phenomenological enquiry

Phenomenology is not only a research method, it is a philosophy. It arose in Germany in the 19th century from a perceived need to understand that human science was different from natural science, and therefore required interpretation and understanding rather than external observation and explanation as used in natural science (Wilkes 1991).[1] Immanual Kant (1724-1804) was the first philosopher to describe phenomenology as it is now understood. Historically there have been three phases in the development of contemporary phenomenology: the preparatory phase; the German phase; and the French

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1 Human science concerned mental, social and historical perspectives whereas natural science was concerned with physical, chemical, behavioural, and animal studies.

phase. The discussion which follows relating to these three phases is based on the work of Spiegelberg (1969) and Cohen (1987).

The preparatory phase involved the work of Franz Brentano (1838-1917) and one of his students, Carl Stumpf (1848-1936). Brentano's objective was to reform philosophy so that it could provide answers about humanity that religion could not provide. Brentano provided two ideas essential to later phenomenology: inner perception (the ability to be aware of one's own psychic phenomena); and intentionality (the inseparable connectedness of the human being to the world). Strumpf's contribution was to develop the scientific rigour of phenomenology.

The German phase was dominated by Edmund Husserl (1859-1938), a former student of Brentano's, and Husserl's assistant Martin Heidegger (1889-1976). Husserl related phenomenology to the question of knowing. He favoured pure subjective consciousness as the condition for all experience and he placed emphasis on 'essences', which are also identified as the 'beginnings' or 'roots' of all knowledge. Husserl saw phenomenology as a discipline that endeavoured to describe how the world is constituted and experienced through conscious acts. Two other important concepts introduced by Husserl were those of 'intersubjectivity' and the 'lifeworld' (Lebenswelt) or the everyday world in which we live. Central to this is the view that one takes for granted so much of what is commonplace that one often fails to notice it. Heidegger was primarily concerned with 'Being' and 'Time' (Zein und Zeit). The phenomenological view of the person has its basis in Heidegger's work. He notes that a person does not come into the world predefined but becomes a self-interpreting being that defines things for him/her selves in the course of living. A person is seen as "a creative, generating being, who lives embedded in a context of meaning, a

being whose actions and understandings form a comprehensive whole" (Benner and Wrubel 1989, p. 35). Heidegger believes that a person grasps a situation directly in terms of its meaning for the self.

Existential phenomenology had a great influence on the French phase of phenomenology. Three prominent philosophers of this phase were: Maurice Merleau-Ponty (1908-1961), Gabriel Marcel (1889-1973) and Jean-Paul Sartre (1905-1980). Merleau-Ponty developed the case for the importance of considering an individual's experience. He is the most important figure from this group in the development of the phenomenological research as used in this study. Merleau-Ponty (1962, p. vii) speaks of phenomenology as "The study of essences" and "all problems amount to finding definitions of essences; the essence of perception, or the essence of consciousness for example". By this he meant that phenomenology does not merely report the event but seeks to define its essential nature or meaning. It asks the question: What characterises this phenomenon? Consciousness links the subjective experience of the person to the physical experience through bodily contact with the world around them. Merleau-Ponty called for a return to embodied experience, that is the pre-reflective world in which people already live before they develop knowledge about it. Our bodies are in contact with the world around us and it is through sensation, language and speech that we create and store knowledge about the world. Marcel was concerned with phenomenology in the analysis of 'Being'. Sartre developed a philosophy to reconcile the object and subject which has become central to existential phenomenology. He believed that "a person's concrete behaviour (existence) preceded a person's character (essence)" (Cohen 1987, p. 33). Sartre reinforced Husserl's intentionality as the central feature of consciousness.

Van Manen's approach[2] to phenomenological research utilises many of these traditional phenomenological understandings. For him phenomenological research is:

1. The study of lived experience (Husserl, Schutz and Luckman, and Dilthy);
2. The explication of phenomena as they present themselves to consciousness (Sartre);
3. The study of essences and essential relationships (Husserl and Merleau-Ponty);
4. The description of the experiential meanings we live as we live them (van Manen);
5. The human scientific study of phenomena (van Manen);
6. The attentive practice of thoughtfulness, a 'caring attunement' (Heidegger).

Phenomenology and nursing

The use of the phenomenological method in nursing research is advocated by many authors including Parse, Coyne and Smith (1985), Munhall and Oiler (1986), Anderson (1989), Benner and Wrubel (1989) and Wilkes (1991). These authors all point out that the traditional scientific method is inadequate as it fails to address lived experience. They acknowledge that phenomenology provides a scientific method of discovery which is compatible with the humanistic concept, central to the practice of nursing.

Dreyfus (1994, p. x-xi) acknowledges that nursing draws on a mixture of natural and medical sciences, but he also believes

> [T]hat in addition to the human sciences nurses need a way to criticise the Cartesian view of the person as a private subject standing up against an objective world. They need to be able to

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2 From conference presentation I attended by Max van Manen at Monash University, Gippsland campus, Victoria, Australia, January 1995: Researching Lived Experience using Phenomenology.

> describe and legitimise the person in relation with others for coherence in their own self understanding as nurses engaged in caring practices. Finally, studying Heideggerian phenomenology seems to enable them to understand human beings in their physical and cultural diversity and not only as private autonomous Cartesian selves.

Many nurse theorists have used phenomenology as a philosophical approach in their descriptions of the nursing world, or in the development of nursing theories (Wilkes 1991). The work of Watson (1979, 1985) in caring has an existential phenomenological perspective influenced by Heidegger. Parse (1981) uses the tenets of the existential phenomenologists (Sartre; Merleau-Ponty; and Heidegger) in building the assumptions of her Man-Living-Health model of nursing. In her investigations of what constitutes an expert nurse Benner (1984) uses Heidegger's approach extensively. Benner and Wrubel (1989) also use Heidegger's approach in their exploration of caring, stress and coping in health and illness.

Wilkes (1991) stresses: "Only through an analysis and synthesis of the experiences of the nurse and the nursed will an understanding of nursing and caring evolve .....//... If nursing is holistic it should be explored and analysed by research methods that look at the lived experience and describe it" (p. 230). Phenomenology is an approach to viewing and researching lived experience within a subject's world.

Phenomenology allows "participants to describe their everyday concerns and practical knowledge, thereby giving access to practical worlds" (Benner 1994, p. 112). Lawler (1991, p. v-vi) notes that "Nursing practice is essentially and fundamentally about people's experiences of embodied existence, particularly at those times when the body fails to function normally". A clearer understanding of the experiences and concerns of women who live with sickness in pregnancy

will improve the professional care that is offered to them. Bartjes (1991, p. 262) stresses that within the realm of nursing

> [P]henomenology offers a different research approach and meanings for use in understanding the healing experience of the individual within the context of his or her lived-experience. Phenomenology communicates the authentic meaning using a language that deepens the understanding of the lived experience of the person and this understanding of life and healing as it is lived is valuable to the development and growth of nursing knowledge.

Bartjes (1991) is confident that knowledge arising from phenomenological studies will strengthen the foundation for nursing practice and the development of nursing as a discipline. This view is supported by Swanson-Kauffman and Schonwald (1988, p. 97) who insist that "knowledge of lived experiences of health and healing are legitimate topics of nursing inquiry". Furthermore, the focus of phenomenology on the lived experience allows for the provision of nursing care in which patient-identified needs are paramount (Jasper 1994).

Researching lived experience using hermeneutic phenomenology

Van Manen's view of hermeneutic phenomenology goes further than Spiegelberg's (1976) view of seeking the meanings of understandings of a given lived experience. For him it is the study of our lived experience in order to "make some aspect of our lived world, of our experience, reflectively understandable and intelligible" (van Manen 1990, p. 126-127).

His methodology involves a systematic reflection on lived experience of any human experience. It is a human science of lived experience and experiential meaning. Hermeneutic phenomenology does not aim at a certain truth (a danger of positivism) nor absolute essences (a danger of essentialism), but a plausible insight into situations in which we find ourselves. This insight is shaped by contexts such as culture, language, time, gender, and history. There is no

ultimate reality to be interpreted only experience and life-expressions. The perception of the individual is the truth for that individual at a particular time, which may change as the experience is lived over time. For the individual at that time it is absolute (van Manen 1995).

Van Manen argues that as a 'critical philosophy of action' hermeneutic phenomenology is oriented toward understanding an aspect of a person's experience that is otherwise taken-for-granted or glossed over. The researcher or practitioner has a thoughtful involvement, a personal, practical engagement, in addressing the uniqueness both of the experience of another and of their own practice. It is thus a 'theory of the unique', since the researcher is interested in the uniqueness of the experience of persons and "what is essentially not replaceable" (van Manen 1990, p. 7). In 'borrowing', making sense of, and understanding other people's experiences, one seeks to better inform one's personal and professional way of acting in the context of the whole of human existence (van Manen 1984). This is very relevant for nurses and other health professionals.

The research attempts to record the essential characteristics of the experience in such a way that it is comprehensible to others and to give it meaning. Van Manen (1990 p. 27) speaks of a 'validating circle of inquiry' in that a good phenomenological description "is collected by lived experience and recollects lived experience - is validated by lived experience and it validates lived experience". Consequently phenomenological research requires active involvement from the researcher, the participants in the study, and from those who read and evaluate the research report. The researcher aims to transform personal lived experience into consensually validated social knowledge.

The ultimate verification of any research using hermeneutic phenomenology lies in its resonance, or sense of congruence with one's lived or imagined experience so that one "can 'see' (know, feel, understand)" its previously silent, deeper significance (van Manen 1990, p. 130). It is something that we can acknowledge, recognising it as an experience that we have had or could have had in a similar situation.

Overseas research studies by Banonis (1989), Santopinto (1989), Beck (1992) and Reid (1994) have used phenomenology to research various lived experiences. One of the earliest phenomenological studies conducted in New Zealand was by Madjar (1991) who researched the experience of clinically inflicted pain in adult patients. Her research examined pain as an embodied experience and her study has provided guidance to the use of phenomenology within this country. Van Manen's hermeneutic phenomenology also guided a study by Bland (1994) in examining the lived experience of chronic leg ulcers.

Assumptions of phenomenological research

The central assumption of phenomenological research is that knowledge of a phenomenon can be gleaned from understanding and making explicit the experience of those who live the experience (Munhall & Oiler 1986). This rests largely on the participants' ability and willingness to adequately communicate their experience to the researcher. It also depends on the interpretation, sensitivity and thoughtfulness of the researcher, as well as the researcher's scholarly tact and writing talent (van Manen 1990).

A second assumption is that people are able to communicate their lived experience in an honest and trustworthy manner. It has to be accepted that the participants, because they have the direct experience of the phenomenon that the

researcher is investigating, are the 'experts' on the topic of inquiry (Swanson-Kauffman & Schonwald 1988, van Manen 1990).

Methodology for hermeneutic phenomenological research

According to van Manen (1990, p. 180) hermeneutic phenomenology:

> [T]ries to be attentive to both terms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena. The implied contradiction may be resolved if one acknowledges that the (phenomenological) 'facts' of lived experience are always already meaningful (hermeneutically) experienced.

There is no definitive set of steps for phenomenological research, which has led to criticism of the method as "often being ill defined and difficult to understand" (Wilkes 1991, p. 236). Wilkes indicates that the lack of distinctive steps causes many novice researchers considerable difficulty. Although the data collection varies, studies by Giorgi (1970) and Colaizzi (1978) have proposed a similar method for data analysis. The text is read to get a 'feel' for the material, themes are identified and joined together to form relationships, and then a description is written.

Van Manen (1990) outlines six interrelated research activities that provide a methodical structure for research into lived experience and these are followed in this study:

1. Orienting or turning to the nature of lived experience;
2. Gathering the data - investigating the experience of the phenomena as it is lived rather than as it is conceptualised;
3. Reflecting on essential themes which provide a deepened understanding;
4. Describing the experience through the interpretive practice of writing;
5. Maintaining a strong involvement with the phenomenon; and

6. A hermeneutic interpretation - balancing the research context by considering parts and the whole.

The lifeworld as the world of lived experience

Lifeworld existentials are used in this study as a guide to examine the lived experience of sickness in pregnancy. The idea of the lifeworld, or Lebenswelt, as the world of lived experience is derived from the work of Husserl. He described the lifeworld as the 'world of immediate experience'. Van Manen (1990, p. 101) states: "Our lived experiences and the structures of meanings (themes) in terms of which these lived experiences can be described and interpreted constitute the immense complexity of the lifeworld". It is noteworthy that there are multiple lifeworlds that belong to different human existences. For example, the lifeworld of a nurse to that of a patient. People may be seen to inhabit different lifeworlds at different times of the day, a nurse has the lifeworld of the hospital as well as the lifeworld of home. The concept of the lifeworld is central to this study. The lifeworld of women experiencing sickness in pregnancy is very different to the lifeworld of pregnant women who do not experience this phenomenon.

The four fundamental lifeworld themes which pervade all human lifeworlds regardless of their social, cultural or historical situation are: the lived body (corporeality); lived other (relationality or communality): lived space (spatiality); and lived time (temporality) (van Manen 1990). These are largely pre-verbal in that we do not ordinarily speak of them or reflect on them.

Lived body (corporeality) refers to the fact that we are always bodily in the world or embodied. It is through our bodies that we experience the world about us and give meaning to that world (van Manen 1990).

Lived other (relationality or communality) refers to the lived relationship we have with others in the interpersonal space we share with them.

Lived space (spatiality) refers to felt space. It explains why the spaces we find ourselves in affect how we feel. For example, our homes are generally a place where we can feel relaxed and 'be ourselves'. In order to understand the nature of a particular phenomenon it is useful to inquire into the nature of the lived space that renders an experience its quality of meaning (van Manen 1990).

Lived time (temporality) is subjective time rather than clock time. This is the time that appears to speed up when we are enjoying ourselves or slows down when we are bored. Lived time has past, present and future dimensions. Van Manen (1990, p. 104) indicates that: "The temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape".

The four lifeworld themes, or existentials, can be differentiated but can never be separated as they are all interrelated. As van Manen (1990) states: "In a research study we can temporarily study the existentials in their differentiated aspects, while realising that one existential always calls forth the other aspects" (p. 105).

Summary

This chapter began by outlining the three paradigms in the philosophy of science which guide all research in order to highlight the value of the interpretive paradigm to nursing research. This was followed with an examination of the contribution phenomenology has for nursing. The development of phenomenological enquiry was addressed to present the philosophical background of hermeneutic phenomenology as it is used in researching lived experience. The methodological structure of van Manen's (1990) hermeneutic

phenomenological research, as used in this study was described and its appropriateness to this study determined. An examination of the four lifeworld existentials (lived body, lived other, lived space, and lived time) has shown these to be useful constructs to reflect on the lived experience. It is concluded that van Manen's hermeneutic phenomenology is an appropriate methodology to apply to this study.

Chapter Four

STUDY DESIGN AND METHODS

Introduction

The previous chapter focused on the nature of phenomenological enquiry and the reasons for using the hermeneutic phenomenological approach of van Manen in this study. This chapter describes the interrelated phenomenological research activities outlined by van Manen (1990, pp. 39-51) of orienting to the phenomenon, formulating the phenomenological question, and explicating assumptions and pre-understanding. This is followed by an explanation of the design, the methods and procedures involved in carrying out this study. Ethical considerations involved in the study are also addressed.

Orienting to the phenomenon

Orienting to the phenomenon involves focusing on the phenomenon of interest and concern to the researcher to clarify their approach to the problem. Chapters one and two report the process of orienting to the phenomenon of sickness in pregnancy as addressed in this study.

Formulating the phenomenological question

According to van Manen (1990, p. 42) "to do phenomenological research is to question something phenomenologically and, also to be addressed by the question of what something is 'really' like". The phenomenological question formulated for this study was:

What is the nature of living with sickness in pregnancy?

By addressing the nature of the lived experience one attempts to discover what the associated embodied meanings and implications are for a particular group of people. The objective for this study was then redefined as:

> *To understand more about the impact of sickness on the everyday life of pregnant women so that the realities of living with this phenomenon would be revealed.*

Explicating assumptions and pre-understandings

Van Manen (1990) warns that a problem of phenomenological enquiry is that a researcher's pre-understandings, assumptions and existing knowledge often predispose them to interpret the nature of the phenomenon before they have "come to grips with the significance of the phenomenological question" (p. 46). Many phenomenological approaches require the researcher to 'bracket', or set aside assumptions and expectations about the phenomenon being investigated (Swanson-Kauffman & Schonwald 1988). Van Manen (1990, p. 47) considers that it is more appropriate to "make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories" in order to expose them and to avoid unwarranted implications or conclusions in the study.

My own experience of nausea and vomiting during pregnancy, nursing experience, and familiarity with the relevant literature contributed to the following assumptions and expectations prior to the beginning of this study:

1. Experiencing sickness in pregnancy can be very distressing, disturbing the lives of those who experience this phenomenon.
2. Women will share their experience with the researcher in differing degrees. Some women may not wish to fully communicate their experience of this phenomenon.

3. As a mother of four children who had experienced nausea and vomiting with each pregnancy I may be seen by the participants to be someone who was likely to empathise with their experience. This may affirm their willingness to share their experiences with me.
4. The experience of this phenomenon will differ with individuals, and with different pregnancies, but will exhibit some basic commonalities or 'essences'.

Study design

Investigating a phenomenon involves accessing the sources of 'lived-experience' descriptions in order to answer the question 'What is this experience like?' The participants in the context of a research study transform their private experience into actions and language and make these available to the researcher. A 'purposeful sample', where "the researcher selects a participant according to the needs of the study" (Morse 1991, p. 129) was required for this study. The design was to include women who had direct experience of the phenomenon under study.

Because one can never enter or sense directly another's experience we rely on the information provided by the participants. This relies on the participants' ability to communicate the experience and the researcher's ability to assist the participants to reflect on their experience. To clarify the information provided by the participants it was important that the researcher continually reflected meanings and confirmed understandings of descriptions and explanations given throughout the study. The women were invited to share their lived experience of this phenomenon with me in conversational interviews and together we were to explore what this experience meant to them. Van Manen (1990, p. 66) refers to this as a "conversational" relationship. I then examined the transcripts of these

interviews, using hermeneutic phenomenological reflection, to answer the research question. The following chapters of this thesis are the result of this process.

Identifying participants for the study

A local General Practitioner assisted me to contact participants for the study. The study was explained to the doctor in person and he was given a copy of the research proposal. Questions relating to the study were answered and any issues or concerns he had in identifying suitable participants were clarified .

The criteria for inclusion in the study were that:

1. The woman was pregnant at the time of the study and was experiencing or had experienced sickness in her current pregnancy;
2. The woman was able to communicate clearly in English;
3. The woman had been born into or substantially adopted the values of Maori or Pakeha New Zealand culture. (Most studies that I had identified in relation to sickness in pregnancy were overseas ones. This study was to be based specifically on New Zealand cultural values).

The doctor mentioned the study to likely participants. Those who showed interest in participating were given the information sheet (Appendix 1) which outlined the study and the degree of involvement required of participants. Potential participants made their own contact with me or indicated their willingness to be involved to the doctor by requesting that I contact them. Other pregnant women who heard about the study offered themselves as participants. Where these volunteers met the criteria for inclusion in the study they were accepted. The possibility of this 'snowballing' effect had been planned for in the

research proposal as this had been experienced in an earlier fieldwork study (Wenmoth 1992).

Contact was made with prospective participants to reaffirm their interest to be involved, and to seek their approval to visit them to discuss the study in more detail. Once participants had been identified there were no refusals to being involved in this study. Arrangements were made so that I could interview each participant at a time and place that was convenient to her. All but one of the women chose their own homes for the initial interview and the majority chose a time when they were the only adult present. The other participant chose to have her initial interview at her place of work in a private interview room.

The study was further clarified in person prior to the first interview. Participants were given the opportunity to discuss the research and to consider whether they still wanted to participate. In all instances the offer was made to come back at another time so they could think about the study and decide their level of participation. This was not required. All participants appeared eager to share the stories of their experience. The ten women freely chose to participate in this study and their written consent was obtained.

Description of the study participants

The participants in this study came from a variety of backgrounds and social situations. All met the three predetermined criteria (as noted above). For some of the women the experience of symptoms had settled on entry to the study while for others it was continuing at the time of interview. This is acceptable for a study examining lived experience as "Reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through" (van Manen 1990, p. 10). As some of the women were in the latter stages of

their pregnancy on entering the study the second interview followed the birth of their baby.

For five of the women this was their first pregnancy, for three it was their second pregnancy and for two it was their third pregnancy. Their ages varied from 20 to 45 years. Eight of the women were married and living with their spouses. The other two women were living with family members. The women illustrated variability in the symptoms they experienced as well as the duration they were present. This varied from experiencing nausea alone (three participants), nausea and vomiting (four participants), nausea and retching (two participants) and one participant who experienced nausea, retching and vomiting. All of the women reported that the nausea and / or vomiting began between the third and sixth week of their pregnancy. For four of the women it had disappeared by the twelfth or thirteenth week, for three of the women by the sixteenth week and for one at the twentieth week of her pregnancy. The remaining two women experienced symptoms throughout the term of their pregnancies. The pattern or time of the day when the experience of these symptoms peaked showed similar diversity. Two of the women experienced symptoms in the morning only, two experienced symptoms during the evening only and one participant experienced symptoms both in the morning and in the evening. Three of the women experienced symptoms all day, while for the other two participants there was no characteristic pattern and their experience varied from day to day (sometimes it was worst in the morning, sometimes in the evening and occasionally even all day).

Ethical considerations for the study

The study proposal was approved by the Human Ethics Committee of Massey University and all ethical considerations have been complied with. Protection of

the rights of the study participants was of paramount importance. The ten women chose freely to participate and understood that they were free to withdraw from the study at any time. Individual written consent forms were signed by each of the women participants and myself as the researcher (Appendix 2).

All interviews were recorded using a microcassette tape recorder. The interviews were transcribed onto computer and a printed transcript obtained. The printed transcripts were shared with the woman concerned for verification and correction. No one chose to delete any material. The tapes were stored in a secure place.

It was intended that each woman, and any other persons identified in the transcripts, would be given pseudonyms for the final report. The use of pseudonyms was discussed with the participants and they had the opportunity to select their own. Only one participant chose to do so. Every attempt to preserve the participants' anonymity has been maintained.

It was made clear to the participants, that although I am a registered nurse I would not be seeing them in this role. For the purposes of this study I was a post graduate student with the Department of Nursing at Massey University. Because I was aware that during visits I may be asked for my professional opinion I stressed my role as a researcher, not as a professional nurse. No conflicting situations arose during this study.

Provided that I made every attempt to maintain anonymity and confidentiality there were no potential long-term disadvantages to subjects participating in this study. There was the possibility of the interviews being distressing to the

participants either because of the physical aspects of symptoms like nausea and vomiting, or in relation to emotional factors when reflecting on the extent to which sickness had impacted on their quality of life. It was made clear that should the interview appear to be distressing to the participants for any reason then the interview would be stopped. The need for this did not arise.

Hutchinson, Wilson, and Skodol Wilson (1994) suggest that, while the risks associated with participation in qualitative studies for health research have received attention, little has been reported of the potential benefits that may be experienced. The benefits to the ten participants were not formally addressed in this study, however all of the women expressed their appreciation for the opportunity to share their stories and to assist me with this study.

Data collection

As indicated data for this study was collected by the use of interviews with women who had experience of the phenomenon. Van Manen (1990) states that the interview serves very specific purposes:

> (1) it may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon, and (2) the interview may be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience (p. 66).

The interviews for this research addressed both of these purposes. Two interviews were held with each participant with each being approximately one hour in duration. The interviews were conducted over a six month period.

At the first interview participants, in addition to sharing their experience of sickness in their current pregnancy, were asked to share some background information such as their age and number of previous pregnancies. The

participants were also invited to keep a record of their experience noting anything that occurred to them between interviews or that they had subsequently remembered about their experience. Most participants had difficulty with keeping a written record but some did raise issues later that were not raised in the first interview.

Because sickness in pregnancy is personal and has often been perceived as a symptom of not coping with pregnancy (Birks 1993), it was important to create an atmosphere of trust and confidentiality so the participants would share their experiences fully. Swanson-Kauffman and Schonwald (1988, p. 101) stress that the success of gathering the data depends on "the researcher's ability to engage with the informants' reality" which requires empathy, intuition, and attentiveness. In-depth interviews provided the opportunity to develop a good rapport with each participant. The interview process began with an open question; "Thank you [participants name] for agreeing to share your experience with me. Could you tell me what the sickness has been like for you and what it has meant to you in your daily life?" The interview proceeded in a conversational manner with questions arising to probe the experience in greater depth or to seek clarification relating to issues surrounding their experience. The interviews used 'talk-turning', where probing questions developed out of the respondent's preceding replies and descriptions. As the rapport developed so did the flow and depth of the information given. Often the second interview gave a richer picture of the lived experience of the phenomenon.

Between interviews I would read the previous transcript and note any points for clarification or elaboration at the second interview. Transcripts of the initial interview were returned to each participant before the second interview. In this way participants could both verify their transcript as correct and make any

necessary corrections. Only a few minor corrections were necessary. The transcripts enabled the participants to further reflect on their experience, confirm understandings, gave an opportunity to clarify or to enlarge upon details given and prompted new information for the second interview.

