EXPLORING THE EXPERIENCE OF WOMEN WHO UNDERGO A LATE DISCLOSURE OF PREGNANCY

By

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Dedicated to:

Kevin Thynne
Eamon & Margaret Tonge
Pat Sherlock
Acknowledgments

The idea for this thesis emerged from the work of Maeve Tonge and Catherine Sherlock, two medical social workers in University College Hospital Galway. These practitioners were pivotal to this research. Thanks also to Aileen Davis and her team, Imelda Ryan and Elaine Murray in the Teen Parents Project in UCHG for attempting to contact participants. I also wish to express my gratitude to senior social worker Mary McMahon in UCHG for agreeing that this was a worthwhile piece of research for her staff to be involved in. Dr Meena O’Neill & Dr Geraldine Gaffney, thank you for your support and encouragement and agreeing to supervise this project. I wish to express gratitude to the advice and assistance of Catherine Conlon and Cathy Fox especially in the formative days of this project. I wish to thank the social workers in community care: Aoife Staunton, Patricia Randals, John Donnelly, Elaine Walsh, Dee O’Brien and Sharon Hughes who contacted potential participants on my behalf. I owe words of thanks to both Cathriona Conroy and Dr. Su Sarma for assisting me through the ethical approval procedures involved in this research. Malie Landendick and Elaine Curran thank you both for taking the time to read and analyse the transcripts and for giving your feedback. I wish to thank Todd Morrison and Hans Gerritsen for their advice regarding statistical analysis. Hans, thank you for patiently offering encouragement and support. Niamh and Lisa Vaughan, thank you both for your hard work. Most importantly, this project would not have been possible without the openness, time and commitment, with which the participants who took part in this research shared with the researcher. Because of you we now know a little more. Thank you.
The Researcher

After completing a BA in psychology in 1995 in University College Galway, I qualified as a social worker in 1999 from Queens University Belfast and worked in Dublin in the area of child protection. In 2001 I started work in University College Hospital Galway (UCHG) with older adults and with the cardiac-rehabilitation team. In October 2003, I commenced my clinical psychology training at NUI Galway.

During my time as a social worker in UCHG, I was involved in peer-supervision in which complex cases were discussed with colleagues. Such cases included situations where women had delayed disclosing their pregnancy. As practitioners we often struggled to comprehend this experience. Therefore, when the opportunity arose to investigate an area of interest, late disclosure of pregnancy was my obvious choice.

Without the links with colleagues in the UCHG social work department, I feel I could not have completed this piece of work. I also feel that my five years clinical experience both as a social worker and trainee clinical psychologist placed me in a uniquely qualified position to carry out this sensitive piece of research. I am in no doubt that my previous training helped me to design and implement the methodology and also influenced my analysis and interpretation of the findings. My genuine desire to explore this phenomenon ‘from the inside’ and to honour the women’s experience played a central role in moulding how this study was designed and completed.
Abstract

This thesis explores the phenomenon of late disclosure of pregnancy. The concepts of denial and concealment, which are used in the literature to describe this process are framed largely by a medical ‘outsider’ perspective, and are based on an implicit assumption of pathology. Prior research has focused on the negative medical outcomes for both mother and child following this phenomenon and a dearth of psychological research exists in this area. In addition, there is a lack of Irish based psychological research examining this subject matter. Furthermore, no research has explored the meaning of late disclosure of pregnancy from the ‘insider’ perspective namely of the women who experience it. The current thesis comprises of two studies aimed at enhancing clinician’s understanding of this phenomenon. Study one explores late disclosure of pregnancy by employing in-depth interviews with a sample group of Irish women (n=8). The women were asked about their experiences of pregnancy and why they felt it was necessary to delay disclosure. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). Delayed disclosure of pregnancy emerged as a dynamic and multidimensional concept. Study two investigated the socio-demographic profile of women in a target group who had delayed disclosure of pregnancy (n=43) and a smaller aged-matched comparison group (n=30). The demographic profiles of women drawn from these two groups were compared. Late disclosure was more common in women from a rural background and women who feared a negative parental reaction.
## Table of contents

### Section one: Context and literature review

1 CONTEXT AND LITERATURE REVIEW

1.1 Introduction

1.2 Late disclosure of pregnancy

1.3 Pregnancy and maternal preparation

1.4 Denial and concealment

1.5 Denial of pregnancy and concealment of pregnancy

1.6 Reasons for late disclosure

1.7 The psychological impact

1.8 Under-researched populations

1.9 Prevalence

1.10 Socio-demographic details

1.10.1 Age

1.10.2 Previous experience of pregnancy

1.10.3 Other demographic details

1.11 Physical risks to the infant and mother

1.12 Urgency of further research

1.13 Crisis pregnancies in Ireland

1.14 Aims of this thesis

### Section two: Ethical issues and practical concerns

2 ETHICAL ISSUES AND PRACTICAL CONCERNS

2.1 Introduction

2.2 Terminology used by the researcher

2.3 Ethical issues

2.3.1 Selection of participants

2.3.2 Contacting participants

2.3.3 Anonymity, respect and confidentiality

2.3.4 Follow-up

2.3.5 A consent issue concerning the quantitative study

2.4 Practical concerns
Section three: Qualitative methodology and findings

3 RESEARCH METHODOLOGY OF THE QUALITATIVE STUDY

3.1 Introduction

3.2 The need to research this subject sensitively

3.3 The process of enhancing theoretical sensitivity

3.4 Attempts to counterbalance the power differential

3.5 Selection of participants

3.6 Materials

3.6.1 Instruments

3.6.2 Equipment

3.7 Procedure

4 ANALYSIS OF QUALITATIVE DATA

4.1 Rationale for using Interpretative Phenomenological Analysis

4.2 Stages in analysis using IPA

4.2.1 Stage One: Transcribing interview tapes

4.2.2 Stage Two: Familiarisation with the transcripts

4.2.3 Stage Three: Continuing the formulation of themes

4.2.4 Stage Four: Assigning codes

4.2.5 Stage Five: Clustering of themes

4.2.6 Stage Six: Researcher triangulation

4.2.7 Stage Seven: Diagrammatic representation of the themes

4.2.8 Stage Eight: Using a systemic model to analyse the findings

4.2.9 Stage Nine: Writing up

4.2.10 Stage Ten: Integrating and reflecting upon the feedback

5 RESULTS OF THE QUALITATIVE STUDY

5.1 Introduction

5.1 Case summaries
5.1.1 Mary
5.1.2 Ann
5.1.3 Carmel
5.1.4 Brenda
5.1.5 Fiona
5.1.6 Nuala
5.1.7 Susan
5.1.8 Monica

5.2 Summary of the findings

5.3 The women’s descriptions of the phenomenon
5.3.1 A defence mechanism

5.4 Interpretation of the women’s descriptions
5.4.1 Coping strategies
5.4.2 Dynamic and temporal aspects of the phenomenon
5.4.3 A continuum model
5.4.4 Partiality of the disclosure

5.5 Summary of initial interpretations of the findings

5.6 Proposed model of late disclosure

5.7 Societal influence: Macro-system
5.7.1 Societal attitudes towards single mothers
5.7.2 Stigmatisation of adoption process
5.7.3 Negative attitudes towards termination

5.8 Family Influence: Secondary system
5.8.1 Prior family stress
5.8.2 Poor maternal relationships
5.8.3 Feared parental reaction
5.8.4 Familial coping strategy

5.9 Support
5.9.1 Impact of familial support
5.9.2 Lack of familial support
5.9.3 Friends as sources of support
5.9.4 Professional intervention

5.10 Individual influences at the primary system
5.10.1 Personal coping-style
5.10.2 Knowing-self
5.10.3 Needing space and time to think
5.10.4 Mental Health
5.10.5 The women’s beliefs about adoption

5.11 The impact of the baby
5.11.1 Physical presence
5.11.2 Growth of foetus
5.11.3 Prenatal bonding dynamics
5.11.4 Birth process and its impact on decision making
5.11.5 Postpartum attachment
5.11.6 Baby’s temperament
5.11.7 The psychological and physical dyad

Section four: Quantitative methodology and findings

6 QUANTITATIVE METHODOLOGY
6.1 Design rationale
6.1.1 The rationale for control group
6.1.2 Rationale for demographic questionnaire design
6.2 Primary objective of quantitative study
6.3 Participant selection procedure
6.4 Collating birth weights
6.5 Method of analysis

7 RESULTS OF THE QUANTITATIVE STUDY
7.1 Age
7.2 Birth weight
7.3 Experience of previous deliveries
7.4 Relationship status
7.5 Education level
7.6 Employment status
7.7 Urban or rural background
7.8 Infant and maternal complications
7.9 Nationality
9.3.4 Impact of participant feedback

9.4 Ongoing process issues

Section six: Discussion

10 DISCUSSION

10.1 Introduction

10.2 Summary of the findings

10.3 Aim one: To explore and expand the concept of late disclosure

  10.3.1 A continuum model

  10.3.2 Temporal nature

  10.3.3 The potentially adaptive nature of the phenomenon

10.4 Aim two: To create a conceptualisation of this phenomenon

10.5 Aim three: To explore the psychological and physical aspects

  10.5.1 Individual problem-solving style

  10.5.2 Individual beliefs regarding adoption

  10.5.3 Mental Health

  10.5.4 The bonding process

  10.5.5 Underlying individual issues

  10.5.6 Influence of family members

  10.5.7 Perceived family reaction

  10.5.8 Family dynamics

  10.5.9 Physical outcomes of pregnancy

10.6 Aim Four: Add to demographic information

  10.6.1 Prevalence rates

  10.6.2 Reoccurrence of delayed disclosure of pregnancy

  10.6.3 Biological fathers

  10.6.4 Age

  10.6.5 Education and employment status

10.7 Aim five: To explore the role of cultural influences

  10.7.1 Nationality

  10.7.2 Stigma

  10.7.3 Mental health, neonaticide and cultural issues

10.8 Aim six: To explore the reasons for delayed disclosure

10.9 Aim seven: To explore the impact of late disclosure

10.10 Conclusion

11
<table>
<thead>
<tr>
<th>List of Tables</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1. Summary of main studies reviewed</td>
<td>23</td>
</tr>
<tr>
<td>Table 2. Case summaries</td>
<td>61</td>
</tr>
<tr>
<td>Table 3. Frequency of themes across interview</td>
<td>69</td>
</tr>
<tr>
<td>Table 4. Outline of descriptive data</td>
<td>113</td>
</tr>
<tr>
<td>Table 5. Underlying difficulties</td>
<td>123</td>
</tr>
<tr>
<td>Table 6. Source of supports</td>
<td>124</td>
</tr>
<tr>
<td>Table 7. Source of referral</td>
<td>124</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>List of Figures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1. Outline of study one</td>
<td>45</td>
</tr>
<tr>
<td>Figure 2. Visual representation of epistemological perspectives</td>
<td>54</td>
</tr>
<tr>
<td>Figure 3. Initial themes</td>
<td>68</td>
</tr>
<tr>
<td>Figure 4. A continuum of delayed disclosure</td>
<td>75</td>
</tr>
<tr>
<td>Figure 5. Summary and formulation of themes</td>
<td>77</td>
</tr>
<tr>
<td>Figure 6. Systemic view of the phenomenon</td>
<td>79</td>
</tr>
<tr>
<td>Figure 7. Extended systemic model</td>
<td>100</td>
</tr>
<tr>
<td>Figure 8. Outline of study two</td>
<td>109</td>
</tr>
<tr>
<td>Figure 9. Age</td>
<td>114</td>
</tr>
<tr>
<td>Figure 10. Birth weight</td>
<td>115</td>
</tr>
<tr>
<td>Figure 11. Previous pregnancy</td>
<td>116</td>
</tr>
<tr>
<td>Figure 12. Education</td>
<td>117</td>
</tr>
<tr>
<td>Figure 13. Employment</td>
<td>118</td>
</tr>
<tr>
<td>Figure 14. Place of origin</td>
<td>119</td>
</tr>
<tr>
<td>Figure 15. Supports informed</td>
<td>120</td>
</tr>
<tr>
<td>Figure 16. Family reaction</td>
<td>121</td>
</tr>
<tr>
<td>Figure 17. Decision on discharge</td>
<td>122</td>
</tr>
</tbody>
</table>
Deliveries without the woman’s subjective awareness of an existing pregnancy occur approximately threefold more often than triplets. The common view that denied pregnancies are exotic and rare events must definitely be characterised as no longer valid.

Chapter One

1 Context and literature review

1.1 Introduction

This thesis explores the phenomenon of late disclosure of pregnancy from both a qualitative and quantitative perspective. This report is written up in six sections. Section one examines the literature relevant to this area, in particular definitions of the pertinent terms and limitations of previous research. Section two outlines the ethical and practical considerations that were reflected upon before commencing this study. Section three presents the qualitative methodology, analysis, and results of study one. Section four describes the quantitative methodology and results of study two. Section five illustrates the validation and reliability methods and process issues that related to this piece of research. Finally, section six considers the implications of the findings, and discusses the limitations of the present thesis and the possible future direction of research in this area.

1.2 Late disclosure of pregnancy

In clinical practice, it is not uncommon that a pregnancy remains unrecognised up to the end of the first trimester, especially for primiparous women who are unfamiliar with the symptoms of pregnancy (Wessel, Endrikat & Buscher, 2003). However, from the point of view of obstetric practice, a pregnancy that remains undisclosed in the second and third trimester is considered highly unusual and can pose a severe threat to the life and health of the child and mother involved (Brezinka, Hunter, Biebl & Kinzl, 1994). Risks to the infant reported in the literature are, prematurity, lower birth weights, an increased likelihood of being admitted to a neonatal unit and a higher peri-
natal mortality rate than comparison groups (Rodie, Thompson & Norman, 2002; Treacy, Byrne & O'Donovan, 2002; Wessel et al., 2003). Women who deny a pregnancy and who present in labour have been reported to have poorer obstetric outcomes. They have an increased risk of breech presentations and maternal complications (Treacy & Byrne, 2003). Obstetric literature in this area highlights that a better understanding of this phenomenon is important for the health and well being of the baby and mother involved (Kaplan & Grotowski, 1996). Due to the potential serious consequences of a late disclosure of pregnancy, the exploration of this phenomenon was considered to have clinical significance and relevance.

Before examining the literature relating to this phenomenon, it is necessary to examine how previous researchers have defined the general processes of pregnancy, denial and concealment. After considering these basic definitions, the specific definitions that have been ascribed to denial of pregnancy and concealment of pregnancy will be examined and discussed. Once these definitions have been reviewed, the prevalence and demographic details regarding this phenomenon will be outlined. When reviewing the literature, the terms denial and concealment are used in the same way that the authors cited have used them.

1.3 Pregnancy and maternal preparation

Pregnancy has been portrayed as a period of maturation crisis during which the woman is challenged to adapt to her new maternal role (Uddenberg & Nilsson, 1975). Cohen (1988) described a four-stage process of mental preparation that takes place while the expectant mother adapts to her new disposition. Stage one is an acceptance of the pregnancy, stage two is attachment to the foetus, stage three is the preparation for
the birth and the fourth and final stage is forming a realistic perception of the neonate. Uddenberg and Nilsson argue that without accomplishing primary acceptance that one is pregnant, it is impossible to progress through subsequent pregnancy maturational stages, leaving the woman unprepared for delivery and motherhood. Furthermore, Smith (1994), who examined first time mothers having a planned pregnancy, maintains that women, positively reconstruct their identity as they transition to motherhood. However, research has also contended that teenage girls and women who are ambivalent about being pregnant are slower to accept the maternal role identity and are also slower to display attachment behaviours towards their unborn child (Mercer, 1995).

1.4 Denial and concealment

A review of the concept of denial in literature relating to physical illness concluded that denial is a complex construct, with different meanings in different contexts varying from pathological to adaptive (Goldbeck, 1997). Denial has been defined as an unconscious defence mechanism, used to resolve emotional conflict and to allay anxiety by disavowing thoughts, feelings, wishes, needs or external reality factors that are consciously intolerable (Werner, Campbell & Frazier, 1980). Denial has also been described as one of the most primitive defence mechanisms, which is used primarily by children and child-like adults (Neifert & Bourgeois, 2000). Interestingly, denial has been reported as the most significant factor explaining delayed pregnancy testing for adolescents (Kaplan & Grotowski, 1996).

The other term that is frequently used in the literature regarding late disclosure of pregnancy is concealment. In contrast to denial, concealment is seen as a conscious act
Chapter 1. Context and literature review

(Kirkpatrick, 1983). Dictionary definitions of concealment include; to hide, obscure, to cover up, mask, suppress, to keep something quiet, veil, cloak, to keep secret, to camouflage.

1.5 Denial of pregnancy and concealment of pregnancy

Sadler (2002) points out that there is no universal definition of a concealed pregnancy. Most researchers formulate their own definition of the concept, thus complicating this area of research even further. Sadler defines concealed pregnancy as follows: when a female, through fear, ignorance or denial, does not accept, or is unaware of, the pregnancy in an appropriate way. This definition highlights a trend in the literature, whereby two very different concepts “denial” and “concealment” are subsumed together under a single term, suggesting that they are synonymous; whereas, in fact, they may vary greatly. Spielvogel and Hohener (1995) also describe these concepts as if they were the same process. They suggest that, “Failure to verify a possible pregnancy and to adjust lifestyle and attire are more subtle manifestation of denial” (p. 220). This concurrent use of the two concepts within the literature is confusing.

Wessel, et al., (2003) refer to concealment of pregnancy as a situation where a woman is aware of her pregnant state, however, she attempts to hide her pregnancy from the outside world. On the other hand, their definition of denial is “a process when an observation or established fact is ignored or refused recognition to avoid anxiety and pain” (p.29). The concept of denied pregnancy was also explored by Treacy and Byrne (2003). They defined a denied pregnancy as a situation in which a woman conceals a pregnancy from others but also fails to acknowledge the pregnancy to herself.
Furthermore, the phenomenon of a denied pregnancy has been described as an extreme example of the denial of reality, which is expressed both psychologically and somatically (Milstein & Milstein, 1983).

Maldonado-Duran, Lartigue and Feintuch (2000) refer to three types of denied pregnancy. The first type is ‘total denial’ of pregnancy, despite all evidence to the contrary. They suggest that this type of denial is observed in women with psychosis. The second type of denial is where the woman does not know she is pregnant and believes that her discomfort is due to a physical illness. An example of such may be a peri-menopausal woman who is unaware that she is pregnant. The third category is defined as ‘less blatant denial’. This type of denial, they postulate occurs when a woman unlike in the other categories, knows she is pregnant, but acts as if she were not. In such a case the woman may not experience common symptoms that people associate with being pregnant (tiredness, morning sickness). They suggest that women experiencing these types of denial may fail to seek prenatal care and fail to make any physical or psychological preparation for the arrival of their baby. The third type of denial mentioned by Maldonado-Duran, Lartigue and Feintuch is very similar to what others refer to as concealment (Wessel et al., 2003; Treacy & Byrne, 2003).

In summary, although often used interchangeably, two different concepts of denial and concealment emerge from the literature. Denial denotes a lack of acknowledgement by the mother of her pregnant state. Concealment refers to a situation where a woman is aware of the pregnancy but chooses to hide it from others. Green and Manohar (1990) argue that the line between conscious and unconscious denial is not a fixed one. A difficulty exists when one tries to define these terms and
the line distinguishing a concealed pregnancy from a denied pregnancy is not clearly defined in the majority of published psychological papers dedicated to this research area.

From her clinical observations of pregnant women who deny their pregnancy, Berns (1982) proposes that a continuum of behaviours exists ranging from simple concealment to professed unawareness. Her study stands out in the literature in acknowledging the dynamic, fluctuating nature of the construct of denial as proposed by Goldbeck (1997). Furthermore, the literature relating to denied and concealed pregnancy is limited and dated. With the exception of a few studies (Maldonado-Duran, Lartigue & Feintuch 2000; Neifert & Bourgeois, 2000; Treacy & Byrne, 2003; Wessel, et al, 2003) the majority of the studies reviewed were published one or two decades ago. Additionally, the studies comprise of case reports and control groups are generally absent from the research design, with only three studies listing inclusion criteria (Table 1).
Table 1: Summary of main studies reviewed relating to late disclosure of pregnancy

<table>
<thead>
<tr>
<th>Investigators</th>
<th>Sample size</th>
<th>Type of study</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Berns, 1982 (U.K)</td>
<td>N=unknown</td>
<td>Clinical reflections</td>
<td>Experience used to illustrate characteristics of the mother</td>
</tr>
<tr>
<td>Finnegan, Mckinstry, Robinson, 1982 (Canada)</td>
<td>N=3</td>
<td>Case studies</td>
<td>Psychodynamic explanation of the phenomenon</td>
</tr>
<tr>
<td>Milstein &amp; Milstein, 1983 (UK)</td>
<td>N=1</td>
<td>Case study</td>
<td>Woman diagnosed as having atypical personality disorder</td>
</tr>
<tr>
<td>Miller, 1990 (USA)</td>
<td>N=26</td>
<td>Case studies in psychiatric setting</td>
<td>Categorisation into psychotic and non-psychotic denial</td>
</tr>
<tr>
<td>Green &amp; Manohar, 1990 (UK)</td>
<td>N=1</td>
<td>Case study</td>
<td>Case used to illustrate characteristics of mother</td>
</tr>
<tr>
<td>Brezinka, Hunter, Biebl &amp; Kinzl, 1994 UK</td>
<td>N=27</td>
<td>Structured clinical Interviews</td>
<td>Proposal to refer to denial of pregnancy as adjustment disorder</td>
</tr>
<tr>
<td>Spielvogel &amp; Hohener, 1995</td>
<td>N=4</td>
<td>Case studies</td>
<td>Categorisation of women into non-psychotic and psychotic deniers</td>
</tr>
<tr>
<td>Kaplan &amp; Grotowski, 1996 New Zealand</td>
<td>N=1</td>
<td>Case study</td>
<td>The phenomenon is referred to as a conversion disorder</td>
</tr>
<tr>
<td>Spinelli, 2001(USA)</td>
<td>N=16</td>
<td>Case studies in a prison population</td>
<td>Women assessed as having psychiatric diagnosis</td>
</tr>
<tr>
<td>Stotland &amp; Stotland, 1998 (USA)</td>
<td>N=2</td>
<td>Case studies</td>
<td>Denial is not always pathological</td>
</tr>
<tr>
<td>Sadler, 2003 (UK)</td>
<td>N=0</td>
<td>Clinical reflections</td>
<td>Conclusion that the phenomenon is complex</td>
</tr>
</tbody>
</table>
1.6 Reasons for late disclosure

Stotland and Stotland (1998) point out that some women who deny pregnancy are found to be psychotic when examined using the mental status test. However, they also point out that psychosis does not explain all cases of concealed or denied pregnancy. In most instances of non-psychotic denial of pregnancy, the women do not replace their current reality with an alternative reality and thus do not appear to be experiencing a true psychotic episode. Stotland and Stotland argue that immaturity, lack of experience, ignorance, lack of resources and sheer terror play a role in many such cases. Miller (1990) explains that psychotic denial of pregnancy occurs in chronically mentally ill women (usually women with schizophrenia) who may experience the physical symptoms of pregnancy but attribute them to delusional causes. Miller proposes that women who are referred to in the literature as ‘psychotic deniers’ experience fluctuating acknowledgment of their pregnancy depending on the course of their illness. Their family would be generally aware of the pregnancy because the woman makes no effort at physical concealment.

Milstein and Milstein (1983) argue that certain physical factors contribute to the occurrence of concealed or denied pregnancies. Such factors included a minimal weight gain and an absence of pregnancy symptoms experienced by the women involved in such concealed or denied pregnancies. Other research reports continued vaginal bleeding throughout the denied or concealed pregnancy (Finnegan, McKinstry & Robinson, 1982), which would lead a woman to believe that she could not be pregnant. Spielvogel and Hohener (1995) highlight that early sexual trauma may put women at risk for complete or partial denial of pregnancy. Other factors they highlight, which
may contribute to explanations of this phenomenon, include the woman’s own experience of maternal deprivation, and anger she may hold towards the baby’s father.

Wessel et al. (2003) cite and use Vaillant’s (1971) concept of denial as a primitive defence mechanism, which healthy individuals under severe stress may experience, as a mechanism to explain the concept of denial. These researchers suggest that there is no single dynamic underlying denial of pregnancy and they urge that each case be examined on its own merit. Brezink et al. (1994) concluded that denial of pregnancy is a heterogeneous condition with different psychiatric diagnoses in different women, and argue that the psychological term “adjustment disorder” best explains non-psychotic denial of pregnancy. These authors propose that pregnancy and motherhood require a woman to make adjustments regarding her lifestyle, her relationship with her partner, her career and her role orientation. Depending on her living conditions and life situation, conflicts may be present that may result in psychological and social adjustment problems. They suggest that external stressors play an important role as precipitating factors for the development of such an adjustment disorder. On the other hand, Kaplan and Grotowsky (1996) explain the psychological mechanism involved in a denial of pregnancy as a conversion disorder. However, they argue that this condition defies easy conceptualisation and suggest that it cannot be explained by referral to a particular psychological model.

It could be argued that the use of language such as adjustment disorder, conversion disorder and non-psychotic denial, pathologises the concept of late disclosure. These terms portray the phenomenon as being something that is irrational, disordered and/or maladaptive. This viewpoint arises out of the professional
Chapter 1. Context and literature review

experiences of clinicians who have encountered this phenomenon in psychiatric and obstetric settings. However, in other spheres of health care, denial has been found to have positive adaptive functions, for example in cardiac illness or patients with cancer (Goldbeck, 1997; Julkunen & Saarinen, 1994; Strauss, Spitzer & Muskin, 1990). It is therefore not a forgone conclusion that late disclosure of pregnancy is always maladaptive.

Cultural and societal influences have recently been considered in the literature. Some researchers in this area hypothesise that women who experience domestic violence may be more likely to conceal or deny their pregnancy (Hollanddeer, 1997). Chapman’s (2003) work in a Mozambican population concluded that women’s perception that their unborn infants would be targets of witchcraft was one of the most significant reasons to conceal. Mahon, Conlon and Dillon, (1998) refer to the cultural and familial factors in Ireland that influence non-martial pregnancy such as stigma and parental reaction. Therefore, the notion that the experience of concealment and denial of pregnancy may be influenced by specific cultural and religious beliefs exists within the literature. However, the role of such cultural influences on late disclosure of pregnancy has not been explored in an Irish sample.

1.7 The psychological impact

The psychological impact of the experience of a late disclosure on the mothers, and on their relationship with their infant has been largely unexplored. For example, prenatal attachment has been hypothesised to be a good predictor of early mother–

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1 The Mahon, Conlon & Dillon (1998) study involved in-depth one to one interviews with 104 Irish women who had travelled to England to terminate their pregnancy and 207 Irish women who experienced a crisis pregnancy. This study revealed many cultural and familial influences that impacted on the women’s decision-making processes.
Chapter 1. Context and literature review

infant relationship in regular pregnancies (Siddiqui & Hagglof, 2000), yet the impact of delayed disclosure of pregnancy on attachment remains unknown.

1.8 Under-researched populations

To date no qualitative research has been published which specifically studies the concept of concealment and denial of pregnancy within a non-psychiatric Irish sample. No study has investigated the experience from first-hand accounts of women who present to services having delayed the disclosure of their pregnancy. Furthermore, although many factors have been mentioned in the literature as contributing to the occurrence of a concealed or denied pregnancy, no conceptual model has been proposed which attempts to illustrate how these factors relate to each other.

1.9 Prevalence

Due to the confusion regarding the definition of the concepts concealed pregnancy and denied pregnancy, prevalence rates for this phenomenon are difficult to interpret. Wessel et al. (2003) estimated that 1 in every 475 pregnancies in Berlin are denied pregnancies. They based this on a large quantitative study relating to denial of pregnancy, using the following definition of denial of pregnancy: no disclosure of pregnancy by a woman at 20 weeks. They also specified that the women in their sample had no subjective perception of the existing pregnancy, and that the women did not obtain a doctor’s diagnosis of pregnancy during the first 20 weeks of gestation. The researchers do not give a clear rationale as to why the 20 weeks gestation was established as the point after which a pregnancy was considered as denied. One can only presume that in obstetric practice lack of prenatal care and a lack of confirmation of pregnancy at 20 weeks would be considered highly unusual (Enkin et al., 2000).
Chapter 1. Context and literature review

In an Irish context, a study based in the Rotunda Hospital (Dublin City), where a concealment sample was taken from a general un-booked pregnancy sample, the incidence for concealed pregnancy was 1 in every 765 births (Treacy, Byrne & O’Donovan, 2002). Fox (2004) investigated the prevalence of concealment for the Western Health Board Crisis Pregnancy Agency. Fox adapted the definition proposed by Wessel et al. (2003) and defined concealed pregnancy as a situation where a woman (1) presents for antenatal care past 20 weeks gestation (2) has not availed of antenatal care elsewhere and (3) has not disclosed the pregnancy to her social network. Fox found a much higher prevalence of concealment than the two other studies. Her figures indicate that of the 1800 births annually (in a hospital in the West of Ireland), on average 50 pregnancies are concealed, which is a ratio of 1 in every 36 births.

The prevalence rates of these three studies, which all used inclusion criteria, suggest that concealment of pregnancy may be more common than denial of pregnancy. The vast difference between the prevalence rates could be explained by the urban-rural variable in that late disclosure of pregnancy might be more common in rural based populations (County Galway) than urban based populations (Berlin and Dublin city). However, as different definitions were used in the studies they cannot be compared directly and the influence of the urban-rural variable requires more research.

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2 The terms booked and un-booked deliveries are used in the medical literature surrounding this area. Un-booked women are defined as women who have received no antenatal care during their pregnancy or who may have had some antenatal care but presented to hospital with no record of this care (Treacy, Byrne & O’Donovan, 2002).
1.10 Socio-demographic details

1.10.1 Age

The portrayal of concealed or denied pregnancy, in the media in Ireland, has often been a source of controversy. A common portrayal is of young inexperienced schoolgirls abandoning or fatally neglecting their newborn infants because of psychiatric illness or fear (e.g. “Infanticide”, 2004; Strunsky, 2004). Kaplan and Grotowski (1996) reviewed the literature on the topic of denied pregnancy and commented that this phenomenon appeared to be more common in teenagers.

 Contrary to Kaplan and Grotowski’s (1996) work and the impression in the Irish media that this is an exclusively teen phenomenon, recent research on concealment and denial of pregnancy reveals that this phenomenon is experienced by women from a wide range of age groups. Both Wessel et al. (2003) and Treacy et al. (2003) found the mean age of the mothers involved to be around 26-27 years of age.

1.10.2 Previous experience of pregnancy

Words used in the literature and media to describe this target group of women include naive and inexperienced. However, in the study by Treacy et al. (2003) seven of the fifteen women studied had had one or more previous deliveries. In the Wessel et al. study (2003), which was based on a sample of 65 women, 36 women had had at least one previous delivery. Again, these findings contradict the stereotype portrayed in the media of inexperienced teenagers concealing or denying their pregnancy.

1.10.3 Other demographic details

In the Treacy et al. study (2003) 14 out of the 15 women were unmarried and nine were unemployed. In the Wessel et al. study (2003) 54 of the 65 women had a
close partner and 18 were on welfare. The findings from these two studies suggest that the women who deny or conceal a pregnancy tend to be unmarried and unemployed. However, further socio-demographic factors such as level of education and cultural background, which may be involved in this phenomenon, remain unexplored.

