THE UNIVERSITY OF HULL

'Choices made by women in pregnancy, birth and the early postnatal period, after a previous traumatic birth'

being a Thesis submitted for the Degree of Doctor of Philosophy

in the University of Hull

by

Anne-Mari Greenfield, MA (Open University), MA (Open University), PGC (University of Derby), BA (University of Leeds)

March 2017

Acknowledgements

I would like to thank the nine women who took part in this research, both for giving up your time to speak to me, and for allowing me to discuss such personal, emotional and intimate issues about your pregnancies, births, relationships and babies. It was a huge privilege to be allowed to travel with each and every one of you on your journey. Your courage in facing birth, after your previous experiences, was inspirational. Without you, this research would not have been possible.

To my supervisors Julie and Lesley, I would like to extend my gratitude for helping me to channel my passion into academic words, and for reining in my enthusiasm in such a kindly way. The guidance you provided was considered, challenging and always helpful.

My family and friends have provided unwavering support to me, tolerated plans cancelled at last minute because I needed to write, reassured me on days when I felt unable to do justice to the stories women shared with me, and have put up with me talking about my research at every given opportunity. Thank you all, especially my children, Jo and Pip.

And lastly, thank you to Susan Stephenson, whose words and care inspired me to believe I could actually write this thesis. You were my midwife, my colleague and my friend, and this thesis is dedicated to you.

Contents

List of figures

List of tables

Chapter 1 – Introduction

This chapter provides a contextual guide to the structure of the thesis, and an overview of the need for the associated research.

1.1 Need for the research

Experiencing childbirth as a traumatic event is a factor that has been highlighted as contributing to poorer psychological outcomes. Up to 30% of women in the UK experience childbirth as a traumatic event, with many consequently going on to experience some form of anxiety, depression, or post-traumatic stress disorder (PTSD) following childbirth (Slade, 2006; Ayers, 2014). When childbirth presents as a traumatic experience it can impose a profound effect on the lives of mothers, fathers (Nicholls & Ayers, 2007), their children (Allen, 1998) and family and friends (Beck, 2004a; Ayers, Eagle & Waring, 2006). If left untreated the effects can last many years (Forssen, 2012). Consequences of traumatic birth include enduring mental health problems (Forssen, 2012; Beck, 2004a), compromised maternal infant relationships (Nicholls & Ayers, 2007), poorer quality marital relationships (Ayers, Eagle & Waring, 2006) concomitant depression in partners (Nicholls & Ayers, 2007) and can present a challenge to future reproductive decisions (Fenech & Thomson, 2014). This is therefore an important area to research, in order to alleviate some of these difficulties.

The causes of traumatic birth are complex and multi-faceted (Simpson & Catling, 2016). Predisposing factors include pre-existing psychological issues (Grekin & O'Hara, 2014) or prior traumatic experiences, such as rape and sexual abuse (Ford & Ayers, 2011). Other risk factors include obstetric emergencies and neonatal complications (Grekin & O'Hara, 2014). Poor care during labour can compound these experiences, or be traumatic in its own right (Ford & Ayers, 2011; Elmir, Schmied, Wilkes & Jackson, 2010; Beck, 2004a). Attachment styles and relationships with partners can influence the likelihood of developing psychological disorders following a traumatic birth, and may influence whether a birth is experienced as traumatic too (Iles, Slade & Spiby, 2011).

Women who have experienced a traumatic birth are less likely to have a subsequent pregnancy (Fenech & Thomson, 2014; Gottvall & Waldenstrom, 2002). If these women do become pregnant, they are more likely to request a non-medically indicated caesarean section (Kottmel, Hoesli, Traub, Urech, Huang, Leeners & Tschudin, 2012; Gamble & Creedy, 2001). What is less

well known is what other choices women make about pregnancy and birth following a previous traumatic birth.