The second interview involved verifying transcripts, expanding on issues identified by participants and myself and further examination of their lived experience. New questions arising from the transcripts were probed in terms of the meaning of experience to the participant. In this manner van Manen (1990) notes that the interview turns into "an interpretive conversation wherein both partners self-reflectively orient themselves to the interpersonal or collective ground that brings the significance of the phenomenological question into view" (p. 99).

The transcripts of the second interview were similarly prepared for return to participants for verification. Some of the participants indicated that they did not want their second transcript returned and this wish was respected. Participants where possible were contacted following the conclusion of the study to share the major themes that emerged and to reflect on their participation in the study.

Data analysis

Analysis of data was continual from the first interview as each woman's experience was examined. This involved treating all data as 'text' which could be thematically analysed for the 'essence' of the phenomenon. This 'essence' encapsulates the nature and the meaning of the experience rather than simply recording the experience. It involves "a thoughtful, reflective grasping of what it is that renders this or that particular experience its special significance" (van Manen 1990, p. 32). This later becomes the basis for the phenomenological

description and the interpretive (hermeneutic) commentary on the phenomenon in order to bring "into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitude of everyday life" (van Manen 1990, p. 32).

Analysis involved the reading of the verbatim transcripts, reflecting on the whole and parts of the data, producing memos relating to insights and noting questions for further consideration. The transcripts were analysed to determine the meaning of the women's experience and to identify common themes. For example, early reading of the first few interviews suggested 'overwhelming tiredness and fatigue' was a significant aspect of the lived experience. This was then clarified with the participants and emerged as a theme being "an aspect of the structure of lived experience" (van Manen 1990, p. 87). Van Manen stresses that no theme, conceptual formulation or single statement can possibly capture the full mystery of an experience. "A thematic phrase only serves to point at, to allude to, or to hint at, an aspect of the phenomenon." (p. 92).

Three approaches towards uncovering thematic aspects of a lived experience as outlined by van Manen (1990, pp. 92-94) provided a framework for the analyses undertaken in this study. These are:

1. A wholistic or sententious approach. Each transcript was read as a whole and questioned "What is the fundamental meaning or main significance of this transcript?" I then tried to express this by formulating a phrase that captured this meaning. An example being 'an absolutely rotten experience' (Research notes).

2. A selective or highlighting approach. After reading a transcript several times any statements or phrases that seemed essential or revealed something about the phenomenon were highlighted. This enabled me to discover experiential themes that recurred as commonalities in the descriptions gathered from the participants. Many of these statements have been used in presenting the findings of this study.

3. A detailed or line-by-line approach. This involved a very close reading of the transcripts asking of every line, sentence or sentence cluster- "What does this tell me about this woman's experience?" Notes were made in the margins of the transcripts. These notes indicated meanings of individual experiences as well as revealing recurring themes which were common to all participants. An example being 'a loss of control over one's body'.

While some aspects of the lived experience were immediately obvious, other themes were more difficult to identify. The dominant theme that emerged for this study was that of living through the experience.

Presenting the study findings

The objective in presenting the study findings is to give a description and an interpretation of what it is like to live with sickness in pregnancy. This has to be understandable and intelligible, yet capture the meaning and essence of this phenomenon. Van Manen (1990, p. 131) indicates that to do justice to the fullness and ambiguity of a lived experience "writing may turn into a complex process of rewriting (re-thinking, re-flecting, re-cognizing)". Having been through the process of rewriting and rewriting I have endeavoured to 'show' the meaning of 'What is it like to experience sickness in pregnancy'.

In order that one does not lose contact with the experience as it is lived excerpts from the interviews are included in the following chapters to complement and clarify understanding of what I have written, and to show the experience from the participants' point of view. As van Manen (1990) notes the "significance of anecdotal narrative in phenomenological research and writing is situated in its power" (p. 121). This recollected power is that it compels the reader's attention, and leads the reader to reflectively search for the significance thereby involves the reader personally. The reader may be touched or moved by a story.

Van Manen (1990) indicates that there are various ways in which phenomenological writers may structure their texts. As previously stated this study report is structured around the lifeworld existentials of corporeality (lived body), relationality (lived other), spatiality (lived space) and temporality (lived time) as described by van Manen (1990, pp 101-106).

The description in the following chapters should not be regarded as 'findings' but rather as a reflective text through which the reader is invited to "meet with it, go through it, encounter it, suffer it, consume it and, as well, be consumed by it" (van Manen 1990, p. 153). This research can provide one interpretation of the phenomenon. It can not be assumed that this is the definitive or only interpretation. According to van Manen (1990, p. 31) "no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description".

Methodological issues pertaining to the study

In phenomenological research the researcher and the participants become co-participants in the research process. There is however a high potential for researcher bias in the interpretation of the lived experience of others which needs

to be recognised. As I had carried out a previous fieldwork study on this subject (Wenmoth 1992), I was careful that this current study was kept separate and would stand on its own. It was expected that it might build on the previous study but I was mindful that I should not expect it to do so. My own assumptions and expectations for this study have been made explicit so that those reading this study are able to assess whether these pre-understandings have influenced the study findings.

To ensure that the interpretation of the text accurately reflects the experience and meaning for the participants, they were informed where ever possible of the themes that emerged. The participants agreed that the themes presented in the following chapters are an accurate portrayal of the phenomenon. As indicated anecdotes and quotations from the participants' transcripts are used throughout to assist the reader to appreciate the interpretations made by the researcher. This becomes part of the validation process for such a study. Van Manen (1990) emphasises that a research report should stay focused to the participants' expression of their experience.

Trustworthiness of the study findings is achieved through four criteria of credibility, transferability, dependability and confirmability that have been identified by Lincoln and Guba (1985) and Sandelowski (1986).

Credibility was achieved when participants saw the research as a true construction of their reality, of their experience as it was lived. This will be confirmed if other researchers judge the interpretations as being true to the lived experience of sickness in pregnancy.

Transferability refers to the researcher giving sufficient detail of methodology so that another researcher can take the study design and transfer it. This is difficult as meanings are often context specific. Another researcher should be able to independently study the phenomenon and find similarities with themes as they are expressed in this study.

Dependability has been addressed through an enquiry audit. Supervisors who have conducted their own research and are familiar with conducting phenomenological research have monitored this research study, from the formulation of the research proposal through to the completed report.

Confirmability is addressed by providing an audit trail that provides sufficient evidence in this study to allow the reader to confirm the findings that the researcher has presented. .

The ultimate verification of this study lies with the readers of this thesis for their judgement on its resonance, or sense of congruence. Does it correspond with the readers' lived or imagined experience such that they can 'see' its previously silent, deeper significance?

Key to presentation of findings

The following is a key to the presentation of material in the following chapters.

[ ]	Researcher comments to provide clarity, explanation or to ensure anonymity
.../.../...	Text omitted
(Pseudonym, Int, Pg.)	Source of text, indicating pseudonym of participant, interview number, page number.

Summary

This chapter has presented the design and methodological issues used in this research. It began with an outline of the integrated phenomenological research activities as outlined by van Manen (1990) which included the objective for this study. This was followed by an examination of the study design beginning with how the participants were identified. A general description of the ten women who participated was given. Ethical considerations for the study were outlined and the data collection methods explained. The importance of remaining focused on the phenomenon under consideration was stressed. An outline of the method of thematic analysis illustrated how the themes which are to be presented in the following chapters were identified. The chapter concluded by addressing adequacy of the study through the four criteria of credibility, transferability, dependability and confirmability. However, as van Manen (1990) stresses the ultimate verification of this study lies with the readers in recognising this work as a real or possible lived experience.

Part Two

The Study Account

Chapter Five

CORPOREALITY - THE LIVED BODY

Introduction

This chapter focuses on corporeality or the 'lived body'. Relationality, the relationship with others, will be examined in the following chapter. Spatiality and temporality are examined in chapter seven. While these are differentiated for the purpose of presenting these study findings, in reality, they can-not be separated as they form what van Manen (1990, p. 105) describes as "an intricate unity which we call the lifeworld - our lived world".

Corporeality refers to the phenomenological fact that we exist in the world through our body. The concept of a lived body involves bodily actions which others may observe but which the person performing them experiences as uniquely their own. When healthy, we spare little thought to everyday actions as our bodies know how to perform them without any conscious thought. In the presence of illness or disruptive symptoms we lose this habitual skilled body. Benner and Wrubel (1989, p. 73) indicate that: "Without a habitual, skilled body, people find all activity effortful and deliberate".

Pregnancy interrupts the habitual relationship women have with their bodies. For example, pregnant women may be more sensitive to the feeling of their clothing against their bodies and may be suddenly conscious of their bodies' rearranged weight distribution or increased bulkiness. Symptoms of nausea, vomiting and retching because they can be so disruptive, accentuate the change

in relationship with one's body and heighten pregnant women's awareness of their bodies. According to Toombs (1987, p. 230) "In illness the body is experienced as at once intimately mine but also other-than-me, in that there is a sense in which I am at its disposal or mercy". Although experiencing the symptoms of nausea, vomiting and retching in pregnancy is not considered an 'illness', many pregnant women experiencing these symptoms know that they can make one feel 'ill'. The influence of the women's knowledge, expectations and previous experience of sickness in pregnancy on the interpretations presented in this study are outlined. The chapter concludes by exploring the individuality of the experience despite there being similarities.

Becoming aware of being pregnant

For some women the presence of nausea and vomiting informed them something was wrong with the normal functioning of their bodies. This loss of the previously known and familiar self led them to believe that they might be pregnant. For Judith who wanted to be pregnant the nausea confirmed the pregnancy, whereas Lisa, who was not keen to be pregnant, tried to suppress the suspicion that the nausea she experienced was an indication of being pregnant.

> *I was kind of seeing myself different and not quite right. There was this nauseous feeling and it persisted for a few days. My mood swings and just feeling funny, not myself. I knew there must be something else, but pregnancy was really in the back of my mind, but I kind of just kept, you know, denying it Saying to myself "No I can't be, it's all a big joke" and "It's just me going through a funny phase or something".*
>
> (Lisa Int 1, Pg. 10)

For some of the women in this study their previous experience of pregnancy alerted them to the possibility of being pregnant again despite the symptoms in some cases varying between pregnancies. Initially, as with Anne , the

body sensations may be attributed to something else, but when symptoms persisted they were alerted to the possibility of pregnancy.

> *I got up one morning and I felt nauseated and I thought "Oh God, No I must have a tummy bug" and then the next morning I got up and I felt nauseated and I seemed to come right as the day went on, but then as it happens the Doctor's nurse rang me up for a smear test and I said "I think I better bring a urine test in too because I've got this nausea and light-headedness".*
> (Anne Int 1, Pg. 1)

Jennifer and Pauline were more certain of the cause of their nausea and therefore were immediately conscious of being pregnant.

> *Yeah, I knew straight away. The only reason I ever vomit first thing in the morning is because I'm pregnant.*
> (Jennifer Int 1, Pg. 2)

> *I've been using natural family planning and my period didn't come and I'd taken my temperature, I mean I, just the rising temperature confirmed it and then the nauseous feeling confirmed it too. So I knew. I was fairly certain that I was pregnant.*
> (Pauline Int 1, Pg. 8)

For those who did not recognise the nausea as being an indication that they were pregnant the inability to assign a cause to their symptoms was a source of consternation.

> *I had no idea the first time. ..//...he* [Husband] *didn't understand what was going on either and I didn't understand. I just knew that I was sick."*
> (Rose Int 1, Pg. 5-6)

Expecting 'morning' sickness

There were a variety of different sources from which the women derived their expectations of 'morning sickness'. These included previous experience with sickness in general and possibly with pregnancy, knowledge they had acquired from books or information they had been given to read, their own professional development and from interaction with others. The expectation of experiencing 'morning sickness' was common for all primagravidas in this study. It came as

a shock for some to find that their experience was not confined to the morning, as was the case with Jennifer.

> *You expect it. "Right I'm pregnant I'll get morning sickness". And of course some people don't get it. I have friends that didn't get it at all and of course I got it at night time and I wasn't expecting that.*
>
> (Jennifer Int 2, Pg. 3)

Some women considered themselves a 'bit odd' or felt that 'something was wrong' when they did not experience sickness in the morning. This belief was dispelled for the women in this study once they shared their experience with others and were assured that what they were experiencing was normal.

Those who had experienced sickness during a previous pregnancy had some knowledge of the situation they found themselves in. They knew they would get through it, knew it would end, if not at three to four months, at least when the baby was born. Pauline explains it thus:

> *It was still an awful experience. It affected you a lot. It was a bit worse than it was the first time, but having been through it you know it is manageable.*
>
> (Pauline Int 2, Pg. 6)

> *I'm much more accepting. I think, because you know a bit more about what goes on, you don't have the same concerns as first time around. You're not as consciously aware of what is happening in your body. It's much easier to deal with.*
>
> (Pauline Int 1, Pg. 10)

Although individual experiences differed amongst the women who participated in this study all women recognised changes in their body and body's functioning. These included physical, psychological, and emotional factors.

A heightened awareness of the body

For those expecting a first child just being pregnant is a whole new experience. Benner and Wrubel suggest (1989, p. 49) "Because of embodied intelligence,

background meaning, and concern, people grasp a situation directly in terms of it s meaning for the self". A first pregnancy has a profound effect on the woman's relationship with her normal body functioning as she has not developed experiential knowledge from being in this situation before as Lynette explained:

> *You wonder if you are ever going to be normal again. It's such a change that you don't know yourself like you knew yourself.*
> (Lynette Int 2, Pg. 5)

For Elizabeth there was concern and a heightened sensitivity about what was happening to her body now she was aware of it.

> *I was worried about every little ache or pain or any little thing going wrong. I would think I was going to die at times. I didn't have any understanding. I was just so aware of little things happening to me that I hadn't noticed before.*
> (Elizabeth Int 2, Pg. 5)

Experiencing nausea and vomiting in pregnancy

People who have not had any previous experience with a particular phenomenon often try to find some similar lived experience to which they can liken it. Tessa was one of the women in this study who likened the nausea she experienced to that previously experienced with periods.

> *It was the same sort of nauseous feeling as when you had your period. It was pretty similar except a bit more intense...//...it's a similar sort of feeling the way that it affects your arms and legs all those sorts of things.*
> (Tessa Int 2, Pg. 6)

Most women in the study when asked to describe the nauseous feeling found this difficult. They could describe various aspects of it but an encompassing description was difficult to find. Rose's view was shared by others in the study when she explained *"You just feel grotty. Really grotty "* (Int 2, Pg. 5).

The sensations associated with the nausea, which often led to vomiting, although hard to describe were likened to butterflies. It was as if the women were searching for an observable phenomenon to interpret the sensations they experienced within their bodies.

> *It was mainly my stomach and up in my throat. It's kind of like a sick gnawing kind of feeling. It's hard to describe...//...It's like the feeling when if you were to put your fingers down your throat for a few seconds or something like that ....//... Yeah. It's sort of almost like a butterflies feeling in my stomach as well. I know the baby's moving around as well. But it's not that feeling. It's kind of been like that all the way through - an unsettled sort of feeling in the stomach*
>
> (Elizabeth Int 1, Pg. 9)

> *It's just hard to describe. The butterflies really would sort of make me quite dizzy and queasy feeling ...//... and I'd get a really horrible taste in my mouth, which was the nausea, and that'd slowly get worse and I'd sort of get quite phlegmy and that. ...//... When the butterflies were really churning badly would be when I was retching.*
>
> (Jane Int 2, Pg. 2)

> *My stomach was really churning. It was like having massive butterflies in my stomach, really turning over and churning and grumbling and, yeah, just a very sicky feeling. That made me dizzy and that with it but I never vomited. It sort of got to the top of the throat but I never actually vomited.*
>
> (Jennifer Int 1, Pg. 5)

Retching was felt to be the worst of the group of three symptoms of nausea, vomiting and retching that people can experience during pregnancy.

> *The retching is awful. There's nothing much there and you can't get it up and you know that if you were sick you would feel a lot better. I reckon that it's better to be sick than to just have that dry retching.*
>
> (Jane Int 1, Pg. 4)

The women clearly differentiated between nausea and vomiting associated with pregnancy and the same symptoms caused by general illness. Although the symptoms were similar to those associated with ill health the women clearly conceptualised themselves as being well and saw the experience of being sick in

pregnancy as having subtle differences to being ill. Elizabeth and Rose describe the difference thus:

> *When you vomit when you're pregnant, it's not a sickness, it's just part of it. If you've got a virus or something it means there's something wrong.*
>
> (Elizabeth Int 2, Pg. 6)

> *[W]ith the nausea it's different to a flu like nausea whereby it doesn't help to throw up. You might just dry retch all the time which, for the flu should you throw up it gets rid of that thing, but it doesn't go. It still stays there.*
>
> (Rose Int 2, Pg. 2)

Because their usual way of being in the world was interrupted by symptoms of nausea and vomiting the participants were far more conscious of what was happening with their bodies. Benner and Wrubel (1989, p. 43) note: "When embodied intelligence does not work well or when it breaks down altogether, it loses its essential embodied, taken-for-granted quality and becomes something one reflects on consciously". The women became conscious of their bodies' limitations and began to consciously alter their life-styles to accommodate this. What they could or could not do was redefined by their bodies.

> *I had to listen to what my body was telling me. .../I... I had to adjust to what my body could do, not what my mind might want to do.*
>
> (Judith Int 2, Pg. 5)

For some women their new understanding of their bodies included being able to predict when they would be affected.

> *I'd know sometimes I'd get up in the morning and I'd know that I was gonna be sick. I just had this funny feeling not nauseous exactly just thinking 'Oh no this is one of these days. I'm gonna be sick'. I'd just know it.*
>
> (Jane Int 2, Pg. 3)

Some of the participants who recognised that there was a regular pattern to their nausea and vomiting found being able to anticipate the experience caused considerable anxiety.

> *[B]ecause anytime from 4 o'clock onwards I'd start to dread 5 o'clock hitting...and I'd start to get down then, at work, and obviously I would get pale and not be very happy and that. Because people used to say to me 'Oh you're not feeling very well'. And it would really be more anticipation of what I was going to feel like from 5 o'clock onwards.*
>
> (Jennifer Int 2, Pg. 11)

The mechanisms that the women developed to cope with these bodily imposed restraints will be explored in chapter eight.

Becoming focused on aspects of the body

Beyond the need to be aware of their bodies' limitations, many of the women in this study reported specific changes in their bodies. Lisa reported being particularly aware of her skin.

> *My face felt like a baby's face, how it's all nice and soft and silky like ...//... my skin feels a lot smoother than what it used to be like.*
>
> (Lisa Int 1, Pg. 16)

In many instances the women's experience created a focus on a particular anatomical aspect of their body's functioning. One of the main foci of attention became the stomach.

> *Sometimes you just had this.. it wasn't so much in the stomach, or it could have been, it was right up the top here...*[Under your rib cage?] *Yeah under the diaphragm sort of and it was just like a lump of air or a big knot- something was there just making you feel sick.*
>
> (Rose Int 1, Pg. 9)

Jane was extremely conscious of the sensations in her abdomen as on two occasions when she was dry retching she went into premature labour. She felt that one set of contractions set off the other and she couldn't control it.

> *I just couldn't stop retching. And you know your whole stomach contracts and your abdomen contracts and it's no wonder I went into labour. It's not a nice feeling when you are pregnant and you are dry retching or you are vomiting.*
>
> (Jane Int 1, Pg. 2)

For Tessa the stomach was initially the primary focus but as the bout of nausea progressed she experienced its effects throughout her whole body.

> *It was centred on the stomach but it sort of worked right up to the throat. And your limbs felt quite tired and weak. It started at your stomach and then spread it's way all the way out.*
> (Tessa Int 2, Pg. 2)

Several of the women reported a focus on mouth and throat. In trying to describe the nausea she experienced Jennifer reported it as a taste in her mouth.

> *[I]t was just feeling, it was really like a taste and it was like a taste of sick. You know you were forever swallowing and trying to get rid of it . You had the taste in your mouth all the time.*
> (Jennifer Int 2, Pg. 2)

Some women reported unusual taste sensations despite nothing being present in their mouths. Rose referred to a metallic taste in her mouth and from that she knew when the nausea was about to start - it was a forewarning. Others reported a bitter aftertaste when feeling nauseous. For some this persisted even after the nausea had settled down. Many of the participants reported drinking water or milk to try and clear this taste from their mouths despite this not being successful in most cases.

> *And the taste in my mouth, the taste was still there after I'd drunk anything. I couldn't taste anything normally.*
> (Rose Int 1, Pg. 3)

Lisa reported that in addition to drinking lots of water she tried to dispel the way her mouth felt by cleaning her teeth several times a day.

> *It was fuzzy feeling in my mouth...//... It's all fluffy and all on your teeth and everything. You just want to get rid of it.*
> (Lisa Int 1, Pg. 8)

All the women found that they had a heightened awareness of their sensory faculties and could not tolerate various smells, tastes or certain sights while they were experiencing nausea and / or vomiting. This resulted in changes and sometimes reversals of their previously established eating patterns and food

preferences. Jennifer who had previously been particularly partial to Vitafresh now found that this tasted *"horrible"*. Lisa went right off seafood which she had previously liked because it did not have any taste. You *"go to eat it and you don't have the flavour in your mouth"* (Int 1, Pg. 3).

The smells, tastes or various sights that the participants found would set off or accentuate their experience with nausea and vomiting are identified as 'triggers'. These cover a wide variety of things which included car fumes, cooking smells, food and drinks, and were found within their homes, at work or when they were out and about in society. Most of these triggers had not previously affected them.

> *I remember one time I walked into someone else's flat and there was a ham bone or something cooking and I knew I couldn't stay long. That was right at my worst time. So I just said to her 'I'm sorry I can't stay. I have some other things to do'. I didn't really but I couldn't offend her.*
>
> (Lynette Int 2, Pg. 9)

Foods cooked in fat or with a high natural fat content were frequently reported as triggers.

> *We went for a Chinese take-away once and regretted it afterwards. ...//... I just felt ill afterwards like I'd eaten a whole lot of grease and fat and stuff. Just yuk. I normally love Chinese so that was unusual for me.*
>
> (Judith Int 1, Pg. 2)

> *Fried foods. Butter frying would really set me off. At any time during the day if I could smell butter frying that would really churn my stomach and curried foods, any sort of hot foods, I just would take a mouthful and then... yuk, that was the end of that.*
>
> (Jennifer Int 1, Pg. 2)

Sometimes the fat content was not obvious, for example chocolate and milk. These foods were often described as rich rather than fatty. Highly spiced foods such as Asian and Indian meals were commonly identified as food triggers. In some instances the same triggers affected different women through different senses. For Rose it was the smell of the meat whereas for Judith the sight of a

prepared meal including meat was sufficient to trigger a reaction. Judith could however prepare meat without it affecting her.

> *I could cook meat OK. It was just sort of looking at the plate and seeing the meat there and .Oh. Oh..that would set it off.*
> (Judith Int 1, Pg. 3)

More typically preparing food, or in particular cooking meat was a trigger for many of the women. Jennifer's reaction was opposite to Judith's.

> *[T]he thought of food or cooking food or the smell of food would just make me really retch. But if I ate it I felt really good. I could still eat. Even though the actual thought of eating or the smell of food would upset me.*
> (Jennifer Int 1, Pg. 1)

Beverages were also triggers for some women. Rose reported a wide range of drinks that affected her and found that she was really only able to drink water and milk.

> *Couldn't handle tea, coffee or not even chocolate drinks, like Milo. I couldn't have alcohol - mind you we're not supposed to have it. What else? Fizzy - couldn't handle fizzy drinks at all or cordials either. Water and milk. I could handle those. That's all.*
> (Rose Int 1, Pg. 9)

Jane, who was an asthmatic did not have any trouble with smells upsetting her, but couldn't eat red meat. The taste of it, once in her body, caused her to retch. She also found she couldn't eat fish so ate a lot of chicken in her diet *"It was the only thing I could actually eat* " (Int 1. Pg. 7).

Ann who worked as a nurse particularly noticed a heightened sense of smell when she was doing a dressing.

> *It was one of the things I just couldn't cope with the nausea. I just used to dread doing it, absolutely dread doing it. It was so smelly. You know a really terribly smelling dressing. What I noticed more was my intolerance of the whole thing. Normally I can cope with that sort of thing and I wouldn't blink an eye.*
> (Anne Int 1, Pg. 10)

No matter what the specific triggers were they all signalled the same thing to the women - the onset of nausea and / or vomiting with their associated loss of control. 'Triggers' are further discussed in chapter eight when ways the women coped with their experience are explored.

A loss of control

Central to the loss of the habitual body and the changes experienced with nausea and vomiting is the women's loss of control over their bodies. This was experienced by all the participants.