1.11 Physical risks to the infant and mother

A link has been established in the literature between concealment and denial of pregnancy and an increased risk of neonaticide and infanticide. However, many of the studies are anecdotal accounts (Stotland & Stotland, 1998). Spinelli (2001) examined 16 cases where alleged neonaticide had occurred and all 16 women had experienced denial of pregnancy. However, this does not necessarily mean that women who disclose late, are more likely to commit infanticide. Furthermore, all those included in Spinelli’s study had delivered alone and unassisted. Such “out of hospital” deliveries are rare and account for less than 1% of deliveries in the U.K (Rodie et al., 2002).

1.12 Urgency of further research

In recent years, government agencies have been calling for more research into crisis pregnancies in general. One such agency is the Crisis Pregnancy Agency, which was established in Ireland in 2001 (Statutory Instrument No. 446, 2001). The functions of the agency were defined by the order and included a remit that aimed to reduce the number of crisis pregnancies by providing education and advice. A crisis pregnancy is defined by the order as a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her. From the onset, the agency has pledged to find ways of helping to reduce the number of crisis pregnancies by the provision of education, advice and services (Crisis Pregnancy Agency, 2003). One of the recommendations from a report produced for the crisis pregnancy agency by
Chapter 1. Context and literature review

Loughran and Richardson (2005) was that future research should examine the area of concealed pregnancies and the biological father’s role in these situations. Therefore, there is a clinical urgency in trying to achieve a better understanding of this phenomenon, which has been reported in crisis pregnancy literature.

1.13 Crisis pregnancies in Ireland

Crisis pregnancy has a strong historical resonance in Ireland. Flanagan and Richardson (1992) concluded from their review of Irish state policy that the treatment of unmarried mothers since the beginning of this century shows that unmarried mothers constituted a social problem. Their research highlights the strategies for management of non-martial births in Catholic Ireland over the last century. These strategies included encouraging women who “got” pregnant to (1) marry their partners (2) place the baby for adoption (3) enter a mother and baby home which facilitated secret adoptions. With the establishment of abortion legislation in Britain in 1970 a fourth strategy to respond to non-martial pregnancies emerged, with involved Irish women travelling to Britain to obtain an abortion.

Flanagan and Richardson (1992) point out that all these strategies involve an element of collusion with the notion that pregnancy outside marriage does not occur and if it does occur the “problem” pregnancy can be dealt with covertly. Relating to this idea of strategies for dealing with problem pregnancies, Whitty (1993) argues that the rate of infanticide in Ireland decreased significantly in recent decades as contraception, single parent allowances and abortion services have become more accessible to women. He and others argue that with the availability of such services, women no longer have to resort to desperate measures to avoid pregnancy and
motherhood (Adie, 2005; Milotte, 1997). The extent to which, Irish cultural factors contribute to and influence the decision making of women choosing to delay the disclosure of their pregnancy remains unclear. This gap in the literature supports the argument for more research relating to the phenomenon with Irish samples.

1.14 Aims of this thesis

In summary, literature in this area is plagued by unclear definitions. In most studies to date, definitions of these concepts seem to have been derived from the clinical perception and experience of the phenomenon from practitioners in the fields of psychiatry and obstetrics. The research is dominated by studies that concentrate on the physical impact of such an experience on the infants involved. Most researchers have cited pathological explanations such as psychosis, or personality disorder for the causation of this phenomenon. The majority of these studies use case studies or only a small number of participants. Control groups are generally absent from the research design, with only three studies listing inclusion criteria. No published research could be located that has sought to explore the meaning of late disclosure of pregnancy from the point of view of the women who present in this way. Qualitatively seeking the views of women, from a non-psychiatric Irish population will both build on and broaden the existing research in this area.

This thesis aims to address some of the gaps in the literature relating to the phenomenon of late disclosure of pregnancy. In order to take a broad perspective both a qualitative and a quantitative approach will be utilised. The qualitative study will take a step towards clarifying the confusion that exists in the literature by asking women who have presented late in pregnancy how they themselves would describe this
phenomenon. Would they describe this experience as concealment and or denial or something else entirely? And how do their explanations of the experience compare with those cited in the literature? By asking these questions it is hoped to clarify the concept and also gain more insight into this phenomenon while attempting to develop the meaning and conceptualisation of this phenomenon. This study also aims to explore the psychological impact of undisclosed pregnancies by examining women’s perception of the impact this experience has had on them and on their relationship with their child.

Another question that will be addressed relates to whether the Irish historical and cultural context of non-marital pregnancies would resonate in 2005, with a sample of Irish women who experienced an unplanned pregnancy outside of a marital relationship.

The quantitative study aims to provide socio-demographic information for a target group of women living in the west of Ireland who have experienced late disclosure of pregnancy. In particular the study aimed to investigate whether women who delay disclosure of a pregnancy are:

(1) Younger than the average woman who gives birth
(2) Less experienced than the average pregnant woman
(3) Single or married
(4) Employed or unemployed
(5) Limited in education
(6) Delivering babies with lower than average birth weight

Overall it was hoped that the combined findings of this thesis would offer the various health professionals working with this specific client group, new and updated
information and a way to conceptualise the phenomenon in an Irish sample. This informed understanding should facilitate enhanced practice and should also have practical recommendations for clinicians, policy makers and future researchers.
Section Two:
Ethical issues and practical concerns to be considered in the design and implementation phases of the study

Without adequate training and supervision, the neophyte researcher can unwittingly become an unguided projectile bringing turbulence to the field, fostering personal traumas (for the researcher and the researched), and even causing damage to the discipline.

Punch (1994, p.83)
2 Ethical issues and practical concerns

2.1 Introduction

This chapter begins by examining the ethical issues and practical concerns, which influenced the design of study one. Following on from this, the merits of collaboration and the difficulties involved in establishing a meaningful working definition will be discussed.

2.2 Terminology used by the researcher

A lack of clarity exists in the literature regarding the terms denied and concealed pregnancy. Consequently, at the onset of this exploratory research process it was unclear what term would best describe a pregnancy that is disclosed late. Furthermore, it was unclear, what terminology women who experience this phenomenon, would find acceptable, i.e. a concealed pregnancy, a denied pregnancy or something else entirely. The term “late disclosure of pregnancy” was preferred by the researcher as an inclusive term which encapsulates the existing concepts of denial and concealment but with less pejorative connotations to describe both concepts. Furthermore, the term “late disclosure of pregnancy” does not assume knowledge of the processes involved in this experience. This phrase was used in communication with the participants i.e. in the consent form. The term was also used when interviewing the women who had experienced this phenomenon as it was seen as a more neutral means of exploring how they related their experience to terms used in the literature i.e. denial and concealment.
2.3 Ethical issues

2.3.1 Selection of participants

Past research with vulnerable populations highlights that many of the participants considered participation in research as a positive experience and linked this with being able to tell their story (Richards & Schwartz, 2002; Sutton, Erlen, Glad & Siminoff, 2003). Research has also highlighted that participants feel that by agreeing to take part in the research, their story may be of benefit to others. Many other vulnerable participants, however, experience distress when talking about their past painful experience (Cooper, 1998).

One of the key issues in planning this study was the balancing of the risk of participation with the potential benefits of the study both to society and the study participants. Reference was made to the Belmont Report (NCPHS, 1979). One of the basic human rights outlined in the Belmont Report is the right of participants to decide whether to participate in a study or not. However, this rule may be ethically difficult to apply to clinical populations. Thus, the practitioners and the researcher carefully considered the potential benefits and risk to each potential participant. The practitioners involved were effectively gatekeepers to potential research participants (Sutton et al., 2003). This gate-keeping involved balancing the need to protect vulnerable clients with the client’s right to choose to participate thus running the risk of limiting access to potential research volunteers because of well-meaning protection. (Beauchamp & Childress, 2001; Emanuel, Wendler & Grady, 2000).

The social work practitioners, from whose caseloads the research participants were drawn, have several years’ professional experience of working with women who
Chapter 2. Ethical issues and practical concerns

have delayed the disclosure of a pregnancy. Following careful discussion it was deemed inappropriate and/or unethical to contact potential participants who have had any of the following experiences: a miscarriage, a stillbirth, a termination, a recent bereavement, a diagnosed chronic mental health difficulties, or on-going intervention from community social work services. In cases where women were going through an adoption process and where the research was seen as potentially jeopardising this process, the women were not approached.

A clinical decision was reached that it would be insensitive to contact women who had presented in 2005 as the experience was considered to be too raw and thus potentially more distressing to talk about (Dyregrov, 2004). While these women had a right to participate in this study, this right was at times forfeited in what practitioners considered to be the best interest of that client. The social workers professional judgement was respected and accepted as valid and informed. The caveat that the welfare of individuals is greater than any research question was the yardstick by which the sampling process proceeded. Consequently, the sample is not intended to be representative of the total population of women who present late in pregnancy.

2.3.2 Contacting participants

In the interest of confidentiality it was decided that the practitioners would make initial contact with potential participants. For the researcher to “cold-call” a potential participant would breach confidentiality from the onset. It was decided that it would be unethical to conduct home visits as a means of making initial contact with potential participants as clients may feel unable to refuse the practitioners face to face request (Cooper, 1998). By compromising potential participants in this way some of the principles of informed consent would have been violated. Therefore, a telephone call
from the practitioner to their ex-client was deemed the most appropriate way to initiate contact. A telephone protocol was developed by the researcher for the practitioners to use as a guide when outlining the research project to their ex-client (Appendix A). If the participant verbally agreed to take part in the study, their name, telephone number and contact details were given to the researcher.

2.3.3 Anonymity, respect and confidentiality

Based on the work of other researchers who have worked with vulnerable populations (Kvale, 1996; Regan-Kubinski & Sharts-Hopko, 1997) and general clinical practice principles, other factors which were considered included; (1) meaningful informed consent (2) providing anonymity and (3) confidentiality. Consequently, the process by which the interview tapes would be stored, and transcripts anonymised was outlined in both the consent form and on the day of the interview. A coding system was also devised to anonymise the demographic questionnaire. Access to safe storage space within the social work department was also negotiated and arranged prior to the commencing of the research. Furthermore, the procedure to be used in study one and study two was outlined to and approved by the UCHG ethics committee (Appendix B).

Participants’ rights to receive information about the findings and analysis of the research was also deemed to be important not only as a means of validating the findings but as a mark of respect for the participant’s time and involvement (Richards & Schwartz, 2002).

Due to the sensitive nature of the interview transcripts, the researcher was uneasy regarding the inclusion of full transcripts in the appendices of the thesis. The
rationale for the unease was that once the thesis becomes available in the university library in Galway, the women possibly could be identifiable. This concern to preserve anonymity of participants was particularly key because a number of the research participants are in fact third level students and/or live in the Galway area. Therefore, the researcher sought guidance regarding this issue from an expert researcher in the area of Interpretative Phenomenological Analysis (IPA), who advised the researcher not to include the transcripts (J.A Smith, personal communication, January 28, 2006) and a decision was made to include only a section of a transcript in an appendix.

2.3.4 Follow-up

The topic of delayed disclosure of pregnancy is highly sensitive. The researcher was aware that the research interviews could potentially cause distress to the participants, prior to, during or after the process. Participants were assured that withdrawal from the study at any stage was an option open to them and that turning off the tape recorder during the interview was also an option. As an extra measure to manage potential distress of the participants, all were informed of the availability of the medical social worker to support them if they so desired. Follow-up support for vulnerable participants has been suggested by other researchers (Dyregrov, 2004; Sutton et al., 2003). A follow-up phone call was made one week after the interview had taken place to check on the participant’s experience of the interview. The medical social worker took responsibility for this task.

2.3.5 Consent issues regarding the quantitative study

Punch (1994) suggests that professional codes of ethics act as a guideline for researchers as informed consent may not be appropriate. After thorough discussion at
the early stage of the research process it was thought to be less intrusive if consent was not sought for the demographic data relating to the target and comparison age match group in the quantitative study. Ethical approval for study two was sought and received through the hospital ethics committee. In this study the medical social workers carried out secondary analysis on the existing social work files of the target and comparison group applying a coding system, which the researcher designed, which rendered information anonymous.

2.4 Practical concerns

2.4.1. Interviewing skills

The researcher’s clinical training was an important factor in securing the commencement and completion of this piece of research. As a mental health practitioner, the researcher was able to conduct the interviews in a sensitive and respectful way by assuring responsive empathic listening and by engagement with the participants (Dyregrov, 2004). The researcher’s clinical experience facilitated an appropriate response to distressed reactions if they arose.

2.4.2 Collaboration

The desire and impetus to examine the area of late disclosure of pregnancy emerged from a learning need identified by two social work practitioners working in the maternity department in University College Hospital Galway (UCHG). They wanted to know more about the phenomenon of late disclosure of pregnancy and they were examining their practice with this specific population. The researcher had previously worked with the practitioners and thus they had a trust in the researcher’s ability to work in a respectful and sensitive manner. Therefore, the clinician’s mistrust
of researcher’s motives noted by others (Sutton et al., 2003) was not an issue in this instance. This prior professional relationship was a linchpin in bringing this research to fruition. Ongoing collaboration was an essential part of the design and implementation of this research and it took place throughout every aspect of the research process.

The professional relationship that existed between the social work department and the medical staff on the obstetric and gynaecological wards was also an essential element, which facilitated this research project from beginning to end. The assistance of the medical staff with accessing the medical files of the target and control sample was an essential part of the study. The mutual respect that existed between colleagues from the medical and social work teams was vital when the social work practitioners were required to collate the numbers of the relevant files and transfer this information to the medical team for analysis regarding maternal outcomes.

2.4.3 Establishment of working definition

One of the most important initial steps in designing this study was creating a workable definition of delayed disclosure of pregnancy. Given the complexity of the phenomenon, working definitions were difficult to create and only emerged after considerable discussion and constructive debate. Fox’s (2004) definition of concealed pregnancy was regarded as a useful starting point. Fox defined a concealed pregnancy as a situation where (1) a woman presents for antenatal care past 20 weeks gestation (2) has not availed of antenatal care elsewhere and (3) has not disclosed the pregnancy to her social network. However, discussions with the social work practitioners indicated that not all relevant cases would be encompassed by this definition. The social work practitioners pointed out three cases where women had presented to the social work
service prior to 20 weeks but had continued throughout their pregnancy to hide their pregnancy and disclose the pregnancy in a limited fashion only.

By drawing strongly on the work of other researchers in this area (Fox, 2004; Wessel et al., 2002) and in consultation with the social work practitioners, a working definition was developed. The definition used by Fox was expanded on to define late disclosure of pregnancy as a situation where either:

(A) The pregnancy is unplanned and presents as a crisis. The woman presents for antenatal care past 20 weeks, having not disclosed to her social network and not availed of antenatal care.

Or

(B) Limited disclosure prior to 20 weeks gestation This might include disclosure limited to either: (1) her partner (2) a close friend (3) a member of her family (4) a G.P. Those who were aware of the pregnancy were asked (or knew) not to disclose the information to anyone else.

Thus the working definition of delayed disclosure used in this study has been informed by both the existing definitions in the literature and clinical experience.
Section Three: Methodology and results of qualitative study

Qualitative research is multi-method in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural setting, attempting to make sense of or interpret, phenomena in terms of the meaning people bring to them.

Denzin, (1994, p.2)
3 Research methodology of the qualitative study

3.1 Introduction

Two studies were carried out as part of this thesis; the first study was of a qualitative nature, while the second study had a quantitative approach. The current chapter describes the methodology used to carry out the qualitative study (Figure 1) and it also outlines the researchers thinking and preparation during the design stage of the research process.

### STUDY ONE Qualitative Data

A sample of 43 women who had a late disclosure of pregnancy was identified

15 were deemed inappropriate to contact by the medical social workers (MSW)

MSW attempted to contact 17 potential participants

Community social workers (CSW) attempted to contact 8 participants

Teen Parents Project (TPP) staff attempted to contact 3 participants

In total 11 were open to be contacted by the researcher

14 did not wish to take part

3 could not be contacted due to change in contact details

8 interviews took place as

3 of the participants changed their minds about taking part

Data analysed; themes and conceptualisation emerged

Validation process involving three researchers, the participants and the quantitative findings.

Figure 1. Outline of study one
Chapter 3. Research methodology of the qualitative study

The study design was influenced by three main considerations:

1. The need to research this subject sensitively
2. Efforts to enhance theoretical sensitivity.
3. Attempts to counterbalance the power deferential

3.2 The need to research this subject sensitively

“A considerable degree of stigma still adheres to non-marital pregnancy in Ireland” (Loughran & Richardson, 2005, p.112) and a late disclosure of pregnancy is perceived in the literature to be a highly sensitive and private experience that a small number of women encounter (Maldonado-Duran, Lartigue & Feintuch 2000). The choices these women have regarding the resolution of the pregnancy i.e. termination, adoption or parenting also have a varying degree of stigma attached to them (Mahon et al., 1998). Therefore, given the documented level of stigma attached to the area non-marital pregnancies, a methodology was required which was flexible and not predetermined in advance.

Feminist models of qualitative research proposed by sociologists such as Olesen (1993) and Reinharz (1992), influenced how the researcher reviewed the psychological literature in this area. It was found that the voices of women who have experienced this phenomenon had not yet been heard. A major aim of this study was to give a voice to this group of women and respect the participants’ involvement during the process.

Qualitative methods do not make claims about trends or distributions, rather they aim to give a description or explanation of an event or experience and this was the main objective of study one. Willig (2001) describes qualitative methods of data collection
Chapter 3. Research methodology of the qualitative study

and analysis as “ways of listening” (p.150). In the literature, there is a lack of clear hypotheses to explain the phenomenon of delayed disclosure of pregnancy. Furthermore, qualitative research methodology has not been used to date to investigate this area. Therefore, by using a qualitative method the women involved could “lead” the research process and tell their own story. Thus, to facilitate the generation of novel insights and new understandings regarding delayed disclosure of pregnancy, a qualitative methodology was employed.

Mahon et al. (1998) have described survey questionnaires as being impersonal, lacking in sensitivity and lacking flexibility and hence they were deemed inappropriate for the present study. An open interview was felt to be a more suitable approach. Mc Cracken (1988) referred to the long interview as “one of the most powerful methods in the qualitative armoury” (p.9). He proposes that, “the long interview gives one the opportunity to step into the mind of another person, to see and experience the world as they do themselves” (p.9). Thus, the researcher endeavoured to explore this sensitive area by having the participants tell their own story in their own words and a semi-structured open-ended interview was employed with women who had delayed the disclosure of a pregnancy.

By using the open interview style in a sensitive fashion the phenomenon of late disclosure of pregnancy could be explored and hypothesis generated. This style of exploring places the researcher in a position of ‘non expert’ and by using this method further encourages the women to direct the enquiry process (Smith 1996).
3.3 The process of enhancing theoretical sensitivity

It was felt that knowledge of pregnancy and motherhood research would give the researcher a solid base from which to explore late disclosure of pregnancy. Mercer (1995), Bergum (1997) and Rubin’s work (as cited in Mercer, 1995) in this area was examined and this work was found to give a comprehensive review of available knowledge on maternal role attainment and the psychological transition to motherhood. Knowledge regarding the general issues of motherhood also allowed the researcher to be more confident while interviewing and to be more sensitive to individual women’s experience regarding their pregnancy.

A working knowledge of regular antenatal care helped the researcher to examine the differences between the target group and regular pregnancies. In clinical practice, for example, pregnancy sometimes remains unrecognised up to the end of the first trimester, especially in primiparous women (Wessel et al, 2003). However, prenatal care is regarded as a factor contributing to successful pregnancy outcome (Klerman, 1990) and in the UK the majority of women book for antenatal care by 14 weeks with an ultrasound scan occurring at 20 weeks (Enkin et al., 2000). Having a through understanding of regular pregnancy such as frequency of checkups and antenatal care helped the researcher to distinguish a regular pregnancy from a situation were a pregnancy is undisclosed. It also helped the researcher, who has not experienced pregnancy personally, to relate to the participants in a more informed and sensitive manner.

3.4 Attempts to counterbalance the power differential

Since participants may have felt that their efforts to delay disclosure of their pregnancy or the resolution they had chosen were being judged by the researcher, care
Chapter 3. Research methodology of the qualitative study was taken to counterbalance the power differential between participant and researcher. For example, by using the flexible open interview techniques, it was hoped that the power relations between the researcher and the participant could be negotiated and counterbalanced (Kvale, 1996). Equally, other efforts to counterbalance the power deferential were attempted in a number of ways including having a thorough consent process and using one-to-one interviews where the women are seen as experts of this experience.

A second component of centralising participants in the research was related to the collaborative validation process. In order to enhance the validity of the findings, the women received a summary of the researchers interpretation of the thematic findings, which had emerged from the interviews. It was hoped that by seeking their comments and feedback, they would feel they had some influence over the research. It was felt that this process not only enhanced the validity and credibility of the findings but it also made the research process more democratic (Smith, 1996).

3.5 Selection of participants

The medical social work service in the Maternity Department in University College Hospital Galway (UCHG) provides a support, information and counselling service to women who present to the department with difficulties in relation to a pregnancy or gynaecological procedure. The medical social workers receive referrals from medical staff, voluntary/statutory agencies and self-referrals from patients. Thus, the majority of women contacting this department are seeking emotional or practical supports. On the patient’s discharge from hospital, the medical social workers (MSW) refer cases to the community care social work service (CCSW), where appropriate.
Chapter 3. Research methodology of the qualitative study

Therefore, CCSW as well as the MSW were approached to contact potential participants. Staff from the Teen Parents Project Galway, which is attached to the social work department, were also contacted to help access participants from the sample identified by the MSW. For a more detailed account of the services provided by these teams see Appendix C.

Women who had delayed the disclosure of their pregnancies and who were referred to the social work department in University College Hospital Galway, between January 2002 and December 2004 were the target population. A target group of 43 women were considered to fit the working definition of delayed disclosure of pregnancy (para 0).

Seventeen women were contacted by the MSW. Initially, ten agreed to take part but on being contacted by the researcher three had changed their minds. Potential participants who had placed their child for pre-adoptive fostering were contacted via the CCSW. Attempts were made to contact these potential participants by asking their allocated social worker to judge on the appropriateness of the client taking part in the research. Eight women were approached in this way and one woman agreed to be interviewed. The project leader of the Teen Parents Project attempted to contact three participants but was unsuccessful in making initial contact. Therefore, in total eight women were interviewed.
Chapter 3. Research methodology of the qualitative study

3.6 Materials

3.6.1 Instruments

A sample semi–structured interview schedule was constructed (Appendix D). The design was guided by aspects of the phenomenon that the practitioners were interested in exploring and also by the literature relating to questionnaire design and formatting (Borque & Fielder, 2003). The practitioners made suggestions regarding the ordering of questions, the language used and question structure.

Some of the interview questions explored the individual’s subjective understanding, explanation, and perception of their pregnancy experience. The woman’s perception of the impact that her pregnancy had on her and her relationship with her child was also considered. Some questions from Muller’s (1993) prenatal attachment inventory, which tap into maternal experiences of affection, such as fantasising and differentiation of self, were included in the interview. Research highlights that these factors are associated with postnatal mother-infant interaction (Siddiqui & Hagglof, 2000). A mixture of open-ended and more structured questioning was used to enhance discussion in an open, yet structured way, thus gleaning the maximum information from the participants.

3.6.2 Equipment

A Sony cassette recorder model TCM 939 was used to record the interviews.

3.7 Procedure

The medical social workers, the community care social workers and staff from the Teen Parent Project attempted to contact potential participants by telephone to discuss their possible involvement in the research. The reason the research was taking
Chapter 3. Research methodology of the qualitative study

place and the time commitment involved were discussed with the potential participants. If the woman agreed to take part, she was contacted by the researcher, who arranged an interview time. Once a valid postal address was established, a consent form, which outlined the aims and methodology of the research, was sent to the participant. Information on how the data was to be gathered, stored and destroyed was also explained in the consent form (Appendix E). The researcher visited the participants in their own homes or in a location of their choice and consent forms were revisited and signed and a photocopy of this form was returned to the participant with a thank-you note after the interview had taken place. All interviews were recorded in full and transcribed verbatim by the researcher shortly afterwards.

The researcher, in consultation with the practitioners, prepared a summary of the findings (Appendix F). The participants were contacted again by telephone to inform them that the summary and a feedback sheet was to be sent to them and their address was confirmed. Stamped addressed envelopes were used to encourage return of feedback sheets (Fox, Crask & Kim, 1988). These feedback sheets were collated and reflected upon as a means of checking if the researchers analysis was representative of the women’s experience (Appendix G).
4 Analysis of qualitative data

4.1 Rationale for using Interpretative Phenomenological Analysis

The various qualitative methods of analysis have different philosophical roots, they have different theoretical assumptions and they ask different types of questions (Reicher, 2000). As study one is explorative, a realist approach was deemed appropriate as outlined by Madill, Jordan and Shirley (2000). Willig (2001) acknowledges that the classification of epistemological perspectives and methodologies into distinct positions is an artificial process, but one that can be useful (Figure 2).

Interpretative Phenomenological Analysis (IPA) is a method stemming from phenomenology (Willig, 2001) and phenomenology is a philosophical approach focusing on the world as it is subjectively experienced by individuals, within their particular social, cultural and historical context (Giorgi, 1994). IPA lends itself well to the notion of exploring an experience such as a delayed disclosure of pregnancy, which is complicated, complex and diverse. Furthermore, IPA has been utilised by other researchers to explore sensitive and personal experiences such as sexual identity, termination and sexual practices (Walker, 2001; Robson, 2002; Flowers, Hart & Marriot, 1999).
IPA moves a step beyond phenomenology as it recognises the researcher within the research and analytic process. IPA aims to explore the research participants' experience from the participants’ perspective and it is about examining the experience through the eyes of the participants, all the while recognising the researcher within the research and analytic process. It recognises “that such an exploration must necessarily implicate the researcher’s own view of the world as well as the nature of the interaction between researcher and participant” (Willig, 2001, p.53).

IPA considers people's narrative to be products of cognition. Jarma, Smith and Walsh (1997) propose that meaningful interpretation of an individual’s experience
could be achieved by using IPA. An assumption taken by Jarma et al., (1997) and by the researcher in the current research was that there was a link between what the women thought and what they reported. Thus, this method of analysis was deemed as the most appropriate analytical tool for this reason and because it has been successfully used to investigate motherhood and pregnancy previously (Smith, 1994).

IPA reflects the researchers approach to the research question: what the researcher wanted to find out and what type of knowledge was being generated. It was anticipated that, using IPA and allowing the women to tell their own story would generate a richer comprehension of their experience. It was expected that a conceptualisation of this experience would emerge which would not only assist understanding but also ultimately help practitioners engage with this population in a more effective manner.

In summary, IPA was considered an appropriate method of analysing data, as it emphasises that the final analysis is the researchers interpretation of what the participant reported. Thus, as a clinician who understands the transference dynamics between client and therapist, the researcher decided that this approach would marry well with the reality of a dynamic research process. It placed the participants’ experience at the centre of the research while acknowledging the role the researcher played in interpreting the findings.
4.2 Stages in analysis using IPA

Smith, Jarman and Osborn (1999) suggest using a list of themes from the first interview to begin the analysis of the next interview. Themes are identified from the first interview and new themes that are identified in the other interviews are added to the master list. This method of using the master list to analyse subsequent interviews is continued, and eventually a consolidation process occurs where a master list of themes exists for the group of interviews. They propose that the interviews are then analysed again using the final master list of themes. The idiographic case study approach to analysis outlined by Smith, Jarman and Osborn was adopted in the present study as it is considered to work well with sample sizes of ten or less.

4.2.1 Stage One: Transcribing interview tapes

Interviews were tape-recorded and were transcribed by the researcher within two days of the interviews took place. The hand-written transcripts were then typed up and all identifying information was anonymised and line and page numbers were assigned.

4.2.2 Stage Two: Familiarisation with the transcripts

The initial interview was read, and notes regarding first impressions of the script were written in the side margins. These notes represented attempts at summarising, identifying connections and establishing preliminary impressions and interpretations (Appendix H). After a number of readings, a list of the themes, which were present in the script, was written up on a separate page, and the themes were assigned letters a-z so they could be identified (Appendix I).
4.2.3 Stage Three: Continuing the formulation of themes

The list of themes from the first interview was then used to analyse the next interview. Instances of the themes already identified were noted, and new themes were also identified and given codes (Appendix I). The list was adjusted with some themes being added and others being modified as each interview in turn was read and reread until a master list of themes emerged.

4.2.4 Stage Four: Assigning codes

After all the interviews had been read and a master list of codes drawn up, each interview was re-read. As themes were re-identified in the script, an extended letter code was assigned to each unit of meaning (e.g.K1, K2, K3). For clarity, the coded themes from each page were listed on separate pages and supporting quotes were also transcribed on to these pages. The end result was that each interview had about four accompanying pages, which had a list of the themes present, and these themes were accompanied by quotations (Appendix J).

4.2.5 Stage Five: Clustering of themes

While creating the master list, it was observed that many of the themes were overlapping or clustering together. For example the theme of coping style (R) was very similar to the theme related to having skills or knowledge (J2). Smith, Jarman and Osborn (1999) suggested calling these clusters of themes a “super-ordinate concept” as it pulled together a number of initial categories that were identified. Under these super-ordinate titles, several sub-themes existed (Appendix K), and quotes from the transcript were used to illustrate the existence of a sub-theme. For clarity, the page number and line number were recorded beside the quote. This process was repeated until all
interviews had been analysed. Divergent cases were also noted and they were used to highlight the complexity of this phenomenon (Potter, 1996). The supporting quotations of the super-ordinate themes were collated using a standard word processing package.

Some themes, which did not specifically relate to the central concept of late disclosure of pregnancy, were left out. Examples of these included, women’s experience of labour, day care facilities, accommodation difficulties, methods of contraception and future plans. While these themes were interesting, they were not considered to be central to the phenomenon of a late disclosure of pregnancy and were thus omitted.

4.2.6 Stage Six: Researcher triangulation

Researcher triangulation is a term utilised by Shaw (2001), which involves two or more researchers conducting analysis simultaneously and conferring during the process in order to establish a report that best reflects what the participants reported. This concept of researcher triangulation was utilised in the qualitative study by having a validation group, consisting of three psychologists with experience in qualitative research methodology. Following the researchers initial analysis of the scripts, each of the validation group was given one of the transcripts to read. Themes that were noted by the validation group members were compared with the researchers findings. In many of the cases, themes that were highlighted by the others were found to be similar to those noted by the researcher (Appendix L). Where new themes emerged, scripts were re-visited by the researcher and if these new themes were found to occur across cases they were included in the master list. For example, the theme of stigma emerged from one of the validation group members in interview two (CB). All interviews were re-
Chapter 4. Analysis of qualitative data

read with this theme in mind and other incidences of this theme occurring across other interviews were noted. Themes and super-ordinate themes underwent some shifting during this process, as the accounts from the validation group members enriched the understanding of the existing themes or served to suggest connections between themes. The validation group feedback was found to be particularly insightful during the researchers attempts to interpret the themes and was discussed in supervision (Appendix M).

4.2.7 Stage Seven: Diagrammatic representation of the themes

The super-ordinate and sub-themes were written onto a large sheet of paper. Theoretical links between the super-ordinate and sub-ordinate themes were considered. Ways of visualising these links were reflected upon and written out (Appendix N). Was there a way to conceptualise the super-ordinate themes, which clearly tells the story of this phenomenon? Through supervision and revision of the themes a way of conceptualising this phenomenon was realised (Smith, Harre & Langenhove, 1995). A systemic model (Brofenbrenner, 1979) was adapted and applied (Appendix O).