1.2 Rationale for thesis

A narrative literature review, performed as part of the research, showed that there was a body of knowledge about the choices that pregnant women made, having previously experienced a traumatic birth. However, this literature related predominantly to women who wished to have a non-medically indicated caesarean birth. A smaller body of research examined the choices women made after a traumatic birth that were outside of the NHS (or equivalent) guidelines, such as homebirth after a previous caesarean birth (Beck & Watson, 2010), and freebirth (Feeley & Thomson, 2016; Edwards & Kirkham, 2012). Other research examined the effects of a further positive birth upon women who had previously had a traumatic birth (Thomson & Downe, 2013; Thomson & Downe, 2010; Beck & Watson, 2010). A gap in the existing literature related to the choices women made throughout the course of the antenatal and intrapartum periods, their reasons were for making these choices, and how they felt about their choices after the birth.

Understanding the choices women make throughout the whole perinatal period (and why they make these choices) is a necessary pre-requisite to offering appropriate support. During pregnancy women who have previously experienced a traumatic birth may suffer from increased anxiety and distress (Thomson & Downe, 2010), secondary tokophobia (Hofberg & Brockington, 2000), and may request non-medically indicated caesarean births (Pang, Leung, Lau, & Chung, 2008). Providing appropriate support may help to reduce negative feelings during pregnancy (Thomson & Downe, 2010). Optimising the possibility for this new pregnancy and birth to be a positive experience is also important. Beck and Watson (2010) state that

> 'A positive childbirth has the potential to empower a traumatised woman and help her reclaim her life' (p.248).

Identifying the factors that contribute to a woman seeing a future pregnancy and birth as a positive experience is a first step in providing support to make a positive birth more likely.

This study therefore set out to explore the choices this group of women make, when they become pregnant again, by posing the question:

'What choices do women make in pregnancy and birth, when they have previously experienced a traumatic birth?'

The literature search revealed that a range of terms were used to describe traumatic births. Furthermore, the meaning ascribed to the terms were not consistent. The term 'traumatic birth' was used in the literature to describe births which were physically traumatic, or psychologically traumatic, and was also used to describe operative births, regardless of whether the mother found the birth to be a traumatic event. This created a difficulty in carrying out the research, as the subject under investigation needed to be clarified. Therefore, before the research was undertaken, a concept analysis (Walker & Avant, 2011) was performed. Analysing the concept of 'traumatic birth' allowed for clarity in addressing the research question. The definition produced also acted as one of the inclusion criteria for the selection of participants for involvement in the study.

1.3 How the research question was addressed

The research question required the investigation of women's understandings of the choices they have available, the choices they are making, and the reasons for those choices. To address the research question, rich and in-depth data had to be generated. The solicitation and analysis of this data was informed by the feminist constructivist epistemological position of the researcher. Qualitative research was therefore selected as the most appropriate methodology to employ, based on both the epistemological position of the researcher, and the research question itself.

The research question was addressed by undertaking qualitative research with a group of pregnant women who had previously experienced a traumatic birth. A constructivist grounded theory methodology was employed, underpinned by feminist research principles. These methodological choices informed the research design.

To fully address the research question, the research was designed as a longitudinal study, following the women from early pregnancy until after birth. The research was designed to include in-depth semi-structured interviews. Interviews were carried out at certain key points during the perinatal period. The research design included the supplementation of the interview data with elicited self-completion diaries. As the aim of the research question was to understand the women's decision making in their own terms, triangulation from external sources (such as Maternity notes or interviews with those providing care for the women) was not sought.

1.4 Structure of the thesis

The thesis is written in the third person, in order to prioritise the women's experiences. In feminist constructivist research, it is common for a first person narrative to be adopted, in order to locate the researcher as an active participant in the meaning making process, and therefore to address power imbalances between the researcher and the researched. However, a key concern for women involved in this research was struggling to have their choices listened to, recognised and respected – an issue which has been termed 'struggling to be heard' in Chapter 11. Therefore, in this thesis a central concern has been to ensure that the women's voices are heard. Adopting a third person stance can help to ensure that the women's voices take centre stage, because when 'I' or 'we' is used within the writing, this is a participant, speaking directly to the reader of the thesis through a quotation. The use in this thesis of a third person tense is therefore not intended to distance the researcher or claim that she is a neutral observer – the researcher was and is an active participant in the production of the research. Rather, this stance is intended to prioritise what the women themselves would like to say about their experiences.