> *You don't feel yourself. You just don't . You're just not in control of your body. You never know when you're going to feel yuk. You get up in the morning and you might feel fine and then you know half an hour later you feel awful ...//... and you know there's just no control over it.*
> (Anne Int 2, Pg. 2)

> *It wasn't under control. I had no choice in the matter. It was hard because, I would have chosen not to have been sick if I could, but I had no choice. I got this sick feeling and it was horrible ...//... About all I could do was anticipate it happening. Because 99% of the time it happened.*
> (Jennifer Int 2, Pg. 12)

The loss of control was something the women had to get used to, something they had to learn to live with. As Jane stated:

> *[Y]ou cannot do anything about it and you have to sort of go with the flow no matter how difficult and how revolting it's gonna be. 'Cause it is revolting - you're gonna be sick.*
> (Jane Int 2, Pg. 2)

Even those women who felt that they did not have a very bad experience recognised this loss of control and associated feelings of helplessness and frustration.

> *I knew I'd get things done eventually, not when I wanted but maybe the next day or get someone else to do something for me or something, but it was a bit of lack of control. Control in the way that I wanted it done and in my normal habit. ...//... I got things done and it didn't really alter my life that much but it was frustrating.*
> (Judith Int 2, Pg. 9)

> *[E]verytime I went to try and do something I'd start feeling really nauseous and dizzy and I would have to go and sit down. And that frustrated me so much that I couldn't get things done because really I felt fine. Just this feeling that kept coming over in waves every time I'd push myself a bit it would happen again and as soon as I'd sit down I'd come right and then I'd try again...//... I'd be half way through the dishes and have to quickly come and sit down and even like I'd be talking on the phone and I'd just quickly lay down on the floor while I was talking. I mean just as well the person on the other end didn't know.*
>
> (Lynette Int 2, Pg. 7)

> *At times I got very angry because I couldn't stop it. There was nothing I could do to stop it and I got quite angry at times that I was feeling like this.*
>
> (Lisa Int 2, Pg. 2)

Norris (1982, p. 83) notes "Perhaps having control of organs that connect with body surfaces is one of the last controls or footholds in the loss of physical integrity". The nausea and vomiting seemed for some to have had a 'life of its own' because they could not exert any control over it. Many of them reported that this made the future seem a long time away. This distortion of time is one of the topics discussed in chapter seven.

> *Well you didn't know when it was going to stop. You couldn't control it. It had to run it's course. You wanted it to stop.*
>
> (Rose Int 1, Pg. 11)

Often there was no pattern to the nausea and vomiting, a factor which reinforced the feeling of loss of control. Jane explained that just because she had vomited in the morning it did not mean she would not vomit again after lunch or later in the day. She found that she could not plan that she would be ill and she could not plan that she would not be ill. Tessa who worked, found that she could not make any decisions at that time because she didn't know what the future held.

> *But then you're sort of waiting to see if it will pass and how well you'll be in the next couple of months. You can't really make proper decisions in a way because you don't know what the future holds. So you just sort of hang in there when you're feeling awful and you often don't take sick leave too.*
>
> (Tessa Int 2, Pg. 10)

The degree to which the unpredictability of the nausea and vomiting affected the women's lives varied considerably. While many reported it as a major disruption some like Judith described it as a minor inconvenience. *"This would intrude and disrupt my plan or disrupt my day"* (Int 2, Pg. 3).

Within our society there is a common aversion to nausea, vomiting and retching. Part of people's socialisation involves learning to vomit into a suitable receptacle, and to do this privately. Because of this socialisation some people can suppress the urge to vomit until a suitable receptacle is available or it is convenient to do. Several of the women indicated that they were concerned whether they would get to the toilet in time to vomit. They found that unlike vomiting due to other causes, they did not feel they had as much control over their body's desire to vomit during pregnancy. The social aversion to vomiting contributes to the background meaning women bring to their situation. Benner and Wrubel (1989, p. 46) indicate that: "For an individual, background meaning is provided by the culture, subculture, and family to which that person belongs". This social dimension is explored further in chapter six when the women's relationship with others is addressed.

Feeling tired

Varying levels of tiredness, sometimes chronic, was a universal feature of living with sickness in pregnancy. The tiredness appeared to be more significant than the nausea or vomiting in the women's minds because, while the latter was often experienced only at certain times of the day, the tiredness was often present all day long.

> *[T]he tiredness has been a bigger thing for me than the nausea.*
> (Elizabeth Int 1, Pg. 2)

I can remember being a bit nauseous. But that's not what stands out. I think that's because it was only at certain times of the day I felt nauseous, but I felt tired all the time.
(Tessa Int 2, Pg. 8)

I was feeling tired at that time and, yeah, as I was going through it thinking 'This isn't much fun'. In lots of ways it makes your life more hard. I think it was the tiredness more than anything else."
(Pauline Int 2, Pg. 7)

The tiredness was accepted as being part of the experience although some of the women couldn't determine whether it was the pregnancy itself or the sickness associated with the pregnancy that caused the tiredness. Pauline and Elizabeth reported that the nausea was made worse by the tiredness.

If I was more tired I would feel more nauseous. I mean there was a connection for me."
(Pauline Int 1, Pg. 2)

I was tired and I find that if I get tired that's when I feel worse. I feel sick.
(Elizabeth Int 1, Pg. 2)

Some women attempted to attribute a cause to the tiredness. Jennifer attributed the tiredness to the physical act of vomiting or retching using up her body's energy.

It did seem tiring to be sick, especially if I had vomited. I was quite tired afterwards and seemed to use up quite a bit of energy to actually vomit and, I used up a lot of energy to sit there retching as well. So it really does deplete your body's energies and makes you really tired.
(Jennifer Int 2, Pg. 8)

Others, like Lynette, attributed the tiredness to their inability to keep their food down or reported not eating because they were too tired.

I couldn't eat at night because I just felt so nauseous and for a while there I was very very tired and I just came straight home from work and go to bed and not eat any dinner or anything because I couldn't bear the thought of eating and I was really tired so I would just go to bed.
(Lynette Int 2, Pg. 2)

For many of the participants the tiredness did not seem to be related to the actual physical exertion but was a tiredness of the body itself.

> *I did feel a lot more tired. How can I explain it - it was easy to do all the things but you just feel tired. You don't actually get tired through doing the work - you just feel tired - you feel tired and you feel worn out...//...I sat down much more often then during the day... took a little 5 minute break out. I did that quite often. You know just sitting down and relaxing. That's what helped me.*
>
> (Lisa Int 1, Pg. 6)

This tiredness affected the women's daily routines, disrupted their sleep patterns and reduced the amount they could achieve in a given time. Most of the women indicated the need to go to bed early or having to have extra rest during the day.

One participant had to relinquish her new job because she became so tired. However when she was not working she had two pre-school children at home so the opportunity to rest during the day was not available to her. She found the resulting tiredness was all consuming. For those without children even having the opportunity to rest still raised concerns about the acceptability of feeling tired.

> *I didn't think you should have a rest in the afternoon or anything like that. I thought I wasn't coping or something if I had a rest till Mum said that's all she could do to deal with it.*
>
> (Lisa Int 2, Pg. 12)

This indicates that women do not like to feel they are not able to cope and they need to feel that it is permissible to rest. Rest as a coping mechanism is discussed in chapter eight. However, many of the women reported that the tiredness didn't go away when they lay down and slept. They would sleep during the day, or go to bed earlier at night, yet still felt tired.

> *I slept lots more then, but felt so tired, and felt as if I hadn't had enough sleep. Sleep didn't take the tiredness away.*
>
> (Elizabeth Int 2, Pg. 10)

> *Even though the tiredness wasn't really because you didn't get enough sleep it was just it was strange at that time because you got enough sleep but it just seemed like you needed more so you'd have to take time out to catch up.*
> (Rose Int 2, Pg. 5)

Rest or sleep helped for some, even if it did not completely alleviate the tiredness. Rose reported that sleep would satisfy it *"For a short period but then it would come back"* (Int 2, Pg. 6). Elizabeth indicated that she required much more sleep than she had previously needed.

> *Before I used to have 8 hours sleep. Now I need heaps more. I can't seem to get rid of it. If I don't have 10 or 11 hours sleep a night that's just written me off for the day the next day. Even if I had 9-10 hours sleep, which is more than I used to have, I'm still tired and I still find it very hard to get out of bed in the morning.*
> (Elizabeth Int 1, Pg. 13)

For Jennifer and Jane the combination of nausea and tiredness prevented sleep, thus locking these women into a cycle where, because they kept focusing on the possibility of being sick they were kept awake. This, in turn, resulted in them becoming chronically tired.

> *[O]ften the nausea would keep me awake. I just couldn't get comfortable, just couldn't get to sleep. I'd keep thinking "I'm going to be sick, I'm going to be sick". Eventually I'd fall off to sleep 'cause I was so tired.*
> (Jane Int 2, Pg. 7)

For some women the quality of their sleep was degraded. Elizabeth reported that her sleep was disturbed by vivid dreams.

> *I had very graphic dreams all the time I was pregnant so I would be dreaming and then I'd wake up. Sometimes I would be snoring and that would wake me up. It was a lot harder, you know, a lot harder for me to sleep normally.*
> (Elizabeth Int 2, Pg. 9)

The tiredness had an effect on how the women felt emotionally as well as physically. They reported that when they were tired they became more

emotionally vulnerable, which could result in bouts of crying, short temper and irritability.

> *The tiredness was the worst thing for me. It was just that I was so tired ...//... I'd even cry with tiredness at times.*
> Tessa (Int 2, Pg. 9)

Some of the women did not appear tired to others. The fact that their general appearance mitigated against people recognising their tiredness was a source of considerable frustration.

> *Physically I was worn out. Nobody could see that I felt tired or anything. People kept on telling me how well I looked. And I think that's possibly the biggest thing is that you feel really tired- you feel a bit run down and people are telling you that you've never looked better.*
> (Tessa Int 2, Pg. 2)

Tessa was grateful that although she was feeling tired all the time she just had herself and her job to worry about. She dreaded the thought of what it would be like if you had children to look after as well. Caring for others will be addressed in the following chapter.

A further source of frustration was the way the fatigue impacted on their work, especially if this involved paid employment. Often the financial situation of a couple meant that the longer the women worked the more financially secure they would be before they would be dependent on only one income. Those women who were employed at this stage in their pregnancy looked forward to the tea breaks and lunch break. For Tessa this was a time she could *"stop and sit down for an hour"* (Int 1, Pg. 3).

An associated effect was the necessity to perform customary activities at a slower pace. This was partly through fatigue and partly through changes to the body caused by the pregnancy.

> *I noticed I was very sloppy in doing things, like I was slow in my body movements, in, like, closing a door and still forgetting to take my hand away. I was forever dropping things or spilling glasses and it was because of the movement of my hand. It was slow and lethargic. I'd almost forget to pull my hand out of the way when I was closing the oven door or that kind of thing and that's something, I suppose, that's become more conscious. It's sort of happening more often. Even in the last 3 weeks I know it does take me longer to do things.*
>
> (Elizabeth Int 1, Pg. 7)

Balancing sickness with the body's requirement for food

Most of the women reported a change in their daily food intake. Some found that they were more hungry and had to eat more than they used to before they became pregnant. Lisa reported that instead of her usual two sandwiches for lunch she started to have four as well as a big breakfast. *"I was starved all the time. Just hungry. I just wanted to eat and eat and eat"* (Int 2, Pg. 5).

Conversely many of the women found that their food intake diminished due to the nausea. As Jane noted *"I wasn't eating very well anyway because I felt so sick all the time"* (Int 1, Pg. 5). Sometimes the woman's body sent her contradictory signals. Pauline reported that she would go to sit down to eat thinking, *"That looks nice"* (Int 1, Pg. 2), but then suddenly not feel like it. The women were generally very concerned about the consequences of not eating. Although there did not seem to be much point at times to eating the women knew they needed food. Jane, who was severely affected by the sickness in her pregnancy, lost weight and became very concerned for the health of her baby.

> *I didn't have as much energy as I had if I'd had food. I couldn't eat straight away afterwards because I just couldn't face food at all. I kept thinking "If I eat again I'm going to be sick so what is the point in eating"*
>
> (Jane Int 1, Pg. 8)

> *Even though the actual thought of eating or the smell of food would upset me. I still needed to eat to keep going.*
>
> (Jennifer Int 1, Pg. 1)

> *I still got hungry. That's what used to amaze me. I'd feel sick and I was going to be sick but still could eat things. It was like being sick but being hungry at the same time....//...I think I ate because I needed to.*
>
> (Jennifer Int 2, Pg. 16)

The non-fulfilment of two basic physiological needs, those of sleep and food were identified as common 'triggers'. Tiredness and hunger both resulted in an increased disposition towards nausea and vomiting for Pauline.

> *When I was more tired I felt more nauseous and when I was hungry I felt more nauseous. And so if I just ate regular meals and tried not to get so tired it was much more manageable.*
>
> (Pauline Int 1, Pg. 1)

Tiredness and hunger are also commonly viewed as effects of living with sickness in pregnancy and are further discussed in the management of effects section in chapter eight. Not accommodating these basic physiological needs has the potential to create a cycle that spirals out of control: tiredness and hunger cause a woman to feel more nauseated and may cause her to vomit more, this in turn may make her feel more tired and hungrier. If the cycle is not broken the woman can become chronically tired and rundown. Many of the women reported bouts of feeling light headed and dizzy and feeling as if they were going to faint.

> *I would just go all giddy, light headed and that. Sometimes I had hot flushes and things like that. I would just have to lie down. It would just come over you feeling light headed as if you were going to faint.*
>
> (Rose Int 1, Pg. 10)

For some women these feelings were related to food intake or because an eating pattern had been broken.

> *I actually felt wonky and I felt like I was going to faint in the mornings. I don't know if it's because your blood sugar is low in the mornings and you haven't given your body enough sustenance or what.*
>
> (Anne Int 1, Pg. 13)

> *[I]t was lunch time and I had been allocated late lunch and I was due to go shortly and I could feel myself getting a bit dizzy and felt as if I was going to faint.*
> (Judith Int 1, Pg. 9)

Lynette reported that the dizzy spells seemed to be caused by normal physical activity. As she had to interrupt what she was doing to recuperate things seemed to take her a lot longer to accomplish which she found very frustrating.

> *A few times I would be trying to do the dishes or something like that and I would have to sit down quiet.. I had quite a few dizzy spells just during a short period. ...//... for a couple of weeks there every time I tried to do something around the house I would get this feeling of wanting to faint and everything would take twice as long and that really frustrated me.*
> (Lynette Int 2, Pg. 7)

For some of the women as they came to understand their bodies the light-headed and dizzy feelings were just as predictable as feeling nauseous.

> *From about 5 pm onwards I'd start to get light-headed and a bit dizzy ...//... You could almost set the clock by it.*
> (Jennifer Int 1, Pg. 1)

Changing moods

Fluctuations in mood or temperament were reported by most participants. The degree to which mood changes were seen as an issue varied according both to the individual woman, and to how close the interview was to the actual experience of sickness. Some women found when they felt sick that things 'got on top of them' more readily and reported being emotionally labile.

> *I did have mood changes. They were just really like premenstrual mood swings. I guess that's all you'd put them down to. Nothing more than that but just continuous over a longer period of time.*
> (Lynette Int 1, Pg. 5)

> *It's just my mood swings. I'm a normal happy [X] year old...//..I can irritate myself actually. You know if I do something wrong I'll get angry with myself and then I'll just, really go off and then I'll be down for a while then later I'll feel fine, on top of the world in fact.*
> (Lisa Int 2, Pg. 9)

I was pretty up and down to start with. I was terrible actually.
(Anne Int 1, Pg. 8)

Birks (1993) reported that mood swings are common when pregnant, but when experiencing nausea and vomiting "the lows may seem to occur more often and last longer than the highs"(p. 29). The women reported that their changes of mood were very unpredictable and could strike at any time which was very unsettling. Although at times some women acknowledged that they could identify why their mood changed, the majority of the time they could not identify a cause.

[T]hat can start off anytime of the day. I don't have to be tired. I don't have to be anything - it's like something snaps and oh, then I'm off.
(Lisa Int 1, Pg. 1)

I'd feel grumpier and I would burst into tears really easily.
(Anne Int 2, Pg. 7)

I've had some days where I've been in absolute tears the whole day for no reason at all. It's not that I've been upset over something.
(Elizabeth Int 1, Pg. 5)

It's just at the time when you're feeling upset it's quite hard to see what it is that upsets you - that was just me. Normally if I'm having a good day whatever set me off wouldn't upset me but when you're feeling rotten you can get upset so much easier.
(Judith Int 2, Pg. 7)

The loss of control over their emotions added to the distress women felt in relation to the loss of control over physical aspects of the body.

Because all the positive thinking and talking yourself through it and everything it just doesn't work. Usually if I feel a bit depressed or down I can talk myself through it and get out of it and do something. Whereas this felt totally different, like I'd be going off to go somewhere and I say "Well the best thing for me to do is to actually get out and get my mind off it or whatever" but then I'd just burst into tears over nothing. Anyway, it didn't seem like it was something that I could actually control or manage .
(Elizabeth Int 1, Pg. 5)

Most of the women recognised that the psychological impact of their nausea affected others close to them as well as themselves. As Lisa said *"Everybody gets affected. So if I'm in a bad mood everybody knows "* (Int 1, Pg. 1). The effects on the lived other are discussed in chapter six.

The constant ongoing nature of the experience at times resulted in many of the women feeling very depressed. The general misery of the experience itself also contributed.

> *It was a real drag. A real downer because once I started feeling sick it would go all night and, of course, once I'd started feeling sick I'd start thinking "Oh I'm going to be like this again tomorrow night" and it was like a bottomless pit really. I couldn't see any end to it at that stage.*
>
> (Jane Int 2, Pg. 5)

> *You know if you feel sick and nauseated you actually feel depressed. You really feel down to it. You could feel as if you were in a deep black hole and nobody cared. At times you wonder if life is worth it*
>
> (Anne Int 1, Pg. 11)

When incapacitated by nausea and vomiting, unattended housework such as dirty dishes piling up, clothes and toys all over the place added to the women's personal distress. Often when a person is feeling bad they can feel guilty that they feel like that. Anne was very surprised when other people acknowledged that it was all right to feel how she was:

> *Well it wasn't really clear to me that I was feeling so down. You know people say "Oh. Well you are allowed to feel awful. You are pregnant". I hadn't given myself permission to feel yuk sort of style. I hadn't really acknowledged it even - that I wasn't feeling very great.*
>
> (Anne Int 1, Pg. 9)

For some of the women often the fact that were feeling depressed when they were sick was not revealed to them until after the experience had passed and this realisation enabled them to retrospectively understand their experience. It was only on reflection that they realised they had been feeling depressed and how it

had negatively affected their self worth. Anne, who was self employed, found her experience with sickness quite depressing, even to the extent of reluctantly considering giving up her business completely. Once the experience was passed she was very surprised that she had even contemplated such a thought. Anne explained how it was for her:

> *Once it had passed I was really amazed at just how I felt. Just so much better like a weight had been lifted off my shoulders once the nausea went away. I hadn't actually associated how I was feeling down. The reason I was feeling down was the nausea.*
> (Anne Int 1, Pg. 13)

Several of the participants reported that they simply couldn't be bothered with themselves at times when they were feeling miserable. Their lowered self esteem included such things as not caring about what they were wearing or how they appeared to others.

> *It definitely affected my feelings of self worth. I guess if you were to do a video on yourself at that time you'd probably find that your shoulders are stooped and your head's down and you couldn't give a shit about the world....//...It was all to do with my self worth. I felt personally shited on and stood on and ashamed that I couldn't get on top of it.*
> (Anne Int 2, Pg. 7-8)

Birks (1993) noted that 65% of the women in her study indicated their difficulty with morning sickness in their pregnancies had a detrimental effect on their self esteem. The lowered self-esteem could be affected by unsympathetic attitudes from others.

> *I think little things that wouldn't normally set me off or wouldn't normally worry me would set me off. And if some one said something, like a friend came around one day and said "I don't like that outfit you've got on", that really set me off. But normally it wouldn't have worried me. I think I was feeling so low and so conscious of myself that any little criticism just set me off.*
> (Judith Int 2, Pg. 6)

Feelings of inadequacy often occurred when normal chores took longer to complete or when the women became more tired than usual or they felt so bad that they couldn't do any of their usual tasks at all. This resulted in the woman having to depend on others to do housework and to look after children. This loss of independence increased their feeling of inadequacy.

Birks (1993) indicates that women who are incapacitated by the effects of nausea and vomiting during their pregnancy may feel anger towards other women who do not seem to experience these symptoms. The participants in this study perceived these women as being lucky.

It was not uncommon for women suffering nausea and vomiting not only to neglect their appearance, but not want to go out, to socialise or be seen in public. They experienced a reduced social image and felt more isolated and depressed. These aspects will be further explored in the following chapter.

The individuality of the experience

Experiencing the phenomenon of sickness in pregnancy, although a very individual experience exhibits some commonalities as has been illustrated. The effects for the individual women ranged through a continuum from largely dismissing it, to accepting they could cope, to total abhorrence of the effects. Pauline, Judith, and Elizabeth illustrated this continuum.

> *[I]t has it's own distinctive feeling about it but it would be hard to say how. I mean it's just a, you know, it's a pregnancy feeling rather than anything else. Especially if you've felt it before and it does seem to hang around for a bit .*
>
> (Pauline Int 2, Pg. 1)

> *I knew it was not going to last for ever and I would get better. It wasn't devastating. It was just more of a intrusion than anything.*
>
> (Judith Int 2, Pg. 4)

> *It's the most revolting thing.*
> (Elizabeth Int 1, Pg. 1)

The actual physical experience of the nausea and vomiting could be devastating as was the case with Anne.

> [It] *was just an awful feeling, just nauseated. It was constantly with you. You don't know when you're about to 'throw up'. You don't really know what's wrong with you. You just feel like you're gonna die.*
> (Anne Int 2, Pg. 3)

For some women the memory of the experience can be so traumatic that it can be a deterrent to having any more children as was the case with Jane.

> *I just have such vivid memories of being so sick and always being sick and never having a pregnancy without being sick the whole time and it's sheer hell -it's sheer bloody hell. Really there's not one pleasant thing you can say about morning sickness or being sick whatsoever and it really puts me off wanting to have any more kids.*
> (Jane Int 2, Pg. 12)

Accepting the individuality of the experience is a prerequisite to developing an understanding of this phenomenon as Rose indicated.

> *I must say it isn't clear cut, it is very different for everyone and as long as people realise that, then they might be likely to be understanding.*
> (Rose Int 1, Pg. 14)

Rose's viewpoint was supported by most women in the study. All women acknowledged that the experience did or could vary with subsequent pregnancies. The individuality as well as the subjectiveness of the experience was exemplified by Lisa.

> *[I]t's happening to me and it's not happening to everybody else, it's just happening to me. Or it is happening to everybody else you know, but I feel it too. It's not easy, but you know, I'm not letting everybody else feel it. I just feel it.*
> (Lisa Int 2, Pg. 10)

Pauline attempted to relate her experience to what she perceived as the norm which helped her to understand her situation. Consequently she did not consider it to be very serious, there was a total acceptance of the phenomenon.

> *Well as far as nausea and vomiting goes I was fairly nauseous. That's my own judgement, from about three or four weeks of pregnancy on until about 12/13 weeks. I never vomited. So it wasn't very serious but I felt quite nauseous all the time and I think fairly classic, as far as I understand how nausea might be classed.*
>
> (Pauline Int 1, Pg. 1)

Recognising the wide diversity within the experience is in itself a challenge to the conceptions of what is 'normal'.

> *[T]here's still a lot of people who think that their experience is normal and that's it and if you have any other sort of experience well then it's not normal. Like the woman I was car pooling with she never had any sort of morning sickness at all. She was just 100% happy the whole way through the pregnancy. And she thinks therefore that any woman who does experience morning sickness is, somehow, it's psychological .*
>
> (Tessa Int 2, Pg. 12)

The ten women who participated in this study illustrated the diversity of the lived experience of sickness in pregnancy. The popular image of pregnancy never suggests the true severity of the problem - even sufferers themselves are often taken by surprise and cannot understand their situation. It is a highly emotional and personal experience which contrasts vividly with clinical descriptions in the literature. Rose, in the following excerpt, indicates the stark reality as it is lived:

> *[B]ut it was horrible. You could feel this stuff coming up and you'd want to get it out - at times you wondered if it would come out- your mouth's open and you're hanging over the toilet and these waves are coming from your stomach - it tasted yuk. Your eyes watered. You ached and you felt horrible. The books don't tell it like it is.*
>
> (Rose Int 1, Pg. 12)

Summary

This chapter has begun to reveal the experience of being sick as it is lived for the women in the study. It has shown how they are more consciously aware of their bodies which can no longer be taken for granted. The women found the loss of control over aspects of their bodies functioning very distressing. Accompanying the symptoms of nausea and vomiting they experienced an overwhelming tiredness and fatigue. This resulted in additional stress as it could not be eliminated by rest or sleep. Not only did the women have to cope with changes in the physiological functioning of their bodies but the experience of sickness resulted in fluctuations in their mood, changes in temperament, and lowered feelings of self esteem. The physiological and psychological aspects of the experience affected not only the woman herself but the relationships she had with others as discussed in the following chapter.