4.2.8 Stage Eight: Using a systemic model to analyse the findings

The super-ordinate themes and sub-themes were linked with the corresponding parts of the systemic model. The scripts were revisited to check on deviant cases and the fit of the model to the phenomenon. The validation group feedback was also revisited with the systemic conceptualisation in mind. Due to time limits and restrictions on the availability of group members to meet and discuss the themes, the researcher made the final decision on what themes to include.
4.2.9 Stage Nine: Writing up

The process of writing up the findings necessitated being selective about which specific themes were reported. An attempt to summarise and organise the material into digestible quantity and quality was undertaken. Inevitably, there was further refinement of the analysis, and some themes which were not deemed to be central to the phenomenon of late disclosure were pared away at this late stage. In particular, specific feedback regarding service providers was not expanded on during the write up process but this information will be disseminated to hospital staff and crisis pregnancy agency personnel. This issue of refinement was also raised in supervision (Appendix M).

4.2.10 Stage Ten: Integrating and reflecting upon the feedback from participants

Having sent the participants a summary of the findings, returned feedback was reflected upon (Appendix G). The findings were revisited with the participants’ comments in mind and some further quotations were added to the main report to emphasis issues raised by the participants in their feedback.
5 Results of the qualitative study

5.1 Introduction

Table 2 gives a summary of some characteristics of each of the women that were interviewed. A brief trajectory of each woman’s journey is included to assist the reader conceptualise the many factors which contribute to each woman’s unique experience.

Table 2. Summary of characteristics of the women interviewed.

<table>
<thead>
<tr>
<th>Pseudo-name</th>
<th>Mary</th>
<th>Ann</th>
<th>Carmel</th>
<th>Brenda</th>
<th>Fiona</th>
<th>Nuala</th>
<th>Susan</th>
<th>Monica</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at time preg:</td>
<td>17</td>
<td>25</td>
<td>21</td>
<td>25</td>
<td>19</td>
<td>35</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Disclosed to:</td>
<td>Partner</td>
<td>Friend</td>
<td>SW#</td>
<td>Partner</td>
<td>Cura‡</td>
<td>Friend</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>No of weeks of pregnancy</td>
<td>22 weeks</td>
<td>40 weeks</td>
<td>39 weeks</td>
<td>8 weeks</td>
<td>36 weeks</td>
<td>9 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed to:</td>
<td>32 weeks</td>
<td>45 weeks</td>
<td>40 weeks</td>
<td>28 weeks</td>
<td>40 weeks</td>
<td>41 weeks</td>
<td>24 weeks</td>
<td>36 weeks</td>
</tr>
<tr>
<td>family member at:</td>
<td>Mother</td>
<td>Parents</td>
<td>Sister</td>
<td>Mother</td>
<td>Mother</td>
<td>Cousin</td>
<td>Mother</td>
<td>Aunt</td>
</tr>
<tr>
<td>Disclosed to:</td>
<td>Prior Pregnancies:</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Partner at time:</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>With partner now:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Employed/education:</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Living at home then:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marital status then:</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
</tr>
<tr>
<td>Family Supportive:</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Prior stress in family:</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Decision:</td>
<td>Parent</td>
<td>Parent</td>
<td>Parent</td>
<td>Parent</td>
<td>Parent</td>
<td>Parent</td>
<td>Parent</td>
<td>Adoption</td>
</tr>
<tr>
<td>Supportive friend:</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prenatal care:</td>
<td>32 wks</td>
<td>None</td>
<td>None</td>
<td>22 wks</td>
<td>38 wks</td>
<td>20wks</td>
<td>22 wks</td>
<td>None</td>
</tr>
<tr>
<td>Ongoing aspects of Concealment: †</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* = Disclosed post delivery  ‡= A crisis pregnancy agency  † = Significant others still unaware

# = Social worker
Chapter 5. Results of the qualitative study

5.1 Case summaries

5.1.1 Mary

Mary was 17 when she realised she was pregnant. She was living with her family at the time and was in her final year of secondary school. Her family did not approve of her relationship with her partner. A neighbour suggested to Mary’s mother that Mary was pregnant during her seventh month of pregnancy at which time Mary disclosed her pregnancy when asked by her mother. Her partner seemed to be aware of the pregnancy from the third month but Mary and he did not discuss the pregnancy. Mary’s parents reacted badly to the disclosure of her pregnancy and she moved in with her partner. She attended a G.P in her seventh month of pregnancy and following this attended the hospital for antenatal care. Once they moved in together, Mary and her partner began to speak about the pregnancy and the possibility of adoption. Post delivery, the baby was placed in foster care for two months while Mary and her partner looked for suitable accommodation. Mary’s father asked her to keep the news of her pregnancy a secret from her grandmother. Mary currently attends University. She lives with her partner and her child. Her child remains concealed from her paternal grandmother.

5.1.2 Ann

Ann did not realise she was pregnant until she began to feel labour pains. She was 25 at the time. She was employed and was living in shared accommodation. Ann was also grieving for her aunt who had died of cancer some months earlier. Her younger sister was pregnant at the same time as Ann and she also delayed disclosure until her seventh month of pregnancy. Ann did not present to a hospital for antenatal care. She drove to a hospital in another county while in labour. She placed her baby in
Chapter 5. Results of the qualitative study

foster care while she tried to decide what to do. She disclosed to a friend on the day the baby was born on nursing staff’s advice. She asked a neighbour to inform her parents of her situation, five weeks after the baby’s birth. Her family asked her to pretend her baby was a foster child. She refused to do this and her family have not been supportive. The biological father is not aware of the baby. Ann received support from friends and is currently parenting her daughter and working part-time.

5.1.3 Carmel

Carmel was 21 when she realised she was pregnant. She was working in a local bar and doing a computer course. She was living at home and her eldest sister was also pregnant at that time. She was not in a relationship with the father of her baby at the time of the conception and she considered adoption prior to the birth of her child. She presented for antenatal care one week before the baby was born. She told a friend of her pregnancy four days before the birth on advice from a social worker she had just met within the maternity hospital. She did not disclose to her family until after the birth of her child. Her sister informed Carmel’s parents at her request. Her parents are very supportive of her. Carmel and her partner (the baby’s biological father) secured private accommodation six months after the baby’s birth and they are currently parenting their little boy.

5.1.4 Brenda

Brenda was 25 and training in college at the time she realised she was pregnant. She disclosed to her partner after eight weeks of pregnancy and he wished her to terminate and was not supportive of her decision to keep the baby. Brenda also informed her best friend at the eight weeks gestation but she did not disclose to her
Chapter 5. Results of the qualitative study

wider social network. Her friend was very supportive right through Brenda’s pregnancy. Brenda attended the hospital for antenatal care in the fourth months of her pregnancy. She did not wish to disclose to her family, as there was a history of conflict within the family and she feared her mother’s reaction. She told her mother she was pregnant in the sixth month of pregnancy. She wished to parent her child but found it difficult to bond, as her baby was ill for the first three months post delivery. She currently lives with her child close to her best friend and receives no support from the baby’s father or her family.

5.1.5 Fiona

Fiona was 19 and had just enrolled in University when she realised she was pregnant. She planned to place the baby for adoption. She did not trust anyone in University to share her secret and she wore bigger clothes to conceal her pregnancy. She visited the Cura service (a crisis pregnancy agency) at 36 weeks and they directed her to the social work department of a local hospital. She received antenatal care in the hospital at 36 weeks of her pregnancy. She telephoned a friend while she was in labour and her friend advised her to tell her parents. She disclosed to her family the day after the baby was born. She has not informed the baby’s father two years post delivery. Her reason for not disclosing sooner was she did not wish to disappoint her family. She kept her baby and her family have been very supportive. Fiona continues to attend University.

5.1.6 Nuala

Nuala was 35 when she discovered she was pregnant. She told two friends during her third month of pregnancy, they were very supportive but she did not disclose
Chapter 5. Results of the qualitative study

to her wider social network. She previously had a child when she was eighteen, which she placed for adoption in England and no one in her social network is aware of this. She also wished to place the second baby for adoption. She feared she could not afford to raise a child as she was working full-time. She attended for antenatal care during the sixth month of her pregnancy. She placed the child in foster care but after one week decided to parent the child herself. She disclosed to her cousin post delivery and her social network after she took the baby home from the foster home. She informed the baby’s father six months after the birth. He is not supportive. She lives with her child and works part-time. Nuala still has not disclosed to her immediate family about her child.

5.1.7 Susan

Susan was 22 when she realised she was pregnant. Her sister had had a baby prior to this and was living at home. She attended the hospital for antenatal care during her fourth month of pregnancy but she did not disclose to her social network. Susan considered adoption initially. She informed her mother during the fifth month of pregnancy. She had waited to disclose her news, as she feared her parents would insist on a termination. After disclosing, she moved out of the family home and lived in a remote village which she described as “hiding away”. She had a supportive friend and she currently parents her son and attends University. The baby’s father was informed three weeks post delivery and has not been supportive.

5.1.8 Monica

Monica has had three unplanned pregnancies. She delayed the disclosure of the second and third pregnancy. She did not attend the hospital for antenatal care regarding
Chapter 5. Results of the qualitative study

her third pregnancy. She felt unable to parent the third baby and the baby has been adopted. She did not wish to disclose as she felt she would be judged and bullied by her family to keep the baby. She disclosed her pregnancy to her aunt at eight months as her aunt asked her if she was pregnant. The father of her three children has been unsupportive and she considers him unreliable. Monica was in University during her third pregnancy and she felt this helped her to cope. She does not seem to have a strong support network and remains unsure about the adoption and partially regrets her decision.

5.2 Summary of the findings

The main aim of the qualitative study was to hear how women who have experienced a late disclosure of pregnancy describe their experience. Therefore, the first of the findings outlined and interpreted relates to the women’s explanations of this phenomenon. The language used by the women to describe this phenomenon is very powerful and rich. The verbatim phrases are included with minimum interpretations initially. Once their depictions have been illustrated, interpretations are outlined. The process of delayed disclosure is described by terms and phrases, which reflect coping mechanisms. The women’s descriptions portray this experience as something that has a temporal dimension and that fluctuates as the gestation period unfolds. Furthermore, delaying disclosure is not an “all or nothing” phenomenon and the notion of a continuum of behaviours, which the women experienced, is described.

From the women’s descriptions of the factors that influenced their ‘journey’ through the delaying of disclosure process, a systemic conceptualisation is proposed and outlined. Themes, which occurred across the interviews, are discussed in a
Chapter 5. Results of the qualitative study

structured fashion in accordance with a systemic model. Verbatim extracts are used to illuminate themes and interpretations (Smith, Jarman & Osborn, 1999). A summary of the themes, (Figure 3) which emerged from the interviews and the frequency of themes across the interviews (Table 3) are listed.
Chapter 5. Results of the qualitative study

**Themes**

E. Feelings towards the disclosure  
F. How she explained concealment-denial  
F1. Thoughts, feelings on concealment now  
P. Awareness of pregnancy (knowing)  
Q. Physical experience of pregnancy, bodily changes during pregnancy  
T1. Barriers to services,  
T2. Barriers to disclosing  
R. Coping style  
Y. Mood during pregnancy  
D. Motherhood thoughts and feelings about motherhood  
D1. Thoughts of motherhood before the baby was born  
D2. Thoughts on motherhood after the baby was born  
D3. Relationship with own mum and family  
X. Baby’s temperament  
Y1. Mood just after pregnancy  
A. Reaction to pregnancy, (emotional and practical), own, partner, parents, friends  
S. Reaction to birth, babies first few minutes of life  
C. Negative professional intervention  
U. Reaction of others to birth  
B2. Support from dad of the child  
B. Supports available and levels professional and family  
I. Advise, what helped her and may help others  
J1. Lack of knowledge skills equipment  
J2. Having knowledge, skills, coping style  
K. Considering the options, her thought process  
K1. Foster care  
K2. Adoption  
K3. Termination  
K5. Attempt to miscarriage  
K4. Parenting  
G. Changes to lifestyle (clothes, alcohol, food, smoking) during the pregnancy  
H1. Changes since birth of the child to mother’s life  
H2. Life before the pregnancy  
R1. New coping style  
V. Difficulties i.e. accommodation  
W. Future plans, work, university  
Z. Being more able as a person  
Z1. Method of confirming pregnancy, test, scan  
Z2. Interest in the present study  
L. Contraception usage and failure of same  
M. Baby weight, breast feeding  
N & O. Labour experience, painful, ok…..Day care  

**Super-ordinate themes**

What is this phenomenon?  
Attachment  
Own reaction & reactions of others  
What to do?  
Lifestyle & Changes  
Omitted themes

*Figure 3. Initial master list of themes and the condensed super-ordinate concepts*
Table 3. All interviews were analysed by the researcher (R); interviews 1, 2, 5 and 8 were also analysed by a member of the validation group (V). The occurrence of a theme is marked by an ‘X’ and the frequency of occurrence of each theme is given.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Interview number</th>
<th>Analysed by</th>
<th>R</th>
<th>V</th>
<th>R</th>
<th>V</th>
<th>R</th>
<th>R</th>
<th>V</th>
<th>R</th>
<th>R</th>
<th>V</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Reactions to pregnancy</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>11</td>
</tr>
<tr>
<td>B Supports</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>C Negative interventions</td>
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<td>X</td>
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<td>X</td>
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<tr>
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<td></td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>E Feelings towards disclosing</td>
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<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>8</td>
</tr>
<tr>
<td>F1 Understanding of late disclosure</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>9</td>
</tr>
<tr>
<td>F2 Understanding now</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>G Lifestyle changes</td>
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<td>X</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
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<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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5.3 The women’s descriptions of the phenomenon

5.3.1 A defence mechanism

Mary explained her process as follows:

I’d say I knew I was pregnant after two weeks, (P. 1, line 10)… I was totally in denial. I knew that I was, but, like, there is not much I can do about it and I don’t really want to do anything about it, but it went on (P. 1, line 20-21)….I, I wasn’t really hiding it, I didn’t wear baggy clothes (P. 1, line 31-32)…yeah, I knew it was going to happen that I was going to go into labour and there was going to be a baby there, but, I didn’t really think about what I’d do after that, that bit was like miles away, you know (P.2, line 27-28)….

Mary’s experience simultaneously involved elements of acknowledgement, minimisation, and suppression of thoughts relating to the reality of the pregnancy. While she refers to being in denial she was also aware of the pregnancy and only gradually acknowledged the significance of the pregnancy. Carmel’s experience is similar to that of Mary’s in that she too refers to suppression of thoughts regarding her pregnancy and her personal struggle to acknowledge that she was pregnant. Fiona and Carmel also describe the co-existence of acknowledgment and denial. Carmel refers repeatedly to being aware but not admitting the reality of the pregnancy to herself.

I was big, but I just hid it. I didn’t want to admit to myself that I was (P. 3, line 10)…, that’s how it all started, I suppose if I could have admitted it to myself then I could have told earlier (P. 3, line 25). It was more denial to myself but then, I concealed it then from everybody else. …I knew in my heart I was pregnant, but I didn’t want to admit it to myself that I was, do you know that way it would make it more real (P. 3, line 33-34)….When you are in denial you don’t want to admit it to yourself (P. 6, line 7).
Chapter 5. Results of the qualitative study

These findings regarding the fluctuating aspects of denial are novel as previous case studies in the reviewed literature refer to only cases where women report to have had no physical or psychological awareness of their pregnancy (Milstein & Milstein, 1983; Neifert & Bourgeois, 2000).

Monica describes using coping strategies, which can be interpreted as defence mechanisms such as suppression and denial. These mechanisms assisted her to continue living her life as if she wasn’t pregnant. She too described denying her pregnancy while simultaneously acknowledging that she was pregnant:

Being in denial I just said no I’m not…(P. 1, line 25) ..I knew myself, I realised I was, I blanked it out a lot, I just got on with it, I was so busy (P. 4, line 16). Denial was my best friend, that is how it was, it’s not happening to me I was keeping in my stomach... still shopping for size eight clothes (P. 11, line 9-10).

Monica’s way of describing her response to pregnancy is similar to the findings reported from work with pregnancy within the adolescent population by Spielvogel and Hohener (1995). They referred to adolescents having a constricted response to pregnancy due to their cognitive level of development, which normally involves an attitude of “it can’t and won’t happen to me”. It is conceivable that Monica’s disavowal of her third pregnancy could be linked with a regressive type of coping.

When Ann recounts her experience, she initially describes having no physical or psychological awareness of the pregnancy. She describes a process of dissociation from the physical aspects of her pregnancy, which was assisted by unconsciously repressing certain thoughts. Ann’s initial explanation is similar to the denial of pregnancy literature, which outlines cases where women deliver a baby and report having no awareness of their pregnant state (Kaplan & Grotowski, 1996). However, when Ann
Chapter 5. Results of the qualitative study

further describes her experience, she reports being aware that she was pregnant at a subconscious level. This finding is novel in the literature and raises the notion of the complexity of denial. This finding indicates that denial of pregnancy is a dynamic process and not ‘an all or nothing’ phenomenon as the reviewed literature in this area proposes.

For me now it was a totally undisclosed pregnancy, I kind of, blotted it all out. So when I got the pains I kind of knew there was something, you know that I was pregnant obviously but I didn’t acknowledge it (P.1, line 1-3)…. I knew towards the end that my stomach was hard and I probably was pregnant but I never said it to myself that I was (P. 2, line 10-11) ... I totally blocked it out...(P. 5, line 3). In my deep deep subconscious it was probably there, I knew I was pregnant, I had to have felt the kicking, but I can’t remember, I suppose it wasn’t even disclosed to myself. It wasn’t really concealment from other people it was concealment from myself...(P. 5, line 8-11). I think it was more denial more than concealment. I wasn’t concealing it, I wasn’t trying to hide it from people, people just never noticed. (P. 5, line 13-15).

The majority of women felt that terms such as denial and concealment related to their experience. However, Nuala, Susan and Brenda did not tell their family or social circle about their pregnancy but they felt that they did not deny the pregnancy. Both Susan and Brenda felt that they did not deny the pregnancy to themselves in any way but that they concealed the pregnancy, and delayed telling others, as they feared the reaction of their parents. Nuala explains that just because she didn’t tell people about the pregnancy that this did not mean it was concealed. Nuala’s explanation highlights the difference that exists between the idea of actively concealing a pregnancy and not disclosing.
No I hadn’t a hidden pregnancy, I don’t think I did. I told two people, I didn’t tell my family because of going to adopt her, that was my own reason for not telling, ...I didn’t go out and say I’m pregnant (P. 5, line 48-49).

5.4 Interpretation of the women’s descriptions

5.4.1 Coping strategies

The findings from the interviews reveal that the women used defence mechanisms such as minimisation, suppression and repression to deal with their unplanned pregnancy, suggesting that these defence mechanisms act as a functional way of coping with their unplanned pregnancy. These coping strategies are similar to those reported by other researchers regarding the evasive coping styles of pregnant adolescents (Myors, Johnson & Langdon, 2001).

5.4.2 Dynamic and temporal aspects of the phenomenon

The findings also revealed that the concepts denial and concealment were not found to be mutually exclusive and could be seen as fluid constructs whose meanings merge and diverge depending on the women’s interpretation of her experience. From the women’s descriptions, it can be concluded that both the concepts of denial and concealment can be involved in the late disclosure process that begins, evolves and in only some cases ends with the birth of the child. For some women, aspects of denial or concealment were ongoing after the birth of their child. In some of the cases the pregnancy and birth of the child has never been disclosed to certain members of the family or to the biological father. Ann explained her feelings towards this on-going concealment from her child’s father:
He actually doesn’t know that I was pregnant or that I had a baby. (P. 4, line 3) I do feel bad that I haven’t ... I should have told him like, I should’ve made efforts to tell him (P. 7, line 33).

Fiona had similar regrets about not telling the biological father:

I didn’t tell him, it’s got more difficult to tell him as time went on, I feel bad, I don’t know will I ever tell him (P. 3, line 20-21).

5.4.3 A continuum model

The concepts of denial and concealment, as described by the women, vary in their meanings. These constructs could be described as being part of a complex process that is on a continuum from total denial of a pregnancy at one end of the spectrum, (Ann’s case) to an acknowledged pregnancy, which is disclosed in a limited fashion, at the other end of the continuum, (Nuala’s situation). In the middle ground of this continuum could be a situation where denial is accompanied by intermittent awareness (Carmel’s situation). This continuum has a temporal dimension to it and the majority of women interviewed tended to move along the continuum from denial towards disclosure as they progress through the pregnancy and in some cases disclosure was limited even after the birth. Many women did not move sequentially towards disclosure, in some case they skipped stages and moved from full denial to limited disclosure (Figure 4).
Figure 4: The continuum of delayed disclosure throughout the pregnancy process. The eight women’s status of disclosure is symbolised by the eight lines. There was a general trend towards increased disclosure, although not all women fully disclosed even after the birth. In some cases, movement along the continuum was discontinuous i.e. the women did not move sequentially towards disclosure, in some case they skipped stages.

This idea of a continuum was suggested by Berns (1982) and relates to a continuum of pregnancy denial behaviours ranging from full awareness of pregnancy concealment, to suspicion of pregnancy, to full blown denial. The model proposed here expands and extends the continuum model suggested by Berns. The model from the current findings suggests that the women are seen to move along this continuum either in a linear or in a discontinuous fashion not only throughout their pregnancy but after the pregnancy as well. In essence, there is a continued temporal aspect to this phenomenon post delivery that has not previously been discussed in the literature. In summary, it emerged that the phenomenon of a late disclosure of pregnancy is not only a multi-dimensional process but also a dynamic process that is on going in some cases.
Chapter 5. Results of the qualitative study

5.4.4 Partiality of the disclosure

Another finding, which was not mentioned in previous research, was the partiality of the disclosure or the limited nature of disclosure, which seemed to accompany the late disclosure of pregnancy. Six of the women reported disclosing to a friend or partner a number of weeks before informing their families and asking such people to keep the pregnancy a secret. When the women did disclose to their families many chose to tell their parents indirectly by having a friend or sibling inform their parents on their behalf. This finding suggests that, in the interest of maintaining control over the situation, the women elected to inform certain people at certain stages of the pregnancy process and post delivery.

5.5 Summary of initial interpretations of the findings

No particular set of circumstances emerged from the qualitative part of this study that can predict (a) why certain women delay disclosing their pregnancy (b) the impact of the process on those involved. However, certain psychological patterns became apparent. The women spoke about their initial shock and their efforts to problem-solve to try and cope with their unplanned pregnancy. Their problem-solving processes involved behavioural, cognitive and emotional components. The process of a delayed disclosure of pregnancy emerges as a multi-dimensional construct, which evolves fluctuates and alters as the pregnancy progresses. Their decision to delay disclosure of pregnancy was also heavily influenced by external factors such as familial and cultural context. A formulation of this phenomenon is outlined in Figure 5.
Chapter 5. Results of the qualitative study

**Formulation**

Late disclosure emerges as a process, which is on a continuum. It is affected by the various realities in the woman’s life such as; her beliefs, her family, availability of supports and perceived societal factors.

**Other family issues**
- Sister having a baby
- Sister unable to conceive
- Cousin couldn’t have a baby
- Previous adoption
- Bereavement
- Relationships with family

**Reactions to the pregnancy:**
- Mothers
- Family
- Partner
- Friends
- Society
- Professionals

**Professional intervention,**
Social workers, nurses, G.Ps, crisis pregnancy agencies.

(Learning empowerment)
Effective interventions mentioned

**What is it?**
How women describe it
How they feel about it
What assists the process? Coping
Why does it happen? Fear
Physical awareness/changes to body
Feeling now post event

**Attachment**
Bonding issues
Pre-birth/After birth
Affected by mothers mental health and babies temperament
Support system

**What to do effected by….**
Past experience, friends
Self-belief
Belief about termination/adoPTION
Parenting
Practical information

**Life style changes**
Smoking drinking
Dress
Diet
Moving
Pregnancy experience

**Figure 5.** Summary of emergent super-ordinate themes feeding into the initial formulation of late disclosure.
5.6 Proposed model of late disclosure

The reader may find it helpful to conceptualise this complicated phenomenon in a systemic way with Brofenbrenner’s (1979) concept of a macro-system encompassing, a secondary layer and a primary layer of interaction (Figure 6). In this conceptualisation, the unplanned pregnancy is seen as a crisis, which threatens the equilibrium of the individual woman’s system (primary layer). The woman reacts to the crisis in a variety of ways depending not only on her own resources but also on the many layers of influence from familial (secondary layer) and societal sources (macro-system). Therefore, whether a woman commences and continues on a journey along the continuum of late disclosure depends on how all the others levels in her system interact.

This model suggests that any decisions that the woman makes regarding her unplanned pregnancy, are heavily influenced by what she has learned from her own family’s way of dealing with problems. The cultural values of society also influence her family’s view of the world and consequently influence her course of action. The woman will try to gain control over the crisis and endeavour to return to a balanced position. Each layer of the system interacts and affects the other layers in the system.
Chapter 5. Results of the qualitative study

5.7 Societal influence: Macro-system

The notion that the concept of delayed disclosure of pregnancy may be influenced by specific cultural and religious beliefs exists within the literature (Chapman, 2003). Irish culture has specific nuances, which influence people’s perceptions and value systems. The influence of Catholic teachings in Ireland no doubt

Figure 6. A systemic model to represent the systemic nature of the phenomenon of late disclosure of pregnancy. This model involves elements from a primary layer, secondary layer and an all encompassing macro system, as conceptualised by Brofenbrenner, (1979) which all interact and can promote late disclosures.

One way of examining the phenomenon is to try and peel back the layers of a late disclosure of pregnancy, one at a time, by taking this systemic perspective the first layer to be considered is societal influence.
Chapter 5. Results of the qualitative study

informs many beliefs and values concerning pregnancy outside of marriage (Mahon et al., 1998; Milotte, 1997). Therefore, the question must be asked which specifically Irish cultural influences impact on this process?

5.7.1 Societal attitudes towards single mothers

It became clear from the interviews that the women were aware of society’s negative attitude towards unmarried mothers. Ann’s comments regarding being a single mother highlights her sense of being stigmatised because of her single status:

_There is still a stigma attached to it, there is like, single mothers and that whole thing with The Irish Times, stuff like that, and people do go, oh my God, poor Ann on her own with the baby, how is she ever going to cope and her whole life gone_ (P. 10, line 36-40).

Ann’s reference to a newspaper article, which referred to “single women, mothering bastards because it seems a good way of getting money and accommodation from the state” (This article is given in Appendix Q). She also alludes to people in her community pitying her situation. Brenda’s comments also illustrates this point:

_My mother wanted me to kind of marry Joe and I was, you’re mad, we are finished, it’s over and then she was like what are you going to do, you’re a single mother and on and on_ (P. 2, line 32-33).

Brenda’s mother appeared to see marriage as a solution to her daughter’s problem. At least if one is married, the stigma of being an unmarried mother is avoided. The stigma experienced by the women interviewed has been reported in the literature concerning pregnant adolescents (Wiemann, Rickert, Berenson & Volk, 2005).

Another source of stigma originated from professionals. Susan felt hospital staff mistreated her because of her single mother status:
Chapter 5. Results of the qualitative study

I was very disappointed with the staff in the hospital; they didn’t come near me, they were horrible, the girl next to me asked them to help me as I was crying with pain, personally I think it was because I was a young single mother (P. 4, line 12-13).

Susan describes attitudes relating to single mothers in the small village where she was from:

I had to hide my pregnancy. It was drilled into my head that young girls can’t be proud if they are pregnant, they can’t show it and they have to hide it so I wore big jumpers to hide it, it was just drilled into my head. (P. 3, line 13-19). X is only a small village so everyone would’ve known as soon as I started to show, I just don’t like being the topic of conversation, I moved, I moved to Y to get away from the gossip (P 3, line 28-29).

These women had a real sense that single mothers are judged, stigmatised and mistreated. These negative attitudes can be obvious or subtle at times and originate from family members, professionals and the media. It is likely that the stigmatisation from these various sources played a role in why some of the women interviewed delayed the disclosure of their unplanned pregnancy.

5.7.2 Stigmatisation of adoption process

From the women’s perspective, society views single mothers in a negative light. From their stories, it can be concluded that placing a baby for adoption or having a termination also has negative connotations. The women referred to the negative attitude regarding adoption, which they heard from other people in their community. Monica comments on this:

I think people have a negative thing on adoption, they see it as something bad (P. 12, line 4 -5).
Chapter 5. Results of the qualitative study

She also refers to the attitude of one of the nursing staff towards her desire to place her child for adoption:

*The main nurse, the matron, she was horrible she was basically telling me not to do it, that I would regret it for the rest of my life (P. 5, line 48).*

Nuala speaks of not telling people she was going to place her daughter for adoption as she felt they would not support her decision:

*I had intended adopting Sarah [her daughter] and maybe that’s why I wasn’t telling them, I thought that maybe they wouldn’t like that, but when I did tell them they said don’t do that, they kept saying don’t do that (P. 4, line 28-29).*

These comments regarding adoption are negative and portray it as something that will cause life-long regret and guilt. Loughran and Richardson (2005) comment that while adoption is one of the possible options available for women undergoing a crisis pregnancy, it is rarely chosen and a stigma exists regarding adoption. They remark that it appears that the stigma of unplanned pregnancy has moved from that of being an unmarried parent to stigma around being a woman who placed her baby for adoption. However, in this study participants perceived that a stigma existed both for being a single mother and choosing adoption. Only one woman who had placed her baby for adoption wished to take part in the research. Seven other women, who had made the decision to place their baby for adoption, were approached regarding taking part in the study but they declined. The reluctance of these women to talk about their decision to have their child adopted may have reflected the stigmatisation that is attached to the whole area of adoption.
Chapter 5. Results of the qualitative study

5.7.3 Negative attitudes towards termination

It is also significant that none of the women interviewed seriously considered termination as an option. The main reasons given for not considering a termination being (a) a moral issue of termination as being unacceptable to them or (b) they had a friend who terminated who regretted this decision. Ann refers to abortion:

*I know people who had abortions, one of my close friends had an abortion and has never dealt with it properly and I mean that may have impacted on me keeping Alice [her daughter] as well...my friend is still traumatized over it.... I would never consider abortion.*

Previous investigations have suggested that cultural influences such as the illegal status of termination in Ireland and the Catholic Church’s teachings on termination may have also impacted upon the women’s thinking (Mahon et al., 1998; Milotte, 1997).

In summary, the women articulated their sense of being stigmatised and judged by their communities and wider society. Goffman’s (1963) analysis of stigma refers to those attributes that signal difference in relation to an assumed norm and these differences are usually negatively appraised (as cited in Craig & Scambler, 2006). It seems that all three options, being a single mother, having a termination or placing a baby for adoption are all behaviours that go against the perceived accepted cultural norm of their communities (Mahon et al., 1998). Therefore, it is important to keep in mind the cultural context of the women’s stories as their decision to delay disclosure of their pregnancy was informed by the perceived societal norm that non-martial pregnancies are considered unorthodox.
Chapter 5. Results of the qualitative study

5.8 Family Influence: Secondary system

When considering the woman’s circumstances, her family also needs to be taken into account. If one part of a family system is compromised, for example with an illness, this has an effect on the whole family system (Brackbill, White, Wilson & Kitch, 1990; Dallos & Aldridge, 1987; Wilson, Hall & White, 1994). Therefore, prior difficulties within a family may have prevented the woman from disclosing, as she may not have wanted to add more stress to the family system. Furthermore, if prior difficulties exist in the family this additional crisis of an unplanned pregnancy will cause the family system to become even more unbalanced.