To ensure that the position of the researcher as a co-creator in the production of the data is acknowledged, the two sections which outline the researcher's own position in relation to the research are written from the first-person perspective. These sections can be found at 1.5 and 15.6.

The thesis is set out to take the reader through the journey of the research. First, the need for the research is shown, and the research question is formulated. The methodological approach taken is then explained, and the research methods used are detailed. The data gathered is presented over three chapters, corresponding with the three sets of interviews that were carried out with women. Preceding each data chapter is a short chapter which gives pen portraits of each woman's situation at the time of that interview. The findings from the three data chapters are then discussed together. As part of the discussion, theories emerging from the findings are identified. These theories are drawn together in a proposed Care Pathway for pregnant women who have previously experienced a traumatic birth. The final chapter reviews the research as a whole, examining the quality of the research and noting its strengths and limitations. Within this chapter recommendations are also made for future practice and further research.

The purpose of this thesis is to contribute to the literature an improved understanding of the choices pregnant women make, when they have previously experienced a traumatic birth. It is also intended that the findings from this thesis can be used in practice to provide support to this group of women. This overview briefly describes how the thesis is arranged and what is included in each of the chapters hereby summarised.

Chapter 1: Introduction: This chapter has provided a primer to the thesis, introducing the importance of perinatal choices following a traumatic birth. The context leading to the research question has been briefly described. This chapter then lists the organisation of the thesis.

Chapter 2: Background: The socio-cultural context in which women currently give birth in the United Kingdom is examined. The current constructions of choice in childbirth, and traumatic birth are summarised. An overview of the major directions of current research into traumatic birth is provided.

Chapter 3: Literature review: Gives a critical appraisal of the literature relating to the choices pregnant women make, subsequent to a previous traumatic birth. The findings from the existing literature are drawn together through a thematic synthesis. From the discussion of the thematic synthesis, the gaps in the literature which form the basis of the research question are highlighted.

Chapter 4: Concept analysis: An analysis of the concept of traumatic birth, as used in the existing literature is undertaken. The analysis utilises Walker and Avant's (2011) model to produce a definition of the concept.

Chapter 5: Study Rationale: The findings from the preceding three chapters are drawn together, to form the basis for the proposed research. The research question is defined.

Chapter 6: Methodology: The underlying epistemological position of the research is examined. From this, the methodological approach is established. The theoretical underpinnings of feminist research principles are set out. The development of constructivist grounded theory is detailed. The implications of using these methodologies in this research are explored. Reflexivity is an important component of both feminist and constructivist grounded theory research, and different approaches to reflexive practice are discussed, after which the reflexive position of the researcher is established.

Chapter 7: Research Methods: The design of the research protocols are given along with the rationale of the data collection methods used. The steps followed in the selection of participants, the collection and the analysis of the data are described. Details of the challenges faced in the carrying out the research are given. Ethical considerations pertaining the research are discussed.

Chapter 8: Introducing the women: Demographic details of the participants are given, along with brief histories. Pen portraits of each woman are provided, which include their fertility and birth histories, and their plans for the current pregnancy and birth, at the time of the first interviews.

Chapter 9: Findings from first interviews: This chapter is the first of three data analysis chapters, each of which is preceded by biographical information about each of the women involved. Consisting of an interpretation of the first interview with each participant, this chapter highlights the choices women were considering in the early antenatal period. Women discussed how they felt about being pregnant, and about their 'bump'. The women described a process of gathering and carefully analysing information from many different sources, which they used to make plans for this pregnancy, birth and early postnatal period. Even at this early antenatal stage, women were focused on the choices around giving birth.