Chapter Six

RELATIONALITY - RELATING TO OTHERS

Introduction

In the previous chapter it was shown how experiencing sickness in pregnancy interrupts the habitual relationship women have with their bodies. They become acutely aware of their bodies in all aspects of their daily living. In this chapter this heightened awareness is examined from the perspective of another lifeworld existential - relationality or lived other. Van Manen (1990, p. 104) describes relationality as "the lived relation we maintain with others in the interpersonal space that we share with them". Experiencing sickness in pregnancy impacted on existing relationships for example with partners, children and workmates, and on the relationship each woman formed with her developing baby.

Reserved sharing of the experience

As sickness in pregnancy commences in the early stages of pregnancy, at a time when the pregnancy is invisible to the world at large, the woman controls the sharing of the experience and may *reserve* aspects of it to herself, her partner or to significant others. Both the pregnancy and the nausea and vomiting can be *silent and invisible* to the rest of the world until the woman discloses it. The extent to which others are affected at this stage in a pregnancy rests with the individual woman, the nature of her experience and the extent of her communication of it with others. There is *a reserved sharing of the experience.*

Although partners can be unaware of some of the effects of the sickness experience, most frequently it is her partner with whom a woman shares most fully what the experience is like for her. In early pregnancy women and their partners are often concerned that the woman might lose the baby and therefore they often choose not to disclose to people outside a very close family circle, the fact that the woman is pregnant.

> *I like to keep it to myself for the first couple of months, or 3 months anyway...//... I wouldn't want to have to go through telling everyone I was pregnant and then find I had miscarried and I had to go through telling them I wasn't pregnant any more.*
> (Pauline Int 1, Pg. 14)

The women in this study often felt the need to *pretend* that they were well when in fact they were feeling miserable in order to keep knowledge of the pregnancy and the sickness from other people. In such situations physical symptoms of other illnesses often disguised the women's sickness due to pregnancy and relieved her of the need to put on a pretence.

> *I was actually fortunate I had a bad cold that didn't go away for the first three months as well, so in some ways I could pass off my feeling not quite right on that and I think it was probably fairly obvious to some people at work that I wasn't quite my normal self. I was much more tired, but because I had this cold and cough that didn't seem to go away as well, ...//... I didn't have to sort of pretend in some ways that I was feeling fine when I wasn't.*
> (Pauline Int 1, Pg. 14)

The need to pretend limited opportunities for support from others. As the woman's pregnancy progressed and the pregnancy itself became visible to others there was a greater openness to share experiences associated with the pregnancy. There was no longer the felt need to keep it to herself or to pretend. Revealing the pregnancy to others opened opportunities for support.

Needing support in pregnancy

Others perceive that women need support later in pregnancy and this was more forthcoming when the pregnancy was visible. Support is however required early in the pregnancy when experiencing sickness is generally at its worst for most women. This was identified by the study participants and is illustrated here by Tessa.

> *It's the stage before people start letting you sit down, and in some ways you need it* [the support]*as much then as you do later on in your pregnancy.*
>
> (Tessa Int 2, Pg. 2.)

> *[S]ometimes you need just as much care and attention as you do when you're 9 months pregnant and waddling along, but people can see that and so they can see that you looked tired and that you're carrying that bundle around. You probably want a chair to sit down on those sorts of things.*
>
> (Tessa Int 2, Pg. 7)

In general it was the woman's partner or family members that gave her the most support early in her pregnancy and it was the relationships with them that were most affected by her sickness experience. This will be expanded on later in this chapter. The most important new relationship that was affected by the women's experience of sickness in pregnancy was that between the woman and her developing baby.

Relating to the developing baby

Although the pregnancy may be invisible to the rest of the world the woman has already begun a relationship with her developing baby, at a point where the baby-to-be is physiologically little more than a barely differentiated collection of cells (0.5 cm in diameter). Most women spoke of the baby as a person to be from the beginning of the pregnancy. Many of the participants expressed a great concern for the developing baby, particularly a real fear of what their experience

of sickness would do to the baby. This concern for the baby could override the woman's concern for herself. This was particularly highlighted by Jane.

> *When I was so sick most of the time you know I just wanted to get it all over and done with. I was more worried that she wouldn't be normal than all the vomiting and stuff.*
> (Jane Int 2, Pg. 1)

Although this concern was expressed to partners it appeared that because they had not yet developed the relationship with the baby as the expectant mother had, they did not have the associated concern for this person-to-be.

> *It does worry me that the baby will be born with some defect, and yet my husband doesn't feel that way. He's not worried one little bit. But Oh God. I'm absolutely paranoid ...//... I'm really worried.*
> (Jane Int 2, Pg. 16)

The risk of malnourishment or harm to the baby was often the impetus for eating even though it made the women feel sick.

> *I couldn't eat red meat and I couldn't eat fish. They all made me feel sick. Yet I felt I had to eat for the sake of this poor baby else it would never grow.*
> (Jane Int 1, Pg. 7)

Jane had the added concern of what effect the medication she was taking for an existing medical problem would have on the baby.

> *I'm thinking "God you know. What's this going to do to my baby. What's it doing to its bones or whatever's developing at this time ", and they offer you a lot of drugs ...//... and I'm thinking "Oh God. You know I don't want this I don't want to harm my baby."*
> (Jane Int 2, Pg. 15)

There may be not only a concern for the development of the baby but also a fear of losing the baby. Jane had some bad experiences with dry retching. She found whenever an episode of vomiting and retching was prolonged her uterus would start to contract and she was admitted to hospital on two occasions for premature labour. Both occasions were before twenty five weeks gestation

when the chances of a baby surviving are slim. Jane was not only worried by thoughts of delivering the baby prematurely but also was concerned that the extreme nausea, vomiting and retching was indicative of some other physiological factor.

> *In fact when I went into labour the second time at 25 weeks I said to him* [The Doctor] *"Look are you sure that there's not something wrong with this baby - that it just wants to abort itself - that surely its nature doing its thing. Why would I go into labour twice in 6 days if it's not natures way of cleansing the body of something it doesn't want", and he didn't think that. He didn't make me feel that I was being paranoid or anything, but I felt worried you know.*
>
> (Jane Int 1, Pg. 15)

Along with these fears of harm to the baby, or losing the baby, strong maternal feelings of protection develop during the woman's experience of sickness. The suffering endured by the woman served to further strengthen the bond between her and her developing baby.

> *At times I thought "This is my baby and regardless of what goes on I will protect it and I will look after it". It all helped me with the feelings of despair at the situation I was in. I thought "Well it's me" and "I'll have this baby after all this," and "I'll look after it ," and "It's mine," feelings.*
>
> (Elizabeth Int 2, Pg. 4)

Comments were often made about how "precious baby is". At times when the woman was feeling low and life seemed tough it was often the relationship with the baby that helped get her through. It was the baby that called forth the strength and support that the women needed to live through the experience of sickness in pregnancy. Pauline explained how it was for her.

> *[A]s soon as you know that there is a child there you want them for themselves. But you're thinking "How can I manage everything". I was very positive about the baby itself. It's just at that stage when it's quite small you think you've got to get through it, the difficult times, but the child is worth it and you know there's a person in their own right so you get through that stage and not concentrate on the bad things at that time.*
>
> (Pauline Int 2, Pg. 3)

Some participants discussed changes in the evolving relationship with the baby. When the baby is small and vulnerable as in the first few months the woman feels a strong feeling of protectiveness but as the pregnancy develops and the baby grows she establishes a closer bond with her baby. This bond develops throughout the pregnancy and goes through a transition when the baby is born and the woman adjusts to the separate person.

> *Having been through that experience I feel very close to her. Of course, I feel like she is a part of me and she's come through it all with me and because I feel Olivia is what was inside me when I was pregnant. When she was born I was shocked that a baby had actually come out. So its hard to think that she was the baby inside me...//... It's really very special. We built up a special bond and I was concerned for her and was wanting to protect her as well. She was part of me then. Now I am thinking you know someone's going to snatch off with her. Now I have to watch her and protect her more 'cause she isn't with me any longer. She's out there.*
>
> (Elizabeth Int 2, Pg. 7)

Jane who had been constantly worried about her baby during the pregnancy had created a male identity for her baby. When she delivered a daughter she found it quite hard to readjust the identity she had formed.

> *I was really shocked that she was a girl cause I always thought all the way through the whole pregnancy that she was a boy. I kept saying "him" and it took me two weeks to call her a girl after she was born. I was a bit shocked when she was born when she was actually a girl. I said "Good God it's a girl."*
>
> (Jane Int 2, Pg. 6)

Most of the women found that once the baby was born the experience with sickness did not seem so significant and at times they wondered what they had complained about. Their concern was now focused on their baby. While pregnant and experiencing nausea and vomiting there was a worry for some women that the distress caused by the sickness would be channelled into anger and resentment towards the baby. This was illustrated by Anne.

> *It's not good for your relationship really, because you can't help feeling in opposition to something that makes you feel so crook. You're also worried that everything is alright. So you've got all*

> *that anxiety and worry as well .../I... But, to be honest, you do feel a certain amount of resentment really.*
> (Anne Int 2, Pg. 4-5)

In addition, if a woman's actual experience is different to what she expected the baby may be blamed, not only for making her sick, but because it was not what she expected. This was the case with Jennifer.

> *I sort of had a basic preconceived idea of morning sickness, but of course I got it at night which really knocked all the theories that I had in my head. So I wasn't really very impressed with the baby that I was carrying. It wasn't making me feel like I thought I should have been feeling. So she got called quite a few names for the first few months.*
> (Jennifer Int 2, Pg. 2)

Later Jennifer noted how her feelings for her baby changed once the nausea and vomiting had passed and a more positive relationship was formed. Change characterises living through sickness in pregnancy.

> *I began to like the baby at that stage because it wasn't making me feel horrible. I suppose I was blaming the baby for making me feel so rotten. So at that earlier stage I didn't really like it very much. But then after I started feeling good I was happy and on top of the world, I thought "Well hey, this isn't so bad after all".*
> (Jennifer Int 2, Pg. 9)

Birks (1993) reported that for 60% of the women in her study, the experience of morning sickness had not affected their feelings towards the baby; 30% of the women found it to have been beneficial and for 10% it had adversely affected their feelings towards the baby.

It is not only the woman's experience with sickness that influences the development of the relationship with her baby but also whether the pregnancy is planned or not. If the pregnancy is not planned the woman can be confused in her feelings towards the baby and it may take longer for the relationship to develop. Pauline explained how there was a period of adjustment for her.

> *It was a complete surprise so there was a bit of adjustment there. I mean I wanted another child, we wanted another child, but not quite now. So I had a few weeks of coming to accept it and being confused about how I felt*
> (Pauline Int 1, Pg. 8)

Relating to family members

As previously indicated in addition to the relationship with the developing baby the woman's relationships with her partner and her family were typically the most important ones that were affected by her sickness experience. The woman's relationship with her husband or partner was often strained both physically and emotionally. It was her partner who often had to take over additional household duties, particularly if there were other children to be cared for.

> *I was putting a lot of pressure onto Rex too. He was having to do so much more, not being used to looking after the kids in the evenings and bath them and things like that. He umm. He lost his patience for a while.*
> (Jane Int 1, Pg. 6)

The women recognised the difficulties facing their partners who had to help or take over the running of the house, look after the children and hold down their own jobs. Their help and support was really appreciated. Even when there were no children the women still felt that they needed the support and understanding of their partners. Anne found her partner was not very sympathetic.

> *He didn't seem to understand at nights after work I was really tired, or that at times I couldn't face cooking a meal. He never said "Look why don't you stay in bed today you look terrible" - It really put a strain on us.*
> (Anne Int 2, Pg. 7)

Anne's partner found the stress and strain very difficult to cope with and separated from Anne for almost three months during her pregnancy. He returned two months before the baby was due (when Anne's experience of

nausea and vomiting had passed) and he was at this time able to be more supportive. They have remained together since. Anne felt that they had both learned a great deal from the experience and it made them more understanding of each other's needs. Other women in the study also indicated that living through this time with their partner had in many ways served to bring them closer together in their relationship.

Cooking meals was one household task that the women's partners were often called upon to deal with. Tessa appreciated her husband taking care of this even though he was not a good cook.

> *I couldn't have thought of anything worse than having to prepare meals everyday. Horrible. What tended to happen was that we'd be sitting here and then he'd say he'd go and get tea. Just really basic stuff cause he was no cook.*
> (Tessa Int 1, Pg. 5)

Sometimes the women's partners developed new skills in cooking as a consequence of being put in a situation where they had to perform these tasks as they were being relied upon to do it both for themselves and their partners.

> *For someone who says he can't cook, he can cook. I think he just used to use that as an excuse to get out of the kitchen. But when I was really not up to doing it he would cook.*
> (Judith Int 1, Pg. 3)

Allowing others to take over some of the household duties in itself caused a certain amount of anguish for the women. They felt bad that they could not do things themselves. Part of living through their experience was that they came to accept that they could not do everything and they had to hand over some duties to others. This meant a certain amount of *letting go* what was previously their domain and resulted in altered relationships within the household.

In some instances children had to take over additional household duties. This was particularly so when a husband or partner was not present. In many instances this brought a greater closeness between the mother and her children and their relationship was strengthened. From the mother's point of view the children developed greater independence, greater understanding of how they could support others and that they could be relied on. However, some mothers felt they were placing additional burdens upon their children and felt guilty about doing so. The women reported that the children developed a greater understanding of being sick and felt in most cases good about being able to help. [This was not explored with the children themselves]. Jane explained how it was for her.

> *My relationship with the children improved. They were more caring. You know if they hear me retching they'd bring me a glass of water, Haley would rub my back or get me a cold flannel or something because I used to come out in a cold sweat with being sick. They'd be really good like that, they were pretty helpful and that improved their perception of what it was like. But Haley doesn't want to have any children.*
>
> (Jane Int 2, Pg. 5)

Often women found they were less patient and not nearly as tolerant of children (especially toddlers) as prior to being sick and reported they could be snappy and short-tempered with them.

> *At the end of the day I'm feeling tired by 5 pm and you are trying to get dinner ready, you can be less tolerant than you would normally be ...//... I mean if he is doing something that I don't want him to do at that time of day I'm much more likely to put a stop to it.*
>
> (Pauline Int 1, Pg. 4)

Some women developed different strategies to cope with their children at this time. When they recognised that their patience was thin they would send the children to their room, get them to watch a video or get someone else to watch them (often this was their husband or partner). This lack of patience or reduced tolerance was not confined to one's own children but to dealing with children in

general. For Tessa who was expecting her first child it meant a change in her part-time work.

> *I was baby sitting a three year old for a while but that was just very demanding. Really all you wanted to do was just sit down for half an hour or so and she wanted amusing and to do things. I found it demanding, it just was. I was just tired and I wanted some time to myself so I gave that up fairly shortly afterwards.*
> (Tessa Int 1, Pg. 12)

Even voluntary work with children (such as involvement with scouts, guides or swimming clubs) was relinquished. The lack of patience was by no means confined just to children; husbands and partners were also significantly affected. Often this lack of patience was not able to be directly communicated to others but it was certainly recognised by them. Jennifer's husband came to recognise and understand aspects of Jennifer's experience:

> *He just said that you knew when I hit the tired stage that was it. He said I wasn't really very good to talk to because I'd grumble at him or snap at him and that he said that I'd do it so quickly without even any warning. He said one minute I'd be sitting there laughing with him and the next minute I'd snap at him. He'd know then that I was dead tired and I'd need to go to bed instantly there and then.*
> (Jennifer Int 1, Pg. 7)

Jane's husband's work often necessitated his being away from home for periods of time. When he did come home and help with household tasks Jane felt guilty as she recognised that he needed time for himself to recuperate as well. Even simple things such as disturbing his sleep made her feel bad.

> *[H]e came home tired and you know how you like to get back to your own bed. All you want to do is sleep. The last thing you want is somebody being sick or annoying beside you. I used to hate it. I couldn't help it and I knew he needed his sleep too and I was disturbing that.*
> (Jane Int 2, Pg. 7)

Being able to call on extended family members for help and support was valued highly. Mothers were most able to offer the support and understanding that the women felt that they needed. It was recognised that they had been through the

experience themselves and were able to verbally and emotionally share the experience with their daughters. They were also able to provide the physical help and assistance during this time although it depended on the proximity of the living arrangements and the closeness of the existing relationship that the mothers had with their daughters. In some cases, as with Jennifer, it was the woman's own sisters who were able to offer this much valued understanding and support.

> *I've got a sister who has got two children and she suffered 'morning sickness', as in the mornings so she could really understand. She's been really supportive. I've been really lucky.*
>
> (Jennifer Int 1, Pg. 8)

Family members, both intimate and extended, shared and were affected by the unpredictable nature of each woman's experience of sickness in her pregnancy. Family members worked together with the woman to minimise the effects and deal with the changes the experience had on the woman's lifeworld. Pride can be a factor in a woman accepting help when sick because it involves another person looking into what is essentially a private matter. This is why the family's help is more readily accepted.

> *I was lucky I had my sister in at the time and she was helping me. I employed her to come down and do the housework. You start thinking "This is ridiculous really" having to get someone to do things for you. But I'd rather have my sister than anyone else in my home.*
>
> (Anne Int 1, Pg. 7)

Interacting with others when working

In addition to the relationship with the developing baby and her family, the relationships a woman has with work colleagues can be significant. Often work relationships have been built up over a period of time and can be as an important source of support as one's own family. Appreciation of what the experience of sickness in pregnancy was like by colleagues was welcomed and valued.

> *Those that have been through it understand it. Because I do notice a difference with those that I work with who haven't had children. While they're supportive, they don't have that understanding of how you really feel. They sort of see it as a bit strange I think, or outside their experience I suppose,. And those who want to have children are a bit scared of it.*
> (Pauline Int , Pg. 12)

When considering relationships with others at work, it is important to acknowledge that there is an interrelatedness also between work and sickness. Work is influenced by being sick, and being sick is influenced by working. Relating to people other than colleagues in a work situation was very demanding for some participants. Elizabeth's job involved working with people with problems which she found very demanding mentally and physically.

> *I might have had less patience when I felt sick because if I was feeling sick and I had to sit there and listen to someone with all their problems and I was feeling sick in my stomach and the last thing I wanted was to have to sit there and be attentive. I found it really hard to concentrate.*
> (Elizabeth Int 1, Pg. 6)

Even if the women felt nauseated or were vomiting at work they felt a need to keep going because they were being paid. This often created additional stress.

> *I was working, that's why I had to push myself to finish it, but I would try and go a little bit slower, you know kind of slow myself down, to speed myself up, so it's a lot harder. That was when I was working. It's a lot harder when you are working actually ...//... you have morning tea at 10 o'clock and lunch at 12...//... You more or less have to keep going between those times. You have to to get paid*
> (Lisa Int 1, Pg. 7)

The women also tried not to allow the sickness to affect others at work. Because Jennifer experienced nausea and vomiting at night she found that her experience did not interfere with her relationships at work or the actual work she performed.

> *[T]he nausea would come on from 5 pm onwards, I finish work at 4.30 pm and I would get home and feel yukky at home. So it didn't really interrupt my day's work.*
> (Jennifer Int 1, Pg. 2)

Many work colleagues were very supportive of the participants when they understood that they were experiencing nausea and vomiting. Often they would assist with certain tasks or would adjust the day if possible to make things easier.

> *No, once the girls at work actually found out I was pregnant they were brilliant. I'm not allowed to lift and if I do I'll take the feet end or something really really light. They always sent me to first meal breaks in case I fainted on the floor I think. They were really good. If I was tired and sitting down writing notes they would just leave me to it.*
>
> (Judith Int 1, Pg. 4)

Women who work are very conscious of the tenuous position they hold in relation to work and are particularly conscious of maintaining a good relationship with their employers. They do not want to jeopardise their employment by upsetting their employers and are conscious of the cost of them being sick to their employer.

> *[I]f you are taking sick leave in the early months of pregnancy then the employers are losing out again because they have to get relievers in or whatever. So I think you tend to have those sorts of things in the back of your mind and even now when you're talking about paid parental leave and those sorts of provisions.*
>
> (Tessa Int 2, Pg. 11)

The nature of the tasks involved in their work and the understanding of the employer has a large effect on how the women view this issue. Where the women felt they were still able to carry out their usual tasks they could not see why their employment should be in jeopardy should they take a couple of days off as if they had the flu. Some employers attitudes change when they learn an employee is pregnant. The pregnant employee is seen as less productive, with changed loyalties and likely to leave. Those employers who show some understanding of the concerns facing the women, such as employment as long as possible in the pregnancy, importance of regular meal breaks, and adjusting work requirements to make it easier to cope, are highly regarded. Such an

attitude encourages the woman to remain loyal to her employer, and to return to be a productive member of the workforce as soon as possible.

Sharing with others

Sharing and talking to other pregnant women about the experience of sickness was valued. This developed a shared understanding and *confirmed* the experience as one which others share.

> *Talking with people who are pregnant at the same time and comparing experiences I find very helpful because you get an empathy about someone saying "Well I feel the same" or "I feel worse", which makes you feel better while feeling sorry for them.*
> (Pauline Int 1, Pg. 11)

This was very helpful emotionally but the women often needed other forms of support such as physical help as indicated previously. Once help was accepted it was recognised by the study participants that they could become dependent on that help.

> *I used to have to restrict going shopping or doing things. I used to get Kira my friend to come with me and help me and she'd push the trolley around and do those sort of things so that if I felt sick I could just go out side and so I sort of became quite dependant on Kira for a while as she did my house work and helped me with the kids. Anything that would cause me problems she'd help me out with it.*
> (Jane Int 2, Pg. 10)

However others may offer conflicting opinions and advice. This can create a great deal of confusion for the woman experiencing sickness in pregnancy.

> *All the conflicting advice you get is horrible when you're not feeling very well. Drink this sort of tea and do this and do that. Everyone has got their own ideas on what can actually make you feel better and how to look after yourself and everyone is different.*
> (Judith Int 2, Pg. 11)

A common misconception held by many is that sickness in pregnancy is only experienced in the mornings. Several of the participants felt that this was a misconception particularly held by men.

> *I was just talking to Andrew and some men at work about pregnancy and stuff. They just argued "But you don't get it at night time it's 'morning sickness'". It was just odd. So ingrained is the expectation that it's in the morning I guess.*
> (Rose Int 2, Pg. 5)

It was acknowledged by the participants that men do develop a certain understanding from supporting their partners through their experience but this is not seen as the same understanding that a woman develops from living through the experience herself. There is an associated *"women's way of knowing"*. Pauline explains it thus:

> *My male friends are certainly again very supportive but they probably don't have a real understanding. I remember feeling that with my husband last time with James that he found it hard with my extreme tiredness to be understanding about that and to understand what I might need in terms of support then. I mean he had never been mean or anything like that but just he wouldn't have that complete understanding of what it was like to have that bone tiredness that you get. And so I think only women can understand it.*
> (Pauline Int 1, Pg. 12)

The women in this study recognised that it is important for people to develop an understanding of the wide reaching effects of sickness in pregnancy. They felt it is difficult for others to know how you are feeling or what the experience is like for you as an individual unless this understanding is held by others.

> *[B]ecause you've almost got to walk in and announce how you're feeling before people know how to react to you. I think it would be better if people knew that you may feel like this .*
> (Tessa Int 2, Pg. 9)

Some of the women mentioned that at times they felt others thought they were playing at being sick. This was because often the woman would look well to others but feel very ill.

> *If you're looking healthy they sort of look at you like there's something wrong with you if you say that you're not feeling 100% .*
>
> (Tessa Int 1, Pg. 10)

Attitudes such as these could take an extreme form of criticism that the woman was not stoical enough to handle the experience. Jane thought this to be more true of the elderly in society who perceive that they have lived through harder things in their life.

> *I suppose there must be a few taboos about it you know. Like the elderly men and the elderly women who think you know you're letting yourself down, or you've not got a stiff upper lip to bear it. At any rate they couldn't understand why I was so sick and so wretched.*
>
> (Jane Int 2, Pg. 12)

The belief that unless you have lived through the experience you have no understanding was held by many of the women in this study.

> *But unless you've been though it you don't know what it feels like and people used to you got the impression that they thought you were playing on it. But it was a very real thing. But unless you've had morning or night sickness you don't really know what it's like.*
>
> (Jennifer Int 2, Pg. 3)

Limiting social contact

Due to the unpredictable nature of the nausea and vomiting as well as the general misery of it, social contact was often very restricted. This put an additional strain on a couple's relationship, as some social contact such as work related functions can be politically important in a partner's career development.

> *If we have an outing for Ross' work or anything I wouldn't go. There were quite a few social functions on but I just couldn't go to them because I knew that the minute I stood up after eating a meal I would be sick.*
>
> (Jane Int 1, Pg. 10)

Often it was not just the concern for the woman herself, but concern for others that she would come into contact with, that was the overriding reason for

reducing social activities. The participants did not want to spoil a social occasion for others.

> *I did avoid going out because I was embarrassed because I knew I couldn't be normal. If we went, if we're invited somewhere for tea, I'd say to Andrew "No, we'll just go another time", because I knew I would feel crook at night, and I didn't want to embarrass them and not eat their dinner and you really don't want to upset them.*
>
> (Rose Int 1, Pg. 11)

For some of the women social contact had to be planned at a time when the experience could be coped with. This was easier if there was a predictable pattern in the woman's experience such as the time of the day the nausea or vomiting occurred for her. This was still seen as being restrictive but was better than having no social interaction at all.