5.8.1. Prior family stress

Many of the women described difficulties their family was experiencing prior to their disclosure of pregnancy. Such events included other pregnancies in the family at that time, previous crisis pregnancies in the family, a bereavement or family members being unable to conceive. As Fiona described:

\[
\text{My sister can’t have children so that was awful for her, I was having a baby and she couldn’t (P. 1, line 27-28).}
\]

Ann referred to a family crisis that prevented her from disclosing:

\[
\text{My aunt had died and I thought that was trauma or stress, there was a lot of stress at home because my other sister was pregnant as well (P. 1, line 10-11). If my sister hadn’t have been pregnant, I suppose it would have been easier to say it (P. 10, line 9).}
\]

Susan explains her home situation:

\[
\text{My sister had already had a child out of wedlock, a single mother and living at home, I knew my father would..., it was my father’s reaction mainly, he’d think I’d ruined my live and all this (P. 7, Line 11-12).}
\]
Chapter 5. Results of the qualitative study

Pre-existing difficulties also related to having poor relationships with family members. Brenda had pre-existing difficulties with her family, which meant she felt unable to tell them about her pregnancy:

*I was in the middle of a feud with my family, so I went through more than half the pregnancy on my own (P. 2, line 22). I thought I’d leave things off another while because we were just getting back on good terms, I didn’t want to uproot all that again (P. 6, line 40-41)*.

These pre-existing stresses played a role in the women’s decision to delay the disclosure of their pregnancy.

5.8.2 Poor maternal relationships

Spielvogel and Hohener (1995) suggested that maternal deprivation could be a significant factor in this phenomenon. An interesting trend was that five out of eight women reported having a poor relationship with their own mother. Ann describes her relationship with her mother:

*Myself and my mother have never gotten on, we just have a battle of will, we are two different people and we just don’t get on and even without Alice [Ann’s daughter] we just never got on and we don’t see eye to eye, so that was going to disimprove [sic] or improve and it went the other way. She is very cold and we don’t have any..., and that is going on for years. (P.2, line 32-35)*.

These same five women received hostile and unsupportive reactions from their parents once they disclosed their pregnancy. The pre-existing strained relationships may partially explain the low level of support the women received from their family systems.

Previous research has reported that (a) mother-daughter attachments were significantly related to primipara’s psychological well being during pregnancy and (b) that the poorer the mother-daughter relationship the poorer the daughter’s adaptation to
Chapter 5. Results of the qualitative study

the maternal role and the greater the peri-natal complications (Zachariah, 1994). These previous research findings seem to support the findings of this study regarding the importance of the family system.

Many of the family systems were dealing with pre-existing stress prior to the woman disclosing. Many of the systems also had strained relationships prior to the disclosure. These two factors alone go some way towards explaining why some women delayed the disclosure of their pregnancy.

5.8.3 Feared parental reaction

When asked what prevented them disclosing earlier, feared parental reaction emerged as an overriding theme for the women. Wiemann et al., (2005) also reported on this feared parental reaction in their research with pregnant adolescents. In the majority of cases, the participants expected parental reactions were accurate and corresponded to the actual reactions that the women who were interviewed received. This suggests that the women were aware of how their family system would react to this crisis and they wished to delay this reaction. They delayed disturbing the system as a means of protecting their family and in some cases to protect their unborn child. Ann explains her concealment as follows:

_A lot of the concealment would be pride, you don’t want to let people down, you don’t want to hurt people and you don’t want to disappoint people, so it’s pride that stops you telling, there is a stigma attached to it’ (P. 10, line 34-36).

Ann experienced a hostile reaction from her parents when she eventually disclosed:

_I suppose disappointment for them was the biggest thing, they felt upset and betrayed (P. 1, line 39). They were awfully upset, it was_

86
such a shock, (P. 3, line 35-36). I thought they would have been more supportive... they were more angry with me (P. 8, line 8).

In Susan’s situation, she intentionally delayed the disclosure until the 26th week of pregnancy so that her family could not force her to have a termination:

I wasn’t going to let it be known locally but I wasn’t battling with it myself. It was just the timing as to when I was going to tell them. The only reason I left it five months was so they couldn’t force me to have an abortion. That was the reason I waited so long (P. 2, Line 47).

5.8.4 Familial coping strategy

This systemic view of families relates not only to how families react to a crisis but also to how they cope with problems in general. Dallos and Aldridge (1987) highlight a model of family functioning, which is based upon a set of shared constructs, which embody the family’s shared view of the world. This shared view structures but also constrains what each person believes to be possible and permissible. Thus a family’s way of solving difficulties is learned and handed on to the members of that system. Therefore, it is proposed that, in some instances, the women’s coping mechanisms are mirrors of the coping mechanism that exists within their family. It is possible that some of the women could have learned their individual coping style from their family system. Mary explains her parents’ reaction to the news of her pregnancy:

My mother went crazy, crazy, crazy and she started roaring and ripping and I can remember hearing my father outside throwing up on the grass (P.1, line 28-30) They were just horrible for a week, the two of them stayed in bed, didn’t go to work or anything like, they wouldn’t talk to me, wouldn’t give me dinner, you know that kind of stuff. (P. 1, line 35-36).
Mary’s parents present as being angry and shocked by the news but also trying to actively deny and ignore her pregnancy by ignoring her. At the time of the interview Mary’s grandmother was still unaware that Mary has a two-year old daughter.

*It is still a secret from her and it’s sickening, he [Mary’s father] said: tell her later because it will kill her and you will be killing her, so I said: fine do whatever you like, he still hasn’t told her and Anna [Mary’s daughter] is two years old, and still he hasn’t told her (P.1, line 42-45).*

A coping style of secrecy and active denial exists within Mary’s family system. It is possible that Mary learned her own coping style of secrecy from her family. The active denial process within Mary’s family system is similar to the coping mechanisms within Ann’s family system. Ann described how her parents asked her to tell the neighbours that her child was a foster child:

*They feel I should go home and say this is my foster child, the last time I went home, I met one woman who is a cousin of my mothers and she was like, your great for taking on that foster child and that poor child’s mother having to give her up and I went oh my God and I told my parents no, (P. 6, line 20-24).*

As a result of Ann’s refusal to pretend that her own child was a child she was fostering, her parents have failed to support her. Another interesting piece of Ann’s story relates to her younger sister, who was pregnant at the same time as Ann. Her sister did not disclose her pregnancy either. This repetition of the phenomenon within the one family supports this notion of a familial coping style being adopted by family members. Furthermore, in a number of the interviews the women mentioned being asked by family members if they were pregnant before they disclosed this information. This is an interesting point as it suggests that while the pregnancy was undisclosed,
many people in the woman’s family network may have suspected the pregnancy as indicated by Fiona’s experience:

At Christmas time I was at home ... Mum said are you pregnant and I said no (P. 1, line 10).

Carmel also explained that her mother suspected she was pregnant but she did not disclose when asked, using a more passive denial response than Fiona’s:

A few people said to me, asked if I was pregnant (P. 1, line 11). There was a few times.......... my mother asked me a few times, but I didn’t say anything (P. 4, line 41).

By adoption of this systemic model it is possible to postulate that family members suspected a pregnancy but denied this reality in a passive manner to maintain the status quo within their family system. Goldbeck (1997) highlights this aspect of denial in coping with illness and proposes that denial has important interpersonal aspects and is adopted by relatives and friends as well as the patient. It is conceivable that this familial coping mechanism of active or passive denial influenced the woman’s own coping style when she discovered her pregnancy.

In summary, the women described their initial shock regarding their unplanned pregnancy. They expressed being aware of negative societal attitudes towards single mothers, termination and adoption. They also described their coping strategies and prior stresses that existed in their family system and fear of their parents’ reaction. These familial and societal factors could have played a role in reinforcing a woman decision to delay disclosing her pregnancy. These factors must be kept in mind when considering the women’s rationale and understanding of their experience of delayed disclosure of pregnancy.
Chapter 5. Results of the qualitative study

5.9 Support

5.9.1 Impact of familial support

Previous research has highlighted that support from partners and significant others are positively related to maternal health and pregnancy outcome (Browne, 1987). Emotional and tangible support provided by a partner during pregnancy has also been found to be positively related to the expectant mother’s mental well being (Gjerdingen, Froberg & Fontaine, 1991). Yet, only one of the women interviewed received support from her partner during her pregnancy. The concept of support or lack of support was mentioned by all the women interviewed in this study. As previous research would suggest, the variable of social support seemed to play a role in not only the delayed disclosure process but also in the decision making process regarding the outcome of the pregnancy.

In two of the cases, families were supportive post disclosure, which eased the women’s experience. Carmel found the transition to motherhood quite easy but she associated her ease of transition with the support she had available to her at the time:

I just took to it, I mean I had so much help at home there was always someone there, my mother took a few weeks off work and that, I did a lot of it myself, but I felt I always had help at home (P. 3, line 28-30).

5.9.2 Lack of familial support

Monica placed her child for adoption and she was unsupported by her family or friends regarding this decision. She presented as being deeply affected by this lack of support. Her family tried to dissuade her from having the baby adopted by saying she’d regret it for the rest of her life. Monica describes her sense of isolation and uncertainty about her decision:
Chapter 5. Results of the qualitative study

Nobody has said you made the right decision you did what you had to do (P. 10, line 8).

I sometimes think have I done the right thing? Have I really? (Pg 8, line 29).

This lack of support and validation seemed a very difficult part of the adoption process for this woman. To have made a decision on her own which no one in her social support network agreed with, was a very isolating and distressing experience for her.

From Monica’s experience, the complexities involved in placing a child for adoption and living through the reality of that process appear overwhelming. Many who place a child for adoption may feel isolated because the macro-systems that surround them, object to this decision. Those who place a child for adoption may be left feeling unsupported and marginalized while simultaneously dealing with the emotional impact of the adoption itself. Those who chose to parent a child against their parents’ wishes may also experience isolation and rejection by family members, which was the experience of Susan, Ann, Mary and Brenda.

5.9.3 Friends as sources of support

This rejection by family was buffered by support the women received from work colleagues or friends. Six of the eight women referred to close friends they disclosed the pregnancy to, either before or after the birth. Their friends provided a listening ear, practical supports and understanding. Studies have demonstrated that there is a positive relationship between social support and foetal attachment (Cranley, 1984). Ann described her experience of being supported by her friends:

I had support even if it wasn’t from my parents and I had the support of my friends and work people and it wasn’t such a bad thing to have a baby you know (P. 9, line14-15).
5.9.4 Professional intervention

Professionals also played an important role of offering or refusing support. Susan described her positive experience with the medical social workers:

They helped me so much, I don’t know what I would have done without them (P. 6, Line 4).

However, there were also negative experiences with professionals; Ann referred to a G.P, whom she felt, undermined her, which resulted in her delaying antenatal care even further:

The doctor I went to in X ate the face off me for not telling people earlier, like about the pregnancy and she made me feel like I wasn’t good enough to be alive even that I was wasting her time, she was just pure ignorant (P.5, line 32-34).... If you meet one bad person that just condones what you are doing, you are going to loose all confidence in everybody that doctor really turned me off, I probably would have got help if I hadn’t gone to her I swear to God (P.10, line 25-26).

This variable of support influences the systemic process of delayed disclosure of pregnancy and it also influenced how the women adjusted to their decisions post delivery. Women who received support from family or from a partner post delivery reported a smoother transition than the women who negotiated this transition on their own. In some cases, friends and professionals also provided a certain level of social support, which was reported by the women as being helpful.

5.10 Individual influences in the primary system

A woman facing a crisis pregnancy can react in a variety of ways. Her initial behaviour and decision-making can be influenced by mediating factors such as an
individual problem-solving style (Pajares, 1995), knowledge of self, mental health and belief systems.

5.10.1 Personal coping-style

The way a person deals with a stressful situation can be affected not only by their coping strategies but also by their perception of their ability to cope (Lindsay, Harrison & Dickinson, 1999). A theme, which emerged from this group, was the women’s belief in their own ability to cope with difficulties. Two personal styles of coping emerged from the interviews. The predominant style, which seven of the women referred to, was an active style, which involved personal agency and independence. The other style was more passive and involved having a fatalistic belief that things would just work out for the best. Some called the active style being private, being independent, and not wanting to burden others. Fiona described her way of dealing with problems:

*If I have a problem, I handle it myself, it’s my problem, I wouldn’t want to put it on to other people, I’m independent (P. 2, Line 24-25).*

Ann also uses the word independent to describe herself:

*I knew I was always very independent and strong and I knew I could have the baby and no one would find out, (P. 2, line 11). You keep things to yourself, people don’t need to know everything about people (P. 4, line 16). If you do need help you can ask for it but usually I can deal with things myself (P. 8, line 41-42).*

Susan’s style is similar and she describes her style of coping:

*I work it out myself, I don’t mind listening to other people but I can’t stand stupid comments where I know I can work it out for myself, (P. 3, Line 44-46).*
Chapter 5. Results of the qualitative study

Mary’s style is different from the other women and it is a more passive approach, where she believes things will turn out fine if she waits and lets things happen, illustrated by her remark:

*I’ll worry about that when the time comes, I’m sort of like that anyway about everything, something will come up (P. 2, line 30).

She also remarked that:

*Some people think they can get on, on their own and they can do it... no one else can help, this is ‘my’ problem, the end (P. 10, line 4-5).

Therefore, the women’s decision not to disclose the pregnancy may have been influenced by their personal coping-style. These personal coping-styles tended to be private coping styles either based on self reliance or reliance on chance.

5.10.2 Knowing-self

Knowing-self emerged as a theme and refers to the comments the women made regarding their perception of their own ability to carry out the task before them, pregnancy and possibly motherhood. They seemed to base their decision about the outcome of the pregnancy partially on their perception of themselves. Five of the women spoke about their strengths and weaknesses. Ann described herself:

*I knew I was always very independent and strong and I knew I could have the baby and no one would find out (P. 2, line 11-12). I had no real reason to give her up only my parents’ disappointment, I knew I could cope with her and I knew I could rear her. I knew I could provide her with love and attention that she needed and the only reason I would have given her up for adoption was to protect my parents and at the end of the day that wasn’t enough of a reason (P. 9, line 20-24).

Brenda was very sure of what she could and could not do:

*Yeah I was definitely going to keep her, there was no way I could give her up I don’t understand how people go through the whole
Chapter 5. Results of the qualitative study

*nine months and the labour and then, here you go, that was never an option* (P. 4, line 17).

Monica on the other hand sensed she would not be able to cope with a third child and this helped her decide on adoption:

*I was afraid I’d get depressed, I was afraid of everything. I didn’t want that for her and the younger two, I didn’t want to get depressed, there was money, their father, there was everything, I couldn’t deal with it. ... I know that I panic everyday looking after the two I have. I am going to lose it if I had three* (P. 8, line 6-8).

By recognising their own abilities and weaknesses and what was acceptable to themselves the women seemed more able to make decisions regarding their pregnancy.

### 5.10.3 Needing space and time to think

This theme is related to the fore-mentioned concepts of coping-style and knowing self, yet it is a unique and separate dimension as it relates to some of the women’s particular needs when trying to problem-solve. Some of the women referred to their desire to have space to think out their decision. By not disclosing, the women had time to think for themselves and maintain control over the situation. This time was not interrupted by the thoughts or opinions of their family or friends. Ann refers to having time, which allowed her to reach a clear decision:

*I wanted to give myself enough time to be able to know how to deal with the situation, if there were questions to be asked* (P. 3, line 31-32). *I kind of feel that I didn’t disclose it and that was my decision and I had 5 weeks to decide what I was going to do and what was best for Alice [her daughter] and myself and I made those decisions clearly* (P. 7, line 5-7).

Nuala also felt she needed time to think:
I wanted time for myself to adjust to having a child, so I said give me
week, so it gave me that week to decide what I wanted to do (P. 2,
line 44-45).

This need for space to think on one’s own seemed to be very important to four of the
women interviewed.

5.10.4 Mental health

Mental health relates to the mood experienced by the women during their
pregnancy. Three of the mothers’ described experiencing symptoms of depression
during the pregnancy and feeling that they could not cope with their newborn baby for
a number of months post delivery. They were both commenced on anti-depressants
during their pregnancy. Major depression has been linked in the literature with denial
illustrated that peri-natal and postpartum depressions are extremely complex syndromes
and that these types of depression may be under diagnosed.

Monica spoke about being depressed after her second child was born. She also
described trying to induce a miscarriage in her third pregnancy by inflicting harm on
herself. This could be interpreted as an attempt to kill her unborn child:

I thought the more I do, the less I eat something might happen, I
might collapse and lose the baby, I tried a lot of stuff, tightening a
belt around my stomach, drinking, smoking, I fell, I tried everything
(P 4, line 18-19).
I was afraid I’d get depressed, I was afraid of everything, I didn’t
want that for her and the younger two, I didn’t want to get depressed
(P.8 line 6-7).
Chapter 5. Results of the qualitative study

This was the only time throughout the eight interviews that the desire to miscarry was reported. Monica felt she could not cope and in her mind a miscarriage would have solved the problem pregnancy. This desire to induce a miscarriage was also reported by Mahon et al., (1998), who interviewed women who experienced a crisis pregnancy. This finding suggests that a woman’s mental health plays a role in how she perceives and proceeds with an unplanned pregnancy.

5.10.5 The women’s beliefs about adoption

Seven of the eight women interviewed, seriously considered adoption. Their beliefs about adoption related to impressions they had in relation to the process of adoption. An aspect of the women’s thinking process, which emerged from the interviews, was their belief that adoption could remain a secret. The women also expressed their belief that they would be criticized regarding their decision to place their child for adoption. The woman’s thinking seemed to be that if she placed her child for adoption, she did not want anybody to know she had done this and thus her pregnancy must remain hidden. If she successfully concealed her pregnancy and placed her child for adoption then nobody would find out about the pregnancy or the adoption.

Nuala illustrates this:

I knew I was pregnant…. I could feel her, (P. 1, line 3)... I didn’t tell my family because of going to adopt her, that was my own reason for not telling, ... (P. 5, line 48-49).

Fiona had a similar experience:

I denied it for a while and I concealed from people, as I didn’t know if I was going to give her up to adoption or not I didn’t want people to know (P.6 line 15-16).
Chapter 5. Results of the qualitative study

The secrecy aspect of the concealment and the subsequent adoption would have shielded the woman from the scrutiny of others. Ann comments on her beliefs about adoption:

*If I had given her up for adoption then no one would ever of know or ever judged me or criticized or said anything (P. 7, line 1-2).*

Monica shares this belief that a secret adoption would have been the best solution for her:

*My plan in the beginning was not to tell anybody, to have the baby during the day, and be out of hospital the next day and no one would ever know. I feel you wouldn’t have this pressure from everybody else to get on with it, it would have been a lot better (P. 6, line 12-15). If I did do it in secret, I wouldn’t have had to deal with my family (P. 10, line 40).*

Thus, the decision process regarding hiding the pregnancy has some relationship with some of the women’s wish to secretly place their child for adoption. The desire to place a baby for adoption seemed to be fuelled by the notion that this would remain a secret and therefore others would not judge or influence their decision. This link between the desire to place the baby for adoption and the decision to delay the disclosure of the pregnancy is significant and may contribute to partially explaining the delayed disclosure process.

5.11 The impact of the baby

The reality of the baby during gestation and post delivery added a new element and uniquely affects the multiple layers of the systemic model. It is proposed that the developmental stages of the gestating foetus influence the systemic model in a temporal way. The individual mother, and the systems which surround her, influence how she interacts with the baby both during and after gestation. Furthermore, as the foetus
grows and interacts with the mother the role the systems play in this process is altered. The systemic conceptualisation previously illustrated can be expanded to include the new element of the developing foetus and the pending decision regarding outcome of the pregnancy (Figure 7). The baby influences the mother in a physical, behavioural and emotional sense.

5.11.1 Physical presence

In this study, seven of the eight women reported being physically aware that they were pregnant, some within a few weeks of conceiving. However, they delayed or avoided seeking prenatal care. This finding of delayed prenatal care has been reported previously for women who are ambivalent about their pregnancy (Fogel, 1993). Most women in this study reported feeling tired, moody, missing a period, noticing foetal movements, feeling nauseated or a change in their body shape. Most of the women reported eating well or healthier than usual during their pregnancy and these behaviours have been referred to by other researchers as seeking safe passage (Rubin, 1984 as cited in Mercer, 1995). The majority of the women attempted to reduce their alcohol consumption and cigarette smoking. Therefore, within a short space of time, the foetus influenced the mothers both physically and in a behavioural sense except in the case of Ann who did not acknowledge her pregnancy psychologically or physically until she experienced labour pains.
Chapter 5. Results of the qualitative study

Macro system: Society
- Single parent stigma
- Termination stigma
- Adoption stigma

Secondary system: Family
- Professional support services
- Negative parental reaction
- Familial coping strategy
- Prior family conflict
- Prior family stress

Primary system: Individual
- Age
- Mental health
- Knowing-self
- Beliefs on adoption
- Personal coping style
- Unplanned pregnancy
- Beliefs about adoption
- Beliefs about adoption
- Needing space and time

Primary system: Partner or Friends
- Support (or lack of)

Primary system: Society
- Single parent stigma
- Termination stigma
- Adoption stigma

Figure 7: Adaptation of proposed systemic model to include the neonate, which, over time, influences the delayed disclosure process and the decision process regarding the outcome of the pregnancy.
Chapter 5. Results of the qualitative study

Patterson, Freese and Goldenberg (1990) reported that after the reality of pregnancy is realised and a decision is made to continue with the pregnancy, safe passage through pregnancy and childbirth is sought by the majority of women. Although their study was based on uncomplicated pregnancies, it seems from the present study that some of the women who delayed disclosure also followed this pattern of seeking safe passage.

5.11.2 Growth of foetus

The physical growth of the foetus influenced the women’s behaviour. Additionally, as the pregnancy progressed, some of the women referred to gaining weight and looking pregnant. Three women physically moved away from home and their local village to prevent disclosure. The physical growth of the foetus thus impacted on the women in this way.

5.11.3 Prenatal bonding dynamics

When the women became aware of their unplanned pregnancy, they attempted to deal with the crisis by problem solving. Some of the women toyed with the idea of adoption right up until they had given birth to their child. Five of the mothers described their attempts to avoid bonding with their child, as they believed they were going to give the baby up for adoption once it was born. Therefore pre-attaching behaviours (Siddiqui & Hagglof, 2000) such as visualising, fantasizing about the baby were actively avoided by some of the mothers. Fiona explains why she did not talk to her baby before he was born or imagine what he looked like:

*No I didn’t go there, because I didn’t know what I was going to do*  
*(P. 2, line14).*
Chapter 5. Results of the qualitative study

Other women referred to their decision not to prepare for the baby because of their decision to adopt. Nuala’s comments:

*I had nothing done because as I say I was going to have Sarah adopted* (P. 5, line 8-9).

Ann spoke about her thoughts on the link between lack of attachment and abandonment:

*I can see how easy it is for people not to disclose it and I see how easy it is for girls to give up their babies for adoption, without seeing their babies and how they can abandon them at a church, it’s pure panic at that stage and if you haven’t acknowledged your pregnancy for nine months and suddenly your in labour and you have your baby you can just leave it because you haven’t got attached to it* (P. 9, line 45-49).

The indecision about the outcome of the pregnancy did not prevent three of the women from interacting with their unborn child and making some preparations. These three women, while not knowing whether they would keep the baby or not, still interacted with the unborn child by singing, by playing music and by purchasing a few items for the baby. Susan describes her experience:

*I had fun like, I would go down to a friend’s house and play him music and stuff, I enjoyed it on my own but outside the house I covered up* (P. 3, line 34-35). *I had bought a few things for him, I bought a cot, I bought a few things in Roches [a department store], to have when he was being taken away, blankets...* (P. 5, line 8-9).

The mothers’ thinking regarding the outcome of the pregnancy influenced the way some mothers interacted with their baby in utero. Some of the women who were thinking about adoption did not interact with their unborn baby while others did.
5.11.4 Birth process and its impact on decision making

The decision to adopt, became much more difficult once the women had actually given birth and spent time with their child. This difference between deciding on adoption before the baby is born and after the baby is born is referred to by Fiona:

> If you are thinking about adoption, it easier when the baby is not there, but when the baby is there it’s different (P. 5, line 24-25).

For many of the women adoption was no longer an option once the baby was born. Nuala explains:

> I was going having [sic] Sarah adopted, then when I was in the hospital I was looking after her for 3-4 days, you know, I just had to take her home...then I had her and I wanted to keep her (P. 2, line 39-40, P. 3, line 3).

Fiona’s experience parallels Nuala’s in that once the baby was a physical reality; parenting replaced the idea of adoption:

> I was thinking about adoption but when I had her I knew I couldn’t give her up (P. 1, line 19).

Monica also experienced this shift from adoption to parenting once she had her second baby who was ill post delivery:

> At first, when I was pregnant, and I was, I can’t have another baby. I had this thing I was giving him up and from when he was born he was brought up to special care, the guilt just hit me and I said no I can’t do this, it wouldn’t be right (P. 2, line 30-32).

In summary, the transition from thinking about adoption to parenting is influenced by many factors. For many of the women, once they had delivered their baby, the rationale for adoption was out-weighted by their emotional connection with their child. The baby’s actual presence influenced the mother’s decision-making process. Before the birthing process, the majority of the mothers had decided to place
their baby for adoption. This decision had been influenced by societal, familial and individual factors and resulted in the mother’s avoidance of pre-attaching behaviour. In the majority of cases, the reality of the birth of the baby altered this decision to one of parenting. However, how the new mothers interacted with their newborn was heavily influenced by their previous thoughts and beliefs about their pregnancy.

5.11.5 Postpartum attachment

Mental rehearsals for the maternal role are associated with adaptation to the role and fantasising about one’s future mothering role has been found to prepare women for labour, delivery and mothering (Hees-Stauthamer, 1985). Consequently one of the questions that emerged before the interviewing stage was: did the women who delayed disclosure have difficulties attaching to their child in the first few weeks post delivery?

Leifer (1977) reported that those who show less attachment towards their unborn, experience more postpartum adjustment difficulties. Leifer’s findings resonate with what was reported by some of the women in the current study. Most of the women interviewed, did describe their bonding process as problematic and they also acknowledged minimal pre-attachment interactions prior to delivery. Four mothers reported having difficulty acknowledging that the baby was theirs in the minutes preceding delivery. Nuala explains her dilemma:

I didn’t want Sarah, they gave me Sarah and I didn’t want her, I asked could someone take her, I wasn’t able to look after her, as I thought,... I had no interest in holding her, it was like holding a doll, I didn’t look at her, I couldn’t look at her (P. 3, line19-24).

Fiona also experienced some initial difficulties in bonding with her daughter:

It did feel a bit strange, it didn’t feel like normal, like other mothers, having a baby, I wasn’t delighted, it didn’t feel right, I didn’t go out
with her even here, I was afraid of what the neighbours were saying..., It’s hard to explain, I felt embarrassed (P. 5, line 2-5).

Ann placed her child in foster care while she tried to decide what to do. She describes feeling no bond towards her child and struggling with this for a number of weeks:

When I did actually see her, she didn’t feel like my baby, she could have been anybody’s, so that kind of took a few weeks (P.3, 40-41)… I couldn’t acknowledge that I had a child, it was easier not to see her and it was so easy not to see her. I could’ve pretended my whole life that I never had a baby (P. 9, line 2-3). She just didn’t feel like my baby. It was, I felt guilty for that I suppose, oh my God if I do keep her will I be able to bond with her as her mother? (P. 9, line 8-9).

These findings support the work of Leifer (1977). However, other findings contradict Leifer’s hypothesis in that two of the mothers who displayed no prior attachment behaviours described forming an instant bond once they held their baby. Carmel had made no preparation for her baby nor did she ever talk to her baby before it was born. However she explained:

When I had him I just fell in love with him and that was it (P. 3, Line14).

Therefore it can be seen that the relationship between prenatal attachment and postpartum adjustment difficulties is a complex one.

5.11.6 Baby’s temperament

The baby’s temperament also seemed to influence the bonding process. A baby that was placid seemed to be easier to bond with than a baby that was cranky (Wilkie &
Ames, 1986). Brenda describes how her baby was ill for a number of months post delivery and how this had had a negative impact on their bonding process:

It was hard to bond with her, as I had no time to bond with her. You can’t bond in a hospital and because she cried so much you can’t bond with a crying baby.... (P. 7, line 28-30).

I do feel like her mother now, I have all along but there was never this bond between us because she was sick for a long time (P. 7, line 12-13).

Mary, on the other hand describes how her child’s temperament positively influenced her mothering experience:

It’s all down to how Anna is as well, as she was so good you know, I probably would have had to wing first year [in university] if she had of been cranky or anything or waking up in the middle of the night, she slept right through since she was born and eating well (P. 5, line 40-43).

5.11.7 The psychological and physical dyad

The interactions between the baby and the mothers can be conceptualised in a systemic way. The complexity of the bi-directional influences of these systems upon each other is vast. A physical expression of the bi-directional influences of the various systems could be one explanation as to why many of the women reported minimal weight gain during their pregnancy despite the fact that they ate a balanced diet throughout the pregnancy. Psychological factors such as perception of social support or level of depression, which were not assessed in this study, may explain this physical aspect of this phenomenon (Green, 1990; Hall, Gurley, Sachs & Kryscio, 1991; Hodnett & Frederick, 2003).
In summary, the nature of the explanations given illuminates the dynamic, complex and multifaceted nature of the process of late disclosure of pregnancy. The meaning of late disclosure of pregnancy encompasses aspects of denial and concealment. Many of the disclosures seemed to take place in a gradual and limited manner as the women seemed to move along a continuum towards partial or full disclosure. In some cases, concealment continued after the birth of their child, which highlights the temporal aspect of this phenomenon. The majority of the women interviewed, were aware of the physical reality of being pregnant and altered their life style accordingly. However, they continued to keep the pregnancy hidden by using certain individual coping strategies. Beliefs about the adoption process and their own abilities seem to play a role in assisting the women to delay the disclosure. Both family dynamics and perceived societal stigma played a convoluted role in the women’s decision-making process. The gestation period and birth of the child added a new dimension to the women’s reality. For the most part, the women interviewed who decided to parent, were satisfied with the decision, but acknowledged having had difficulty bonding in the initial few weeks, which may be related in some cases to; the lack of pre-natal attachment behaviours, the mothers mental health, the temperament of the child and the level of support available. The one woman who placed her child for open adoption continues to struggle with the open adoption process.
Perhaps as psychology becomes ever less defensive about its scientific credentials, it will not only be more receptive to investigations employing qualitative methods, but also more mature in its understanding of the proper role of quantitative methods.

Chapter Six

6 Quantitative methodology

A summary of the outline of study two is displayed (Figure 8). For ease of presentation the term “target group” is used to describe the data for the late disclosure of pregnancy group.