Chapter 10: Update on the women: This chapter gives a brief update about each individual woman as her pregnancy approached full-term. Any changes to previous birth choices are given, alongside details of events during the pregnancy that women discussed as significant issues.

Chapter 11: Findings from second interviews: In this second data analysis chapter, the findings from the second set of interviews are presented. The evidence shows that women have had variable experiences throughout their pregnancies. Women are actively seeking support for the choices they wish to make from partners, healthcare professionals, and in some cases from wider family and friends. Some women are successful in negotiating the support they need, whilst others have found this difficult to achieve.

Chapter 12: Update on the women: The final update on the participants is given. The chapter includes brief details of the last few days or weeks of pregnancy, the women's birth stories, and relevant postnatal experiences.

Chapter 13: Findings from third interviews: This chapter provides the findings from the post-natal interviews. Women reflect on the choices they made during pregnancy, birth, and in the early postnatal period, exploring the common themes about what was actually important to them in retrospect. Postnatal choices are also discussed.

Chapter 14: Discussion and theories emerging: The discussion chapter brings together the interpretation findings from Chapters 9, 11 and 13, into an analysis of women's choices throughout the perinatal period. The central characterisation by women of pregnancy as an embattled state in fighting to assert the right to make choices is explored, using the work of Carl Von Clausewitz's (1832) treatise 'On War'. Relationships of trust and mistrust between women, their partners, and healthcare professionals are discussed. The chapter highlights the journeys women took through pregnancy and birth, from which a model of factors that reassure this group of women is developed. Based on this model, a potential care pathway for pregnant women who have previously experienced a traumatic birth is proposed.

The discussion brings out how the evidence from this research compares with the existing literature, highlighting where new knowledge has been added to the field through the research.

Chapter 15: Conclusions: The final chapter of the thesis sums up the conclusions and implications of the evidence from this study. A methodological evaluation of the research is provided. The chapter concludes with recommendations for both practice and future research.

1.5 Researcher's position

This section outlines the researcher's interest in the area, and her orientation to the area of research at the beginning of the study. It is complemented by section 15.6 at the conclusion of the thesis, which outlines how her positionality was affected by the course of the research. These sections are written from the first-person perspective, in order to ensure that the role of the researcher in co-creating the data through the research is acknowledged.

Following the birth of my first child, I trained as a doula (through Doula UK), and as a breastfeeding counsellor (with La Leche League). I worked with many families throughout the perinatal period, assisting them with antenatal preparation, supporting them during labour, and providing postnatal care, including infant feeding support. I have worked in these roles for almost a decade.

As a breastfeeding counsellor, I was surprised to hear how many women, presenting with infant feeding difficulties, had underlying unresolved difficulties relating to their experience of giving birth. Common themes of disempowerment, feelings of failure and of having been failed, and uncaring care emerged from the discussions. Reading the academic and medical literature, it was apparent to me that a link existed between successful breastfeeding and traumatic births.

Following my training as a doula, I anticipated that I would have a diverse range of clients, including first-time parents, those with limited local family support, and those who had had a previous negative birth experience. I also anticipated that I would support a range of birth experiences, including home births, births in Midwife-led units and Birth Centres, and births within hospitals. Within my first few years of working as a doula, it became clear these preconceptions were both incorrect. Without exception, every client in the first two years of doulaing hired me primarily because they had had a previous traumatic birth. The birth wishes of these clients were also wider than I had envisaged – I attended elective caesarean births and freebirths, as well as home, midwife-led unit and hospital births. Despite the wide differences in the birth choices that women made, it felt to me as though there was a central underlying thought-process occurring for all these women, relating to trust and control.

Later in my practice as a doula, I was hired by other groups of women, including women who were pregnant for the first time, single mothers, and those with limited family support. From these experiences, I noticed a difference in how women who had had a previous traumatic birth approached choices about pregnancy, birth, and the early postnatal period, and how these choices were approached by women who had not had this experience. Yet when I turned to the academic and medical literature to gain a deeper understanding of these differences, I found that no literature specifically addressing these areas existed.