> *It wasn't fair on our friends for me to go out because I just didn't feel very sociable at all. I just preferred to be left alone and it was easiest to do that. We basically told them that I was feeling that way. They were really understanding about it and we used to get together on weekends before, like 4 pm when it really used to hit me. We'd have lunchtime get-togethers and things rather than at night.*
>
> (Jennifer Int 1, Pg. 8)

Social contact was recognised as being important. When a woman is feeling sick and stays at home she can become very lonely and depressed. This is particularly so if the experience with sickness is prolonged during the pregnancy. Even if it meant forcing themselves to go out when they were not feeling up to it, the social contact often made the women feel better and boosted their morale. Once the experience of sickness had passed there was a marked increase in the women's social interaction with others.

> *I became more sociable and more happy. We could go anywhere at any time we wanted to. It was neat. We could go out with friends and that again, and go places and do things without being restricted to this time limit. Having to do everything during the day and weekends doing it during the day to make sure your sort of home around 5 ish was very restricting and I found we used to visit a lot more people and people used to come around and visit*

> *us knowing that they weren't gonna be struck by this person who wasn't feeling very well and wasn't very sociable.*
> (Jennifer Int 2, Pg. 17)

Reducing social contact to avoid revealing sickness and embarrassing self and others was not always possible. In Jane's case the uncontrollable nature of the experience meant she was quite often sick in public. She found that people did not accept it very well which caused her a great deal of embarrassment.

> *Even from the early stages when I was pregnant and didn't even show I felt sick and was visibly sick. People would sort of shun you and you would think that they would be saying "Good God look at that women being sick in the street" . They just don't have any perception of what it's like for somebody .*
> (Jane Int 2, Pg. 10)

Jane found that it was much more emotionally upsetting to be sick in front of men. Partly this difference is because women are acknowledged as having some understanding.

> *I did it out-side the school once in front of one of the teachers. I was taking the kids to school and she said "You don't look alright ". I said "I just feel sick". She said "Are you alright?". "No". I opened the door and was sick as ever, and the Head Teacher came out to see what was up and he's a man. I find those kind of situations really embarrassing. Like I didn't feel so embarrassed if it was a woman .*
> (Jane Int 2, Pg. 9)

Relating to health professionals

Health professionals are seen as the experts who care for women during pregnancy. However, the information about sickness associated with pregnancy and the understanding and support that was expected of this group of people was not forthcoming for the participants in this study.

Although the doctor was seen as the person with the knowledge some women, like Tessa did not know *"what things are important to mention and what things*

aren't" (Int 1, Pg. 15). They did not want to bother the doctor with things that are considered irrelevant as Tessa elaborated:

> *When you are talking to the doctor you are never quite sure what to say to the doctor. He'd say "How are you?" and you're never quite sure about it, about what to say. "Oh well I've been really tired this week or whatever". ...//... you know maybe you're just whinging about something that you should be putting up with.*
> (Tessa Int 1, Pg. 14)

Tessa went on to explain that she felt the doctor was not questioning her about important things and she, at the time of the visits, didn't think about them.

> *'How are you?' is such a general sort of open-ended question that I could sit there and tell him about the terrible day I had at school or, I've just had a row with Peter or whatever. Which is totally different to "Oh well I've been feeling nauseous." If he had asked more specifically I would have been able to respond more appropriately. If he said "Have you had these symptoms?" that sort of thing. Then I would have known what was normal and what wasn't normal too I suppose.*
> (Tessa, Int 1, Pg. 16)

Most women would welcome the opportunity to know what to expect and what was considered normal in relation to their experience. Seeking and being provided with information was seen as important. It was expected that health care professionals would provide this information. Birks (1993) stresses that information about the effects of 'pregnancy sickness' is needed by both sufferer and significant other persons in her life. When this information was not forthcoming as in the case of Elizabeth this reflected on her impression of her current doctor.

> *I don't think my doctor was very good...//...Nobody here said anything to me about the pregnancy or booking into ante-natal classes or anything like that. I managed to pick some things up from people at work and I went out and bought a book to read <u>The New Zealand Pregnancy Book.</u> The Doctor never told me what things to expect or anything like that.*
> (Elizabeth Int 1, Pg. 10)

The women judged their relationship with the doctor by the amount of time that doctors spent with them. The women felt that they needed time in their visits to

discuss things as an individual with the doctor rather than being rushed and under pressure. As the doctor is seen as the person with the knowledge involved in their care they felt that this was one person who would be able to understand their concerns and to provide the information they required.

> *When I've gone to the Doctor it's been such a rush in and out to see her for a couple of minutes and I haven't even had the opportunity if I've had any concerns or anything that I think need to be addressed to bring it up with her .*
> (Elizabeth Int 1, Pg. 11)

Several of the women did not discuss their experience of sickness with their doctor. Some of this was related to an attitude perceived to be held by some doctors that experiencing nausea and vomiting was just a normal part of being pregnant and was not an issue for them to be concerned about.

> *I never discussed it with any doctor to be quite honest* [Why was that?] *It never occurred to me to go to the doctor and say look "I feel absolutely ratshit . Can't you help me?" I think I probably would have expected his reply to be "Well you are pregnant - you are expected to feel like that".*
> (Anne Int 1, Pg. 13)

Midwives were seen in this study as relating to women better than doctors. This was in part because the midwives were considered to have more experience with the everyday concerns of the women.

> *Having the midwife has been good. I've got a Domino midwife and well I think that she knows a little bit more about it than what the doctor does. He knows the sort of advanced stuff if there's any problems and that sort of thing, but she knows more about what's normal I think....//... That's what they deal with all the time. Whereas the doctor has to have a lot wider knowledge and so possibly isn't always focused on what the pregnancy itself is like. Plus, I suppose, the midwife is a woman and she has been through it, or seen others through it .*
> (Tessa Int 1, Pg. 17)

For health professionals to have a genuine interest and concern for the woman's well being was seen as being very important by the women in this study. The attitude of the doctor or midwife affected how much of their experience the

women disclosed. Judith was the one that appeared to have the ideal relationship with the health professional that cared for her.

> *I've had good advice - a really good rapport. We get on really well. My Doctor's very supportive and easy to talk to in a very relaxed manner. You just walk in there and you feel you're the most important person to her even if she's got a waiting room with about 4 or 5 other pregnant women out there. I think that's fairly important to be able to talk to your GP and not hold anything back.*
>
> (Judith Int 2, Pg. 16)

The attitude of health professionals in accepting and acknowledging that nausea and vomiting does exist is important as it leads to openness and sharing by the women. In the following excerpt Jennifer shared how good it was to have her specialist and midwife believe in her.

> *I felt he didn't make me feel like I was making it up or I was talking nonsense. He really made me feel like he believed in what I was saying. And I had a really good midwife who was really good as well...//... I was lucky I had two people that did believe me and I think it would be very difficult if people didn't believe you. ...//... But because I really just sort of had a queasy feeling and just dry retched it wasn't quite so visible to people. So to have them believe me that what I was saying did exist made it a bit easier.*
>
> (Jennifer Int 1, Pg. 14)

The invisibility of the experience of sickness is one of the difficulties in the development of acceptance of this as a concern for health care professionals. Pain is now commonly accepted as being what the person experiencing it says it is (McCaffery 1979). It is anticipated that a similar level of acceptance for the experience of sickness in pregnancy will come in the not too distant future.

Summary

Sickness in pregnancy is a very private experience and is disclosed to others to varying degrees. There is a reserved sharing of the experience. It is not easy for a non-sufferer to imagine the effects of this phenomenon as it is usually invisible. The participants' experience of sickness in pregnancy impacts on their

existing relationships with partners, family, friends and work colleagues; and also on their developing relationship with the baby.

For a woman experiencing sickness, support and understanding are very important, although she does not always find it easy to accept help. Emotional and physical support can come from different people, but in particular it comes from the woman's partner and family . The stress of living with sickness in pregnancy can exert a strain on some relationships, especially that involving the women's partner. Often there is growth in the relationship from living through this experience together.

Health professionals are accepted by participants as being the experts with the knowledge relating to a woman's experience of pregnancy and it is from them that the women seek information as well as support and understanding. Nurses and midwives, wherever they come into contact with women socially or in a work situation, can play an important role in acknowledging the reality of the experience for women. Ultimately it may take a fellow sufferer to empathise with the women's situation.

The importance of perceived time (temporality) and lived space (spatiality) in relation to experiencing sickness in pregnancy will be examined in the following chapter.

Chapter Seven

TEMPORALITY AND SPATIALITY

Introduction

The previous two chapters in examining corporeality and relationality have given some insight into the lifeworld of a small group of women who experienced sickness in their pregnancies. This chapter will continue to illuminate the women's lived experience by considering the remaining two lifeworld existentials of temporality and spatiality.

Two aspects of temporality will be discussed: firstly that temporality is concerned with the women's subjective perception of time rather than clock or objective time; and secondly temporality involves the women's temporal landscape and its past, present and future dimensions. Although at times the women did look at time objectively, more often they experienced time subjectively which concerned the rate at which time passed for them. Often daily routines or activities had to be adjusted as they seemed to take longer to complete. The severity of the women's sickness as well as when it occurred in relation to the interviews significantly affected how they viewed their past, present and future.

The severity of the sickness also affected how the women viewed their lived space. Space in the context of this thesis relates to Heidegger's concept of 'Dasein' or a way of being in the world and concerned the women's 'felt' space. There were two main settings that women could clearly identify, these being

private space and public space. How the women felt and functioned in each setting was significantly different and was largely influenced by the social expectations associated with each setting. As indicated previously, all four existentials influence and are influenced by each other so in examining temporality and spatiality aspects of corporeality and relationality will be discussed further.

Temporality

Most of the women reported that time seemed to *slow down* for them during the period that they felt sick. Often this feeling was referenced back to a clock time to emphasise the perceived lengthening of time.

> *[I]t used to start from about 5 o'clock onwards and I'd be in bed by 8 o'clock. So I really wasn't up for long but it did seem to feel like it was dragging. Feeling sick it was sort of endless. The time did really drag. It seemed like it was eight hours instead of three.*
>
> (Jennifer Int 2, Pg. 9)

It wasn't just the hours that dragged and seemed to go slow. The days, weeks and even months seemed to go slow, or even for some stand still. A few weeks seemed endless and a long way off.

> *You didn't know when it was going to stop and like they say it usually subsides after 3 months. So you're sort of looking at yourself at 6 weeks and you've just got it, and you're thinking "My God 3 months - that's a long way away".*
>
> (Rose Int 1, Pg. 11)

On reflection once the experience had passed this perception of temporal slowness was revised and the time frame of being sick was recognised as being quite short.

> *I was only sick for a short period which was good but while you were sick you were wondering when it was going to end. - you just didn't know. It seemed as if the days were not passing and time had stood still.*
>
> (Rose Int 2, Pg. 2)

According to Van Manen (1990, p. 104) "The temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape". How the individual women viewed their lived time depended on the severity of their experience and when it was situated in relation to the interview (that is, present or past).

Some of the women while they were experiencing nausea and vomiting found it difficult to maintain their present situation in perspective. They began to perceive themselves as eternally trapped in their present predicament. It became difficult to maintain the view that the present difficulties would eventually pass and that they could look forward to the future. Lisa summed this up thus:

> *I like to see light at the end of the tunnel if things are getting rough. But this at times, I thought it would never end. It seemed to be going on for ages and ages.*
> (Lisa Int 2, Pg. 14)

Things were so miserable for Anne that the previously anticipated future seemed distant and unclear.

> *When I was in those first few months I thought "This is going to kill me". "I don't want this". At times it seemed as if life had ended it as I knew it. It really did.*
> (Anne Int 2, Pg. 10)

All the women found that living with nausea and vomiting affected the timing of their daily activities. They reported that various activities took longer to do and that they had to adjust their time accordingly.

> *I felt slowed down, tired, sick and miserable. It seemed to take forever to do things. Just doing the washing, cleaning up the house, ironing and that sort of thing took ages. I just had to accept that things took longer to do or they just didn't get done.*
> (Tessa Int 2, Pg. 10)

For the women who were in paid employment this had a dramatic effect on the time they had to accomplish even the most basic of everyday tasks. Elizabeth felt that she was always running late for work.

> *When I think about getting ready in the morning to go to work that takes me - that seems to take me you know longer than normal. I'm always running late for work to get there in the morning that's because I guess I'm tired and feel sick and have to do things at a slower pace. I can't eat my breakfast on the run or rushing you know putting clothing on and getting ready whatever. I can't eat a piece of toast on the run, I've actually got to sit down and have it.*
>
> (Elizabeth Int 1, Pg. 8)

Some of the participants appeared to simply accept the interruption in their lived time others however felt frustrated by it. The frustration ranged from annoyance to an absolute hatred of this aspect of their sickness.

> *I found it a bit frustrating. Probably because I like doing things when I want to do them, not when my body say s it's ready to do it and not when anyone else tries to stop me.*
>
> (Judith Int 2, Pg. 5)

Even activities such as keeping a diary, which are sometimes seen as being beneficial in helping to understand one's situation and to identify coping mechanisms, were not seen as being advantageous at all. Lisa found that drawing attention to her sickness dragged everything out further.

> *It dragged the week out. Most people say you go quickly through your pregnancy, nine months isn't long. And I started the diary and kind of wrote down everything everyday and the weeks seemed to drag out so long because you're writing out things. So I decided to stop it.*
>
> (Lisa Int 2, Pg. 12)

How temporality is affected by previous experience

Benner and Wrubel (1989, p. 67) state that "temporality is not experienced in the abstract. It is specific and formed by what has gone on before and by what is anticipated". For those who are experiencing sickness in pregnancy for the first time temporality differs from those who have been in this situation before.

Women who have experienced this phenomenon in a previous pregnancy have acquired a framework in which to interpret their present experience. This could have both positive (the experience is short lived and will pass) and negative (the dread of going through it all again) dimensions. Pauline who was experiencing her second pregnancy indicated her acceptance of her situation yet still maintained hope that the sickness would pass quickly.

> *I hoped that it was going to be short lived. I mean it was a difficult, virtually, three months. I found it difficult and I didn't enjoy it and that feeling because it was pretty constant. But I think when you know something is only temporary and you know what's causing it, it's much easier to deal with*
> (Pauline Int 1, Pg. 3)

Jane, who experienced severe nausea and vomiting throughout the whole of her pregnancy, found that placing her present experience in a context of what she had experienced before was a great help to her. This was despite the nausea and vomiting being more severe with this pregnancy.

> *If it had been my first pregnancy and faced with all that I would have been really daunted. I'd have wanted to cut my head off or something but having been through it before with the other two I sort of knew what to expect and knew how long it may go on for, that it may go on for the whole pregnancy or it may not. It was a real help that.*
> (Jane Int 1, Pg. 11)

A woman who is embarking on her first pregnancy does not have this perspective from which to view the current experience but this will develop as she lives through her experience. The experiences of family, friends and work colleagues can have an influence on the women's present perspective. Tessa noted that her mother had suffered terrible morning sickness in her pregnancy so she was expecting to have a similar experience. However she felt relieved that her own experience wasn't anything like her mother's.

> *My experience was nothing compared to Mum's. My mother used to go and throw up every morning and I expected something*

similar to what she had gone through. And I didn't. It was much better.

(Tessa Int 1, Pg. 3)

Jennifer, another primagravida, indicated how much better prepared she would be for dealing with the phenomenon in a future pregnancy.

I think it would be easier next time though because I would know what to expect. I'd probably be able to handle it a bit easier too. I wouldn't let myself get so down about it because I'd know that it'll eventually stop ...//... It isn't for a life time it's only for a basically short space of time. I mean when I was first pregnant it felt like this first 3-4 months is like 4 years. But the second time round it wouldn't feel so bad because I'd know what to expect I'd know how to feel and what to do to help myself. I wouldn't be going into it blind.

(Jennifer Int 2, Pg. 13)

Previous difficult experiences are retained as memories that can be called upon to assist the individual manage the present experience. The past leaves its traces on the individual's being as learning, which changes how one views the present experience. The present experience in turn changes how one has viewed the past as it serves to reinterpret the experience. The future is what all people live towards and is constantly being reinterpreted by the process of being in the world. Hopes and expectations for the future, be it a day a week or a month, are constantly affected by the present.

The women's outlook on life

Experiencing a distressing phenomenon can influence a person's time horizons and alter their normal outlook on life. Anne reported how miserable her future looked early in her pregnancy and how she developed a degree of acceptance of the nausea and vomiting. This was an experience identified by several of the women but it did not mean that the *hope* of it coming to an end was abandoned. The women looked forward to the time the experience would pass for them. It gave them something to anticipate - hope that there would be a future without

feeling miserable. No matter how desperate there was always hope that the experience would end or that there would be some relief.

> *[I]t seemed never ending the actual nausea as such, feeling absolutely rotten. I associated with it ending at 3 months but I crossed my fingers because I wasn't sure ...//... For me, it was "Oh please God what am I going to do if it doesn't finish in 3 months". You know there was just no way I thought I could cope with the pregnancy and cope with the* [business] *and anything in my life if this continued on ...//... I think what I'm getting at is, it was just so miserable, so rotten that you almost can't find the words to describe it and you looked forward to that 3 months time and hoped and, in anticipation, that it would go away.*
>
> (Anne Int 2, Pg. 10)

For some women experiencing nausea and vomiting was so overwhelming that they became desperate for it to pass. Jennifer said *"I just prayed for a day of not having it"* (Int 2, Pg. 4). Women who live with this phenomenon right throughout the pregnancy (like Jane), although they may know from previous experience that it will end with the birth of the baby, find the thought of going overdue can be horrendous.

> *[I]t was too much ...//... I knew that it was gonna stop. I hoped it would stop. I just knew that eventually it was gonna stop anyway from when she was born. So I was just hoping I wasn't going to go overdue. At times I thought I'd never get through it.*
>
> (Jane Int 2, Pg. 14)

As indicated previously once the sickness stops it may come as quite a shock it has actually passed. Once it had passed the women all felt better, their outlook on life look brighter and the future appeared more positive.

> *I just prayed for a day of not having it really, and then I got like, one day I didn't have it, I didn't feel quite so bad from 5 o'clock onwards, and then the next day I was the same again. And then slowly it dawned on me that I'd gone 4 or 5 days without actually feeling horrible and I thought "Oh, this is wonderful. Why am I feeling so good? Oh, it's because I'm not feeling sick". Everything seemed so good so marvellous.*
>
> (Jennifer Int 2, Pg. 4)

Once the experience had passed the passage of time and intervening events changed how the woman viewed the experience. Jennifer's temporal landscape was significantly altered after the birth of the baby.

> *I complained over such a short period of time really. I mean it wasn't a very nice thing to go through and sure the thought of having another baby and going through it again isn't a happy thought. But it really doesn't seem as big an issue now as it did then. It's definitely faded. Lots of other things happened since to have made that seem quite insignificant really.*
> (Jennifer Int 2, Pg. 15)

An inability to control the nausea and vomiting meant planning for the near future was often difficult. As Lynette said *"You would never know when it will hit you"* (Int 2, Pg. 13). Just as the women could not be certain when the nausea and vomiting would affect them they could not predict how it would affect them either. However, as they reflected and became more knowledgeable about their experience and could identify patterns and triggers they could plan some aspects of their lives. This included developing strategies to better cope with the disruption to their lives caused by the nausea and vomiting. The way the women coped with being in the world is the focus of the following chapter.

Spatiality

People are situated not only in terms of their experience of time but also in terms of their experience of their lived space. As indicated in the introduction to this chapter, the participants clearly identified two main settings: one private, the other public. Some women also identified an intermediate setting that was neither private or public. Different settings evoked different feelings for the women. Jennifer explained the difference as follows:

> *I felt much safer at home or at Mum and Dad's, I was quite happy out there, but I preferred to be at home. I was more comfortable and relaxed. If I wanted to lie on the couch I could lie on the couch. Whereas if you were visiting somewhere you*

> *sort of felt compelled to sit there and be sociable. And if you're not feeling very well it wasn't very easy.*
> (Jennifer Int 1, Pg. 8)

The security of private space

The private setting was the one in which the women *felt safe and secure.* In this space they felt that nobody was watching them and they could be themselves. Usually this was identified as their own home or the home of close family.

> *But for me coming home at night is like coming to a secure place that I feel comfortable in. I've been away a couple of times to my family in Auckland and Wellington and that's been OK but when I've actually come back home it's been so good to be back home. It's like I suppose a relief type of thing. It's my home and I can be myself.*
> (Elizabeth Int 1, Pg. 5)

Home according to van Manen (1989, p. 102) is "where we can be what we are". Anxiety is reduced in places where people feel safe. Home was one place where all participants did not have to expend energy on pretences or put on a face in front of others. It was a place that was really appreciated, especially after work.

> *It was somewhere where I could collapse on the couch and feel how I wanted to feel without having to put on a happy face. If I wanted to feel lousy and curl up on the couch I could happily and comfortably do that. I didn't feel like I had to put on a happy front all the time. It was wonderful I couldn't wait to get home.*
> (Jennifer Int 2, Pg. 11)

The security provided by being at home extended beyond merely being able to relax and more readily accommodate their physical needs. Rose explained how she felt able to give vent to her true feelings when she was at home.

> *I was quite moody sometimes I suppose more towards my partner than anybody else ...//... I was working but I never let it get away with me there but at home it was different. It was different because home is a place you can be yourself.*
> (Rose Int 2, Pg. 3)

Home for some was described as a sanctuary. Often remaining at home allowed the women to feel more secure about accommodating their physical needs but the constancy of Jane's nausea and vomiting resulted in her sometimes feeling trapped because she couldn't get out and about as she would have liked. Having previously vomited on several occasions in public places she was so ashamed of her body letting her down in public that she avoided going out as much as possible.

Although home was regarded by women as a safe place some home activities could even violate this sense of safety. Lisa related how she had to get out of the house at teatime when certain foods, such as fried bacon and eggs, were cooking saying; *"I'd usually disappear out of the house just to get away from the smell".* (Int 1, Pg. 7).

The need to get out of the house, either for physical or psychological reasons, meant that other safe places had to be found. Neighbours, parents, in-laws or close friends homes often provided such sanctuaries.

The increased security associated with the transition from public to private space was so significant for some women that it could outweigh other stresses. Rose was working full time and when she got home from work she had to look after her three year old toddler and cook the dinner (her husband did not finish work till 8 pm). She found this time of the day stressful. Despite this stress it was not as bad as being at work, *"As soon as you got home you felt better ".* (Int 1, Pg. 7).

The unease of public space

Public space is considered to be anywhere populated or likely to be populated by strangers or people with whom the women do not have a close relationship. The social constraints of public environments heightened the women's awareness of how they should behave and what was socially acceptable in such spaces. The women felt uneasy in such environments and felt they had to be on guard in case their body's let them down. They felt that they had to put on a face and could not relax and be themselves. As a result such settings were often avoided.

The women made various provisions for the possibility of vomiting unexpectedly in public spaces, such as ensuring a towel was kept in the car or a box of tissues being carried in one's handbag. This was usually a learnt behaviour resulting from their having been caught out a few times and feeling very embarrassed by it.

> *I'd never really made any provisions at first. Normally I was at home and it didn't matter. But the time that I was sick at school three days in a row I thought "Oh God, I had better put a basin in the car".*
>
> (Jane Int 1, Pg. 6)

The women expressed an abhorrence of revisiting places that had previously triggered their nausea and vomiting. If it was possible these places were avoided.

> *I couldn't handle greasy stuff, like fish and chips and stuff like that. Even the smell, like if you went past a fish and chip shop or KFC or places like that. Oh Yuk. I had to avoid those places.*
>
> (Rose Int 1, Pg. 11)

Women struggled to meet the expectations of the environments they were obliged to frequent. One such place was work. Lynette explained how meeting the expectations of her workplace affected her.

> *[D]uring the day while I was at work I wasn't tired. I guess because you are on the go and you are really quite busy ...//... But when I got home from work I would just collapse and I'd be absolutely exhausted*
>
> (Lynette Int 2, Pg. 4)

As her job involved fieldwork Elizabeth often found the physical environments that she had to frequent made her more aware of the physical aspects of her experience, particularly if she could not get away from triggers that would set the nausea and vomiting off.

> *[N]ormally I could handle going into a home that was extremely smelly and dirty and it didn't worry me. But I actually started to dry retch in there. I think that that was because I was pregnant and the nausea was really getting to me and it didn't take much to set it off.*
>
> (Elizabeth Int 1, Pg. 6)

Jane searched for an explanation for why she had to frequent public spaces that she felt unable to adequately cope with. She tried to place it in a context of social change over the years.

> [In the past]*women hid themselves when they were pregnant. They stayed at home and just got on with the jobs of housework and whatever. But we're a lot more mobile now-a-days. We live in a lot more social community now. We go out more. We get involved in the children's school activities and things like that. So you're out more often. You've got to go and get your groceries. You've got to go to the doctor. He doesn't come to your house anymore. We're therefore more mobile. So therefore we're put in the predicament that we may not be well in public .*
>
> (Jane Int 2, Pg. 11-12)

A few women spoke of the workplace as an in-between space that was neither private or public. This was a space they were familiar with and was populated by some people that they knew. As seen in the previous chapter people at work were frequently acknowledged as being very supportive, understanding and helpful. Pauline indicated that this *"made it so much easier to be at work "* (Int 1, Pg. 6). For many women it was the relative ease of the work environment

and the support of their colleagues that enabled them to continue working during this stage of their pregnancies. For other women this supportive in-between space included sports clubs, church and wherever any special interest groups they belonged to met. These were familiar places.