<table>
<thead>
<tr>
<th>Study Two</th>
<th>Quantitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓</td>
<td>The target sample ($n=43$) was age-matched with the comparison group ($n=30$) of crisis pregnancies, which were randomly selected from a sample of 121 crisis pregnancies, which were referred to the social work department between the years 2003-2004.</td>
</tr>
<tr>
<td>↓</td>
<td>Demographic information was gathered on these two samples</td>
</tr>
<tr>
<td>↓</td>
<td>Birth weights and maternal complication information were located for 36 of the target group and 30 of the comparison group</td>
</tr>
<tr>
<td>↓</td>
<td>Comparisons drawn between the target and comparison group</td>
</tr>
</tbody>
</table>

*Figure 8. Outline of quantitative methodology*

6.1 Design rationale

6.1.1 The rationale for control group

In order to identify the contingencies leading women to delay disclosure of a pregnancy, it is necessary to study women who chose to delay disclosure in relation to women exposed to similar contingencies, that is a crisis pregnancy, but who did not delay disclosure (Mahon et al., 1998). It was felt that this group should act as an age-matched comparison group and differences in the demographic information between these two groups could highlight some of the most pertinent factors that contribute to
women delaying the disclosure of a pregnancy. Age is potentially one of the most important demographic variables contributing to a woman’s reaction to her pregnancy (Kaplan & Grotowski, 1996). Therefore this variable was controlled for by age matching the samples.

### 6.1.2 Rationale for demographic questionnaire design

The demographic questionnaire consisted of 36 questions (Appendix Q). It was devised to include questions that examine several areas of the pregnancy process. Questions were developed by considering the findings of previous research (pp 27-30) and by questions raised by the social work practitioners. The social work practitioners were interested in examining the source of referrals, the stages at which personal supports are informed, which supports are required by the women and what the outcomes of the pregnancies were.

A template questionnaire of demographic information that was of interest to the practitioners and the researcher was designed and piloted. Researchers involved in a similar study in a different area of the county were contacted to clarify any overlap and to discuss the possibility of combining data in the future (C. Conlon & C. Fox, personal communication, May 15, 2005). Their suggestions regarding relevant demographic information were discussed, and informed the construction of the questionnaire. The questionnaire was re-designed to aid in the accuracy and ease of completion.

### 6.2 Primary objective of the quantitative study

The primary objective of the quantitative study was to build a demographic profile of the target group of women who delay the disclosure of their pregnancies. By
having such a profile, practitioners might be more aware of potential risk factors, which may contribute to a woman choosing to delay the disclosure of her pregnancy. Variables which were informative to the social work practitioners and of interest to the researcher included: the age of the women; their nationality, marital status; original family domain; the influence of family/partners; supports required; their level of education/employment; and the outcomes of pregnancies following a late disclosure. Variables of interest to the obstetric staff included: birth weights; admission rate to neonatal units; the prevalence of maternal complications; reoccurrence of this phenomenon in the target group and the prevalence of late disclosure of pregnancies in UCHG over a two-year period.

6.3 Participant selection procedure

The social work practitioners gathered the demographic information for the target population from social work files ($n=43$). This sample met the criteria for inclusion within the working definition of a late disclosure of pregnancy (para 2.4.3). The files of a sample of women who had a crisis pregnancy but who did not delay the disclosure of the pregnancy were also examined. The comparison group ($n=30$) were selected based on age matching criteria, from the social workers records of all crisis pregnancies ($n=121$), which were referred to their department between 2003-2004. The age matching took place using the following procedure: all the coded names and ages of the 121 crisis pregnancy cases were written on slips of paper, which were folded and mixed up in a container. Next they were drawn one by one and the age was checked to see if this individual was required to match an individual in the target group. If there were sufficient individuals of a certain age drawn from the larger sample, any additional individuals of that age were rejected. In cases where there were not enough individuals
in certain age classes, the larger group was sampled again and the individuals of the closest age class were selected.

6.4 Collating birth weights

The birth weight record books from UCHG, where birth weights are recorded, were accessed by the medical social worker and the relevant weights recorded. Records of maternal complications were collated from the patient’s medical chart. For this to take place, a list of the relevant medical chart numbers were collected and given to the medical team who compared the target group and control group in relation to maternal complications experienced. When the weights were being collated it was noted that seven of the women in the target group did not deliver in UCHG and therefore no birth weight or information on maternal complications could be located for these women and the target sample was reduced to 36 in relation to that factor.

6.5 Method of analysis

Demographic information on both the target population and the comparison group yielded a large volume of information. Categorical data was analysed using Chi-square tests (Howitt & Cramer, 2003). An alpha level of .05 was used for all statistical tests. For ordinal data, the Kolmogorov Smirnoff two-sample test was applied (Zar, 1999). A summary of the groups and the variables compared is given in table 4.
Chapter Seven

7 Results of the quantitative study

A summary of the findings are given below in table four.

Table 4

Outline of descriptive data of the target and comparison groups. Standard deviations are given between brackets.

<table>
<thead>
<tr>
<th>Description</th>
<th>Target group</th>
<th>Comparison group</th>
<th>Statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>Delayed disclosure</td>
<td>Crisis pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>43</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth weight</td>
<td>22.9 (±4.8)</td>
<td>22.5 (±4.8)</td>
<td>T=0.183</td>
<td>p=0.855</td>
</tr>
<tr>
<td>Prev. pregnancies</td>
<td>N=9</td>
<td>N=7</td>
<td>$\chi^2$=0.060</td>
<td>p=0.087</td>
</tr>
<tr>
<td>Single status</td>
<td>N=20</td>
<td>N=14</td>
<td>$\chi^2$=0.143</td>
<td>p=0.705</td>
</tr>
<tr>
<td>2nd Education</td>
<td>N=37</td>
<td>N=25</td>
<td>$\chi^2$=3.298</td>
<td>p=0.348</td>
</tr>
<tr>
<td>Employed</td>
<td>N=30</td>
<td>N=15</td>
<td>$\chi^2$=2.870</td>
<td>p=0.09</td>
</tr>
<tr>
<td>Rural origin</td>
<td>N=28</td>
<td>N=10</td>
<td>$\chi^2$=7.15</td>
<td>p=.007*</td>
</tr>
<tr>
<td>Family reaction</td>
<td>N=34</td>
<td>N=12</td>
<td>$\chi^2$=12.72</td>
<td>p=0.001*</td>
</tr>
<tr>
<td>Parent on discharge</td>
<td>N=29</td>
<td>N=26</td>
<td>$\chi^2$=2.510</td>
<td>p=0.119</td>
</tr>
<tr>
<td>Underlying issues</td>
<td>N=13</td>
<td>N=14</td>
<td>$\chi^2$=0.058</td>
<td>p=0.809</td>
</tr>
<tr>
<td>Professional Support</td>
<td>N=29</td>
<td>N=17</td>
<td>$\chi^2$=0.293</td>
<td>p=0.588</td>
</tr>
</tbody>
</table>

7.1 Age

The mean age of the women in the target group was 22.9 years ($SD=4.8$). The comparison and target group were matched for age therefore no age difference could be calculated. The resulting age distributions were not significantly different when tested with a t-test; $t=.183$, $df=71$, $p=0.855$. However, the number of teenage pregnancies was low in both groups.
Figure 9: Ages of women in the target and comparison group. The comparison group was age-matched with the target group and the modal age of women in these groups was 20-24 years.

7.2 Birth weight

The mean weight of infants in the target group was lighter \((M=3.1\text{kg}, \ SD=0.7)\) than the mean weight of the comparison group \((M=3.5\text{kg}, \ SD=0.5)\). Using the Kolmogorov Smirnoff two-sample test, the birth weight of infants in the target group \((n=36)\) was not found to be significantly lower than those infants in the comparison group \((n=30)\). D=.1529, \(p<.906\).
Figure 10. Birth weight of neonates in the target and comparison group. The distributions were similar although the target group had a higher proportion of birth weights of 2-3kg.

7.3 Experience of previous deliveries

A number of women in the target group had given birth previously which is similar to the proportion of women in the crisis pregnancy group. A chi-square test yielded no significance difference between these two groups in relation to previous pregnancies. $\chi^2(1, 73) = 5.671, p=0.225$. Therefore, women in the target group are no more inexperienced as women in the comparison group. However, of the nine women in the target group who had given birth previously, seven of the women had previously delayed the disclosure of a pregnancy (Figure 11).
Figure 11. The majority of women in both groups had never previously experienced pregnancy. Of the women in the target group that had previous pregnancies, most disclosed these pregnancies late.

7.4 Relationship status

Approximately half of those who delayed the disclosure of their pregnancy were not in a relationship at the time of pregnancy. This is similar to the proportion of women who were not in relationship in the comparison group. A chi-square test yielded no significance difference between these two groups in relation to relationship status. \[ \chi^2(1, 73) = 0.143, p=0.705 \]. The women in both groups were more likely to be single than married with one woman being married in the target group and three in the control group. Therefore those who delay the disclosure of pregnancy are more likely to be single than married. Expressed as a percentage, 95% (69/73) of the pregnancies in this included in this study occurred outside marriage, which is much higher than the national average of births outside marriage, which is 31% (McGrath, O’Keefe & Smith, 2003).
7.5 Education level

One quarter of the women who delayed the disclosure of their pregnancy had received higher education. This was similar to the proportion in the comparison group (Figure 12). These two groups were not found to be significantly different regarding educational attainment when tested with a chi-square statistic. \( \chi^2(1, 73) = 3.298, p=0.348 \). The majority of the target group and the comparison group had attained secondary education or higher. Therefore, women who delay the disclosure of pregnancy have similar education patterns to women who have a crisis pregnancy.

\[ \begin{align*}
\text{target group} & : n=43 \\
\text{comparison group} & : n=30
\end{align*} \]

![Education Levels Graph](image)

*Figure 12.* Education levels of women in the target and comparison groups were similar. PLC is a post-leaving cert course providing training in professional skills. 2nd and 3rd ed. refer to secondary and third level education respectively.

7.6 Employment status

Two-thirds of the women who had delayed the disclosure of pregnancy were either employed or in full time education while only half of the comparison group were in employment or education (Figure 13). The difference between the two groups was
Chapter 7. Results of quantitative study

not statistically significant when tested with a chi-square statistic. $\chi^2(1, 73) = 2.877$, $p=0.09$. Therefore, women in the target group were as likely to be employed as women in the comparison group.

![Frequency distribution of employment status](image)

Figure 13. Employment status of women in the target and comparison group

7.7 Urban or rural background

A significant difference existed between the origins of those who delayed the disclosure of their pregnancy from that of women who had a crisis pregnancy. $\chi^2(1, 73) = 7.152$, $p=0.007$, $V=0.313$. A significantly higher proportion of women who delayed disclosure pregnancy were from rural backgrounds than in the comparison group (Figure 14). Therefore, women in the target group are more likely to be from a rural background, when compared to the comparison group.
7.8 Infant and maternal complications

There did not seem to be a difference between the groups in relation to infants being admitted to special neonatal units post delivery, with two being admitted from the target group and one being admitted from the comparison group. Because of the low expected frequencies relating to the variables a chi-square statistic was deemed inappropriate to use. The number of admission to neonatal units was very small in both groups, 5% and 3% respectively, in comparison the average admission rate in UCHG for the years 2003-2004, which was 9.5%. Results regarding maternal complications, (which a medical team in UCHG are investigating), were not available when this report was going to print. However, expected results in this area are awaited.
Chapter 7. Results of quantitative study

7.9 Nationality

Foreign nationals made up 11.7% of the deliveries in UCHG in 2003-2004, whereas the proportion of foreign nationals in the target group was only 5% (2/43). Because of the low expected frequencies relating to the variable a chi-square statistic was deemed inappropriate to use but it seems from this study that more Irish women experience a late disclosure than foreign nationals.

7.10 Prevalence

According to social work records, the prevalence rate of delayed disclosure of pregnancy in UCHG between 2003-2004 was one in every 148 births.

7.11 Informing personal supports

The majority of those who delayed disclosure did not inform personal supports until after the baby was born. A smaller number of women have never told their personal supports about their experience (Figure 15). This was not the case for women in the comparison group.

![Figure 15. Timing of informing personal supports for the target and comparison group](image-url)

Figure 15. Timing of informing personal supports for the target and comparison group
7.12 Perceived family reaction

Perceived family reaction was significantly more often reported to be a crisis factor in the target group than in the control group. $\chi^2(1, 73)=12.721, p<.001, V=0.42$ (Figure 16).

![Bar chart showing perceived family reaction]

Figure 16. Incidents where family reaction was perceived as a crisis factor in both the target and comparison group

7.13 Decision on discharge

On discharge from hospital, the majority of women in both groups decided to parent their child. However, a larger proportion of women in the target group placed their children for adoption than those in the comparison group (Figure 17). Using a chi-square test there was no statistically significant difference between the groups in relation to this variable. $\chi^2(1, 73)=2.517, p<0.113$. The use of a chi-square test is questionable in this circumstance as the observed frequency in one of the cells fell below 5.
Chapter 7. Results of quantitative study

Figure 17. Decision of target and comparison group regarding the outcome of their pregnancy

7.14 Details regarding the biological fathers

Demographic information such as age, nationality and ethnicity was sought on the biological fathers. However, much of this information had not been recorded in the practitioner’s files and as a consequence, no clear findings can be reported relating to these demographics. Information was available on the nationality of 50 of the 73 fathers involved. By considering the fathers’ nationality in both the target group and comparison group together, approximately four fifths were Irish (39/50) and one fifth from other countries (11/50). The level of support provided by the biological fathers to the women was low in both the target (14/43) and comparison group (9/30) with approximately one third of the fathers being supportive in each group.

7.15 Underlying difficulties

A third of the target group were reported to have underlying difficulties, such as mental health problems, while almost a half of the comparison group reported
difficulties in addition to the pregnancy. Some of the issues experienced by women in both groups are listed below (Table 5). Overall, the women in the comparison group reported more underlying issues than the target group but this difference was not found to be statistically significant when tested with a chi-square. \( \chi^2(1, 73) = 0.058, p < .809 \).

### Table 5

Underlying difficulties most commonly reported in social work files

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Target group</th>
<th>Comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Bereavement</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Learning disability</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

#### 7.16 Sources of and necessity for support

Although the target group reported fewer underlying issues, a substantial number of women from both groups appear to require long-term support from support services. This difference in requirements for support was not found to be statistically significant when tested with a chi-square. \( \chi^2(1, 73) = 0.293, p < 0.588 \). Professional support continued to be provided to approximately two thirds of the cases in the target group and half the cases in the comparison group. Social workers in both the hospital and the community were found to be the largest source of support for both groups with the Teen Parents Project also being frequently used as a source of support (Table 6).
Chapter 7. Results of quantitative study

Table 6
Sources of support for women in the target and comparison group

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Target group</th>
<th>Comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work service</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Teen Parents Project</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Other: Life, hospice, addiction services, disability services</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

7.17 Source of Referral

Hospital staff were the main source of referral for both groups with self-referrals being reported as the next highest source which perhaps indicate that women in this target group and comparison group are not linking with community support services in relation to their pregnancy (Table 7). Because of the low expected frequencies relating to the variables chi square statistic was deemed inappropriate to test for differences between the two groups regarding those who self referred.

Table 7
Source of referral in both the target and comparison groups

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Target group</th>
<th>Comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital staff</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Self-referred</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Life/ Cura</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Teen Parents Project</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Section Five:
Validation techniques, reliability and generalisability and process issues

By validity I mean the truth, interpreted as the extent to which an account accurately represents the social phenomenon to which it refers.

Hammersley, (1990, p.57).
Chapter Eight

8 Validation, reliability and generalisability

8.1 Introduction

Kvale (1996) argues that to validate is to question, to check and to interpret on an ongoing basis from the onset of any research process. A number of validation strategies were employed in the current study to reduce potential biases in the researcher’s interpretations of the interviews. Such methods included utilising a validation group, respondent validation, communicative validity, triangulation and the explicit listing of the methodological steps employed.

8.2 Validation Group

Cronbach and Meehl, (1971) referred to validation as a process for developing sounder interpretations of observations (as cited in Kvale, 1996). One means of checking the soundness of the interpretations is to involve others to investigate if they agree or disagree with the observations. Thus, a decision was made to include researcher triangulation, which comprised of a validation group. This group consisted of three clinical researchers who acknowledged the sensitivity of the material and respected the need for careful storage and they were trusted to handle the transcripts respectfully. Scripts were circulated for comment to the validation group members after the researcher had developed a master list of themes. Validity testing involved each member independently analysing the scripts and recording the themes they felt were present in the transcript. The researcher met with each member of the group to discuss the findings and interpretations of the transcripts. Where members of the validation group identified new themes, these were considered for inclusion in the master list.
either as a theme or sub-theme. By checking across cases, the researcher decided whether to retain or omit these themes from the master list.

8.3 Respondent Validation

Miles and Huberman (1994) recommend that researchers seek feedback from participants regarding the findings of their study. They argue that good research goes back to the subjects with the tentative results and refines them in light of the participants’ feedback. Silverman (1997) however, argues that respondent validation cannot be taken as direct validation but instead should be seen as another perspective on the analysis. In this study, it was decided to seek participant feedback and to include this feedback as another perspective on the analysis as Silverman advocates. Thus, the researchers findings could be judged by the reader on their own merits while being informed by the participants’ comments. At the time of the initial interview, participants were asked if they agreed to be contacted in the future to give feedback on the researchers interpretation of the interviews. All eight of the participants agreed to be contacted for this purpose. The collated themes and an explanatory letter were sent to the original research participants for comment and feedback. Two of the eight women participants responded and the interviews were re-visited with their comments in mind. It was hoped that by including their feedback that the research findings would be considered with these comments in mind (Appendix G).

8.4 Communicative validity

The initial findings were presented at the Psychological Society’s of Ireland conference in November 2005. The aim of presenting the preliminary findings was to glean comment from researchers and clinicians. The paper was well received, and the final results will be presented again at conferences in an effort to continue to question
the validity of the results. Kvale (1996) encourages the inclusion of both members of the public and members of the scientific community in the validation process.

8.5 Triangulation

Denzin (1994) advocates the use of several kinds of data and research methods and this he refers to as triangulation. He identified four basic types of triangulation: (a) the use of a variety of data sources (b) the use of multiple methods to study a single problem (c) the use of multiple perspectives to interpret a single set of data and (d) the use of several different researchers. The design of this study incorporates aspects of these four different types of triangulation. Gathering different types of information about this phenomenon from two different sources by using both qualitative and quantitative methodologies incorporates the first two types of triangulation. It was proposed that any overlap between the quantitative and qualitative findings relating to the influence of family and urban-rural background would be evidence of the validity of those findings. The third and fourth type of triangulation procedure, outlined by Denzin, were also utilized. This was achieved by using three clinical researchers to read and highlight themes in scripts and by having the respondents comment on the researcher’s analysis of the interviews. Therefore, the use of “methodological eclecticism” (Hammersley, 1996) was adopted to (a) aid the validation process (b) enrich the findings (c) expand our understanding of this phenomenon.

8.6 Reliability Issues

Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Hammersley, 1996). Shaw (2001) argues that IPA is still in the developing stages and is too new to have attracted a published critical literature. IPA studies are
Chapter 8. Validation, reliability and generalisability

not explicit about how to enhance reliability. Transparency and rigour are often promoted by having a second researcher code the interviews independently (Collins & Nicolson, 2002; Smith, Michie, Stephenson & Quarrell, 2002). Therefore, having a number of clinical researchers analyse the transcripts enhanced reliability. Additionally, methods of reducing bias that have been developed within qualitative methodology were utilized. Kirk and Miller (1986) argue that for reliability to be calculated researchers must document their procedure. Therefore, the method employed to analyse the data is given in the methodology section. The process section (chap. 9) and supervision notes (Appendix M) document the researchers thoughts and decision making during the research process Thus, by outlining the procedure in detail the reliability of the findings can be evaluated by others.

8.7 Generalisability

The findings from the quantitative study have limited generalisability, due to the selection and screening processes used with the sample. Furthermore, the sample of women in the qualitative study, were not randomly selected either and the sample of eight was very small and therefore the findings are not meant to be generalisable. However, inclusion and exclusion criteria were outlined for both studies. Furthermore, although the qualitative findings are not appropriate for statistical generalisation, other types of generalisation may be appropriate. Stake (1994) makes an argument for naturalistic generalisation whereby personal experience leads to expectations rather than formal predictions. Kennedy (1979) argues that for the use of single case studies to generalise whereby the reader could consider the information provided and decide if it could be applied to another situation. Therefore, in the qualitative study, descriptions of
each of the participant were delineated to make it possible for the reader to judge the
typicality of the participant.
9 Process issues

9.1 Introduction

This chapter describes the various thoughts and feelings that arose for the researcher from the onset of this research process. The emotions evoked by (a) the research topic (b) the design issues (c) meeting the participants and (d) having to take responsibility for the findings are outlined. While some of the content described below has been mentioned previously, this chapter aims to capture the personal cognitions and apprehensions experienced by the researcher while carrying out this piece of research.

9.1.1 Process issues before commencing the study

While it was hoped that the participants’ view of their experience was the main area to be explored, I was aware of the dynamic process, which is involved in the research exercise itself. The research interview is an interaction between people, where the interviewer and the subject act in relation to each other and reciprocally influence each other (Kvale, 1996). I was cognisant that access to the participants’ world would be complicated by my own preconceptions (Smith, Jarman & Osborn, 1999).

9.1.2 Potential researcher biases

My knowledge of concealed and denied pregnancy related mainly to cases that colleagues had spoken about in peer supervision and to material that I had read. The picture, which emerged from reviewing the literature in this area, was one where psychiatric issues were seen as the major underlying reason why women delay the disclosure of a pregnancy, and in some cases ultimately kill their unborn. Anecdotal sensationalised accounts of infanticide and neonaticide dominate the research in this
area. I was aware throughout the research process of how negative stereotypes of women who delay disclosure of a pregnancy, could impact on my ability to relate to the participants.

Another pre-existing bias that I brought to the interview process was a vivid memory I had of a tragic story from January 1984. In that case a 15-year old girl, Anne Lovett, gave birth alone in a graveyard in County Longford. Both she and her baby died and it seemed that nobody was aware of her pregnancy. The Irish media covered the issues surrounding this hidden pregnancy extensively. If this was my only concept of an undisclosed pregnancy what transferences would flow into the interview setting?

9.1.3 Efforts to counterbalance bias

These pre-existing influences and bias could not be eradicated totally. However, I felt that awareness of blind spots would encourage me to counteract these transferences. I therefore looked at ways I could instil a collaborative approach on the research process and attempted to engage in the research process in a democratic and respectful fashion.

I was advised by my supervisor from the onset to think about the issues of validity and reliability of the findings of the study and to read the work of Silverman (1997) and Kvale (1996) in relation to these issues. After reading some relevant literature on qualitative research the idea emerged of re-contacting participants with my findings. This idea of involving participants would be a respectful way of including them in the research process and could also act as a means of validating the findings.
Some of the decisions mentioned here were discussed in supervision sessions with my supervisor (Appendix P).

I looked closely at the wording and possible pejorative connotations of words such as concealment and denial. The practice of clinical reflection throughout the research process, both with my supervisor and the social work practitioners, assisted me to consider using the term “late disclosure of pregnancy” instead of concealment or denial. I thought that the phrase “late disclosure of pregnancy” was less negatively loaded than the terms denial and concealment, while encapsulating aspects of both terms as well.

9.1.4 Enhancing sensitivity

I was also aware of the potential distress that the interview process could evoke for the participants. Delaying a disclosure of pregnancy is a sensitive and personal experience and I was aware that talking about it with a stranger could cause distress. I thought of ways that this potential distress could be reduced. For example, some potential participants were deemed inappropriate to contact due to their difficult life circumstances. Contacting all potential participants was deemed insensitive and therefore the decision was reached to have a purposeful sample instead of a representative one.

Another way of reinforcing the sensitivity of the research process was for me to familiarise myself with relevant literature. I knew very little about pregnancy, motherhood or unplanned pregnancies. Therefore, before I telephoned the potential participants or prepared an interview schedule, I made a decision to review the
Chapter 9. Process issues

literature in the area of regular pregnancy, so that I could be genuinely aware of the issues that could arise. I hoped that this would enhance my sensitively when speaking with the women both on the phone and during the interviews.

My supervisor had suggested that I take note of each participant’s presentation both on the telephone when arranging the interview and during the interview itself. These process issues included the tone of their voice, emotion portrayed, their choice of meeting place and what their story evoked in the researcher. What was observed was noted down after the interviews and reflected upon during the transcription and write-up phase.

Given the potential emotional distress that such interviews would evoke, the social work practitioners agreed to do a follow up phone call to participants one week after the interviews had taken place. I saw this back-up support as a vital piece of the research design. If the interview process could potentially distress a participant, then it was essential that a support structure be put in place to alleviate this anguish for the participants. Making contact with the practitioners was also seen as being respectful to them as they were anxious to know how the interviews were progressing and how their ex-clients had presented. In addition, I found this checking-in process with practitioners supportive as it acted as an opportunity for me to debrief regarding the interview process.
9.2 Process issues which arose during the study

9.2.1 Awareness of transferences and counter-transferences

Seven of the eight interviews took place in the participant’s home. This was their choice and it also allowed me to take a step into their world, and in some cases to meet the woman’s child as well. The overriding feeling that resonates for me from interviewing these women is their ability to overcome a very difficult experience and get on with their lives. The majority of those interviewed (6 out of the 8) do not receive support from the biological father of their child, and six of the women receive very little support from their families. Each woman in turn has secured a place to stay, an income and provides for her child. I felt that, at times, it must be a very lonely and difficult task for these women. These were my transferences from the interviews, which needed to be acknowledged and recognised so as to avoid “co-opting” which might lead to emphasising some findings and ignoring others (Kvale, 1996).

The social work practitioners also spoke of their unease about phoning the potential participants. One of them explained this by saying “It is hard to step back into lives after you have left”. They feared unsettling people by reminding them of a difficult time in their life or that perhaps the clients might still have many unresolved issues regarding their experience of pregnancy. The social workers also acknowledged that phone calls to women who they felt they related well with were easier to make. The practitioners felt that the women who agreed to take part were more likely to do this because of this previous positive experience with the service. These transferences were acknowledged openly and it was recognised that the sample was not representative but purposeful.
9.2.2 Researcher’s own anxiety

I approached each participant “blind” in that I knew nothing about their lives other than they had a late disclosure of pregnancy. This decision to “go blind” was taken by the social work practitioners and myself as we felt that disclosures regarding the participants would have been unprofessional and unethical, as the participants had not consented to such an exchange of information occurring. A consequence of this not knowing was that I was always anxious on the day of interviewing. This anxiety was linked to the possibility of upsetting the woman by asking certain questions that the woman may have found difficult or upsetting to answer.

9.2.3 Necessity of reflection

Some interesting process issues arose when I was trying to arrange a venue for one of the interviews. One of the women did not wish to meet at her house or a health clinic and eventually the agreed location was to do the interview in my car. She explained that she was a private person and did not want other people to know we were meeting. When we met she asked that I drive to a forest park where we remained in the car throughout the interview. The woman spoke very softly and remained vigilant throughout the interview to any cars that passed by. Many questions were raised by that particular interview, such as why had I agreed to meet in such a venue? Why did the woman feel that it was necessary to meet in such a way, and by doing the interview in such a location was I colluding with something? The experience felt secretive, covert and somehow sinister. I wondered if this meeting place mirrored this young mother’s view of her undisclosed pregnancy? This woman’s behaviours informed me of how private this research area is and how difficult it was for her to talk to a stranger about that period in her life.
9.2.4 The influence of the social work team

As highlighted previously, my social work colleagues in UCHG were pivotal in the design and execution of this piece of research. Their desire to understand this phenomenon more deeply was the first building block in this research process and this interest was supported by their frontline managers. Their contribution to the screening of participants and the moulding of the inclusion criteria evolved from several debates regarding the balancing of the integrity of the research with the overall welfare of the participants. At times a healthy tension existed between the social work practitioners and myself regarding this balance. However, professional relationships ensured that principles of best practice ultimately underpinned the research process. At times my agenda to push ahead with the research was stalled by the practical realities of the social work practitioners, being too busy to meet or not having had the time to complete the demographic questionnaires. While, I found this frustrating, having worked on the medical social work team previously, I had a clear understanding that casework was the obvious priority of the social work practitioners.

9.3 Process issues during the write-up
9.3.1 Questioning of validity

Process issues were on-going throughout the research process and were present when the interviews were being transcribed into text. Transcription has been referred to as an interpretative process as oral and written languages have different rules (Kvale, 1996). As I listened to the tapes I became aware that I might have rushed the women at times over a pause in the conversation, or perhaps I didn’t pick up on certain cues in my desire to meet my own agenda. I wondered as I listened again to their stories if I was really hearing what they were saying and had I been mindful of the verbal and non-verbal cues of the women.
Chapter 9. Process issues

An anxiety about the validity of the result has been ongoing throughout the research process. From the onset, I have felt privileged to have the opportunity to meet these women and to talk to them about a very difficult time in their life. I had felt the sensitivity of the area to be a heavy burden. I felt each interview was a precious once-off chance. I thought if I didn’t accurately interpret what the women were saying then their true story would remain untold and a precious opportunity would have been lost.

A summary of my interpretations of the interviews was sent to the participants. This process evoked anxiety, as I was conscious that my findings could be difficult for some of the women to read. Would I somehow insult or hurt some of the participants by not highlighting something they had said? This notion of the results being potentially surprising or unsettling to the participants is perhaps a reflection of my own uncertainty about the validity of the findings, which made the respondent feedback even more valuable and relevant.

9.3.2 Researcher’s struggle to interpret and conceptualise

In the analysis phase, participant interviews and validation group feedback were revisited. I found it challenging to step away from the detail of the story and look at it objectively. I decided that deviant cases were to be used to highlight the complexities involved in the many levels of this phenomenon. Not all the findings could be included for the sake of brevity and I found it difficult to drop certain themes, which I found interesting but which did not necessarily relate to late disclosure of pregnancy.
Chapter 9. Process issues

Probably because of my social work training, a model, which seemed to represent the experience of this phenomenon, was a systemic model. Within this model the woman and her individual coping strategies are influenced by her family of origin and by the society in which she lives. This model provides a structure on which to hang the women’s individual stories (Figure 6). I acknowledge that this is just one way of interpreting the findings and many other suitable models may also exist.

9.3.3 Reassurance from validation group

The transcripts tell a very private story and a decision had to be made whether for the purpose of validation certain other researchers would be asked to read and interpret the interviews. They read the scripts ‘blind’ and wrote out their impressions and emerging themes. The feedback from these researchers was reassuring as many of the themes they highlighted were similar to the themes I felt were most prominent in the interviews. This validation group acted as a support as well as a forum for discussion.

9.3.4 Impact of participant feedback

I found the participant feedback very powerful. I received it during the frustrating writing-up phase of the study and it rekindled my belief that this is an extremely important area to explore. The feedback from participants reaffirmed my belief in the value of carefully listening to the voices of this hidden population. It was encouraging that the women felt I had represented their experience accurately. One woman highlighted that by taking part in this research that she experienced some type of validation and comfort knowing that others have experienced a late disclosure of pregnancy. She wrote:
It helped to see it written down on paper, that other women have gone through the same thing. Before this report I thought no one else went through it, it helps to know that I’m not the only person who felt these things when I was pregnant and they went through the same thing with family and their partners.

The therapeutic aspect of the research process was the most personally satisfying result of the research and one I had not considered fully prior to embarking on this study. However, only two of the participants returned the feedback sheets, which was disappointing. Possible explanations for this poor return rate vary from participants mislaying the documentation to not wanting to comment on the report. If more time was available, I feel it would have been better to meet the participants in person to gauge their feedback instead of relying on written correspondence (Bourque & Fielder, 2003).