Through my work as a doula and breastfeeding counsellor, I now had colleague-relationships, and in some cases personal relationships with a number of other birth workers, including doulas, midwives who worked within the NHS and as Independent Midwives, and obstetricians. During informal discussions with them about women's choices, all agreed that women who had had a previous traumatic birth did often require a specific kind of care, distinct from general maternity care, and that that care had common characteristics, regardless of the woman's birth choices. However, no-one could satisfactorily describe the characteristics of that care, or articulate the processes that this cohort of women used to make such choices. Equally, no-one could identify

any literature – academic, medical, or popular – which had examined this area. I therefore decided that, if the literature did not exist, I should investigate this area by conducting academic research, and provide some answers that might help those who were supporting pregnant women who had had a traumatic birth to support them better. Since it appeared that birth workers could identify that this was an issue, but did not have a full understanding of what women were doing, or why, the answer had to lie with the women who were experiencing this themselves. With this aim in mind, I began my doctoral research by investigating what was already known about choices women made after a previous traumatic birth. The next two chapters set out my findings.

Chapter 2 – Background to the research

This research is located in the belief that childbirth is a normal physiological function for women. In the absence of health difficulties or other complications, childbirth is a safe event for women and babies, and a normal vaginal delivery in such circumstances confers health benefits on both mother and child (Chalmers, Kaczorowski, Darling, Heaman, Fell, O'Brien & Lee, 2010). These benefits encompass both physical and mental health.

Within the last century in the Western world, the socio-cultural context of birth has altered, from one in which women supported women in birth as a natural process, to one where birth is perceived as risky and hence necessitates managing (Kirkham, 2010; Oakley, 2005). Alongside this cultural change has come an identification of birth as a potentially traumatic event, with long-term negative sequelae for women and their families (Ayers, Bond, Bertullies & Wijma, 2016; Ayers, McKenzie-McHarg & Slade, 2015; Beck, 2009; Ayers & Pickering, 2001). This thesis is concerned to identify what choices women make when they have experienced a birth as a traumatic event, and subsequently become pregnant again.

2.1 The history of birth

Birth is a physically intense experience for a woman, regardless of how a baby is delivered. Pregnancy and birth are also commonly acknowledged to be emotionally intense experiences for parents (Berg, Lundgren, Hermansson & Wahlberg, 1996; Anderson, 2002). Until the last century, childbirth throughout human history has been a relatively unchanging experience. Women have laboured and given birth either alone, or more usually surrounded by female caregivers, who were known to them (Edwards, 2010; Tew, 1995), with some women specialising in assisting birthing women. In such a historical context, the complications and risks associated with childbirth were often perceived as tragic, but inevitable (Edwards, 2010; Tew 1995). Physiologically, the process of birth has not altered, but the socio-cultural context has changed (Edwards, 2010; Kirkham, 2010).

2.2 Birth in the UK

In the last century in the developed world, there have been multiple changes in the socio-cultural norms of childbirth. The model of intrapartum care women receive in the UK is influenced by the paradigm of birth as a biomedical and technological event, (Oakley, 2005).

Women usually travel away from their home to a hospital to give birth, often some distance away, and are cared for by strangers, surrounded by other birthing women who they can usually hear, and sometimes see, in a room which contained lots of equipment, some for routine use, some of which is not explained, but understood implicitly to be 'just in case' (Pilley Edwards, 2004). The only family member present is usually the father of the baby. The way birth takes place in the UK now, as in most Western countries, is unusual on a historical scale (Edwards, 2010; Kirkham, 2010). Kirkham describes in some detail the history of maternity services in the UK over the last century, and the journey to the present situation and paradigm of birth. As she indicates, mothers in the UK have access to many life-saving interventions (Downe, Simpson & Trafford, 2007) – which can also become life threatening if over used (Tew, 1995). Oakley (2005) attributes this change to the introduction of men and patriarchy into what was previously an almost exclusively female concern, and describes the model of maternity care current in the UK as a 'reproductive machine model' (p.34). Significantly she notes that it is now almost unknown to have a birth without medical intervention in the UK (Oakley, 2005). In the decade since Oakley's work, and indeed in the decade preceding her work, attempts have been made to address the level of interventions in childbirth. However, the medicalisation of childbirth has left an inevitable legacy that influences how both women and practitioners think about the risks of childbirth and the risks of intervention, with the result that a medicalised approach to birth is still the norm (Jomeen, 2010).