Summary

This chapter has examined the lifeworld existentials of lived time and lived space for the women in this study. Subjectively time for all participants while feeling sick was slowed and seemed to drag. When performing physical activities the women found that it took longer to do things resulting in a disruption to normal routines. Tiredness and the need to rest further truncated the amount of time available to women to perform the everyday routines of their lives.

The severity of the sickness experienced by the women and the closeness of the experience in relation to the time of the interview affected the women's temporal perspective. For those women who were severely affected the future seemed distant and unclear as life was so miserable in the present. Some women could objectify the expectation that the experience would pass at the conclusion of, or (hopefully) earlier, in the pregnancy. Often this was based on having lived through the experience once before and knowing that once the experience was over it stayed in the past. For others this objectivity was difficult to achieve and alternating hope and despair began to substitute for certainty, particularly for those expecting their first child.

There were significant differences in how each woman felt in relation to the setting she was in at any particular time. The woman's own home or the home of close family was regarded as a private space. This was a space in which all participants felt comfortable. It was a safe place where they could relax and be

themselves. Public space was anywhere where strangers or other people with whom the women did not have a close relationship were to be found. In such settings the women's confidence was tentative and they felt quite fragile. The social constraints of these environments heightened the women's awareness of how they should behave and what was considered socially acceptable. The participants felt that in such settings they had to be on guard in case their body let them down, they had to 'put on a face' or pretend and they could not relax and feel comfortable. As a result such settings were often avoided. An intermediate space was identified by some participants where they were familiar with people encountered and which was not as threatening as the public spaces, such as the workplace.

Chapters, Five, Six and Seven have provided an insight into the world of women who experienced sickness in pregnancy. Living with this phenomenon is a burden that affects the lives of the women and their families. In order to minimise these effects on their life, the women develop a variety of strategies to retain a sense of normality in the world. These coping strategies are the focus of the following chapter.

Chapter Eight

BEING IN THE WORLD - COPING

Introduction

Despite the distress and interruptions in their lifeworld as revealed in the preceding three chapters, life has continued on for the women in this study. Although the nature of their individual experiences covered a range from mild discomfort to extreme distress all the women strived for a *sense of normality* in their 'being in the world'. This chapter will examine how the women coped with the phenomenon of sickness in their pregnancies.

There was an acceptance of the phenomenon as a 'normal' part of pregnancy not as a health problem or a sickness. The women realised that they had no control over the total experience but they could manage aspects of it and thereby minimise the impact of the sickness on their lives. They reasserted what control they could in living through this experience.

The way the women coped depended not only on the nature of their situation but on their previous experience (or lack of it) with the concerns and background meanings this experience applied to their present situation. Benner and Wrubel (1989, p 125) state: "Coping involves not just how one struggles with situational demands or how one's life is affected by one's changing situation. It also involves personal change through the incorporation of new meanings". For all the women in this study new meanings were incorporated in their 'being in the

world' not just for the present but also for the future. In coping with 'being in the world' the women had to first come to terms with their experience.

Coming to terms with the experience

As previously indicated being pregnant and experiencing sickness interrupts the habitual relationship a woman has with her body and increases her awareness of her body. When being sick became a regular (daily) experience, the women in this study had to make adjustments to their being in the world. In effect they had a different body with which they had to learn to live. Jane summarised the need to accept these adjustments;

> *You just take it in your stride if those sort of things sort of happen to you. You just have to. Your body does it for a reason.*
> (Jane Int 1, Pg. 7)

Jennifer was less confident in her approach and at times felt she had to endure it rather than accept it and find ways to cope. As she said (Int 2, Pg. 8) *"I just put up with it"*. This explains perhaps why she felt she was unsuccessful in finding satisfactory coping strategies. Coping generally involved changes which were part of a learning process through which the women came to accept the limitations that their bodies had imposed upon them. Judith explained it very clearly:

> *I didn't really resent it but I had to learn to cope with it and realize that it's probably just a normal part of pregnancy and just accept it . There's no use getting upset because I couldn't maintain my former racing around. I had to accept that it was part and parcel of it and just learn that it was OK to just take it a bit quieter and a bit slower*
> (Judith Int 2, Pg. 4)

Judith went on to explain how not only had she had to make changes but she also came to recognise that these changes were acceptable. Acceptance for the women involved learning that they could not continue their lives as before.

> *Because I am normally healthy and never get sick the hardest part was accepting it and realising there was a reason and that I could stop ...//... But I just had to realise within myself hey it was OK to stop and rest and its OK to feel tired or sick. There's nothing seriously wrong with me.*
> (Judith Int 1, Pg. 10)

The changes that the women made had to accommodate not only the limitations of their changed bodies but the realities of their daily lives. Those who continued to work during their pregnancies found that they needed to accommodate the requirements of work as well as deal with their experience. Work often had to be given priority over other activities. Elizabeth explained how her life had changed.

> *My whole life's changed really since I've been pregnant. I have felt very much like it's coping with everything. My whole life has had to fit around being able to cope with work, not just the feeling of tiredness and nausea but being able to handle it through the day at work.*
> (Elizabeth Int 1, Pg. 4)

Learning to accept a new situation requires one to let go of the values that underpinned previous behaviour. The flexibility required by the women to adapt to the unpredictable and unreliable nature of their new body necessitated them relinquishing old habits. For some of the women this was frustrating as Judith explained.

> *[I]t's a wee bit frustrating but not really enough to upset me. You had to take heed of your body. If it said rest I'd try and rest. If it said "hey I'm feeling a bit sick" or if I'm feeling a bit queasy I just would take it a bit quieter. The biggest thing for me was just being flexible and not trying to do too much at once. You don't have to get it all done.*
> (Judith Int 2, Pg. 5)

The normality of sickness in pregnancy

Acceptance for the women in the study was made easier by their recognition that sickness can be a normal part of being pregnant. Something that is perceived as normal is much easier to accept than something that is perceived as outside the

norm. By simply accepting the sickness as part and parcel of being pregnant it became for the women their normal way of being in the world. As Judith said: "You *know that it is a normal part of pregnancy."* (Int 2, Pg. 5)

Knowing that many other women had similar experiences during their pregnancies helped the women regard this phenomenon as normal. The realisation that they were sharing a common experience with other women also provided a sense of comfort even if their experience was not the so called classic "morning sickness".

> *I think the only good thing about it was that I wasn't the only one. That numerous women go through it and I wasn't the only person going through it and this wasn't going to kill me. Unfortunately it was just part and parcel of being pregnant for me to have it at night time and to feel sick.*
> (Jennifer Int 1, Pg. 12)

> *I did read quite a bit so every time I got a feeling or generally felt sick or had a different feeling that I hadn't had before I had already read about it. So I knew it was quite normal to be experiencing what I was experiencing. It was good.*
> (Lynette Int 2, Pg. 4)

Although the women in this study generally considered those women who do not suffer sickness as being lucky, the sense of it being normal can be so strong that they can be perceived as unusual. This could sometimes result in them being resented by other women. As Jennifer said: *"I had another girlfriend who didn't get sick at all so she was hated. "*(Int 2, Pg. 12)

Not only was the phenomenon seen as a normal part of pregnancy but it was also seen as having a normal duration. While they recognised that the duration of the nausea and vomiting could range from none at all to the entire pregnancy the women believed that it was usually confined to the first trimester.

> *I sort of hoped that I would be, like some of the average people and stop after 3 months. And so it was really just waiting to get to the 3 months and then seeing what happened.*
> (Jennifer Int 2, Pg. 5)

Acceptance of the normality of the experience meant that some of the women were uncertain whether it was an appropriate symptom of their pregnancy to discuss with their doctor as was the case with Tessa. She also did not want to be made to feel like a fool or to be seen as not coping.

> *[Y]ou're never quite sure what things you are supposed to mention to him and what things you are not because, you know you don't want to feel like an idiot.*
> Tessa (Int 1, Pg. 14)

Accepting the experience as a normal part of pregnancy helped the women maintain a sense of normality in their lives especially as the involuntary and unpredictable nature of the nausea and vomiting resulted in feeling they had lost control over their bodies. Although the women accepted the experience as part of being pregnant, they hoped it would pass, and developed coping strategies to exert what control they could in their lives.

Developing coping strategies

Coping strategies in this study refer to any changes or alterations to the participants' lives which made it easier for them to deal with the sickness they experienced. Sometimes coping strategies just emerged gradually as changed behaviours. Anne indicated that she developed coping strategies even though at the time she was not aware of doing so. For Tessa, necessity was the mother of invention. She described how the fear of not being able to cope gave way to the imperative of having to cope once she began experiencing nausea and vomiting.

> *I suppose you don't think you can cope with it until you actually get in to the situation because you probably don't think you can cope with the morning sickness, even to the extent that I had it, until you get there and then you have to cope and so you cope.*
> (Tessa Int 2, Pg. 3)

Coping strategies appeared to fall into two categories: strategies to manage the causes of nausea and vomiting; and strategies to manage the effects of the

experience of nausea and vomiting. The two types of coping strategies arose due to the cause and effect relationship that women reported. Women perceived that there were certain environmental factors that triggered their nausea and vomiting. The nausea and vomiting in turn was seen as producing flow on effects to their lived bodies and their daily lives as we have seen in the preceding chapters. The relationship is outlined in Fig. 1.

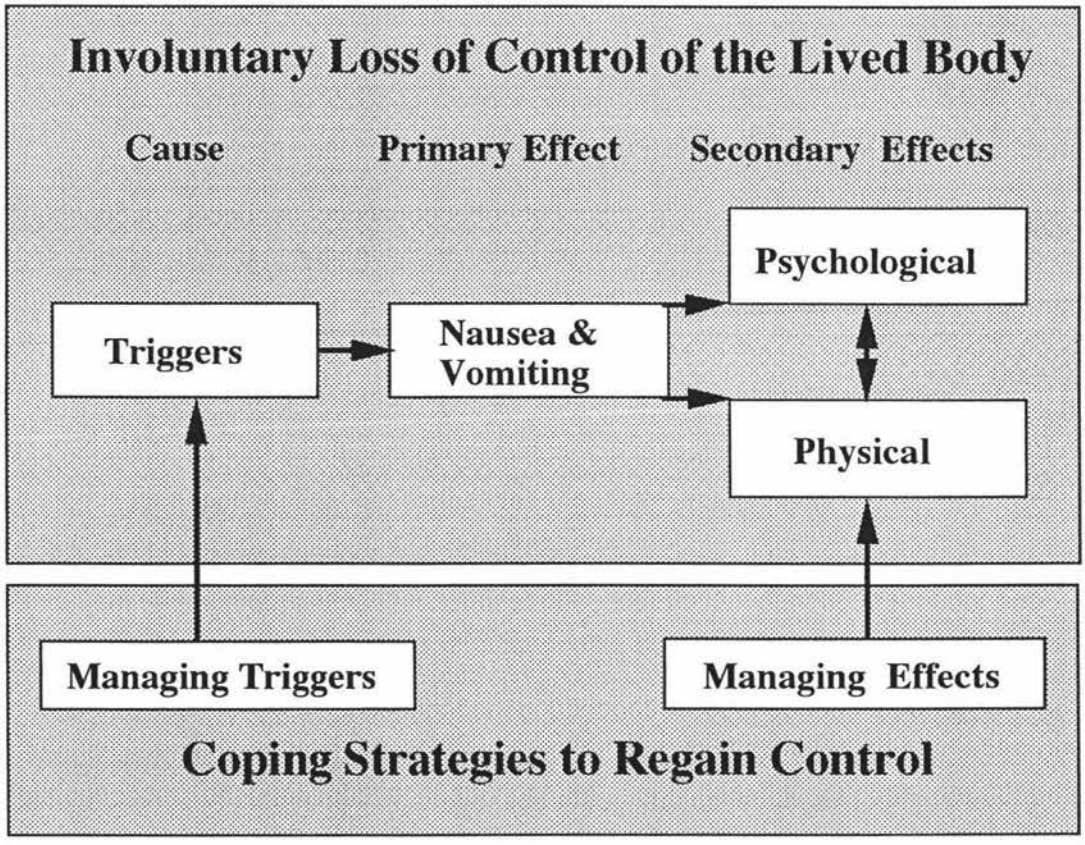

Fig. 1.Coping model.

For most of the women coping strategies were aimed at relieving or minimising the experience of nausea and vomiting, but certain coping strategies allowed some of them to avoid the nausea or vomiting completely.

All participants either developed new coping strategies, or they expanded and refined previously learnt coping strategies. As Pauline said: *"I've learnt that from having had one child and to me that's the way to go"* (Int 1, Pg. 10).

Managing the experience

Most of the participants anticipated having to cope with their experience of sickness in pregnancy and sought information to assist them. While the women found that advice from others, or from books was helpful they often had to experiment to find strategies that worked for them. Often advice from other sources was conflicting so they had to maintain an open mind about what worked and what didn't.

> *[Y]ou actually have to experiment with yourself to find out what helps you. I was reading in a book that you should have dry biscuits, dry toast and stuff like that with a cup of tea before you get up or something like that, but with me it was just anything. Just food basically.*
>
> (Rose Int 2, Pg. 6)

The women often viewed their experience in relation to the experience of others. Finding others who were worse off than themselves, or who had a worse experience than them helped the women to cope by putting the severity of their own experience in a context. In most instances this was very beneficial.

> *A friend of mine who is pregnant now she vomited all day. She basically vomited all day until she was 6 months pregnant. So I had it easy - only a couple of hours every night.*
>
> (Jennifer Int 2, Pg. 12)

The participants often made comparisons with the personal circumstances of others in similar situations. Lynette and Tessa felt that women with other small children were worse off than they were because these women were unable to rest as they could.

> *I don't know how women get on when they have got other little children. I don't know how they cope.*
>
> (Lynette Int 2, Pg. 4)

[If] you were having to worry about looking after 2 children as well that would be worse still.
(Tessa Int 2, Pg. 3)

Despite seeing the experience as unpleasant, some of the women tried to minimise the severity of their experience by making light of the experience.

Well like I could cope with it ...//... It wasn't any worse than, but probably better than a lot of period pain I've got in the past, so I've been able to put up with that .
(Tessa Int 1, Pg. 14)

Not everyone felt that they developed strategies for coping with or minimising the effect of the sickness on their lives. Jennifer reported that nothing much really helped her, yet for Anne and Pauline developing coping strategies was coupled with stoic endurance associated with their experience.

I just went through the paces...//.. That's all I could cope with.
(Anne Int 1, Pg. 9)

You just live from day to day, one step at a time.
(Pauline Int 2, Pg. 4)

The importance of rest

All women reported that when they were tired their nausea and vomiting seemed worse. To cope they would increase the amount of sleep, and tried to find periods during the day when they could rest. The arrangements they developed varied according to their daily routines and personal circumstances. Judith found that once she had got her husband off to work in the mornings then she could go back to bed. Rose found she needed plenty of rest and required time off work when she was working. Tessa who had also continued to work did not take time off but had to compensate for the demands of work by resting more at home and going to bed early. She felt that because she was not ill she could not take days off work.

It's quite difficult the thing with work, though thinking about it -because you sort of push yourself quite a lot further than what you might have done if it had been the flu that you'd had. I think

> *knowing the cause of it you do keep going and going and going rather than necessarily stopping and taking the day off.*
> (Tessa Int 2, Pg. 11)

Lynette also worked but because she arrived home much earlier than her husband was able to rest before he arrived home and thus maintain the normal routine of going to bed at the same time as her husband. Resting after work was a complete change from her usual pattern of 'being in the world' but for her present situation rest was a major concern.

> *I had to come home and have rest and it worked out quite well actually because Shane was working quite late at night and the house was nice and quiet and I'd come home and have a rest which was good. And then I would get up with him for an hour to two before we both went back to bed.*
> (Lynette Int 1, Pg. 3)

Pauline recognised the problem of becoming chronically tried and tried to ensure that she began each day well rested.

> *I'm quite an energetic person so for me the important thing is to make sure that I'm well rested so that I can do what I want to do, so I try not to run myself into the ground because it's just hopeless if you do that.*
> (Pauline Int 1, Pg. 10)

For all the women in this study the tiredness meant that they could not accomplish the same daily tasks as they had previously. Judith described how she adjusted the pace of doing housework to accommodate the fatigue.

> *I had to take it slower and instead of doing it all at once I'd just have to do it sort of throughout the day. And I tended to leave it until my days off as well, when I could do it at my own pace.*
> (Judith Int 1, Pg. 4)

Despite the need for rest sleeping habits often required adjustment for the women in this study. Jane described how lying down to rest or sleep in her normal position would trigger nausea. She had to resort to an uncomfortable sleeping position to overcome this.

> *I couldn't sleep lying flat. I had to sleep with two or three pillows, and I don't like sleeping with more than one pillow*

> *normally, but if I lay down with just one pillow my head's lower than my stomach. I'll be sicker than ever. And it was horrible trying to learn to go to sleep half pie sitting up but I had to.*
> (Jane Int 1, Pg. 5)

Identifying and avoiding triggers

For most of the women there were things that accentuated or would set off their experience. Each woman had to identify for herself the 'triggers' that induced nausea and vomiting and then develop strategies for avoiding them. In most cases once the 'triggers' had been identified avoidance strategies were obvious.

The most prevalent sensory triggers were, as discussed in chapter five, those related to food or drink. Tessa, Judith and Karen found that to avoid most triggers they had to keep all meals plain and simple. At times the food eaten was described as 'bland'. For several of the participants greasy or fried foods were avoided, and for some spicy foods were also avoided. Other strategies were to delegate dealing with the trigger/s to someone else or to contrive to be physically distant from the source. Several of the participants reported that they avoided cooking. Lynette's husband became very enterprising at cooking the evening meal, even if this meant cooking part of his meal outside the house.

> *He cooked nearly every night for himself for a while. I had him out in the shed with the BBQ quite a few times because the smell of meat was just the worst thing I think. Just the smell of meat cooking.* [Face grimacing] *So he quite often would do his veges and leave them boiling and then go and cook his meat out on the BBQ. That worked quite well.*
> (Lynette Int 1, Pg. 3)

Triggers that were associated with work posed a dilemma for some. Anne who worked as a nurse could not cope with smelly dressings. Often such non-food triggers could not be managed by avoidance or delegation.

The use of food in coping

Despite some foods being clearly identified as triggers for the onset of nausea and vomiting many women found that food could also act as a suppresser.

> *[I]t would have been 12 weeks and suddenly I was ravishingly hungry and I found the way of getting around this nausea was to eat ...//... And so it would go away for a while. Then the nausea would come back and I would eat something and it would go away.*
>
> (Anne Int 1, Pg. 1)

> *I found if I ate something, even if it's toast or just as long as I had food in my stomach, I was better.*
>
> (Rose Int 2, Pg. 2)

Once the discovery that some foods could act as suppressers was made women would eat even if they did not feel inclined to in order to suppress the nausea and vomiting.

> *At night even though you didn't want to eat I still made myself have something because I felt better afterwards.*
>
> (Rose Int 2, Pg. 2)

For some the effect of eating provided only partial relief. Anne, who during a previous pregnancy had vomited, was able to avoid vomiting in the subsequent pregnancy by suppressing it with food (she ate toast or crackers before rising). However while this prevented her from vomiting it did not overcome the nausea.

> *[T]his time I never vomited because as soon as I got the nausea I said to Malcolm "You have to bring me something eat". It stopped the actual vomiting but it didn't stop the nausea, it would come back. It would come back and it would just hang around and I felt really yuk.*
>
> (Anne Int 1, Pg. 4)

Women who had previously missed meals especially breakfast now found that to start the day on an empty stomach was disastrous. Any nausea and vomiting was considered to be much worse with an empty stomach.

> *I'd get up in the morning and I'd just feel I couldn't have a shower before I had something to eat. I had to have something to eat first or else I felt really sick and terrible.*
>
> (Anne Int 1, Pg. 4)

> *[I]f I left eating too long then I felt too nauseous to eat but if I left it longer then like I'd feel really sick and so it was just a case of making sure that I ate when I should.*
> (Tessa Int 2, Pg. 8)

For most of the women the foods that worked as suppressers were light and plain. They included fruit, crackers, bread (especially toast) and fluids.

> *I'd just pig out on fruit. I ate lots of fruit because that would stay down.*
> (Jane Int 1, Pg. 8)

> *I just used to drink, try and drink as much fluid as I could and then just eat things like crackers, plain crackers, plain potatoes / boiled potatoes I loved. .../I... Just plain sandwiches I'd take to work for tea.*
> (Judith Int 1, Pg. 2)

The foods that worked as suppressers were unique for each woman, for example Jennifer *"found by eating mince pies at any time of the day I felt really good."* (Int 1, Pg. 1), yet for several of the other women meat pies acted as a trigger for nausea and were avoided.

Some of the women found that they had to change the timing of their meals. Jane needed to sit for a while after eating because she found that sudden movement immediately after eating, such as standing up, would cause her to vomit. This resulted in her avoiding social occasions that involved a meal.

> *There were quite a few social functions on but I just couldn't go to them because I knew that the minute I stood up after eating a meal I would be sick. .../I... I have to try and sit down for quite a while after a meal, but it's not always possible. It severely restricted us in that way.*
> (Jane Int 1, Pg. 10)

Many of the women found that they could cope by eating smaller meals. This coupled with the need for more regular eating resulted in these women adopting a pattern of eating little and often.

> *[D]uring that period I never had a big meal, I just picked. So long as I had something there, like bread.../I... my main diet*

> *would have been bread or something like crackers ... //... bananas were good and veges, got to have veges. Just basically small amounts though.*
>
> (Rose Int 1, Pg. 4)

> *I'd try and eat little and often rather than a big meal all at once. Because if I cooked a main meal at night and I tried to eat it all I would be sick.*
>
> (Jane Int 1, Pg. 5)

Smaller meals did not suit everyone however, Lisa found that she didn't snack and continued to eat three big meals a day. If a cause could not be isolated or dealt with the next likely response was to address the effects of the nausea and vomiting on their lives.

Changing daily routines in order to manage the effects

The women found that they needed to rearrange their daily routines to accommodate the nausea and vomiting and the associated tiredness. This helped the women to cope with their experience by avoiding taxing activities at particular times. Judith said *"I had to rearrange my day until I was feeling better to do the heavier work"*. (Int 1, Pg. 10).

These changed routines developed as the women learnt more about the idiosyncrasies of their daily situation. Pauline likened it to other experiences where you learn as you go along.

> *I find that it is similar to the first few weeks of the baby's life. There's lots of things that you can enjoy but it's pretty hard work. You're trying to establish new routines and in some ways you just live from day to day, one step at a time, and things do eventually get easier.*
>
> (Pauline Int 2, Pg. 4)

For many of the women the nausea and vomiting occurred at particular times of the day. Once the woman's individual pattern was established, activities such as housework could be scheduled at other times of the day. Jennifer found that if

she could get home and cook before 5.30 pm she would be fine but after this time the cooking acted as a trigger. When she arrived home after 5.30 pm her husband cooked the evening meal. Housework was done early in the day before going to work, or at weekends.

> *I found I did housework at 8 o'clock in the mornings or even at 6.30 am in the morning, because I knew night time was going to be out. I'd save a lot of the housework until Saturday mornings and do it in the mornings because I knew from 5 pm it just wasn't worth worrying about anything because I'd just cabbage on the couch basically, or go to bed, it was the easiest thing to do.*
>
> (Jennifer Int 1, Pg. 3)

For some women it was not always possible to predict when the nausea and vomiting would occur. Planned tasks could also be disrupted by fatigue which in itself could not always be predicted. This uncertainty meant the women had to be more flexible in planning their daily routines than previously. For Judith this flexibility was not easily acquired:

> *It* [the nausea]*was intrusive in the way that I couldn't stick to my normal routine of organising things, but flexibility is a good lesson to learn.*
>
> (Judith Int 2, Pg. 8)

While it was necessary to maintain flexibility in their routines, there were some situations where some women found they could not deviate from established patterns. Pauline discovered missed or delayed meals resulted in the onset of nausea. To combat this she focused on having regular meals and having them on time.

> *I would just always take along crackers and cheese to have at morning tea time and make sure I have my lunch at a good time. I mean I'm much more centred around meals, I had to make sure that I ate when I was hungry.*
>
> (Pauline Int 1, Pg. 5)

Often tasks were rescheduled indicating that the women's concerns had shifted. Pauline, Jane and Tessa explain how it was for them.

> *Just prioritise what needs to be done and forget about the rest, well not forget about it but just ignore it and just cope with the things that are really important.*
> (Pauline Int 1, Pg. 10)

> *Every time I vacuumed the floor I went into labour ...//... I just thought well what do you want to do here, lose this baby or do you want to have a tidy house or.... who cares about the housework at that stage. I found that really helpful. I got a lot more rest then.*
> (Jane Int 1, Pg. 12)

> *I was able to say no a lot better if something came up ...//... normally I would just do more, but at the time it was sort of "No I'm not really interested in doing that. I'm not going to". I took a lot more responsibility for myself. My priorities changed.*
> (Tessa Int 1, Pg. 7)

Some daily tasks could not be rescheduled, ignored, or prioritised but had to be met as they occurred. Jane described how difficult it was to cope with the requirements of her young children.