9.5 Ongoing process issues

I remain anxious about how the research will be received. I hope it is credible in its attempt to make sense of the late disclosure of pregnancy. I wonder too whether the research will bring attention to this topic if and when it is published. Many of the women who took part said their rationale for doing so was in the hope of helping others; I wonder if this aim will be achieved. Will other women who are delaying the disclosure of a pregnancy somehow benefit from this research? Will certain professionals be more informed because of this piece of research? These questions remain unanswered at present but I do aim to disseminate the findings to the social work team and the maternity nursing staff in UCHG. In this small way at least I can start an awareness raising process in one organisation and potentially improve staff’s understanding of this complex phenomenon.
Section Six: Discussion

The domain of the personal is a difficult and potentially emotionally disturbing area to start to unpack, but to deny our feelings and our constructions would be to shut out one large part of the research experience.... At the same time, we need to remain emotionally vital enough to step back and appreciate its general contours and overall significance.

King, (1995, p.175)
10 Discussion

10.1 Introduction

The discussion is structured so as to summarise the main findings of both studies and then highlights how these findings address the aims of the thesis. The qualitative and quantitative findings will be discussed in an integrated fashion, where appropriate with recommended future areas to research. Following on from this, the clinical and methodological implications of the findings will be outlined. Additionally, the limitations of the present study will be considered and suggestions for future research design and a summary of future research questions will be outlined.

10.2 Summary of the findings

The main finding from the qualitative section of the thesis is that the phenomenon of a late disclosure of a pregnancy is a dynamic, complex multifaceted and at times adaptive concept. The meaning of late disclosure of pregnancy encompasses aspects of denial and concealment. The majority of the women interviewed were aware of the physical reality of being pregnant and altered their life style accordingly. However, they continued to keep the pregnancy hidden by using cognitive processes and behaviours, which were influenced by the many other systems that surrounded them at the time. Many of the disclosures seemed to take place in a gradual and limited manner. In some cases the concealment continued after the birth of their child, highlighting the temporal aspect of this phenomenon. For the most part, the women interviewed who decided to parent were satisfied with the decision, but acknowledged having had
difficulty bonding in the initial few weeks, which may be related in some cases to the lack of pre-natal attachment behaviours. The one woman who placed her child for open adoption continues to struggle with the open adoption process.

The quantitative findings highlighted that this phenomenon occurs across a wide age range but that it is most common in women in their early twenties. The women in the target group tended to be in an educational settings or employment. These women were predominately single and Irish nationals. Having a rural background was found to be a significant factor as to whether someone delayed the disclosure of a pregnancy and perceived family reaction was reported to be a significant factor adding to the stressful situation. Additionally, a larger number of women from the target group placed their children for adoption than women in the comparison group and long-term support from social services was more common for women in the target group than the comparison group.

10.3  Aim one: To explore and expand the concept of late disclosure

The primary aim of this thesis was to explore the meaning of the phenomenon of late disclosure of pregnancy from the perspective of women who have experienced such a pregnancy. It was hoped that by learning from these women that the meaning and boundaries of the phenomenon could be clarified. The main findings outlined by this thesis relate to the dynamic, temporal and adaptive nature of this experience.

10.3.1 A continuum model

Many of the women reported using defence mechanisms such as thought repression or avoidance techniques as a way of coping with their unplanned pregnancy and the majority of the women in study one described being physically aware of the
pregnancy due to foetal movements or because of weight gain. The situation where a woman is aware of her pregnancy but hides it, fits with the concept of less blatant denial as described by Maldonado-Duran et al., (2000) or the concept of concealment as defined by Wessel et al., (2003).

The women reported that they experienced some level of “denial” and spontaneously used the word denial to explain their experience. However, the women also used the words “concealment”, “hidden”, and “secret” to explain their situation. They explained that because they did not fully admit to themselves that they were pregnant, they could not disclose the pregnancy to their social support network. It seems therefore, that from the point of view of those who have experienced a late disclosure of pregnancy, it is a dynamic phenomenon in which both the processes of denial and concealment are involved to a greater or lesser degree. Concealment explains part of this experience but aspects of denial play a role particularly in the earlier stages of the pregnancy. Consequently, both the concepts explain aspects of this complex phenomenon.

The notion of a woman moving along a continuum between denial and concealment towards disclosure is one interpretation of these findings. Berns (1982) also hypothesised that a continuum of behaviours existed which ranges from simple concealment to professed unawareness of pregnancy. The current finding provides an empirical basis for Berns’ (1982) suggested continuum of behaviours, which was based on her clinical reflections with this population. This continuum model offers a broader understanding to this phenomenon than the definitions previously outlined in the
Chapter 10. Discussion

research (Brezinka, Hunter, Biebl & Kinzl, 1994; Finnegan, McKinstry & Robinson, 1982; Milstein & Milstein, 1983; Spielvogel & Hohener, 1995).

10.3.2 Temporal nature

A second finding from the qualitative data was that the concept of late disclosure does not end at the birth of the baby, thus expanding on Berns (1982) continuum model with an extra dimension. Some of the women reported that collusion and secrecy continued into the child’s first and second year of life. Many of the women have not informed the biological father, about the baby and certain family members have not been informed either. The notion that this phenomenon is on-going after the birth of the child has not been previously documented in the literature and is an area that merits further enquiry. This expansion and development on previous work is a major finding in the present study.

10.3.3 The potentially adaptive nature of the phenomenon

A third finding not previously acknowledged in the literature is the adaptive nature of the experience. The terminology used to describe this phenomenon often includes terms such as conversion disorder (Kaplan & Grotowski, 1996) or adjustment disorder (Brezink et al., 1994). These terms suggest something that is irrational, maladjusted or disordered. However, the women’s reasons for delaying disclosure, i.e. uncertainty about the outcome or a fear of rejection from their family sometimes seem to be well thought-out, rational and reasonable. For example, one woman described delaying the disclosure so as to prevent her parents from forcing her to terminate her pregnancy. In this way the woman may be acting to protect her herself and her unborn child. It seems that previous attempts to explain this phenomenon have not
acknowledged the logical, and at times adaptive explanations for delayed disclosure of pregnancies. This finding concurs with other research regarding the concept of denial, which suggest that denial can have some adaptive functions in cardiac illness or cancer (Goldbeck, 1997; Julkunen & Saarinen, 1994; Strauss, Spitzer & Muskin, 1990;). Therefore, the literature in this area needs to be reviewed with caution, as much of the terminology is derogatory and negatively biased, and fails to recognise the functional facets of this phenomenon.

10.4 Aim two: To create a conceptualisation of this phenomenon

Why this phenomenon occurs is a very complex question. However, the current findings offer a novel way of conceptualising this experience and consequently have theoretical implications. It is formulated that individual, familial and societal factors play an interconnected and complicated role in this experience. Following the interpretative analysis of the themes relating to individual, familial and societal factors, a systemic bi-directional model is suggested as a way to conceptualise this dynamic phenomenon. This systemic model has not been proposed previously in the literature regarding late disclosure of pregnancy and thus the current findings can be interpreted as a move towards the generation of a theoretical framework, which integrates the multiplicity of factor, which contribute to a woman’s late disclosure of pregnancy.

10.5 Aim three: To explore the psychological and physical aspects of the process

The analysis of the findings revealed that the psychological and physical aspects of this process are complex and convoluted. The individual cognitive processes and family dynamics will be presently delineated.
10.5.1 Individual problem-solving style

The eight women interviewed were asked about their style of solving problems. From their descriptions, two coping styles were identified which facilitated their decision to delay disclosure. The style adapted by the majority of the women referred to was where they solved difficulties on their own, privately and without assistance from others. The minority style, which was used by just one of the women, had an optimistic-fatalistic style of believing that things would just work out. Illuminating self-reliant coping-style as an attribute of this phenomenon is a novel finding. This finding merits more detailed investigation with this population. Future research could investigate the factor of internal and external locus of control and its impact on decision-making during a delayed disclosure of pregnancy. Plotnick (1992) examined the factor of locus of control in an adolescent sample during pregnancy. He found that the impact of locus of control on premarital pregnancy is minor. However, given the developmental differences that may exist between the target population in the current study and a teenage population, locus of control is an area that merits further research.

10.5.2 Individual beliefs regarding adoption

One explanation for late disclosure of pregnancy that was raised in the interviews was the women’s intention about the outcome of the pregnancy and the desire to have their baby secretly adopted. The quantitative study also highlighted the inclination of those who had delayed disclosure to be more likely to place their child for adoption than other women who had a crisis pregnancy. This link between delayed disclosure and the decision to place a child for adoption is another innovative finding that has not been cited previously in the medical or the psychological literature.
10.5.3 Mental Health

In the interviews, three of the women spoke of experiencing symptoms synonymous with peri-natal and post-natal depression. This is not surprising, given the relationship between mental health difficulties and regular pregnancy, repeatedly outlined in the research (Sadock & Sadock, 2003) where pregnancy and childbirth are noted to be times of increased vulnerability for the woman. The exact prevalence of peri-natal and post-natal depression in this population is a question that merits more attention.

10.5.4 The bonding process

Siddiqui and Hagglof (2000) studied prenatal attachment behaviour. They hypothesised that these behaviours were a good predictor of early mother–infant relationships in regular pregnancies. Consequently, issues regarding attachment and the bonding process were raised in the qualitative interviews. Explanations as to why the women did not prepare themselves psychologically or practically for the eminent arrival of their child, ranged from repressive-type thinking to uncertainty about what to do. Even the women who were somewhat psychologically or physically prepared for the birth, reported bonding problems. These qualitative findings, although from a small sample, go some way towards supporting the work of Leifer (1977), who reported that those who show less attachment behaviour towards their unborn, experience more postpartum adjustment difficulties.

Factors highlighted by the women that assisted the bonding process, included having a supportive partner or a supportive family. These findings concur with research from non-complicated pregnancies (Cranley, 1984). While the bonding process may
have been difficult initially, the majority of the women interviewed, reported to have a positive relationship and a strong bond with their child. Many reported an improved outlook on life since they became a mother. These findings of mothers feeling rewarded by her infant and having an enhanced self-image are similar to findings in studies that looked at ‘regular’ pregnancies (Mercer, 1995). Therefore, the initial attachment difficulties did not seem to persist with this target population. However, the question of maternal attachment style and long-term effects of initial difficulties would benefit from more long-term focused research to see what ameliorating factors assist in the bonding process over time.

10.5.6 Underlying individual issues which may contribute to the phenomenon

Domestic violence and previous sexual trauma have been cited as playing a role in delayed disclosure of pregnancy (Hollander, 1997; Spielvogel & Hohener, 1995). However, given the once-off nature of the interviews, questions relating to these sensitive issues and potentially traumatising areas were considered inappropriate (King, 1996). In the quantitative information that was collated from social work files, one incident of rape and one incident of childhood sexual abuse were recorded as underlying issues for two of the women who had a late disclosure of pregnancy. Experiencing bereavement, having a learning disability or mental health difficulties were issues that the quantitative study found to exist for a number of women from both the target and the comparison group. These issues have been cited by other researchers as possible precipitating factors for the experience of a delayed disclosure of pregnancy (Brezink, et al., 1994). Therefore, the current findings support previous research that suggests that women who delay the disclosure of pregnancy are coping with several difficulties simultaneously.
10.5.7 Influence of family members

In the majority of the interviews, the women reported being asked by family members if they were pregnant before they disclosed this information. Furthermore, two of the families actively encouraged the woman to continue concealing her baby after the birth of the child. These findings suggest that denial was an active coping strategy for the family members and their way of coping with the unplanned pregnancy. This observation fits with the body of research that views family interactions as a circular process in which each member of the family affects the other and the family as a unit (Brackbill, White, Wilson & Kitch, 1990; Dallos & Aldridge, 1987; Wilson, Hall & White, 1994).

10.5.8 Perceived family reaction

Fear of parental reaction was cited by several of the women as the main reason to delay disclosure. Fear of parental response to pregnancy has been noted in the literature regarding adolescent populations (Moss & Hensleigh, 1990). In the quantitative study, which consisted of women ranging in age from 15 years old to 42 years old, perceived family reaction emerged as one of the most significant reasons for not disclosing. Therefore, this piece of research reveals that fear of family reaction to a pregnancy seems to be a reality for women of various ages and not just a fear that exists during the teenage years.

10.5.9 Family dynamics

Spielvogel and Hohener (1995) suggested that maternal deprivation could be a significant factor in concealed and denied pregnancy. While this issue was not
approached directly in this study, five of the eight women interviewed, did describe their relationship with their mother as poor. This was a thought-provoking finding, as in the cases where a poor maternal relationship existed, the women received very little support from their family once they did disclose. The lack of support from home was described by several of the women as the most distressing aspect of their experience and one, which was difficult to cope with. This area merits more focused exploration and more qualitative interviewing to examine in detail the mother-daughter relationship dyad.

Other researchers have suggested that early relationships with parents become internalised and are thought to have enduring effects on the adult’s social interactions and ability to seek and receive support (Flaherty & Richman, 1986; Sarson, Sarson & Pierce, 1990). It would be interesting for future research to explore the attachment styles of mothers who delayed disclosure and whether these attachment styles contribute to bonding difficulties they experienced with their own child.

10.5.10 Physical outcomes of pregnancy

The minimal weight-gain noted by five of the women interviewed has also been reported in other research papers (Brezink et al., 1994; Finnegan, et al., 1982;). However, the reasons why these women do not experience weight gain, remains unexplored. The majority of the women who were interviewed reported having a healthy balanced diet during their pregnancy. They also reported a reduction in alcohol consumption and attempts to significantly reduce their smoking. Therefore, when the physical aspects of good antenatal care such as a healthy diet and lifestyle are present, other psychological factors may be contributing to the explanation as to why the women involved only experienced minimal weight gain. However, it should be noted
that such questions regarding the women’s antenatal behaviour could have encouraged the women to report a socially acceptable answer (Borque & Fielder, 2003) and therefore the finding should be considered with caution.

The quantitative findings highlighted that neonates in the target group were found on average to have a lower birth weight than that of neonates who experienced a crisis pregnancy. This finding of lower birth weights concurs with previous research (Rodie et al., 2002; Treacy et al., 2002; Wessel et al., 2003). The reasons why the neonates have a lower birth weight remain unknown. Research has highlighted that social support can influence the psychosocial outcomes of pregnancy but not medical outcomes (Hodnett & Frederick, 2003). Future research with this population could consider the influence of psychological factors. The impact of anxiety or low mood, for example, on maternal weight gain during pregnancy and on neonatal birth weight could reveal new dimensions of this experience, as higher levels of anxiety and depression have been noted in single parent families (Hall, Gurley, Sachs & Kryscio, 1991; Green, 1990).

10.6 Aim Four: Add to demographic information
10.6.1 Prevalence rates

The prevalence rate of late disclosures of pregnancies reported in this Galway-based study was 1 in every 148 births. This rate is higher than that reported in a Dublin based study (1 in 765 births) carried out in the Rotunda maternity hospital (Treacy, et al., 2002). However, the prevalence reported in this study is lower than the rate reported by Fox (1 in 36 births) in 2004. One reason for the differences may be that the definitions used in these studies differed. Furthermore, the Fox study was carried out in
Chapter 10. Discussion

a hospital in County Galway, which serves a predominately rural population. University College Hospital Galway serves both a city and rural population and this may further explain some of the differences in prevalence rates reported in these three Irish hospital based studies.

The quantitative part of this study highlighted that a significantly larger number of women who delayed disclosure of their pregnancy were from rural backgrounds. This had been reported in previous case-study type of research (Finnegan, et al., 1982). A study is currently being undertaken to directly compare prevalence rates between rural and urban-based hospitals and awaited findings should be revealing (C. Conlon & C. Fox, personal communication, May 15, 2005). These awaited findings should help clarify the role that urban and rural background plays in influencing prevalence rates of this phenomenon.

10.6.2 Reoccurrence of delayed disclosure of pregnancy

Two of the eight women interviewed, had previously delayed disclosure of a pregnancy. The quantitative data also highlighted that 7 of the 43 women in the target group had previously delayed the disclosure of their pregnancy. The many systems, which surround the women, may play a role in explaining why women find themselves delaying a disclosure of pregnancy on more than one occasion. Further exploratory-style research involving women who have experienced this phenomenon more than once, will help answer such questions.

10.6.3 Biological fathers

Some interesting serendipitous findings, relating to fathers emerged from both the qualitative and quantitative studies. In the quantitative study, one of the findings
was the lack of recording of biological father’s details on social work files. The biological fathers details were not gathered in the larger UCHG obstetric report either. The social work practitioners noted that when a woman presents in crisis, the details regarding the biological father are not seen as significant at the time. An explanation for this could be that approximately half of the women in this study were single at the time of presentation to support services.

This tendency not to enquire about biological fathers was mirrored in the qualitative study. The women were asked about the biological father but they did not expand much about the details other than he had been supportive or unsupportive and the researcher did not enquire further. Thus, a stark finding of this study was the absence of fathers from the lives of their children and the failure by professionals to respectfully question this absence. Future research into late disclosure of pregnancy should actively focus more on the fathers who have been supportive of their partners and their experiences of the late disclosure. These fathers may have feedback regarding the barriers they faced within a maternity setting. These men may also have ideas of how other fathers could be included more in the pregnancy process.

10.6.4 Age

Stotland and Stotland (1998) argue that immaturity; lack of experience, ignorance, lack of resources and sheer terror could partially explain why a woman would delay the disclosure of a pregnancy. While the women interviewed, spoke about being shocked regarding their pregnancy, they did not present as immature. The average age of the women interviewed was 21 and two of the eight women had other children and were not inexperienced regarding pregnancies. The quantitative section of
the study revealed that teenagers were not overly represented in either the late disclosure group or the crisis pregnancy group. The findings of these two studies highlight that delayed disclosure of pregnancy is certainly not exclusively a teenage phenomenon. Therefore, the proposal from Kaplan and Grotowski’s, (1996) New Zealand based study, which reported that teenaged girls comprised the majority of cases of delayed disclosure, was not supported in an Irish sample. This finding adds weight to the relevance of cultural influences on this phenomenon.

10.6.5 Education and employment status

The quantitative findings highlighted that the majority of women in the target group were either in third level education or employed at the time of their pregnancy. These finding are contrary to a previous study, which investigated an Irish sample, (Treacy, et al., 2002) in which the majority of women were unemployed. However, the sample sizes in this current study were small and potentially biased as Galway is a small city with two large third level educational facilities. A larger quantitative study is required to examine the status of these socio-demographic variables in this population.

10.7 Aim five: To explore the role of cultural influences

10.7.1 Nationality

A much smaller percentage of women in the target group and the comparison group, were foreign nationals, compared to the larger proportion of foreign nationals that delivered in UCHG in 2003-2004. This finding suggests that delayed disclosure of pregnancy is more a problem for Irish nationals than foreign nationals. The reasons why more Irish women delay the disclosure of their pregnancy than foreign nationals are not fully understood. One interpretation of the findings could be that in cases where
Chapter 10. Discussion

A foreign national has an unplanned pregnancy there is a lack of cultural/familial influence on the pregnancy process as the individual women are away from their family and country of origin and are in this respect are not as pressured by these systemic influences. To answer the question regarding the role of nationality in this phenomenon more research that involves foreign nationals who have delayed their disclosure of pregnancy is needed.

10.7.2 Stigma

The research by Loughran and Richardson (2005) highlighted that being an unmarried parent is still stigmatising in Ireland. Findings from Loughran and Richardson’s study and the present research, illustrate the real sense of shame and stigma that still exists for some Irish women who have a child outside marriage. More focused research, which examines the international findings relating to delayed disclosure of pregnancy would be helpful. Such international research may help clarify which specifically Irish cultural nuances play a part in explaining the occurrence of this phenomenon in this country.

10.7.3 Mental health, neonaticide and cultural issues

A link has been established in the literature between delayed disclosure of pregnancy and an increased risk of infanticide and neonaticide (Spinelli, 2001; Stotland & Stotland, 1998). The literature in the area comprises of anecdotal accounts of how mothers with serious mental health difficulties have fatally harmed their newborn infants. The role that cultural attitudes play in infanticide have been overlooked in the psychological literature, which seems to focus on the micro-system level such as the woman’s mental health status (Miller, 1990; Neifert & Bourgeois, 2000).
One woman in the present qualitative study spoke about her attempts to induce a miscarriage during her third pregnancy. This was the only participant that expressed a desire to harm her unborn child. Perhaps in this study the woman’s mental health status did play a role in her attempts to induce a miscarriage. However, research has demonstrated that being a single mother, placing a baby for adoption or having a termination are all value laden terms that are stigmatising (McCashin, 1996; Mahon et al., 1998). Women who choose any one of these options report feeling judged and stigmatised. Perhaps at some level, experiencing a miscarriage would have offered the woman an escape from the judgement of others. This thesis suggests that a macro-systems view of one woman’s desire to miscarry is a more useful and meaningful perspective than one, which focuses solely on the mental health status of the individual.

10.8 Aim six: Practice and policy implications

10.8.1 Practice implications

The findings from the present research suggest that by adopting a systemic conceptualisation, practitioners understanding and interventions regarding this phenomenon could be enhanced. The findings advocate that individual, familial and cultural systems are all involved in a woman’s decision-making process towards the delayed disclosure of her pregnancy. The current findings propose that practitioners working with this population should be cognisant of:

1. The multi-dimensional and complex nature of a late disclosure of pregnancy, which advocates an understanding and sensitive approach.

2. The potential relationship between peri-natal and post-natal depression and late disclosure of pregnancy.
3. The broad age range of women who experience this phenomenon
4. The role a woman’s individual coping-style plays in this phenomenon and the validity of encouraging other coping strategies.
5. Appreciating the role a woman’s family plays in this phenomenon and a woman’s fear of her families reaction to her unplanned pregnancy.
6. The need to challenge the fallacy of secret adoptions and provide women with accurate information regarding contemporary adoption policy

The reoccurrence of this phenomenon is another important finding from both the quantitative and qualitative studies. This finding suggests that if a woman delays the disclosure of a pregnancy on one occasion she may be more at risk of delaying the disclosure of future pregnancies. This finding has clinical implications for the practitioners working with this population. Research from teenage pregnancy prevention strategies could perhaps help inform practice in relation to addressing this issue of reoccurrence. Previous research with teenage pregnancies suggests that attending to the issue within the context of the individual, family and community and advocates that a systemic model is a more effective way of trying to change behaviour (Knott & Latter, 1999; Tabi, 2002). The systemic model proposed by this current study marries well with the findings from teen pregnancy research and may be useful to social work practitioners when they are considering methods of intervention with women who delay disclosure of their pregnancy.

10.8.2 Policy implications for medical staff

Many of the women interviewed reported being mistreated and patronised by nursing staff. Judgemental and unhelpful attitudes have been reported in studies
looking at single mother’s perceptions of health visitors (Knott & Latter, 1999). No literature on single mothers perceptions of maternity nursing staff in an Irish context could be located. However, research from an Australian study reported that young single mothers have reported experiencing negative attitudes directed towards them by nursing staff (Hanna, 2001).

The negative experiences reported in the interviews raise important serious practice issues. The findings suggest that women who present in a maternity ward without an antenatal history may be subjected to unprofessional staff behaviour and that nursing staff may be unskilled in dealing with this complex case where a mother is uncertain about keeping her child. Awareness raising, education and training have been found to help medical staff practice in a more professional non-judgemental fashion (Majumdar, Keystone & Cuttress, 1999). The current findings suggest that by creating clear multi-disciplinary policy and practice documentation relating to delayed disclosure of pregnancy situations, staff may feel more informed and competent when working with this population.

10.8.3 On-going support requirement

Overall, support services remain involved in the vast majority of cases where a pregnancy had been undisclosed. This implies that women who delay disclosure of a pregnancy do require on-going support post delivery. Loughran and Richardson (2005) called for an increase in the availability of post-natal support counselling for women who experience a crisis pregnancy and choose to either parent or to place a baby for adoption. The current finding is relevant to service providers involved with this
population and resources will need to be made available to develop and sustain long-term intervention for this vulnerable population.

10.8.4 Adoption Policy

Open adoption refers to the sharing of information and contacts between the adoptive and biological parents of an adopted child, before and/or after the placement of the child and perhaps continuing for the life of the child (Berry, Cavazos, Barth & Needell, 1998). Research, which examines the impact of the process of open adoption, is limited (Richardson, 2003). Furthermore, the findings from Loughran and Richardson’s (2005) study underline the fact that the long-term consequences of open adoption have not been thoroughly considered. Monica’s story, illuminated in study one, highlights the life-long nature of her decision to place her baby for open adoption and the distress she experiences by the ongoing contact with her child. The current policy in Ireland of encouraging open adoption does not appear to be informed by research. More Irish based qualitative and quantitative research is required to expand our limited understanding of this complicated and painful adoption process. Such findings will inform policy and consequently practice in the arena of adoption and will be evidence-based.

10.8.5 Discriminating policy and practices

The current findings raise interesting practice issues for the social work practitioners and psychologists working with this population. It is not clear how fathers can be involved while simultaneously respecting the mother’s point of view. Other researchers have suggested that service providers are viewed by fathers as constituting an additional barrier to paternal involvement. (Allen & Doherty, 1996; Speake,
Cameron & Gilroy, 1997). Bunting and McAuley (2004) suggest that anti-discriminatory policy and practice necessitates recognising sexism in the practitioners, in the family system, statutory systems and in society. For example, by reflecting on the findings of this study the two social work practitioners involved in this study are mindful of being more inclusive of fathers and working more from a child’s rights perspective. The current finding highlights the need to create an anti-discriminatory policy and practice in relation to inclusion of fathers in childcare matters.

10.9 Methodological implications

Overall, from the interviews a wider conceptualisation of this phenomenon emerges which demonstrates the value of taking a qualitative approach in exploring this under-researched area. This approach helped to illustrate how complex and varied the experience of a late disclosure of pregnancy is for the women involved. A new rich source of data has been accessed, which highlights the temporal, dynamic and often functional nature of delayed disclosure of pregnancy and offers an expanded alternative to the static medical explanations previously suggested in the literature. Without using a qualitative methodology these new insights would have been difficult to access and these novel findings supports the use of this style of research when researching complex human experiences (Smith, Michie, Stephenson & Quarrell, 2002). More qualitative work in this area will enhance practitioners’ awareness of the complexity and sensitivity that is required to engage with women who are placing a baby for adoption. However, as this study also highlights, women who place a child for adoption can be reluctant to be involved in research.
10.10 Limitations of the present study

10.10.1 Biasing effects of sampling and screening methods

The main limitation of the current research is the nature and size of the samples in the study. Given the sensitive nature of the topic, many people who were asked to participate in the qualitative study declined the invitation. Another factor related to the sensitive nature of this area was the use of purposeful sampling as opposed to random sampling. The logic and power behind purposeful selection of informants is that the sample should be information rich (Patton 1990) and this was the case with the sample selected but the sample size was low.

A link has been made in the literature with late disclosure of pregnancy occurring more often in women with mental health difficulties (Spinelli, 2001; Stotland & Stotland, 1998). However, individuals with serious mental health difficulties were screened out of the present study. Furthermore, women who may have decided to keep their pregnancy a secret before they terminated their pregnancy were not represented in this sample. Therefore, the sample is biased in these respects and this must be remembered when considering the findings.

Attempts were made via the Teen Parents Project at UCHG to interview teenagers who had delayed the disclosure of their pregnancy. Given the developmental differences between teenagers and adult women’s problem solving styles (Herman-Stahl & Petersen, 1996), differences in their experience and reasons why they delayed their disclosure were expected. However, it was not possible to link with any teenagers regarding their experience, and thus the phenomenon remains unexplored with this population.
Women who placed their child for adoption were also poorly represented in the qualitative study with only one woman being interviewed. Although attempts were made to link with these women via their community care social worker, the vast majority of the women who were approached declined to take part. This is worthy of note but also disappointing, as their stories remains untold.

The quantitative sample for the target and comparison group was taken from the social work files in UCHG for the years 2003-2004. These records give a picture of delayed disclosure of pregnancy and crisis pregnancies within that specific social work department at that given time only. Details relating to cases that were not referred to the service, clients who did not link with the service, or clients who presented to other hospitals remain unknown. Thus the findings have limited generalisability.

10.10.2 Problems with data collection

When the demographic information for the quantitative study was being collated, it was noted that information on the biological fathers was not recorded in many of the files. While the lack of recording is significant it also limits the study in that no real conclusions can be made regarding the fathers and their involvement in the process in the quantitative study. Also, seven of the birth weights were missing as seven women had delivered in other hospitals. This missing data reduced the sample size available when looking at neonate birth weight.

Another problem with the data relates to the medical team not being in a position to carry out the planned analysis regarding maternal complications at birth.
Therefore, the relationship between late disclosure of pregnancy and maternal complications in this specific population sample remains unknown as yet.

A third problem involves the poor return of feedback forms from participants. This is disappointing and the researcher is unsure as to why this occurred. This poor return means that the expected function of this data of adding to the validation process is limited.

10.10.3 Issues with the design of the studies

By utilizing a comparison group of crisis pregnancies in study two, certain normative data was not available when comparing the two groups. A more comprehensively designed study would have included data from a normative group. The problem with such a normative participant sample is that their information would not be in social work files, as in most instances planned pregnancies are not referred to the social work service in UCHG. However, certain demographic information may be stored in their medical files and thus such a design could be feasible in the future.

A second issue regarding design involved the wording of certain socio-demographic questions. The education and employment status question was confusing and poorly constructed. There should have been two separate questions relating to these variables. This problem in design was not picked up in the pilot study and made the analysis of this question very difficult.
10.11 Suggestions for future research design

10.11.1 Future potential samples

The process of carrying out this piece of research highlighted the large number of social workers and nursing staff working with this population, within both hospital and community care settings. These professionals have many years experience and many hold insights that have been overlooked by this study. Future research would benefit from engaging with social workers, nursing staff and support services personnel who work with women who have delayed the disclosure of their pregnancy. Talking to these professionals could tap into much of the knowledge that practitioners have accumulated. This expert knowledge could reveal other facets to this multidimensional concept and act as a foundation for future research questions. Furthermore, information regarding this population is recorded in files in various services nationwide. A large-scale quantitative study could be designed that examines some of the questions raised by this study. By gathering a more representative sample from various services, a more comprehensive understanding of this phenomenon would emerge.

The findings from this thesis highlight the role played by family members in a delayed disclosure of pregnancy. Future qualitative researchers should engage with family members of the women involved, to assess the level of awareness people had of the pregnancy before it was disclosed. It would be valuable to explore the familial rationale for encouraging ongoing concealment and secrecy regarding the pregnancy where this occurred. Such research could reveal more details of the impact of delayed disclosures on family systems and support systems. It is important to gather different perspectives regarding this phenomenon; as such research could highlight the potential merits of social work practitioners adapting family-interventions regarding this
complex phenomenon, where appropriate. However, engaging with family members of
the women who delay a pregnancy, will require the researcher to be sensitive to matters
concerning consent and confidentiality of the women involved in the first instance.

10.11.2 Difficulty with research with vulnerable populations

The concept of stigmatisation of single mothers, adoption and termination is
worthy of note and it was a theme that emerged for a number of the women
interviewed. Perhaps this sense of stigma could partially explain why only one woman
who had placed her child for open adoption agreed to take part in the research. Future
research needs to consider more sensitive and creative ways of involving women who
have placed their children for adoption in the research process.

10.11.3 A Collaborative research style

The benefits of collaborative research were perhaps one of the most illuminating
findings this study revealed. Any future research with this vulnerable population would
benefit from using a similar partnership between practitioners, participants and
researcher. The main advantage of this approach was it facilitated a research design that
was driven by principles of good clinical practice. These principles of good practice
assisted the respectful treatment of participants from the beginning to the end of the
research process as well as facilitating access to the sample.

In summary, future research should take a narrower focus on some of the questions
raised here, for example:

(1) What role does locus of control play in the experience of coping with a late
disclosure of pregnancy throughout the developmental spectrum?
Chapter 10. Discussion

(2) What is the trajectory when placing a child for adoption? What is the impact of open adoption on the individuals involved?

(3) What role does maternal attachment patterns play in the process of delayed disclosure of pregnancy?

(4) What role do psychological factors such as anxiety and depression play in the physical and psychological outcomes of a delayed disclosed pregnancy?

(5) How is the phenomenon of delayed disclosure experienced by significant others such as family members and biological father?

(6) How does a rural upbringing and specific cultural factors influence the process of late disclosure of pregnancy?

10.12 Conclusions

This piece of research brings attention to an area that has been neglected in psychological literature. As a result of speaking to women with direct experience of this phenomenon, a systemic conceptualisation of this dynamic, temporal phenomenon has been proposed that adds to our theoretical understanding of late disclosure of pregnancy. The benefit of using a qualitative methodology such as IPA to explore this sensitive area has also been demonstrated and revealed the potentially adaptive nature of late disclosures. Furthermore, the findings have pointed towards practical suggestions for social workers, nursing staff and psychologists working with this population. The findings also have suggestions for those developing policy relating to service provision for this group. Additionally, ideas regarding the design and direction of future research have been outlined. Future research with this population will add further to our understanding of this complex human experience, which is influenced by individual, familial and cultural factors.
References
References


Richards, H.M., & Schwartz, L.J. (2002). Ethics of qualitative research: are there special issues for health service research? *Family Practice, 19*, 135-139.


Appendices
Appendix A: Telephone protocol

Hello. This is X /Y calling from the social work department/ teenage parenting project/ in UCHG. Is this a good time, can you talk at the minute?

The reason I am ringing you today is because we are planning a research project in our department. An ex colleague Clare Thynne is interested in looking at the experience of women who have a late disclosure of pregnancy. The main reason for doing the research is to try and learn more about women who disclose their pregnancy late so we can try and improve the service that women receive. I suppose we are trying to understand your experience better.

Clare has asked that I contact women that I have met in the past two years who have experienced a late disclosure and we are wondering if you would be interested in talking to her.

She plans to visit people in their homes if that was suitable and speak to you for an hour about your experience, i.e. what would have helped you or what were your biggest fears at the time you discovered you were pregnant. She hopes to tape the conversation and to put the information together and submit it to NUI Galway as part of her thesis.

No identifying information like i.e. name, address date of birth will appear in the study. Thus the information will be confidential.

The most important thing is that taking part in the study is voluntary. If you do not wish to take part or wish to withdraw at any stage your medical treatment in UCHG or the social work service in UCHG will not be compromised.

Do you think you would be interested in talking to her?
Have you any questions or queries?

If no. Thank you for your time and all the best
If yes, well can I send you out on information sheet explaining the study a little more what address will I send that to? Will anyone else open your mail?

With your permission Clare will call you in a few weeks time to arrange a date, a time and a place to meet. If you have questions please contact us here in the social work department or Clare on 0860867251.

Regards X
Appendix B: Application to UCHG ethics committee

Dr
Chairperson of the Ethics Committee,
Galway.
21. 12. 2004

Dear Dr

Please find enclosed my application to the ethics committee. The area I am interested in researching is area of concealed pregnancies. Limited research exists in this area and the research to date tends to focus on the physical risks to infants who have been concealed.

The main objective of my study is to explore this phenomenon by speaking with women who have direct experience of a concealed pregnancy. I am interested to know how they perceived this pregnancy and whether they feel their experience of pregnancy had any psychological impact on them or on their relationship with their child. I am also very interested in the reasons why women felt it was necessary to conceal their pregnancy.

This proposal stems from a real interest from the medical social workers in UCHG wishing to know more about this phenomenon, which they encounter regularly in their work. The proposed sample would be women, who have concealed their pregnancies and who had contact with the MSW in UCHG between January 2002 and December 2004 (N=30). The suggested matched control group would comprise of 30 women who had crisis pregnancies during this time frame who also had contact with the MSW department in UCHG. This control group of women did not however conceal their pregnancies.

The research proposed, will be mainly qualitative interviews (N=10) with women who have concealed their pregnancies. Emerging themes from these recorded interviews will be coded and collated. Demographic information of the larger sample and the control group will be collated by the medical social workers and analysed quantitatively. This may yield a profile of factors that are common in this unique target population.

Ultimately, the main aim of the study is to learn more about this phenomenon and to hopefully inform the health professionals working in this area as to why some women conceal their pregnancy and how the women involved perceive the impact of this experience.

Please find enclosed a copy of my proposal. I appreciate your attention to these matters.

I look forward to hearing from you in the New Year.

Sincerely,
Clare Thynne.
Clinical Psychologist in training (clarethynne@hotmail.com)
UNIVERSITY COLLEGE HOSPITAL GALWAY FOR PERMISSION TO
CONDUCT A CLINICAL TRIAL

(Please Type Application Form)

Applicant  Research Investigator: Clare Thynne

Supervising Consultant: Dr Geraldine Gaffney UCHG
Mary McMahon Senior Social Worker UCHG
Dr Meena O’Neill academic supervisor NUI Galway

Sponsor  (Drug Company) Not applicable

Date Of Application  21.12.2004 and 17.02.2005

Title Of Project  To explore the experience of women who have a concealed pregnancy/late disclosure of pregnancy.

1. Describe The Objectives Of The Trial
   - To explore the phenomenon of concealed pregnancy/late disclosure
   - To explore the perceived psychological impact of the concealed pregnancy/late disclosure
   - To identify reasons for concealed pregnancy/late disclosure
   - To explore demographic information of those who conceal/disclose late to identify if any profile exists
   - To inform health care practitioners

2. Describe The Trial Plan And Organisational Structure
   a. From Social work records in UCHG, patients will be identified who have had (a) crisis pregnancy or (b) concealed pregnancy/late disclosure
   b. Once these patients have been identified analysis of their demographic information will occur
   c. Interviews with consenting participants who have concealed a pregnancy/disclosed late will be carrying out and qualitatively analysed

3. What Are The Criteria For Recruitment?

Patients identified by UCHG medical social workers from records of those who presented with either
   i. a crisis pregnancy: which has been defined as a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her (Crisis pregnancy agency, 2001) or
   ii. a concealed pregnancy defined as a patient who has not disclosed her pregnancy to her social network before 20 weeks.
She will not have sought antenatal care before the 20-week period either (Wessel, Endrikat & Busker, 2002).

4. **How Will Participants Be Recruited?**
The files of 30 patients who experienced a crisis pregnancy will be audited by the medical social workers.

Identified patients who fit the definition of having concealed a pregnancy will be contacted (N = 30) by phone by a medical social worker. A home visit will be offered to explain the research further and consent will be sought.

5. **Is There Any Inducement Provided To Those Who Participate?**
   - **If Yes Provide Details:**
     - Not applicable

6. **Detail The Medical Examination/Evaluation Prior To Entry …**
   - Not applicable

7. **How Will Participants Health Be Monitored During And After The Trial?**

   Emotional Health: The researcher is sensitive to the fact that talking about these experiences may be distressing to the participant. The interview will be stopped and immediate support offered in such an instance. Follow-up counselling and support will be available to all interviewee participants by the relevant medical social workers in UCHG who will telephone the participants one week post interview to determine if supports are required.

8. **Is There An Independent Medical Examination?**
   - No

9. **What Are The Potential Risks To Participants?**
   - Yes

   Potential emotional distress, this will be managed by offering counselling and support

   a. **Will All Participants Be Capable Of Understanding The Objectives, Risks And Nature Of The Proposed Trial?**
      - Yes

10. **Will Informed Written Consent Be Obtained?**
    - Yes

    See consent letter attached. This relates to those women who will be interviewed.
Consent will not be sought regarding the demographic analysis of social work files, as this audit will be carried out by medical social workers as an internal audit. No identifying information will appear in this study.

12. **Will Patients Identity Be Kept Confidential?**
   Yes
   **If Yes, Describe How This Will Be Achieved**
   
   Demographic information on both groups of patients will be collated by the medical social workers only. No identifiable information will be included in this study and the researcher is bound by a professional code of practice.

13. **Are You Capable Of Conducting The Trial?**
   Yes
   **If Yes, Justify, In Terms Of Your Qualifications, Experience And The Resources Available To You**
   
   - Trainee Clinical Psychologist in NUI Galway with academic advisor
   - Graduated with Master in Social Work in 1997
   - BA Degree in Psychology 1995
   - Previous employee in UCHG social work department

In The Case Of A Clinical Trial Subject To The Requirements Of The Clinical Trials Act Of 1987 As Amended In 1990 No Application Will Be Accepted Unless It Is Accompanied By A Copy Of The Following Documents. Please Indicate If A Copy Of Each Document Is Enclosed By Circling Yes Or No.

14. The Full Copy Of The Ministerial Permit For The Trial (And Any Amendments)
   Not applicable

15. Copy Of The Indemnity Provided By The Drug Company For The Trial, In The Amount Of At Least €6,500,000 Any One Accident, Extended To Cover And Specifically Naming Yourself, Any Co-Investigator, University College Hospital And The Western Health Board
   Not applicable

   **Indemnity Agreement Must Be Reached Between Pharmaceutical Company And Western Health Board Before Final CREC Approval Is Granted**

16. 13 Copies Of The Final Protocol For The Trial
   NO
   One paper and one electronic copy of
17. Two Copies Of The Current Investigators Brochure For The Study Drug

Not applicable

18. Two Copies Of The Patient Information Leaflet

Not applicable

19. Two Copies Of The Consent Form

Yes

20. Two Copies Of The Financial Agreement

Not applicable

21. 13 Copies Of This Application Form

No

22. Payment Must Be Made For Any Tests Or Additional Work Carried Out On Trial Patients Beyond Normal Clinical Practice E.G. Laboratory Tests, X-Rays, Scans, Pharmacy Etc. Investigator Agrees To Make Such Payment?

Not applicable

23. Will You, Directly Or Indirectly, Receive Any Reward For Conducting The Trial?

Yes

No financial rewards but research will be submitted in fulfilment of clinical psychology training requirements

Signature: Research Investigator: Clare Thynne

Supervising Consultant: Dr Geraldine Gaffney UCHG

Mary Mc Mahon Senior social work UCHG

Dr Meena O’Neill academic supervisor NUI Galway

Date: ____________________
Appendix C: Description of the three social work services

A direct social work service is provided to patients and their families attending the unit by the social work department in the maternity department of University College Hospital Galway. This involves covering a duty service to ante natal clinics and providing a service to antenatal, post natal and gynaecology wards, premature baby unit and the fertility clinic. A service is provided to women and their families from their first clinic visit to some time following discharge home depending on the need. Referrals are from medical staff in the unit, self-referrals and the referrals from GP’s and other voluntary or statutory agencies.

Services
- Crisis intervention for various personal and family difficulties.
- Family support and liaison with medical team in relation to psychosocial care of patients.
- Counselling and support for women requesting adoption.
- Counselling and support for women to cope with an unplanned pregnancy.
- Counselling and support for women to cope with a difficult pregnancy.
- Support for families regarding involvement of fathers.
- Mediation and counselling in relation to family issues.
- Counselling and support for women in situations of domestic violence.
- Identification, counselling and support for women with post natal depression.
- Counselling and support for women at the time of diagnosis of serious illness.
- Support in relation to childcare issues.
- Bereavement counselling and support for parents and family members following stillbirth, miscarriage neonatal death.
- Liaison and other agencies involved with the family.
- Advocacy and support in relation to accessing various services.
- Referral to relevant local agencies and local support organisations.
- Provision of information regarding social welfare entitlements.
- Awareness raising in relation to relevant issues.
- Involvement in research, training and policy development.

**Crisis pregnancy**

The Medical Social Work Department offers supportive, non-biased counselling to patients presenting with a crisis pregnancy. We offer three options counselling or as requested by a patient. We provide a hospital outreach service as best meets the needs of the individuals. We are dedicated to developing departmental expertise and resources in these areas consistent with best practice.

**Family Support**

Funding was secured from the Crisis Pregnancy Agency in 2003 to provide the maternity social work team with a Family Support Worker. Family support services aim to identify vulnerable families, promote the welfare of children to minimise circumstances where children have to be received into care and reduce the stress in difficult family environments. The lack of practical support available was identified as a major limitation in the support services provided by the social work team.

The aim of this project is to provide any woman who is experiencing an unplanned pregnancy with intensive practical support. The social work team makes assessment for the service. This work includes

- Family assessment
- Outreach service-this is offered on a short-term, 6 week initial contract.
- Advice and information
- Sexual health and awareness and education
• Emotional support
• Sourcing childcare facilities
• Liasing with relevant agencies and support groups

Refugees/Asylum seekers

An increase in the numbers of asylum seekers attending the unit has necessitated expansion of the service to meet specific needs of this marginalized group. Ms Catherine Sherlock, Medical Social Worker, has carried out, extensive work and research. This work has involved

• Completion of an information pack for staff, one copy sent to all Units, Wards and Heads of Departments in University College Hospital, Galway and Health Service Executive, Western Area Multidisciplinary Group on Asylum Seekers.

• Continuing work on building up a network between the Hospital and voluntary groups working with asylum seekers and refugees and with refugee communities themselves

• Information sessions: presenting information from the pack developed earlier in the year

• Continuing with establishment of a resource base in the form of literature and published reports on the circumstances of asylum seekers in Ireland.

Information provided by Ms Mary McMahon Senior Social Worker In UCHG
Description of the Teen Parents Project based at the maternity unit University College Hospital Galway.

The Department of Health & Children in, March 2000 set up the Teen Parents Programme as part of a national pilot scheme. Similar projects were set up in Limerick and Dublin. Since the completion of the evaluation report in June 2002 and the National Launch of the three projects, it is now part of mainstream services within the Western Health Board. The Galway programme is based at the Maternity Unit, University College Hospital Galway and is attached to the social work department. The programme provides support for young parents under 20 and their children during pregnancy and for the two years following.

Project Aims

- To empower young parents in their parenting role.
- To provide support to young parents and their children during pregnancy and for two years following.
- To work in partnership with other organisations and to make appropriate referrals and links with existing services.
- To identify the needs of young parents, the services available to them and any gaps in those services.

Service Provision

The philosophy behind the project is to offer a non-judgemental, non-stigmatising service to all young parents. The aim is to provide a holistic service in order to address the individual needs of all young parents.

This support covers a range of information and advice on welfare entitlements, childcare, accommodation options, support networks, family relationships, education and parenting.
Referrals
Most of the referrals come through the maternity unit at University College Hospital Galway. Others are referred by GP’s, Public Health Nurses, schools, community groups and some are self referred and may have heard of the project through a friend.

Information provided by Aileen Davis, Project Leader of the Teen Parents Project.
Description of community care social work service in Galway

The community social work service provides support to children and families who are experiencing difficulties. The service response to the following

- Assessment of concerns regarding children’s welfare e.g. children who are being neglected, physically or sexually/emotionally abused.
- Support to families who are finding it difficult to manage the care of their children.
- Referring families to other support services e.g. child guidance, legal aid ect.
- Finding alternative care when this is needed.

This information was provided by members of the community social work team.
Appendix D: Sample questions for semi-structured interview

- Would you like to talk a little about your last pregnancy?

- Can you tell me about the first time you discussed your situation with someone and what was that like for you?

- What do you feel prevented you from sharing this information with someone up to that point?

- Looking back was there anything that would have helped you talk about your situation sooner?

- What was your worse fear about telling others?

- What prompted the discovery of pregnancy weight gain/ foetal movement/ morning sickness?
• People use words like denied pregnancy or concealed pregnancy when talking about late disclosure of pregnancy. I’m wondering if you feel these words describe your experience accurately?

• Can you describe your mood and general feelings during your pregnancy?

• What were your thoughts on being a mum before the baby was born?

• Do you feel you body shape changed dramatically during your pregnancy?

• Do you feel others noticed you shape change?

• Can you tell me a little about any changes you made to your life-style on discovering you were pregnant?

• In the past if you had a problem, financial or physical how would you go about solving the difficulty?

• Before you told someone you were pregnant did you ever talk to the baby or wonder what they would look like?
- What was your experience of labour? Was anyone with you?

- What were your thoughts about being a mum just after the baby was born?

- What kind of a relationship would you say you have with your baby now?

- What words best describe your baby?

- Do you think that keeping your pregnancy to yourself had any impact good/ bad on you as a mum or on your baby?

- Would you have advice for someone who is experiencing what you did and fearing the disclosure of her pregnancy?
Appendix E: Participant information and consent form

Title of the research Project
Exploring the experience of women who have a late disclosure of pregnancy

ABOUT THE RESEARCHER: My name is Clare Thynne. I am training to be a clinical psychologist and I am in the second year of a three-year doctorate program in NUI Galway. The postgraduate research committee in NUI have approved this proposed research and my academic supervisors name is Dr. Meena O’Neill. She is based at the psychology department at NUI Galway. My field supervisor is Mary McMahon who is a senior medical social worker in University College Hospital Galway. Dr Geraldine Gaffney Obstetrician/Gynaecologist, is acting as my clinical supervisor and she is also based at UCH Galway. When I have completed this piece of research it will be submitted to the NUI Galway. In time I hope that the findings of this research will be published in an academic journal.

Prior to my starting my psychology training I worked as a medical social worker in University College Hospital Galway from 2002 to 2003.

THE PURPOSE OF THE RESEARCH: The aim of the research is to learn more about the experience of women who have gone through a late disclosure of pregnancy. The research is been undertaken so as to deepen health professionals understanding of the issues involved. It is hoped that the research findings will be used to try and improve the service received by women who undergo a late disclosure of pregnancy.

THE REQUIREMENTS: Participation in this study will require you to be interviewed by myself. I will be talking to you about your experience of pregnancy. I will tape record our conversation so that I can transcribe it and analyse it at a later time. The
interview will take between an hour and an hour and a half and it can take place at your home or a location of your choice. Demographic information (such as if you live on your own or whether you live in a town or a rural area) from your social work file will also be collated by the medical social worker you were involved with in UCHG. This information is being gathered to see if a common set of circumstances exist for women who find themselves in the situation of late disclosure of pregnancy.

CONFIDENTIALITY

All of the information that is gathered in this study will be kept strictly anonymous confidential. In time when analysis has been completed all audio and written records will be destroyed. The identity of the women I have spoken to will be known by your medical social worker from NUIG and myself only. No identifying information (name, address, date of birth) will appear in this study.

POTENTIAL RISKS The experience of talking about a pregnancy can be difficult. Should you experience any discomfort following our interview support and follow up service will be available by contacting the medical social workers in UCHG Catherine Sherlock or Maeve Tonge on 091-544089. Catherine or Maeve will telephone you one week after the interview to check if you regarding the impact of the interview and to enquire if you feel you require any further support.

The most important point is that your involvement at any stage in this research is voluntary. If you wish to withdraw from this study, you may do so at any time without penalty or consequence. Your medical treatment in UCHG or social work service in UCHG will not be compromised if you wish not to take part or withdraw your participation at any stage.
I wish to thank you sincerely for the time you have taken to read this form. If you wish to contact me directly with questions or concerns my number is 091-592398. Dr Meena O’Neill can also be contacted for additional information on 091-492956. If we are unable to address your concerns satisfactorily please contact the Head of the Psychology Department at 091-493454. A report outlining the major findings of this study will be made available to participants if requested.

If you wish to take part in this research I ask that you sign the accompanying consent form (see overleaf). I will also sign this and return a copy to you.

Yours Sincerely

Clare Thynne
I have read and understood the information sheet provided and have been given a verbal explanation of what participation in this research entails. I understand what this research is about and I consent to taking part in this study.

Name of Participant…………………………………………
Signature of participant……………………………………
Date…………………………………………………………

Signature of researcher………………………………………..
Appendix F: Letter and summary of findings sent to participants

Dear
You may remember that we met some months ago and we spoke about your experience of pregnancy. In total I spoke to eight women about their similar experiences. As you may remember I tape-recorded our conversation. I have typed up the eight discussions now and have tried to pick out common themes, which reoccurred a number of times. I have included below a summary of my findings.

I would appreciate it if you could read the enclosed summary and on the paper provided write down your thoughts. I am hoping that themes I have noticed are somewhat representative of the experiences you and others have shared with me. I hope that you will be as honest as possible when you write your comments. You may find some of the findings do not relate particularly well to your experience and please feel free to comment if this is the case. I have also included some of the general findings from the study, which you may find interesting. These general findings relate to all the recorded incidence of late disclosure of pregnancy in UCHG between 2002-2004.

Please use the stamped addressed envelope to post your comments back to me. Once I receive the feedback sheets I will re-examine the findings and make corrections as appropriate. I can send you a summary of all the findings in June 2006 if you wish. I want to thank you again for your time and openness in your conversation with me. I look forward to reading your comments and general impressions.

Sincerely,

Clare Thynne,

C/o Maeve Tonge- Catherine Sherlock, Social Work Department, UCHG.

(091-544089)
Summary of the findings

The main aim of this study was to try and gain a deeper understanding of why some women delay the disclosure of their pregnancy. In previous research no one had ever asked women themselves what the experience means to them. The task involved in this study was to examine the interviews with the eight women who had taken part and try and hear their story.

Do the women call this experience a concealed pregnancy, a denied pregnancy or something else entirely? Why do the women feel it happened? Does it have a lasting effect on the women and children involved?

What is a late disclosure of pregnancy?

The women described their experience in a variety of ways. Some of the women felt that they did conceal and hide their pregnancy from people. Others felt they denied their pregnancy from themselves. In other cases women described using both concealment and denial at various stages of their pregnancy. The picture, which emerges is that this experience is on a movable continuum or scale (Figure 1). In some cases a pregnancy is both denied and concealed and in fact it may be explained by aspect of both these terms. For example a woman may be in denial about her pregnancy but at times she acknowledges the pregnancy to herself. As she journeys through her pregnancy she may begin to fully acknowledge the pregnancy but still wishes to keep it hidden from certain people. The important finding here is that the experience may changes as the pregnancy progresses.

What is also important to note is that aspects of denial or concealment may still be ongoing after the baby is born. Many of the women did not inform certain family members or the biological father about their pregnancy and in that sense the baby
remains concealed from significant others. Late disclosure of pregnancy is a very complicated experience that in some cases it is ongoing after the baby’s birth.

Figure 1.

Another finding that I think needs to be highlighted is that this experience does not happen in isolation. The reasons why this experience occurs are extremely complicated. A delayed disclosure of an unplanned pregnancy is influenced by not only the woman’s own coping skills, but also by perception of her families likely reaction and the attitudes of those in the society in which she lives. The physical reality of the baby also played a role in how the unplanned pregnancy was resolved. The first of these influences to be discussed here is the societal influences.

**Factors that influence delayed disclosure of unplanned pregnancy**

(1). Societal Influences

**Irish Culture**

Being raised in Ireland leaves an impression on people. Many of the women spoke about the shame and disappointment they felt their unplanned pregnancy would bring to themselves and their family. They felt they would be judged if they were to become an unmarried mother. They felt neighbours; friends and their communities would judge them.
Professional’s attitudes to young single mother’s

Some of the women referred to unprofessional attitudes they experienced by service providers such as hospital staff, crisis pregnancy personnel and GPs. They felt that people treated them differently because they were young pregnant single women.

Options during a crisis pregnancy

The women were also aware of societies views on adoption and termination. Many felt that people see adoption as a negative thing and something that people inevitably regret. Thus they felt that people would not support them in their decision to have their baby adopted. Therefore they kept the pregnancy hidden so that they would not be judged if they chose adoption. None of the women strongly considered termination. They felt they did not agree with termination for their own reasons. Again this is interesting given the legal status of termination in this country.

It seemed from talking to the women that an unplanned pregnancy places a woman in an impossible situation as all three options, being a single mother, choosing adoption or having a termination all seem to have stigmatising labels attached to them.

(2). Family Influences

The women’s families played a significant role in explaining why the pregnancy remained undisclosed.

Pre-existing family difficulties

Many of the families had other difficulties occurring at the time the woman realised she was pregnant. Pre-existing problems included, a sister’s previous pregnancy, another pregnancy in the family at the time, a bereavement, a sister being unable to conceive, disapproval of the woman’s partner or poor communication between family members.
Fear of negative reaction

The women I spoke with were aware of how their family would react to the news of their pregnancy and they feared this negative reaction. By delaying the disclosure the women felt they would protect themselves from this disapproving response. The actual family reaction to the pregnancies was negative overall (with only two of the eight women receiving a high level of support from their families). Some family members actively encouraged termination or adoption. One woman concealed her pregnancy until 24 weeks of gestation to prevent her family from forcing her to terminate her pregnancy.

Familial coping strategy

Once the baby was born, a small number of parents wanted the baby to be concealed from certain family or community members. This desire to keep the baby a secret could be described as the family’s coping strategy. This familial strategy of denial and secrecy may have been passed on to family members as a way to cope with difficult situations.

Some of the family members asked the women were they pregnant before the women had disclosed their pregnancy. It is possible that family members suspected but did not persist in questioning the woman as perhaps they feared the answer and thus indirectly encouraged the woman to keep the pregnancy a secret.
(3). Individual Factors

Personal coping skills
The eight women interviewed spoke about their way of coping with problems. The majority of the women spoke about their preference of dealing with a difficult on their own, without ‘burdening’ others. They described themselves as private, independent or believing that things would just work out. They felt they could cope with problems themselves and therefore did not tell others about their pregnancy. By not telling others, this allowed the woman space to think about her situation and what was the best way to deal with the pregnancy.

Personal beliefs
Prior beliefs the women had regarding the process of adoption and termination influenced each woman’s individual journey. Seven out of the eight women considered adoption before their babies were born. Some of the women believed that if they kept their pregnancy a secret then the adoption could remain a secret and no one would ever find out. Others considered adoption as they felt they could not offer their child a financially secure future. Some of the women also referred to knowing their own strengths and weaknesses and they took these into account when deciding whether to parent their child or not.

How did the women decide what to do?

Reality of the baby
Although seven of the eight women interviewed considered adoption before the baby was born, after the birthing process most of the women reconsidered their options. Some of the women decided on parenting once they held their baby. Others started to consider parenting after spending some time with the baby on the ward or in the foster home. One woman who already had two children did place her third child for adoption.
This decision was extremely difficult. It was heavily influenced by the lack of understanding she experienced from her extended family and the poor level of support she received from her partner.

**What is the impact of the late disclosure on the women and children involved?**

While the majority of the women spoke about initial bonding difficulties these problems seemed to resolve with a few weeks. The level of support the women received from family, their prior experience with children and the child’s temperament all influenced the bonding process. Those women who received a high level of support from their family or partner seemed to find the transition to motherhood quite easy. In cases where the child was ill or cranky the mothers were under a higher degree of stress and the bonding process took a little longer. Overall the women were happy with their decision to parent. They had a positive outlook on the entire experience and they spoke about having a strong and loving attachment to their child.

The woman who placed her child for adoption also attached to her baby. The adoption is open which means communication goes back and forth from the mother to her child. This is a very painful livelong process but at the time this was the right decision for this women given her circumstances.

In summary the experience of having an undisclosed pregnancy is very complicated and there are many complex reasons why women find themselves in this situation.
Summary of general findings

Delayed disclosure of pregnancy is not uncommon. This study found by looking at social work records in UCHG, one in every 148 births was undisclosed in 2003-2004. This is a higher rate than that found in Dublin maternity hospitals. The women’s ages range from 15-43 years but women in their twenties were more likely to delay disclosure that women in their thirties. Being from a rural area increased the likelihood of delayed disclosure, as did fearing parental reaction. The women who delayed disclosure of pregnancy tended to be either in education or employed, single and of Irish nationality. In a small number of cases women found themselves delaying disclosure of pregnancy on more than one occasion.
1). Having just read the summary what are your initial thoughts and feelings? (Surprise, interest…anger.)

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2). Did anything in the summary cause you distress when you read it? Please be specific.

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3). Do you think certain things have not been mentioned that should have been? Please list what you feel should get more attention

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4). Do you feel the report in some way represents your experience of a late disclosure of pregnancy?

If yes, in what way? …………………………………………………………….
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If no what is missing?…………………………………………………………
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5). What do you think could improve the accuracy of this report?

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6) Is there anything else you would like to say regarding any aspect of your involvement in the study?

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I would like to receive a summary of all the findings in the June 2006.

Please tick the appropriate box below

YES ☐ NO ☐
Appendix G: Participant’s feedback

1). Having just read the summary what are your initial thoughts and feelings?
(Surprise, interest...anger.)

2). Did anything in the summary cause you distress when you read it? Please be specific.

3). Do you think certain things have not been mentioned that should have been? Please list what you feel should get more attention.

4). Do you feel the report in some way represents your experience of a late disclosure of pregnancy?

If yes, in what way? 
...through the same thing...it's not the same person before this report it's through

If no what is missing? 
...through...it helps to us...that we not the only person felt the same things when I was pregnant and went through the same thing...
5). What do you think could improve the accuracy of this report?

6). Is there anything else you would like to say regarding any aspect of your involvement in the study?

I would like to receive a summary of all the findings in the June 2006.

Please tick the appropriate box below

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
1). Having just read the summary, what are your initial thoughts and feelings?

(Surprise, interest...anger.)

fascinating...very...interesting...well...written...

easy...to...read...comment...

happy...wills...the...content...

2). Did anything in the summary cause you distress when you read it? Please be specific.

I...could...pick...out...negatives...relevant...to...my...own...situation...and...some...memories...

Come...back...otherwise...not...distressing...

3). Do you think certain things have not been mentioned that should have been?

Please list what you feel should get more attention.

Maybe...the...length...some...women...went...to...the...conceal...the...pregnancy...or...how...it...made...the...lies...in...concealment...become...

4). Do you feel the report in some way represents your experience of a late disclosure of pregnancy?

If yes, in what way? Almost...every...negative...been...something...relevant...to...me...could...fill...my...personal...story...together...

If no what is missing? I...felt...my...biggest...problem...wo...access...to...a...ge...I...could...easily...access...and...trust...he/she...may...have...given...me...the...confidence...I...needed...
5). What do you think could improve the accuracy of this report?
From my personal point of view, it was accurate enough to give a good idea of the women's reactions, etc.

6). Is there anything else you would like to say regarding any aspect of your involvement in the study?
It is exactly what I expected. Information wise, if there was any more information, it would be too personal, only less.

I would like to receive a summary of all the findings in the June 2006.

Please tick the appropriate box below

YES [ ] NO [ ]
Appendix H: Example of script page

Interviewee referred to as many, partner referred to as Tom and her child is referred to as Anna.

Interview one

Confidentiality issues discussed as was tape recording consent form and tape was turned on after these discussions.

T: There are no right or wrong answers I am interested in your experience. I don't mind I have this told so many times to social workers and lectures and chéché workers.
C: Oh that might be good in a way. Ok my first area is about how you discovered you were pregnant or how many months do you think you were pregnant. Do u remember how?
T: I remember exactly. I never took a test or anything. I just knew.
C: Right.
T: I sort of knew and say after my last period that ya I feel totally different and between vomiting and...
C: Ok so you had morning sickness?
T: I knew. I had morning sickness for the whole 9 months, which was unfortunate but
C: So even after your first month many u had an inkling had you?
T: I'd say I knew after two weeks because I could tell them the exact date you know and they were like i o how did u do that without a test, or counting back. I just knew the minute it happened.
C: Right and it was with Tom. Tom is annas dad? Right so you had a flat idea in your head from the minute it happened. How long did it take from then to share that information with Tom or family or?