> *While you're being sick it's lovely if you've got no children. But when you've got other children then you have to be able to cope with it. If you're being sick it makes it very hard to cope, very hard to deal with their requirements, everyday life, decisions and all sorts of stuff because you just feel so wretched all the time.*
> (Jane Int 2, Pg. 12)

Coping at work

Work was an activity that could not be rescheduled so other adjustments had to be made. Elizabeth recounted that she had to adjust to going to work with the house not very tidy. If one chooses to work, often one does not have any choice within that work, however one aspect of work that could be avoided was that of overtime and carrying out extra duties. Jennifer reported: *"I didn't bother working late or doing any overtime during the period because I just wasn't capable of doing it"* (Int 1, Pg. 11). Sometimes, despite other coping strategies, some of the women found that they became so tired that they had to take time off from work.

> *You found yourself taking time off work quite often. Maybe you felt that um maybe work was getting a bit much so you'd have a day off here and a day off there just to catch up with your sleep and stuff like that.*
>
> (Rose Int 2, Pg. 5)

Time off from work had to be very carefully balanced as the women did not want to jeopardise their employment. How important their continued employment was depended very much on the particular households financial situation. In the previous chapter it was seen how supportive and helpful work colleagues were to the participants who were involved in employment in this study. In addition to the physical assistance with work loads women found that emotional support and reassurance provided by colleagues was important to them in coping with being in the world.

> *[W]here I work, there are a lot of women there, there are certain women who obviously, people you know better or get on with a bit better, who have been extremely supportive and can remember back to the children they had. And their children might be in their 20 s now but they will say "Oh yes I remember how that feels" and that is really helpful I think. Because you feel as if there's an understanding of how you are feeling, that it's common. It's a common feeling and that you are not abnormal and that it's quite all right that you feel that way.*
>
> (Pauline Int 1, Pg. 12)

The importance of support and reassurance

In their daily lives most of the women relied on support from their husbands or partners. The nature of the support varied depending on the couples' situation. Help with household tasks, especially meals and attending to the needs of children, were common areas where husbands and partners provided support.

> *My husband had to do a lot more and I found that most of the time I would have to come home from work and go straight to bed or even come in and have a lie down. And then either Greg would get tea or I'd get it later. My whole life's changed really since I've been pregnant.*
>
> (Elizabeth Int 1, Pg. 4)

> *I'm not quite sure how I coped. I just did it. I guess with Andrew's help. If I didn't have Andrew, my husband, I don't*

> *know how I would have coped because he dealt with her* [Their daughter] *at night time. But if I was on my own I suppose I would have been at wits end - possibly.*
> (Rose Int 1, Pg. 7)

Friends and relatives also provided support for some of the women. This was especially important when the woman's spouse or partner was not present. However a few women, like Pauline, did not seek help and hence did not avail themselves of an important resource for helping them cope with 'being in the world'. She said *"I didn't seek out any help because I didn't feel there was anything I or anyone could do ".* (Pauline Int 1, Pg. 7).

Because of the difficulties in managing their housework some women reported that they employed a housekeeper to help with household chores. Jane found it provided welcome relief.

> *I got to the stage where I thought right I'm not a very tidy housekeeper - that's not my priority. My priority is my kids and getting things for them and when she came, like you know when people get a housekeeper and they run round and do all the work first, I thought "Oh bugger it. She can do it". And it did, it eased off and I got more rest. Like if I felt sick I could just sit down whereas before I would just push myself to keep going and I found that really good.*
> (Jane Int 1, Pg. 12)

Anne found housework was intolerable and employed her sister to do the housework. The women generally preferred to have family or close friends to help rather than strangers.

Birks (1993) stresses the needs for both emotional and physical support for women experiencing nausea and vomiting associated with pregnancy. This support is increasingly important as the severity of the experience increases, and explains why Jane was so dependent on her friend Kirra.

Talking to people and sharing experiences can be very supportive. This does not have to be people who are currently in a similar situation, it could be anyone who has lived through the experience. Once someone has experienced the phenomenon of sickness in pregnancy they retain an understanding of how others feel. Books can also be a source of reassurance as well as a source of information. Pauline and Tessa found books very reassuring, especially those with a New Zealand context.

> *I read a reasonable amount. The books that there was NZ material in I find much more helpful because people here are a bit different from someone in England or America and the advice is different and it just doesn't seem quite so applicable. So the NZ pregnancy book was really helpful.*
> (Pauline Int 1, Pg. 11)

> *[G]enerally everything that I felt I'd read in one of my books somewhere or other then that was quite normal. It was quite reassuring to know that some things were normal.*
> (Tessa Int 1, Pg. 11)

The strength of Birks' (1993) book is that it has been largely based on the reports of New Zealand women and provides many suggestions for coping with 'morning sickness'. Articles in New Zealand parenting magazines, such as that by Welsh (1995), also raise women's awareness of the anguish that others experience when they suffer nausea and vomiting associated with their pregnancy within this country.

Psychological strategies in coping

Some of the women took steps to overcome the negative emotional effects that resulted from the ongoing nausea and vomiting and the associated chronic fatigue. It was noted earlier in this chapter that women accept the normality of their experience. However, because it was normal some of the women felt that society expected them to cope and to continue to function as usual. Complaining

or seeking relief was seen as taking advantage of their position, or of being weak.

> *[P]eople still expect you to function as normal ...//... you're still expected to carry on and do what you were doing.*
> Anne (Int 2, Pg. 5)

> *If you complain you feel like you're taking advantage of it or something. My mother went through it and other women they went through it and everything and so they all coped alright. So if you're not coping alright then there's something wrong with you.*
> (Tessa Int 2, Pg. 12)

Birks (1993) supports this view indicating that women with morning sickness, even if they are quite incapacitated and are confined to bed, are "expected to get on with life as usual or be labelled 'incompetent' and 'copping out'"(p. 21).

Although sharing has been identified as psychologically beneficial, there was a reluctance by some participants to share their experience with health professionals. Women don't want to be laughed at, scoffed at or be seen to be a failure by other people, in particular health professionals.

> *[P]eople still make out, and certainly used to in the past, about how it was all in the mind and how women made it up that they were feeling sick. Because my mother -in-law had been told by somebody when she was in her pregnancy "Oh It's all in your mind and if you thought positive thoughts you'd get rid of it you know" and that really annoys me a lot that other people try to minimise the experience. It can be awful and that sort of thing doesn't help you cope with it all. It makes you feel unhappy.*
> (Pauline Int 2, Pg. 8)

Several of the women deliberately invoked positive thinking, not to make the experience go away but to help them live through it. They focused on what was good about being pregnant (such as the developing baby and the closeness with their partner) and looked forward to enjoying the child when it was born. In this way they were able to focus beyond their current situation to good things to come.

> *[L]ooking forward to the future that all helped. Sort of taking my mind off the way I felt and having sort of an anticipation of good times ahead.*
>
> (Elizabeth Int 2, Pg. 4)

> *The nausea didn't worry me because it's just normal and I knew it would go. And I wanted to be pregnant, I wanted these babies so had to accept that I was feeling sick.*
>
> (Judith Int 2, Pg. 4)

Lisa found that the nausea gave rise to mood swings. On recognising she was becoming moody she tried consciously to create a diversion to avoid taking her moodiness out on the people around her.

> *I knew I was going to have another mood swing and so I decided to go jump on the computer. And I sat down and played these games on the computer and that seemed to calm me down.*
>
> (Lisa Int 2, Pg. 3)

Throughout this study it was evident that the way in which each individual coped with her experience rested heavily on her knowledge, her previous experience and the support available to her. The experience itself involved considerable personal learning for the women. Jennifer explained the changed understanding she gained from experiencing the nausea and vomiting personally

> *[U]nless you've been through it yourself you don't know what it's like and up until then I just used to say "Oh yup OK. So you're not feeling very well. Fine". But now I can honestly say that "Yes I know exactly how you feel" and you know you can relate a lot better.*
>
> (Jennifer Int 2, Pg. 13)

Summary

Although each woman's experience of sickness associated with pregnancy differed, each saw it as a normal part of pregnancy. This is not an experience that one can easily control, nor predict with certainty when the experience will pass for any individual. The women coped by taking control of those aspects of their daily lives that they could, and in so doing minimised the impact being sick had on their 'being in the world'.

The coping strategies that the women utilised depended not only on each individual's situation, but also the concerns the woman had within her situation. In many instances new strategies were devised or were extensions of those already developed from previous experience. Whether this was a woman's first experience or a repeat experience, new meanings were incorporated into her way of 'being in the world' for the future. Life for them would never be the same. Increased understanding and knowledge of the experience would remain with them and assist them in the future, just as Jennifer indicated:

> *I think it would be easier next time though because I would know what to expect . I'd probably be able to handle it a bit easier too. I wouldn't let myself get so down about it because I'd know that it'll eventually stop or if it didn't eventually stop, it wasn't going to kill me, and it isn't really life threatening, and besides the end results worth it.*
>
> (Jennifer Int 2, Pg. 13)

Chapter Nine

DISCUSSION AND CONCLUSION

Introduction

This study has provided an insight into the lifeworld of ten women who experienced sickness associated with their pregnancies. The research followed the approach of van Manen (1990) to make 'visible' and to 'illustrate' the realities of the women's experience of sickness in pregnancy.

This chapter summarises the findings of the study and relates these to the literature as discussed in part one of this thesis. The women's relationship with health professionals is discussed and the limitations of the study are addressed. The chapter concludes by outlining areas for further research and the implications for practice that have arisen from this study.

Living through sickness in pregnancy

The difficulties women encountered as they lived through the experience of sickness in pregnancy were distressing but were ultimately overcome, if not early in the pregnancy then with the birth of their baby. Those who had experienced sickness in previous pregnancies were better prepared to cope with their current experience.

A common finding was that the nausea and vomiting experienced by the women was not confined to the morning as the term 'morning sickness' would imply. Deuchar (1995) indicates this terminology is essentially descriptive and has

become the term most commonly used. 'Pregnancy sickness' was suggested by some of the participants as being a more suitable terminology. This terminology is beginning to be used in some study reports such as those by Billet (1992) and Anderson (1994). However the term 'sickness' can be a misnomer. The women who participated in this study did not see themselves as being in ill health as the term 'sickness' can imply, rather they viewed the sickness they experienced as being a normal aspect of pregnancy that any pregnant woman could experience.

All participants recognised that the experience of sickness associated with pregnancy was unpleasant and disruptive to their lives. However, their experiences ranged from minor unpleasantness for those who had minimal disruption to each day, to an experience that was 'downright disgusting' and 'unbearable' for one participant who suffered this phenomenon each day all day throughout her whole pregnancy. In all instances the women had a heightened awareness of their bodies as the sickness interrupted the habitual relationship women normally had with their bodies.

The women described a loss of control over their bodies. If they were going to feel nauseous, they couldn't stop or control it, and when they were going to vomit, it would happen when their body wanted, not when and where they felt was socially appropriate. All coping strategies were aimed at minimising their disruptive bodily experiences by attempting to exert what control over aspects of the experience that they could.

Jenkins and Shelton (1989) reported twenty - nine self care actions (Table 1, Chapter two) which are indicative of strategies that may reduce the discomfort of nausea and vomiting associated with pregnancy. The first twelve of these were frequently reported by the ten women in this study as valuable strategies in

coping with their sickness experience. The most valuable self-care action identified by Jenkins and Shelton (1989) and confirmed in this study was getting more rest. This was highly relevant for all women, regardless of home, family or work commitments. Additional rest did not dispel feeling or being sick, it only helped the woman to live through her experience. The next most valuable coping strategies consisted of avoidance of triggers and dietary modifications. Avoidance of triggers included avoidance of bad smells, cooking and certain foods, especially greasy or fried foods and spicy foods. Dietary modifications included eating when feeling nauseated, keeping food plain and simple or 'bland' and eating several snack meals rather than having three main ones a day. Of the remaining self care actions reported by Jenkins and Shelton (1989), only support and sharing their experience with other women were referred to by all participants.

Next to the loss of control over their bodies, tiredness and feeling fatigued was the most common effect of sickness in pregnancy. Dilorio and van Lier (1989) reported that the women in their study complained of fatigue on an average of four out of the seven days they sampled. My research did not attempt to quantify the time as did Dilorio and van Lier's study, but tiredness and fatigue was reported by all women and affected the women's daily routines, sleep patterns and the amount of work (paid or unpaid) that they could manage.

It was not the intention of this study to determine if the tiredness was due to the pregnancy itself or the nausea and vomiting. All the women found that as they became more tired they became more nauseous, and the more nauseated they felt the more tired they became, indicating that the two are inextricably linked. It was for the women a vicious cycle.

Getting more rest and sleep was an important coping strategy. Some women however found that no matter how much sleep or rest they had, they still felt tired. Dilorio and van Lier (1989) reported in their study that lying down was the relief measure used most frequently. They stated that "although lying down or resting to relieve nausea is noted in the literature it is not emphasised as an important intervention"(p. 263). At the conclusion of their report they noted that women need permission to rest, and stated that "Nurses can provide pregnant women with a new interpretation of rest, rest as a form of therapy that may actually relieve nausea and allow for continued performance in work or home life" (p. 265). Certainly within my study the women indicated that they often needed others to reinforce to them that it was acceptable for them to rest.

Although the lived experience was dominated by the effects on the physical body the associated emotional and mental manifestations were significant. The women reported feeling 'down' and emotionally labile due to the constancy of the nausea and vomiting, and their initial perception of inability to do anything about it. At that point in time the experience did not seem to have an end. Jane's remark: *"I could not see the light at the end of the tunnel"* (Int 2, Pg. 13) captures this premise. When feeling down the women were very conscious of the comments of others and sometimes even became upset or hurt by people who were trying to be helpful.

Once the symptoms of nausea and vomiting passed the world was viewed differently by the women. Some women felt that they then reclaimed control of their bodies. Anne explained it thus:

> *The only way I can describe it, it's like the cotton wool is starting to come out of my head and I'm starting to think more clearly and I'm starting to feel like a person. That's not just to do with the thinking. It's to do with the feeling. It's starting to reclaim my body as such as mine.*
>
> (Anne Int 2, Pg. 2)

All women felt that they had been changed by the experience. New meanings had been incorporated in their 'being in the world' not just for the present but for the future. The point of arrival, once the experience has passed, is different from the point of departure prior to which the experience was only anticipated. For the women who live through such an experience much of the old self remains, but significant changes have occurred and they feel that they 'will never be the same again'.

Some participants reported going through the experience made them feel more confident and stronger. Birks (1993, p. 34)) indicated that for some women the fact that they had battled through the bad times was taken as confirmation that they had been put through a test, had passed, and they "could now feel secure in the knowledge that, come what may, they would cope".

In the examination of relationality what others believed about the experience of sickness in pregnancy, and how they portrayed what they believed, had a great impact on the women in this study. It was found that other women who had experienced sickness in pregnancy were very understanding and supportive, while those who had not personally experienced this phenomenon were to some extent seen to be disbelieving of the impact on the lives of those who suffered. Support, reassurance and above all being believed and understood by others, in particular health professionals, was important for women in coping with sickness in pregnancy.

The women's relationship with health professionals

Some of the health professionals involved with the women in this study were perceived to dismiss the women's experience as being insignificant. Rose interpreted it as follows:

> *The doctors and books and all that is geared towards nausea more. It's as if "Oh don't worry about it. It's only 3 months, just have a cup of tea and a dry biscuit in the morning and you'll be right". Men doctors of course. And if it's bad then they put you onto some tablets or something ...//... they just had no inkling at all of what you were going through. When you went for your next visit it was "Do you still have it" and it's "Yes" and then it's "Oh Dear. Never mind it won't be long now". And that doesn't make you feel any good*
>
> (Rose Int 1, Pg. 12-13)

Toombs (1992) describes how a doctor is trained to focus on the physical signs and symptoms of an illness, while the patient experiences it "essentially in terms of its effects upon everyday life"(p. 11). This was confirmed by the women in this study. Dr Lynn Sadler who worked as an obstetrics registrar at National Women's Hospital in Auckland explained a doctor's perspective as follows:

> *"As doctors, if we don't understand what something is caused by, we're less able to accept it as having a physical basis and we're more likely to attribute it to some psychological basis ...//... It's the way we think as doctors. That's the way classical medicine works".* (Welsh 1995, p. 29)

However following her own experience of nausea and vomiting in pregnancy she developed more understanding of this phenomenon. She reported:

> *"I didn't understand how draining it is on family relationships. I didn't realise how much support you need yourself. You need unqualified support without being told to pull yourself together".* (Welsh 1995, p. 29)

As pregnant women usually have contact with at least one health professional during their pregnancy their view of the woman's experiences at this time is important to the woman's overall well being. Just as it is accepted that pain is whatever the person experiencing it says it is (McCaffery 1979), so should any experience of sickness in pregnancy be viewed.

In discussing the different perspectives of physician and patient Toombs (1992) states that they "apprehend illness from within the context of separate worlds,

each providing its own horizon of meaning"(p. 10). Gadow (1985) indicates that often the subjective meanings of a person's experience are forgotten as many health care providers focus on the body as a scientific object and base clinical decisions on external, measurable observations. In order that a nurse and a patient have a caring relationship the patient must remain at the centre of their experience (Gadow 1985). The meaning and understanding of the body as seen by the patient must be included in clinical decision making. This view is supported by Zanter (1985) and Benner and Wrubel (1989).

Benner and Wrubel (1989, p. 13) indicate that the ability of a nurse to "presence oneself" is the basis of much of nursing. This term originally came from the translation of Heidegger's work on Being and Time. To presence oneself means that "the person is available and accessible to another so that the other feels that he or she is understood and supported" (Benner and Wrubel 1989, p. 411). Jennifer illustrated this point when she was talking about the relationship she had with her doctor and midwife:

> *He believed me in what I was saying I felt. He didn't make me feel like I was making it up or I was talking nonsense. He really made me feel like he believed in what I was saying and I had a really good midwife who was really good as well. ...//... having had them believe that it does exist that you do feel sick really helps. I was lucky I had two people that did believe me. I think it would be very difficult if people didn't believe you.*
> Jennifer (Int 2, Pg. 14)

Limitations of the study

This study has examined the lifeworld of ten women who lived through sickness in pregnancy as a step to understanding this phenomenon. The study findings relate specifically to the group of women who participated and are not definitive of the experiences of all pregnant women.

This research study provides a beginning interpretation of experiencing sickness in pregnancy. It can not be assumed that this is the only or a definitive interpretation. As van Manen (1990, p. 31) says: "no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description". However, this study has begun to reveal aspects of the experience that others may also share.

Although the number of study participants may appear low at ten, this is in keeping with phenomenological studies which aim to focus on in depth analysis of specific lived experiences. Time and resource constraints were a limiting factor in this study. Every effort has been made to ensure that this has not affected the conclusions contained in this report.

All participants had the opportunity to validate and clarify their own transcripts. They did not have access to the transcripts of fellow participants so could not validate the overall findings as presented here. The findings were discussed with participants as the opportunity presented but the outcome of this thesis has not been shared in detail with all participants. The stages in the development of this thesis have been shared with supervisors who were in a position to validate the findings arrived at and analytical processes used to draw valid conclusions from these women's experiences.

A limiting factor was that as I am not a midwife I can not bring to this study the knowledge and experiences of such a health professional. I believe that as a nurse researcher I have reasonably examined the lived experience of the ten women studied.

Areas for further research

There is very little published in New Zealand relating to the experience of sickness in pregnancy. Birks (1993) gives the most comprehensive account of the experiences of New Zealand women and provides many suggestions on how to cope with this phenomenon. Such work needs to be continued through more formal research.

There are no published epidemiological studies within this country and with the prevailing view that experiencing the symptoms of nausea and vomiting is just a normal part of pregnancy, it is unlikely that funds to explore this area further will be readily made available. However, in the last decade this area has gained focus in some overseas studies through the efforts of researchers dedicated to the care of women (DiIorio (1988), DiIorio and van Lier (1989), Jenkins and Shelton (1989), O'Brien (1990), and O'Brien and Naber (1992)). It is imperative that New Zealand women's experiences of pregnancy are researched to provide a sound base for the care of pregnant women within this country.
Toombs (1992) identifies there is a need for further research into ways to construct shared worlds of meaning between health professionals and their patients in order that the patients experience can be more fully understood by doctors and nurses. This would facilitate the provision of care that is better tailored to the individual patient because the impact on the patient's life would become the focus of the care rather than just the biological functioning.

As the experience itself is understood better so will more understanding be gained in what effective treatments, or self care actions there are available to women. Despite the historical awareness of the phenomenon Dilorio (1985, p. 372) notes that "research on the subject has failed to identify a precise cause or an effective non-pharmacologic treatment". Perhaps it is because sickness is

regarded as a natural part of pregnancy that no clear treatment regime has evolved.

Recent research studies mentioned in this thesis have indicated that nurses and midwives can promote self care actions for women to manage the nausea and vomiting and associated effects, and thereby help alleviate the discomfort many women experience. The lack of research, and the inconclusive results of much of the research that has been conducted, has been an impediment to the development of accepted treatments. Cotanch (1989, p. 247) states "As more projects are launched to better understand the mechanisms of nausea and vomiting, better pharmacological and behavioural therapies are being discovered to help improve patient comfort."

The entire field of sickness in pregnancy offers considerable scope for research into both the physiological and psychological factors affecting living through this experience. More nursing research is needed to verify and expand upon the information that has been generated by this and other recent studies. One significant area that requires research is the tiredness that women experience. It would be advantageous to know if the tiredness is an effect of the pregnancy itself, or due to the sickness. Understanding this would provide rich material to assist women to cope with the overall experience.

This study was designed specifically to examine the pregnant women's experience but it became obvious during the data collection phase that the experience of sickness had a significant impact on the lives of the women's spouses, partners, family members, friends and relations. The impact on others and their understanding of the phenomenon would be valuable areas for further

study. In particular health care professionals' understanding of the women's experience would be worthy of further study.

Implications for practice

The women in this study did not share the discomforts, concerns and distress in living through their experience with the health professionals that cared for them. In part this was due to the women's belief that the phenomenon is just a normal part of pregnancy, and as such is not a sickness or health problem worth troubling the health professionals about. In addition some women have been socialised into believing that sickness associated with pregnancy is not something to fuss about. This study provides an impetus for health professionals to take the initiative in extending their concerns for the pregnant women for whom they provide care.

Nurses, midwives and doctors who are in contact with pregnant women have the opportunity to promote self-care by discussing minor life-style adjustments that may help to reduce the discomfort of sickness associated with pregnancy. The findings of this study and that by Jenkins and Shelton (1989) outline a basis for such interventions. Jenkins and Shelton (1989) recommend that nurses should give pregnant women information on effective self-care actions as soon as pregnancy is confirmed. According to Woollery (1983, p. 33), promoting self-care "is particularly useful in obstetric nursing where patients are usually eager to accept, and want responsibility for, their own health".

Other strategies which nurses can offer in order to promote better comfort for women who experience the phenomenon are identified by Pole (1989). She suggests the use of a self-report tool to help pregnant women identify their own patterns of nausea and vomiting, including the noting and measuring of the

effectiveness of relief measures. This is also advocated by Rhodes (1990). In my study some women found the use of diarying drew their attention to the unpleasantness of the experience and they were reluctant to continue this practice. Discussion can be an alternative mechanism to elicit each woman's own patterns of these symptoms as a basis for her to schedule work and rest periods around times when the symptoms are most likely to occur.

Pole (1989) also advocates the use of support groups, (consisting of the pregnant woman, her friends and relatives who have experienced nausea and vomiting in pregnancy, and, perhaps her nurse or midwife) to effectively discuss ways of managing.

Conclusion

This study has given some illumination to the phenomenon of living with sickness in pregnancy. A case has been put forward that this is a worthy area for further research in that once the experience itself is better understood so more effective treatment should arise.

This study has exposed this particular lived experience to phenomenological scrutiny to reveal previously hidden elements and meanings that comprise the experience. From the stories of the women a picture has arisen of their frustration at the loss of control over their body's functioning, and the efforts they made to maintain what control they could over various aspects of their lives as they lived through the experience of sickness in pregnancy.

Although the experience of sickness was confined to a short time frame in each woman's life it was for her very significant. All women felt that they had been changed by the experience. New meanings had been incorporated in their 'being

in the world' not just for the present but for the future. It is therefore imperative that health professionals acknowledge the significance of sickness in pregnancy and in so doing provide more effective support and care for pregnant women.

In concluding I wish to thank again the women who shared their experiences with me, who through this thesis have revealed their lived experience to others for the benefit of all pregnant women and their health care.

REFERENCES

Allen, D., Benner, P. and Diekelmann, N. L. (1986) Three Paradigms for Nursing Research: Methodological Implications. *Nursing Research Methodology: Issues and Implementation..* Chin, P.L.(Ed). Rockville Aspen Publishers. pp 23-38.