T: Well it happened trickly enough you see. I was after taking the pill and I got sick. I puked. I couldn't keep anything down I got chicken pox and that was in January and I missed that pill then and I never really thought much about it because I was so sick that's how it happened. I said it to him straight away I feel weird........ different. I'm after missing a period like he was like........ well maybe its nothing maybe your sick still........ like he was sort of in denial as well he knew like I was telling the truth but I was lying and he didn't really mind that much it wasn't like oh my god oh my god what are we going to do and I wasn't like that either........ I was totally in denial I knew that I was 2.5 but there is not much I can do about it and I don't really want to do anything about it but it went well........ 7 months before I told my parents and I didn't really tell them then I think it was someone told them. Someone who doesn't know me had heard from......... I think Tom's mother had.

C: Did you put on a lot of weight and you don't eat at all like and your sick in the morning so what is going on like?

T: Right so Tom's mum twiggled or something.
C: Yes and the sort of tells everything anyway so I think she said it to one of her friends and his his b India.

T: And she got back to my mother and my mother went absolutely crazy crazy crazy and Tom's mother was delighted like I remember the day it happened like I was in bed and I remember the morning she came in and she pulled the covers and she started roaring and ripping and she can remember hearing my father outside throwing up on the grass. The shock and everything they had no idea like I wasn't really hiding it. I didn't wear baggy clothes or anything but they just id say if they thought about it as such they put it out of their minds, it nothing.

C: And I went to toni house then after that it was six miles away and I walked it because I just didn't want to be there like. I was just horrible for a week. The two of them stayed in bed didn't go to work or anything like they wouldn't talk to me wouldn't give me dinner. I know this kind of stuff. I had to do everything myself and I said this is going to toni house and I went there and there were all helping me and Toni mother just clicked into gear like straight down to mother in law gathering everything, getting a pian off friends. Just to see my parents in bed and his parents and all his brothers and sisters running around the place doing this and breaking my heart it really did now and as well you know my grandies beside my parents and she is feeble enough and she has a lot of arthritis that she has with everywhere, she is old and small, she listens to everything my father says. He said tell her afterwards because it will kill her store dead and you will be killing her, fine so I said fine do whatever you like but I still hasn't told her and anna is a year and a half and still he hasn't told her.

T: Right ok what's that like for you.
C: It's horrible if I go home, because she is so old and feeble, if I go home she raised me.
**Appendix I: Coded list of themes from initial reading of interviews**

<table>
<thead>
<tr>
<th>Code</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Reaction to pregnancy, own, partner, parents, friends</td>
</tr>
<tr>
<td>B</td>
<td>Supports available and levels, family and professional</td>
</tr>
<tr>
<td>C</td>
<td>Negative professional intervention</td>
</tr>
<tr>
<td>D</td>
<td>Motherhood thoughts and feelings, before D1 and after D2, about the baby,</td>
</tr>
<tr>
<td>E</td>
<td>Feelings towards disclosure</td>
</tr>
<tr>
<td>F1</td>
<td>Understanding of concealment/denial</td>
</tr>
<tr>
<td>F2</td>
<td>F2 thoughts now</td>
</tr>
<tr>
<td>G</td>
<td>Changes to life style during pregnancy, clothes, alcohol, food smoking</td>
</tr>
<tr>
<td>H</td>
<td>Changes since birth of child to life</td>
</tr>
<tr>
<td>I</td>
<td>Advice, what may help what helped her</td>
</tr>
<tr>
<td>J1</td>
<td>Lack of knowledge skills equipment</td>
</tr>
<tr>
<td>J2</td>
<td>Having skills</td>
</tr>
<tr>
<td>K</td>
<td>Considering 3 options, her thought process</td>
</tr>
<tr>
<td>K1</td>
<td>Foster care</td>
</tr>
<tr>
<td>K2</td>
<td>Adoption</td>
</tr>
<tr>
<td>K3</td>
<td>Termination</td>
</tr>
<tr>
<td>K4</td>
<td>Parenting</td>
</tr>
<tr>
<td>L</td>
<td>Contraception, usage, failure</td>
</tr>
<tr>
<td>M</td>
<td>Baby weight/changes to mother</td>
</tr>
<tr>
<td>N</td>
<td>Labour experience</td>
</tr>
<tr>
<td>O</td>
<td>Day care</td>
</tr>
<tr>
<td>P</td>
<td>Awareness of pregnancy (knowing)</td>
</tr>
<tr>
<td>Q</td>
<td>Physical experience of pregnancy, changes during pregnancy</td>
</tr>
<tr>
<td>R</td>
<td>Coping style, old, new style</td>
</tr>
<tr>
<td>S</td>
<td>Reaction to birth, babies first few minutes of life</td>
</tr>
<tr>
<td>T</td>
<td>Barrier to services, T2 barriers to disclosing</td>
</tr>
<tr>
<td>U</td>
<td>Reaction of others to birth</td>
</tr>
<tr>
<td>V</td>
<td>Barriers to parenting (accommodation)</td>
</tr>
<tr>
<td>W</td>
<td>Future plans (university, work)</td>
</tr>
<tr>
<td>X</td>
<td>Baby temperament, behaviour, describing baby</td>
</tr>
<tr>
<td>Y</td>
<td>Mood during pregnancy, just after</td>
</tr>
<tr>
<td>Z</td>
<td>Being more able, as mother, father</td>
</tr>
</tbody>
</table>

**Themes added from other interviews**

<table>
<thead>
<tr>
<th>Code</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3</td>
<td>Relationship with own mother/father/family</td>
</tr>
<tr>
<td>Z1</td>
<td>Confirming pregnancy, method, scan, tests</td>
</tr>
<tr>
<td>Z2</td>
<td>Interest in study, confidentiality</td>
</tr>
<tr>
<td>H2</td>
<td>Life before pregnancy, context</td>
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<tr>
<td>B2</td>
<td>Support from child’s father</td>
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<tr>
<td>CB</td>
<td>Feeling shame, stigma</td>
</tr>
<tr>
<td>K5</td>
<td>Desire to miscarry</td>
</tr>
</tbody>
</table>
Appendix J: An example of theme pages which accompanying script pages

Interview 1 - open coding
Themes + categories

Confidence in talking about her experience. H

Early awareness of pregnancy-physical changes, illness. P L

22-1

4-15

On the pill contraceptive - failure L

19-18

Intravenous/Pulse reaction - no reaction "in denial" A(E) V

22-18

Other reaction - nausea - P & F mother - "delighted" 29 V

22-18

Can mother's reaction - "crazy" shock A V

41-32

Concealment explained by woman "I wasn't really aware of it, I didn't wear baggy clothes F 1"

44-21

Continued concealment from all family members even friends.

35-35

Went parents because - they were just house, reading

35-35

Nippy, he hadn't told his A V

35-35

I never took a test or anything - I just knew. P

28-28

"I feel totally different between wanting." +

28-28

The two girls stay in bed = = A V

37-37

I went out, I was all helping me A + B...

145-145

The sad thing is everyone knows not to say it to her F 2.

27-27

Concealed as feared parental reaction F 3 - father & parents don't accept the child. " Might have decided all grandparents of child as a consequence A & B.

27-27

Denied to self & others - "I didn't really think about it"

27-27

Certainly about gender of child D.

27-27

Healthier eating style - early reduced smoking & drinking.

27-27

Body shape - no massive gain in weight or

27-27

Body weight - normal weight So

27-27

I'll worry about that when the time comes. I'm sorry like hat R
Appendix K: Initial master list of themes being condensed to superordinate concepts

E. Feelings towards the disclosure
F. How she explained concealment-denial
F1. Thoughts, feelings on concealment now
P. Awareness of pregnancy (knowing)
Q. Physical experience of pregnancy, bodily changes during pregnancy
T1. Barriers to services,
T2. Barriers to disclosing
R. Coping style old
Y. Mood during pregnancy

D. Motherhood thoughts and feelings about motherhood
D1. Thoughts of motherhood before the baby was born
D2. Thoughts on motherhood after the baby was born
D3. Relationship with own mum and family
X. Baby’s temperament
Y1. Mood just after pregnancy

A. Reaction to pregnancy, (emotional and practical), own, partner, parents, friends
S. Reaction to birth, babies first few minutes of life
C. Negative professional intervention
U. Reaction of others to birth

B2. Support from dad of the child
B. Supports available and levels professional and family
I. Advise, what helped her and may help others
J1. Lack of knowledge skills equipment
J2. Having knowledge, skills, coping style
K. Considering the options, her thought process
K1. Foster care
K2. Adoption
K3. Termination K5. attempt to miscarriage
K4. Parenting

G. Changes to lifestyle (clothes, alcohol, food, smoking) during the pregnancy
H1. Changes since birth of the child to mother’s life
H2. Life before the pregnancy
R1. New coping style

V. Difficulties i.e. accommodation
W. Future plans, work, university
Z. Being more able as a person
Z1. Method of confirming pregnancy, test, scan
Z2. Interest in the present study
L. Contraception usage and failure of same
M. Baby weight, breast feeding
N & O. Labour experience, painful, ok ....., Day care
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<tr>
<th>Theme</th>
<th>Freq</th>
<th>Interview 1</th>
<th>Interview 2</th>
<th>Interview 3</th>
<th>Interview 4</th>
<th>Interview 5</th>
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<td><strong>U Reaction of others to birth</strong></td>
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<td><strong>K5 Thoughts on miscarriage</strong></td>
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#r = researcher. *v = other researcher
Appendix M: Supervision notes

Minutes of supervision meeting on the 17.12.2004

Present: Clare Thynne and Dr Meena O Neill

- Meena had discussed the issue of 13 copies of application with XXXXX and from XXXXX experiences 13 copies are not needed.
- XXXXXX the obstetrician in UCHG has been emailed and a response is being awaited.
- Changes to consent form can be created parallel to draft consent form that NUIG psychology department has produced.
- Suggestion of using the term late disclosure as opposed to denied/concealed pregnancy was discussed and original draft of proposal to be changed accordingly.
- Concept of validation discussed. Idea of sending participants draft of findings to see if they are reflective of their experience. If this is to happen original proposal and consent letters would perhaps ask participants if a second shorter interview would be possible depending on the findings. Another way around this would be to just ask participants at the first interview if a second interview was possible or desirable.
- Concept of validation of qualitative research discussed and the notion of having two raters or have a colleague challenge ones analysis.
- Concept of audit trail discussed, i.e. the writing up of ones thinking during the analysis process. A reflective log could be of use of how the interviewer felt during and after the interviews would be logged.
- Procedure of stopping interview if person is distressed is to be included in application form.
• To include in application that while no financial gain that the research is to fulfil requirements of clinical course.

Plan: To change letter to Mr XXXX hospital manager

1. Have internal audit of the two files commenced by hospital staff
2. Construct proposal so that the study is explained in two parts, one which involves the audit of the files and the other part involves the interviewing of participants.
3. Send application form to Dr XXXXX before Christmas
4. Send copy of application to Meena
5. To read Silverman chapters that look at validity and reliability and credibility.

Decisions made

• Had spoken about terminology with practitioners late disclosure of pregnancy less derogatory than denial/concealment
• Had thought about ways to validate findings (1) return to participants which would be respectful in the first instance
  This will be challenging as will have to present findings back to participants, “warts and all”
• Have other raters or readers to read over the transcripts as a way to validate findings as well
Supervision Notes from meeting with Meena O’Neill on 08.01.2005

No response from potential nominal supervisor. Will inform Meena of progress with awaited email and she will undertake to write an email regarding the research project and wish for a meeting.

Clare to try and locate other appropriate doctors emails and prepare to write to this people regarding nominal supervisor idea.

Clare to arrange meeting with colleagues in the hospital regarding checking two files with template and to adjust as necessary. At this meeting the notion of admin support to be raised.

Reading regarding process issues is ongoing suggested Kvale as good reference
Clare to contact XXXXX regarding tape recording equipment.
Clare to make links with statistician regarding appropriate use with demographic information is sample of control and target group ==30.

Prepare task analysis before next meeting set for 3pm on the 18th of February
To check with hospital staff regarding word ‘ethnicity’.

Decision: To read back through proposal and replace late disclosure of pregnancy
Minutes from last meeting with Meena O’Neill and Clare Thynne Jan 2005

- Meena will be away in Feb 10th - 11th and 14th.
- Clare to check that template of demographic information fits with the information held on file.
- A back up plan to approach another member of the medical staff in UCHG will be prepared by Clare and she is to locate the emails and phone numbers of three other members of the medical team.
- Clare to email Dublin team and make them aware of what stage research is at.
- Clare to check if admin support would be available from UCHG MSW dept.
- Clare to think about process of approaching participants post interview to check if they feel what has been recorded and coded is accurate.
- Process issues will be recorded during the research process and this will be a record of how decisions were made in the research.
- Clare to prepare an initial timeline of the task that need to take place and when.
- Clare to check with XXXX about the tape recorders within the department and back up systems.
- Next placement was discussed and copy of abstract will be forwarded to meena.
- Check what statistics to be used.
- Clare to go over consent form and writing to date in relation to terminology.
- Clare to look for references from Kvale regarding interviewing and process issues.
- To include question within interview around lifestyle and drinking patterns.
- To update and send letter to XXXXXXX regarding intention to do research.
Decisions

- Demographic information based on areas of interest of the practitioners, on a template used by the other researchers in a hospital in the West of Ireland. Piloting will need to occur to check that the questions are well structured and relevant information is being retrieved

- Terminology used in the consent form has to be changed to late disclosure, similar in letters to participants. Maybe be open with terminology until women in the research define these terms and what they mean to them.

- Need to read about the art and science of doing semi-structured interviews with vulnerable populations and a sensitive topic. To think about how this process with impact on the participants

- Make myself familiar with normal pregnancy process so I can relate to the women in a more sensitive fashion and that I will be more comfortable during the interviews

- Perhaps should have a interview protocol for the social workers to use when contacting participants, This would mean that the types of information used in all initial calls is similar and that should help somewhat towards bias control
Task analysis February 2005 onwards

**Feb 2005**  Pilot demographic data with data on files

Have social workers find youngest, oldest and mean age of those you delayed disclosure and try and match these ages with those who had crisis pregnancy

Having social workers use demographic template to go through 30 files of those who have concealed and 30 files of those women who have had crisis pregnancy

Have social workers locate weight of all children involved in the study

Analysing data from demographics checking if questions relevant

Get recording equipment, tapes, batteries etc

**March 2005**  Meetings with nominal clinical supervisor

Meeting with social workers asking them to begin calling clients and arranging visits to explain the research project or getting permission to send on consent forms within a short period of time if possible

Reading regarding lit review/ methodology

Sending out consent form and getting consent form returned

**April 2005**  Phone calls to secure meetings with clients

Booking of venues for interviews

Childminding arrangements perhaps

**May 2005 – Sept 2005**  Travelling to and from interviews

Email to hospital social work staff. Meetings with front line staff

Meetings with academic supervisor and nominal supervisor
October – Dec 2005

Transcribing interviews
Coding interviews
Analysis of data
Securing cross analyser to check coding
Writing up own process
Checking back with participants on the nature of the writing
Visiting participants again or ending data in post and calling them regarding this
Literature review and introduction write up

Jan- Feb 2006 Methodology write up

First draft written up

March 2006

Write result and discussion, references and appendices
Full first draft prepared

April-May

Corrections and finish
Minutes from meeting on 19th of February 2005

Looked at task analysis form

Issue of checking back with participants regarding accuracy of report

Will need to challenge own data i.e. via conference

To contact Dr xxxxx once consent received

To check quality of tape recording equipment

Start diary of process of the research

To get date for social workers regards meeting

To look at area of validation

To look at interview protocol

To reread proposal and read up on normal pregnancy process

If contacting XXXXX regarding stats acknowledge same

Plan for after Easter to pilot interview

To trial equipment before Easter

To meet clinical supervisor

To look into end note

To meet with social workers regarding starting to contact participants i.e. prompts used and to emphasise reason for the research
Supervision meeting with Meena O’Neill 28th of October 2005

- Meena highlighting that research can be written up or divided up into several papers depending on the audience, has relevance to medical staff, social workers, and general knowledge.
- Spoke about the process of doing the research, from the researchers experience and the practitioners. i.e. meeting places.
- Clinically relevant information when working with vulnerable samples
- Mindful of audit trial
- Research group to read the scripts part of validation process
- Go back to participants is part of validation process does the summary represent their experience. Think about language used
- Visual representation of data maybe helpful.
- Record thinking

Decisions.

I have started to draw the various themes and the sub-themes from the scripts, which branch out of these. There seems to be 8 themes, which stem from the questions asked. Difficult to see overriding unifying theme that pulls the whole phenomenon together. Themes are

1. Concealment/denial, why and now they feel now, physical aspect of it
2. Reactions to the pregnancy, parents, partner, friends, own
3. Experience of pregnancy/labour
4. Coping strategies, which includes supports, what helped: good interventions, suggestions for the future
5. Changes to life style
6. Reframing of the situation
(7) Decision to parent/to adopt/to terminate

(8) Motherhood attachment.

(9) A journey, beginning, middle, end and now

To meet again in the November 2005

**Supervision minutes with Meena O’Neill on the 22.11.05**

- Check in regarding the conference in Derry, Did get two good questions from the audience.
- One question related to normal concealment by mothers of their pregnancy until they are ready to tell.
- The other question related to how one will incorporate the feedback from the participants in the final write up. This feedback will allow the readers to have more information.
- The Press were interested in the paper but it was felt not to be appropriate to make contact with the press while interviews are still on going. In the future the area of non-national births being a large number to the un-booked pregnancies maybe an issue of interest.
- Contact has not been secured with the 8th interviewee as she has some family commitments at present.

Feedback on the draft of the introduction and methods:

- Main rationale for doing the study is lack of previous work, which involved participants in defining their own experiences.
- Explicitly state at the end what the terms concealment denial mean to the researcher.
• Give more details of the studies that are referred to.

• Funnelling effect of information from general to why doing this specific piece of research in this way.

• Theories to date seem to pathologies concealment and denial, described as a disorder, illogical irrational whereas the interview may reveal an adaptive nature of this behaviour.

• Give better rationale for the demographics used in the quantitative data based on past studies.

• Separate chapter regarding ethical and clinical issues which need to be considered before commencing the study and issues that arose from carrying out the work, clinical decisions made regarding sampling, cut off points working definitions, collaborative work,

• Look at the literature of vulnerable groups in general how this work builds on past work and any other special considerations i.e. teenager parenting group.

• Include section on who the researcher is, own clinical background.

• Rationale or using IPA may include reference to Smiths work.

• To prepare and send supervisor script with themes ASAP, so far considered

• Need to consider whole area of what other raters will be asked to do, challenging to thinking not necessarily agreement. Include log of how decisions were made regarding this.

**Decisions**

• Press not to be approached till women have commented on the findings as their perspective on the findings is essential
• Good question from the conference of how the women’s feedback will be presented as a whole or analysed. Maybe both ways so the reader can decide on the feedback too.

Meeting with Meena O’Neill 14th of December 2005

✓ Meena had read one of the scripts and she had thought about themes she felt were present in the data.
✓ Asked the question what is concealment, is it a process, is there an end to it, its very complex
✓ Are there different types of disclosures, passive/active/other types
✓ Emotional journey
✓ Reaction to a crisis, is it like regular reaction to a crisis?
✓ Learning point possibly for professionals to have a look at their reactions to the disclosure, not professional
✓ Core beliefs systems, define the construct
✓ Personal growth and identity change
✓ What is the crux of the construct?
✓ What was own process?

Looked at themes Meena had seen in the data quite similar to what I had seen.
Her themes included
(1) Meaning of the concealment
(2) How it was disclosure
(3) Reactions to the disclosure
(4) Personal identity
(5) Bonding-relationship to the baby
(6) Life style changes
(7) Belief systems
(8) Barriers to medical attention
(9) Emotional Journey
(10) Process of decision making – variables involved
(11) Parents denial

**Decision:**

- Looking at the belief systems and personal identity and the parents’
  denial were new areas to focus on when rereading the scripts.

- Again feedback from the second rater mirrored the themes I had
  noted. The themes she noted included. These themes were the same
  as my own.

(1) Initial reaction to the pregnancy
(2) Reasons for concealment
(3) Awareness of the pregnancy
(4) Pregnancy options
(5) Coping strategies
(6) Labour
(7) Diverse family reactions/support
(8) Reaction friends neighbours
(9) Professional support
(10) Post pregnancy
(11) Her advice to others
Next meeting in January 2006

Meeting with Meena O’Neill in January 2006

✓ Wanted map for each of the women their journey, case summary.
✓ Separate out the two studies. Study one demographics study two the women’s story
✓ More theory required, more interpretations
✓ What was the process for the women
✓ Cultural context
✓ At the moment findings are descriptive, needs more interpretations on variations of these concepts
✓ Theoretical linking needed, paradigm, models
✓ What are the ranges of the experiences
✓ Look at normative literature, comparisons with bonding process
✓ Constant comparisons be clear about analysis.

Decision: Read other IPA type studies as findings are missing theoretical links and lacking in interpretation. Reading health psychology articles relating to coping strategies, cognitive behaviour and emotional reactions.

Feedback from third rater mentions defence mechanisms, theme of shame, journey, lack of control-coping, self-concept, on going denial.

Looking as it three levels, individual/family and wider society involved.
Supervision meeting with Meena 7\textsuperscript{th} of Feb 2006

- Feedback was that findings section lacked connection
- The many dimensions of the concept of concealment not made explicit enough
- Make more of crisis in life say this earlier
- Perhaps present model up front
- Look at concept in past literature
- Temporal issue dynamic ongoing
- Attributes of the construct
- Coping mechanism with family dynamics
- Fear of reaction form community and extended family
- Cultural level
- What is the story, what have I found out about the phenomenon?

Decision

Because of my own background in social work and how the concept have emerged in the data I feel a systemic approach is a good broad way to try and ground the findings. Some of the detail regards services will not be given due attention in the write up but at presentations to the hospital and thus in this way it will have its effect. Brofenbrenner ecological model if adapted covers a wide range of the themes in an appropriate way. Rereading scripts to see of this model is appropriate and allows the richness of the data to shine through. Looking at negative cases.
Appendix N: Analysis of initial super-ordinate themes

1. **What is it? & Why? How?**

   The notion emerged of concealment and denial being involved in late disclosure and it being an ongoing process even after the baby is born. Many levels to reasons why it occurs, prior family stress, fear of parental reaction, a way of coping.

2. **Reactions**

   Notion that how society/professionals/partner/friends/family members would react to the pregnancy and being a single mother affected delayed disclosure process.

3. **What to do?**

   Woman’s attitude towards adoption/termination/parenting influenced by her own beliefs, her coping style, and her attitudes, past experience and expected family reaction.
4. **Lifestyle & Changes**

The changes a woman made to her life style during her pregnancy, smoking, drinking, diet and clothes worn

5. **Attachment**

The woman’s struggle with the bonding process while being unsure of the outcome of the pregnancy. Mother’s mood affected this process, as did the reality of the child.
Appendix O: Systemic model

Brofenbrenner’s model adapted to explain the concept of late disclosure of pregnancy by analysis of super-ordinate themes, which fall into three broad categories of either, individual, family or cultural factors.

Primary system = Individual influences

- Personal coping style
- Knowing-Self
- Needing space and time
- Beliefs about adoption
- Mental health
- Age
- Unplanned pregnancy
- Baby’s temperament
- Prenatal attachment behaviour

Secondary system = Family/friends influences

- Prior family stress
- Prior family conflict
- Familial coping strategy
- Negative parental reaction

Friends & Partner
Support (or lack of)

Macro-system = Society-cultural influences

- Stigma of single mother
- Stigma of adoption
- Attitude towards termination
Appendix P: Article by Kevin Myers regarding single mothers (2005)

How did Edward Walsh feel as he found himself sitting outside the warm tepee of political correctness, and in the howling blizzard of reality, after his remarks about unmarried mothers? Kevin Myers writes.

Not very comfortable, probably. Never mind, Ed, I’m used to the vitriolic epistolary hiss in the column inches that besiege me in my little corner here. We can sit together here in the snow and perish together - or maybe think the unthinkable.

Such as that our system of benefits to unmarried mothers is creating a long-term time-bomb. Even as things stand, we are bribing the unmotivated, the confused, the backward, the lazy into making the worst career decision of their young lives, and becoming professional unmarried mothers, living off the State until the grave takes over. Our welfare system is creating benefits-addicted, fatherless families who will be raised in a culture of personal and economic apathy - and from such warped timber, true masts are seldom hewn.

The response of Anne Bowen, policy officer of the One Parent organisation was - naturally - that Ed’s remarks were “offensive” and “hurtful”. God knows why she didn’t say “unhelpful”, “unsavoury” or “distasteful”, which form part of the usual verbal repertoire of the politically correct. This assesses any political observation not on its factual merits but on the lachrymosity of the audience.

So she naturally declared that it would be extremely “hurtful” to suggest that women would choose single parenthood for financial pain, or that “they would be put themselves before their children”. No doubt it is hurtful. But is it true? And how many girls - and we’re largely talking about teenagers here - consciously embark upon a career of mothering bastards because it seems a good way of getting money and accommodation from the State? Ah. You didn’t like the term bastard? No, I didn’t think you would. In the welfare-land of Euphemesia, what is the correct term for the offspring of unmarried mothers? One-parent offspring? But when we use that deceitful term, one-parent, we actually mean fatherless, in the social meaning of the word, though not of course in the genetic sense. The lads who (in Sinead O’Connor’s immortal word) are the donors are probably off elsewhere, donating away wherever and whenever they can, and usually without having to pay a penny of child support for the results of their generous donations.

Ed had suggested that mothers of bastards could earn up to £20,000 a year from benefits. Through her gushing tears, Anne inconsolably declared that a lone parent (i.e., a MoB) gets only £148.80 a week, plus £19.30 per child. And indeed, this would be impossible to live on if it were all that the State forked out; but it is not. In addition, the State pays
for the MoB’s rented accommodation - worth over £13,000 or more a year. So the MoB’s real income could come to nearly £23,000. If you’re working, you have to have pre-tax earnings in the region of £38,000 to match that income.

All of which is a long-winded way of describing insanity - because we all agree it is mad to bribe impressionable young women into a life of MoBbery, which is crushingly limiting, with little sense of achievement or personal ambition, and no career to speak of, other - that is - from cash-crop whelping.

And how do MoBs cope when their male bastards (in a literal sense) become metaphorical bastards in adolescence? How does a woman assert her will over a sour, aggressive, uncommunicative teenage boy? Well, she usually doesn’t - as a study of the parental backgrounds of gang members in London and New York - where they are ahead of us in such matters - will tell you. Mob members usually have stressed-out MoBs for mothers, and absent FoBs for dads.

The central heresy underlying welfarism is that benefits don’t influence general conduct and that all the State is doing is simply helping individuals. Social groups - the argument goes - do not emerge in direct response to welfare payments. That’s what liberals in the US said, so they formulated policies that were kind and good, and certainly not ones that were designed to corrupt and deprave. But corrupt and deprave they did. Welfare lines and teenage moms by the hundred thousand emerged as a direct result of the apparently but illusorily attractive State incentive not to work.

Well, even that compulsive sharer of pain, Bill Clinton, knew something tough had to be done: at the instigation of a Republican-dominated Congress, he began a concerted drive against MoBbery, cutting welfare and introducing strong tax incentives for working MoBs. The results were amazing. After 30 years of unbroken increase, the rise in MoBbery was swiftly halted. Welfare handouts plummeted; and 10 years on, two out of three MoBs are now in work.

We just know that’s not going to happen in Ireland while debate remains mired in the schoolgirl swamp of what is “hurtful” and “offensive”: why, thith howwid talk makes one want to cwy. Even our super-sized MEP, Big Mac, tearfully denounced Ed for his heartless remarks. Well, naturally. After all, Sinn Féin/IRA have strong proprietorial feelings about single-parent families, having made hundreds and hundreds of them out of what had originally been two-parent families: why, God love them, they’ve even dabbled in making a good few no-parent families.

We have 80,000 MoBs, and the numbers are rising; time to ring the alarm bells. But of course, in Dáil reann, we’ll get some weepy, sanctimonious bilge over what is “offensive”, while the rest reach for the ear-plugs.
Appendix Q: Demographic questionnaire

1) Assigned code number .................................

2) Age of individual at initial presentation.........................

3) Nationality Irish (county.............) / Other......... / Unknown

4) Ethnicity
   White / Traveller / Black /Asian / Other.............

5) Relationship status at time of pregnancy
   Single / Married / Separated / Short term / Long term relationship (>6 months)

6) Current relationship status
   Single / Married / Separated / Short term / Long term relationship (>6 months)

7) Is this relationship with biological father
   Yes / No

8) Relationship with biological father of the child at time of pregnancy
   Once-off / Casual / Short term / Long term relationship (>6 months)

9) Age of Biological father ...............................

10) Nationality biological father
    Irish (county.........) / Other......... / Unknown

11) Ethnicity biological father
    White / Traveller / Black /Asian / Other

12) Marital status biological father
    Single / Married / Separated

13) Is woman presently living
    On own / With partner / Family / Friends / Shared / Supported accommodation

14) Employment status on presentation
    Secondary / Third level / University / Employed / On benefit / Other.......... 
    If in education: Full time / Part time 
    If employed: Skilled / Unskilled

15) Education level
    Secondary / PLC course / Third level Undergraduate / Postgraduate

16) Did the individual live in (Rural / Urban) area during her pregnancy

17) Factors adding to the crisis
    Financial / Relationship / Education / Perceived family reaction / Other........
18) Available supports while pregnant
   Friends / Family / Partner / Professional

19) Available supports since delivery
   Friends / Family / Partner / Professional

20) When were personal supports informed
   ………. (No of weeks) Before / After presentation at UCHG / After delivery

21) When did professional supports become involved
   ………. (No of weeks) Before / After presentation at UCHG / After delivery

22) Is current partner Aware / Unaware and are they Supportive / Unsupportive

23) Referral source to MSW
   Self / Other agency ………./ Hospital Staff / GP / CWO / Other ……

24) Reason for referral
   Crisis pregnancy counselling / Adoption / Support / Other ……..

25) Information requested
   Benefits / Support/ Adoption / Other………. 

26) Were any other supportive services accessed and if so, which
   CURA / GP / Life / Other………. 

27) Outcome of this delivery Stillborn/ Twins / Living singleton

28) Did the mother experience adverse pregnancy complications due to
   concealment/crisis pregnancy……Yes/No If so what………..

29) Was baby admitted to PBU or paediatric ward
   Yes / No If so, for Medical reasons / Social reasons

30) Baby’s weight at birth…………

31) First concealed pregnancy
   Yes / No / NA

32) Outcomes of previous pregnancies
   Miscarriage / Termination / Parenting / NA

33) Other children
   Yes / No If yes which age(s) …………

34) Are underlying issues present
   Mental health / Domestic violence / Lack of support / Substance abuse / ……
35) Decision on point of discharge: Parenting / Adoption / Fostering

36) Status at time of coding this study: Parenting / Pre-Adoptive / Fostering

37) Support remaining involved

38) Community care social worker / MSW / CURA / Life / Other