Alley, N. M. (1984) Morning Sickness. The Client's Perspective. *Journal of Obstetric and Gynaecological Nursing*. May/June. pp 185-189.

American Medical Association Department of Drugs.(1979) *American Medical Association drug evaluations*. 4th ed. Massachusetts. Publishing Sciences.

Anderson, A.S. (1994) Managing pregnancy sickness and hyperemesis gravidarum. *Professional Care of Mother & Child*. Jan/Feb. pp 13-15.

Anderson, J.M. (1989) The phenomenological perspective. *Qualitative nursing research: a contemporary dialogue..* Morse, J.M. (Ed) Rockville. Aspen.

Banonis, B.C. (1989) The Lived Experience of Recovering from Addiction: A Phenomenological Study. *Nursing Science Quarterly*. pp 37-43.

Bartjes, A. (1991) Phenomenology in clinical practice. In Grey and Pratt (Eds) *Towards a discipline of Nursing*. Churchill Livingston. pp 247-264.

Barnum -Stevens, B. J. (1990) *Nursing Theory* . Illinois. Scott, Foresman and Little.

Beck, C. T. (1992) The Lived Experience of Postpartum Depression: A Phenomenological Study. *Nursing Research*.. 41 (3). pp 166-170.

Behrman, C.A., Hediger, M.L., Scholl, T.O., and Arkangel, C.M. (1990) Nausea and Vomiting During Teenage Pregnancy: Effects on Birth Weight. *Journal of Adolescent Health Care*. 11. pp 418-422.

Belluomini, J., Litt, R. C., Lee, K. A. and Katz, M. (1994) Accupressure for Nausea and Vomiting of Pregnancy: A Randomized, Blinded Study. *Obstetrics and Gynecology*. 84 (2). pp 245- 248.

Benner, P. (1984) *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, California. Addison-Wesley.

Benner, P. (1985) Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science*. 8(1). pp 1-14.

Benner, P. (1994) Introduction. *Interpretive phenomenology. Embodiment, Caring and Ethics in Health and Illness*. Benner, P.(Ed). Thousand Oaks, California. Sage. pp xiii -xxvii.

Benner, P. (1994) The Tradition and Skill of Interpretive Phenomenology in Studying Health, Illness, and Caring Practices. *Interpretive*

phenomenology. Embodiment, Caring and Ethics in Health and Illness. Benner, P. (Ed). Thousand Oaks, California. Sage. pp 99-127.

Benner, P. and Wrubel, J. (1989) *The Primacy of Caring: Stress and Coping in Health and Illness.* Menlo Park, California. Addison-Wesley.

Biggs, J.S.G. (1975) Vomiting in pregnancy - causes and management. *Drugs.* 9. pp 299- 300.

Billett, J. (1992) A closer look at pregnancy sickness. *Professional Care of Mother and Child.* Nov/Dec. pp 310-311.

Birks, E. K. (1993) *Coping with 'Morning' sickness.* Dunedin. University of Otago Press.

Bland , M. (1994) Challenging the myths: The lived experience of chronic leg ulcers. Unpublished MA thesis, Department of Nursing and Midwifery, Massey University, Palmerston North, New Zealand.

Bluff, R., and Holloway, I. (1994) 'They know best': women's perceptions of midwifery care during labour and childbirth. *Midwifery.* 10. pp 157-164.

Brands, J. M. (1967) First trimester nausea and vomiting as related to outcome of pregnancy. *Obstetrics and Gynecology* . 30 (3). pp 427-431.

Brucker, M. C. (1988) Management of Common Minor Discomforts in Pregnancy. Part III: Managing Gastrointestinal Problems in Pregnancy. *Journal of Nurse-Midwifery.* 33 (2). pp 67-73.

Cohen, M.Z. (1987) A historical overview of the phenomenological movement. *Image: Journal of Nursing Scholarship* . 19 (1). pp 31-34.

Colaizzi, P.F. (1978) *Psychological research as the phenomenologist views it.* Existential-phenomenological alternatives for psychology. Valle, S., King, M. (Eds). New York. Oxford University Press.

Conrad, K. and Ponte, C. (1981) Controlling nausea and vomiting in Pregnancy. *Drug intelligence and clinical Pharmacy.* 15. pp 1001-1002.

Cotanch, P. H. (1989) Management of Nausea: Current Bases for Practice. *Key Aspects of Comfort.* Funk, S.G., Tornquist, E.M., Champagne, M.T. et al (Eds). New York. Springer. pp 243- 248.

de Swiet, M. (1989) Preface. Medical *Disorders in Obstetric Practice* . de Swiet (ed) Second Edition. Oxford, London, Edinburgh. Blackwell Scientific Publications.

Deuchar, N. (1995) Nausea and vomiting in pregnancy: a review of the problem with particular regard to psychological and social aspects. *British Journal of Obstetrics and Gynaecology.* Vol 102, pp 6-8.

Deutsch, H (1945) *The Psychology of Women Vol 2 Motherhood* New York Grune and Stratton.

Diggory, P.L.C. and Tomkinson, J.S. (1962) Nausea and vomiting in pregnancy. A Trial of meclozine dihydrochloride with and without pyridoxine. *Lancet.* 25. pp 370 -375.

DiIorio, C (1985) First trimester nausea in Pregnant Teenagers: Incidence, Characteristics, Intervention. *Nursing Research,.* 34(6). pp 372-374.

DiIorio, C (1988) The Management of Nausea and Vomiting in Pregnancy. *Nurse Practitioner ; American Journal of Primary Health Care.* 13(5). pp 23-24, 26-28.

DiIorio, C.K. and van Lier, D.J. (1989) Nausea and Vomiting in Pregnancy. *Key Aspects of Comfort.* Funk, S.G., Tornquist, E.M., Champagne, M.T., Copp, L.A., and Wiese, R.A. (Eds). New York. Springer. pp 259 - 266.

DiIorio, C. van Lier, D. and Manteuffel, B. (1994) Recommendations by Clinicians for Nausea and Vomiting of Pregnancy. *Clinical Nursing Research.* 3 (3). pp 209-227.

Dorsey, C. W. (1949) The use of pyridoxine and suprarenal cortex combined in the treatment of the nausea and vomiting of pregnancy. *American Journal of Obstetric and Gynecology* . 58. pp 1073-1078.

Dreyfus, H. (1994) Preface. Interpretive *phenomenology. Embodiment, Caring and Ethics in Health and Illness.* Benner, P. (Ed)./ Thousand Oaks, California. Sage. pp v- xii.

Evans, A. T., Samuels, S. N., Marshall, C., and Bertolucci, L. E. (1993) Suppression of Pregnancy-Induced Nausea and Vomiting with Sensory Afferent Stimulation. *The Journal of Reproductive Medicine.* pp 603-606.

Fagan, E. A. (1989) Disorders of the gastrointestinal Tract. *Medical Disorders in Obstetric Practice* de Swiet (Ed) Second Edition. Oxford, London, Edinburgh. Blackwell Scientific Publications. pp 521-583.

Fairweather, D.V.I. (1968) Nausea and vomiting in pregnancy. Current developments - an evaluation. *American Journal of Obstetrics and Gynecology* . 102 (1). pp 135-175.

Fairweather, D.V.I. (1978) Nausea and vomiting during pregnancy. *Obstetrics and Gynaecology.* 7. pp 91-99.

Gadow, S.A. (1985) Nurse and Patient: The Caring Relationship. *Caring, Curing, Coping: Nurse, Physician, Patient Relationships.* Bishop, A. H., and Scudder , J. R. (Eds). University of Alabama Press. Alabama. pp 31-43.

Gadsby, R. (1994) Pregnancy sickness and symptoms: your questions answered. *Professional Care of Mother and Child.* 4 (1) pp 16-17.

Gadsby, R., Barnie-Adshead, A.M., and Jagger, C. (1993) A Prospective study of nausea and vomiting during pregnancy. *British Journal of general Practice.* 43. pp 245-248.

Giorgi, A (1970) *Psychology as a human science : a phenomenologically based approach.* New York. Harper and Row.

Heidegger, M. (1962) *Being and Time.* McIntyre, J. and Ramsay, I.T. (Eds). London. SCM Press. (translated from the German 7th ed. 1927).

Hogan, C.M. (1990) Advances in the Management of Nausea and Vomiting. *The Nursing Clinics of North America.* 25 (2). W. B. Saunders Company, pp 475-497.

Hutchinson, S.A., Wilson, M.E. and Skodol Wilson, H. (1994) Benefits of participating in research interviews. *IMAGE: Journal of Nursing Scholarship.* 26 (2). pp 161-164.

Hyde, E. (1989) Accupressure Therapy for Morning Sickness. A Controlled Clinical Trial. *Journal of Nurse-Midwifery.* 34 (4). pp 171-178.

Jablonski, S. (1993) *Dictionary of medical acronyms and abbreviations.* 2nd ed. St Louis. Mosby.

Jacobson, G. (1994) The Meaning of Stressful Life Experiences in Nine - to Eleven - Year-Old Children: A Phenomenological Study. *Nursing Research.* 43(2). pp 95-99.

Jarnfelt-Samsioe, A., Samsioe, G., and Velinder, G. (1983) Nausea and vomiting in pregnancy- A contribution to its epidemiology. *Gynecological and Obstetric Investigation.* 16. pp 221- 229.

Jasper, M.A. (1994) Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing*. 19. pp 309-314.

Jenkins, M. L. and Shelton, B. J. (1989) The Effectiveness of Self-Care Actions in Reducing "Morning Sickness". *Key Aspects of Comfort.* Funk, S.G., Tornquist, E.M., Champagne, M.T., et al (Eds). New York. Springer. pp 267-272.

Kestenbaum V (Ed) (1982) *The Humanity of the Ill: Phenomenological Perspective*. Knoxville. The University of Tennessee Press.

Klebanoff, M.A., Koslowe, P.A., Kaslow, R., and Rhoads, G.G. (1985) Epidemiology of vomiting in early pregnancy. *Obstetrics and Gynaecology*. 66. pp 612-616.

Lawler, J. (1991) *Behind the Screens: Nursing, Somology, and the Problem of the Body*. Melbourne. Churchill Livingston.

LeWitt, P. (1986) Nausea and Vomiting: Diagnostic and Therapeutic Considerations. *Physician Assistant*. 10 (6). pp 117-8, 123-4, 129.

Leonard, V. W. (1994) A Heideggerian Phenomenological Perspective on the Concept of Person. *Interpretive phenomenology, Embodiment, Caring and Ethics in Health and Illness*. P. Benner (Ed). Thousand Oaks, California. Sage. pp 43-63.

Lincoln, Y.S., and Guba, E.G. (1985) *Naturalistic inquiry*. Beverley Hills, California. Sage Publications.

Madjar, I. (1991) Pain as embodied experience: A phenomenological study of clinically inflicted pain in adult patients. Unpublished PhD dissertation, Department of Nursing Studies, Massey University, Palmerston North, New Zealand.

McCaffery, M. (1979) *Nursing Management of the Patient with Pain*. 2nd ed. Philadelphia. Lippincott.

Meleis, A. I. (1985) *Theoretical nursing: Development and progress*. Philadelphia. Lippincott.

Merleau-Ponty, M. (1962) *Phenomenology of perception*. (Translated by Colin Smith.). London. Routledge and Kegan Paul.

Minturn, L., and Weiher, A. (1984) The influence of diet on morning sickness: a cross-cultural study. *Medical Anthropology* . 8. pp 71-75.

Mori, M., Amino, N., Tamaki, H., Miyai, K., and Tanizawa, O. (1988) Morning sickness and thyroid function in normal pregnancy. *Obstetric and gynaecology* . 72. pp 355-359.

Morse, J.M. (1991) Strategies for sampling. *Qualitative nursing research: A contemporary dialogue* (revised edition). Morse, J.M. (Ed). Newbury Park, California. Sage Publications. pp 127-145.

Morse, J. M. and Johnson, J. L. (1991) Toward a theory of illness: The illness-constellation model. *The illness experience: Dimensions of suffering*.

Morse, J. M. and Johnson, J.L. (Eds). Newbury Park, California. Sage Publications. pp 315-341.

Munhall, P. L. (1981) Nursing philosophy and nursing research: in apposition or opposition. *Nursing Research* 31 (3). pp 176-177.

Munhall, P. L. and Oiler, C.J. (1986) Epistemology in nursing. *Nursing research: A qualitative perspective.* Munhall, P.L. and Oiler, C.J. (Eds). Norwalk, Connecticut. Appleton-Century-Crofts. pp 27-46.

Newman, V., Fullerton, J. T., and Anderson, P. O. (1993) Clinical Advances in the Management of Severe Nausea and Vomiting During Pregnancy. *Journal of Obstetric, Gynecologic and Neonatal Nursing.* 22 (6). pp 483-490.

Norris, C. M. (1982) Nausea and Vomiting. *Concept Clarification in Nursing.* Norris, C.M. (Ed) Rockville. Aspen System Corp. pp 81-110.

O'Brien, B. A. (1990) Nausea and vomiting during pregnancy (NVP): A descriptive correlational study. Unpublished PhD dissertation, Rush University.

O'Brien, B., and Naber, S. (1992) Nausea and Vomiting During Pregnancy: Effects on the Quality of Women's Lives. *Birth* 19 (3). pp 138-143.

O'Brien, B. and Newton. N. (1991) Psyche versus soma: historical evolution of beliefs about nausea and vomiting during pregnancy. *Journal Psychosomatics, Obstetrics, Gynaecology.* 12. pp 91- 120.

O'Brien, B. A., Relyea, M. J., and Taerum, T. (1996) Efficacy of P6 accupressure in the treatment of nausea and vomiting during pregnancy. *American Journal of Obstetrics and Gynaecology*. 174 (2). pp 708 - 715.

O'Brien, B., and Zhou, Q. (1995) Variables Related to Nausea and Vomiting During Pregnancy. *Birth*. 22(2). pp 93 -100.

Parse, R.R. (1981) *Man-Living-Health - A Theory of Nursing*. New York. Wiley.

Parse, R.R (1987) *Nursing Science: Major paradigms, theories and critiques.* New York. Saunders.

Parse, R.R., Coyne, A.B., Smith, M.J. (1985) *Nursing Research. Qualitative methods*. Prentice -Hall, Bowie.

Patterson, B. (1986) The Experience of Acute Illness - Whose Experience? *Nursing Praxis in New Zealand*. 1 (4). pp 3-8.

Plager, K. A. (1994) Hermeneutic Phenomenology. A Methodology for Family Health and Health promotion Study in Nursing. *Interpretive Phenomenology. Embodiment, Caring and Ethics in Health and Illness.* Benner, P. (Ed). Thousand Oaks, California. Sage. pp 65-83.

Pole, L.E. (1989) Relieving Nausea: A Discussion. *Key Aspects of Comfort* Funk, S.G., Tornquist, E.M., Champagne, M.T. et al (Eds) New York. Springer. pp 272- 275.

Profet. M. (1993) Understanding Pregnancy Sickness. *Organon's Magazine on Women & Health.* No 4. pp 44-47

Ray, M. (1990) The phenomenological method for nursing research. *The nursing profession. Turning points.* Chaska, N.L. (Ed). St Louis. C.V. Mosby.

Reeves, N., Potempa, K., and Gallo, A. (1991) Fatigue in Early Pregnancy. An Exploratory Study. *Journal of Nurse-Midwifery.* 36 (5). pp 303-309.

Reid, S.S (1994) The Experience of Prolonged Vomiting and Nausea Post-Myocardial Infarction: A Hermeneutic Phenomenological Understanding. Paper presented at Nursing research: Scholarship for Practice Conference - The 3rd Annual Conference of the School of Nursing, Deakin University.

Rhodes, V.A., Watson, P.M., Johnson, M.H., Madsen, R.W. and Beck, N.C. (1989) Postchemotherapy Nausea and Vomiting. *Key Aspects of Comfort.* Funk, S.G., Tornquist, E.M., Champagne, M.T., et al (Eds). New York. Springer. pp 248 -258.

Rhodes, V. A. (1990) "Nausea, Vomiting and Retching". *Nursing Clinics of North America.* W. B. Saunders company. 25 (4) . pp 885- 900.

Riezzo, G., Pezzolla, F., Darconza, G., and Giorgio, I. (1992) Gastric Myoelectrical Activity in the First Trimester of Pregnancy: A Cutaneous Electrogastrographic Study. *The American Journal of Gastroenterology.* 87 (6) pp 702-706.

Rummel, L. (1993) The proving ground: the lived world of nursing students in their pre-registration clinical experience. Unpublished M.A. thesis, Department of Nursing Studies, Massey University, Palmerston North, New Zealand.

Sahakian, V., Rouse, D., Sipes, S., Rose, N., and Niebyl, J. (1991) Vitamin B6 is Effective Therapy for Nausea and Vomiting of Pregnancy: A Randomised Double-Blind Placebo-Controlled Study. *Obstetrics and Gynecology*. 78 (1). pp 33-36.

Sandelowski, M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* . 8 (3). pp 27-37.

Santopinto, M. D. A. (1989) The Relentless Drive to be Ever Thinner: A Study Using the Phenomenological Method. *Nursing Science Quarterly*. pp 29-36.

Schuster, K., Baily, L.B., Dimperio, D. and Mahan, C.S. (1985) Morning sickness and vitamin B6 status of pregnant women. *Human Nutrition: Clinical Nutrition*. 39. pp 75-79.

Soules, M.R., Hughes, C.L., Garcia, J.A., Livengood, C.H., Prystowsky, M.R. and Alexander, E. (1980) Nausea and vomiting of pregnancy: role of human chorionic gonadotropin and 17 - hydroxyprogesterone. *Obstetrics and Gynaecology*. 55. pp 696-700.

Spiegelberg (1976) cited in Oiler, C.J. (1986) The phenomenological movement. *Nursing Research: A Qualitative perspective* . Munhall, P.J. and Oiler, C.J. (Eds) Norwalk. Appleton- Century -Crofts. pp 69 - 84.

Spiegelberg, H. (1971) *The Phenomenological Movement: a Historical Introduction.* 2nd ed. The Hague. M. Nijhoff.

Stainton, M. C., and Neff, E. J. (1994) The Efficacy of SeaBands for the Control of Nausea and Vomiting in Pregnancy. *Health Care for Women International* . 15(6). pp 563-575.

Swanson-Kauffman, K. and Schonwald, E. (1988) Phenomenology. *Paths to knowledge: Innovative research methods for nursing.* Sarter, B. (Ed). New York. National league for Nursing. pp 97-105.

Temkin, O (Ed) (1956) *Soranus' Gynecology.* Baltimore. John Hopkins Press.

Tiran, D. (1996) Complementary therapies for nausea in pregnancy. *Modern Midwife.* March.

Todd, A. D. (1989) *Intimate Adversities. Cultural Conflict Between Doctors and Women Patients.* Philadelphia. University of Pennsylvania press.

Toombs, S.K. (1987) The meaning of illness: A Phenomenological approach to the patient-physician relationship. *The Journal of Medicine and Philosophy.* 12. pp 219-240.

Toombs S.K. (1992) *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient.* Dordrecht, Boston. London. Kluwer Academic Publishers.

Uddenberg, N., Nilsson, A., and Almbren, P.E. (1971) Nausea in pregnancy: Psychological and psychosomatic aspects *Journal of Psychosomatic Research* . 15 (3). pp 269-276.

van Manen, M (1990) *Researching Lived Experience. Human Science for an Action Sensitive Pedagogy.* London, Ontario. The Althouse Press.

van Manen, M. (1995) Researching Lived Experience using Phenomenology. Conference presentation. Monash University, Gippsland campus, Victoria, Australia. January 1995.

Vellacott, I.D., Cooke, E.J.A., and James, C.E. (1988) Nausea and vomiting in early pregnancy. *International Journal of Gynaecology and Obstetrics..* 27. pp 57-62.

Voda, A.M. and Randall, M.P. (1982) Nausea and vomiting of pregnancy: "Morning sickness". *Concept Clarification in Nursing.* Norris, C. M. (Ed). Rockville, Md, Aspen Systems Corp. pp 133-165.

Walker, A.R.P., Walker, B.F., Jones, J., Verardi, M. and Walker, C. (1985) Nausea and vomiting and dietary cravings and aversions during pregnancy in South African women. *British Journal of Obstetrics and Gynaecology.* 92. pp 484-489.

Walters, A.J. (1995) A Heideggerian hermeneutic study of the practice of critical care nurses. *Journal of Advanced Nursing*. 21: pp 492-497.

Watson, J. (1985) *Nursing: Human science and human care.* Norwalk. Appleton-Century-Crofts.

Weinstein, B.B., Wohl, Z., Mitchell, G.J., and Sustendal, G.F. (1944) Oral administration of pyridoxine hydrochloride in the treatment of nausea and vomiting of pregnancy. *American Journal of Obstetrics and Gynaecology* . 47. pp 389-394.

Weinstein, B.B., Mitchell, G.J., and Sustendal, G.F. (1943) Clinical experience with pyridoxine hydrochloride in the treatment of nausea and vomiting of pregnancy. *American Journal of Obstetrics and Gynaecology*. 46. pp 283-285.

Wenmoth, J.D.A. (1992) Fieldwork report: A study examining the experience of nausea, vomiting and retching associated with pregnancy.

Welsh, R. (1995) More than Morning Sickness. *Little Treasures. New Zealand's own parenting magazine.* No. 49. pp 28-31.

Willis, R.S., Winn, W.W., Morris, A.T., Newsom, A.A., Massey, W.E. (1942) Clinical observations in treatment of nausea and vomiting in pregnancy with vitamin B1 and B6. A preliminary report. *American Journal of Obstetric and Gynecology* . 44. pp 265-271.

Wilkes, L. (1991) Phenomenology: a window to the nursing world. *Towards a discipline of nursing*. Gray and Platt (Eds). Churchill Livingston. pp 229-246.

Wolkind, S and Zajicek, E (1978) Psycho-Social Correlates of nausea and vomiting in pregnancy. *Journal of Psychosomatic Research*. 22. pp 1-5.

Woolery, L.F.(1983) Self-care for the Obstetrical Patient. A Nursing Framework. *Journal of Obstetric and Gynecological Nursing*. Jan/Feb. pp 33-37.

Young, I.M. (1984) Pregnant Embodiment: Subjectivity and Alienation. *The Journal of Medicine and Philosophy* . 9. pp 45-62.

Zanter, R.M. (1985) "How the Hell Did I Get Here?" Reflections on being a Patient. *Caring, Curing, Coping :Nurse Physician Patient Relationships* Bishop, A.H. and Scudder, J.R. (Eds). Alabama. University of Alabama Press.

Appendix 1

INFORMATION SHEET FOR RESEARCH PROJECT EXAMINING THE EXPERIENCE OF NAUSEA, VOMITING AND RETCHING ASSOCIATED WITH PREGNANCY

This research project is for the purpose of my thesis which is a part requirement for a Master of Arts (MA), majoring in Nursing.

The aim of the study is to examine the experience of nausea, vomiting and retching associated with pregnancy from your point of view. This will look particularly at the experience of these symptoms and how you coped / are coping with these. The study will allow you to talk about your experience and help increase knowledge in this area of nursing practice.

I would like to visit you on two occasions. Each visit will take approximately an hour of your time in talking about your experience. I would like to tape our conversation so that I can be sure no valuable information is lost. Should you wish you may review your tape transcript to verify it is correct.

The information you give me will be collated with similar information from other pregnant women for the purposes of this project. I may wish to contact you when collating the information to clarify any points that you may raise. A further visit may be required for this purpose.

The collated information will form the basis of a written thesis and possible professional nursing publications or seminar presentations.

If you take part in this study, you have the right to:

-ask any further questions about the study that occur to you during your participation

-refuse to answer any particular question,

-provide information on the understanding that your identity remains completely confidential to the researcher. All information is collected anonymously, and it will not be possible to identify you in quoted extracts that may be used in the final report.

-be given access to a summary of the findings from the study when it is concluded.

-to withdraw from the study at any time

This research will be supervised by Ms Jo Walton, Lecturer, Nursing Studies Department, Massey University.

Please feel free to contact me at any time should you wish to discuss any aspect of this study. I can be contacted c/o Nursing Studies Department, Massey University (Ph 3569099), or at home [redacted]

Thank you,

Joyce Wenmoth

Appendix 2

CONSENT TO BE INVOLVED IN RESEARCH

EXAMINING THE EXPERIENCE OF NAUSEA, VOMITING AND RETCHING ASSOCIATED WITH PREGNANCY

Statement by participant

I have read the Information Sheet for this study and have had the details of the study explained to me. I have had the opportunity for discussion with the researcher, Joyce Wenmoth, and my questions about the study have been answered to my satisfaction. I understand that I may ask further questions or seek further clarification at any time.

I am aware that:

I am free to withdraw from the study at any time,

I may decline to answer any particular questions in the study.

I agree to provide information to the researcher on the understanding that my identity will remain confidential to the researcher and that all information will be collated anonymously. I understand that I will not be able to be identified in the published research reports.

I am satisfied that I understand the requirements of the study and agree to participate under the conditions outlined on the Information Sheet.

Participant

Signed;----------

Researcher

Signed;----------

Joyce D. A. Wenmoth

Date:----------