In 2009 in the UK there were only 135 intrapartum stillbirths that were born at term with no signs of a major congenital anomaly (CMACE, 2011[1]). This is a very low rate, but when such tragedies do occur, there are investigations into what professionals did at each stage of the labour, and these investigations are mandatory (CMACE, 2011). Babies dying during labour is not something which is any longer an accepted norm, and this shift in expectation has had an impact on the whole paradigm of birth.

The aim of most medical intervention is to save lives, and when maternity care becomes a medical event, this aim is no different (Oakley, 2005). In this model of birth, the goal of having a live baby and mother becomes the defining criteria for the success of a birth (Hall, Tomkinson & Klein, 2012). The NHS organisational policies for intervention are all geared around this criterion,

---

1   It has been concluded, that because of the extent of missing information in the 2010 data collected by CMACE and the 2011-2012 data collected via the MPMN portal, it is not possible to reach reliable conclusions based on an analysis of these data, and therefore the latest available figures are from 2009.

and view birth as a medical event (Lowdon, 2012). This view leads to medical interventions being used in situations where there is any perceived risk to the baby's life. The consequence of this, however, is that intervention then becomes routine (Kitzinger, 2006), a situation that is reflected in UK provision of maternity care (Oakley, 2005). Birth is a physiologically normal event, but has become a medicalised, technologised event, in which any perceived risk to the baby's life, however small, is a reason to intervene. Risks are vigorously sought out, and normal birth has been redefined as low/no risk birth (Tew, 1995). The use of technology during birth has become a normal standard, and even a standard to be aspired to (Oakley, 2005; Tew, 1995).

Within this model, women are viewed passively, as the container for the baby, who's welfare is paramount (Hill, 2014; Oakley, 2005), and assumed to want a healthy baby whatever the cost to them personally (Bassett & Iyer, 2000). This is true for most women, but not at *unnecessary* cost (Hill, 2014). Attempts to question a course of action recommended by a health professional may be automatically met with the question 'but don't you want a healthy baby?', which discourages further questions and effectively silences women (Kitzinger, 2006). At the same time, women are also required to actively give or withhold consent to procedures and must make decisions about antenatal care, labour and birth.

2.3 Competing birth models within the NHS

In the UK all women are offered antenatal care by midwives through the NHS. Some women may also have some appointments with an obstetrician (NICE guideline CG62 – Antenatal Care: Women requiring additional care). By its nature, the obstetric model of birth is geared towards a medicalised risk-averse model of birth, whereas a midwifery led model may be dominated by an expectation of normality (Klein, Kaczorowski, Hall, Fraser, Liston, Eftekhary, Brant, Mâsse, Rosinski, Mehrabadi, Baradaran, Tomkinson, Dore, McNiven, Saxell, Lindstrom, Grant & Chamberlaine, 2009). The obstetric approach is frequently justified on the assumption that it saves lives, and indeed it may save babies' lives, though the retrospective historic evidence for this is not compelling (Oakley, 2005). For example, in the USA where the medical model of birth is very dominant (albeit within a different legal context), maternal mortality rates are actually rising (Amnesty International, 2010), suggesting that this model of birth favours the life of the baby over that of the mother. The dominance of the medical and technologised approach to childbirth has been linked to unnecessary increases in intrapartum interventions, which can themselves increase risks for mothers and babies (Downe, Simpson & Trafford, 2007).

Conversely, midwives have the potential to be the guardians of normal birth (Berg, 2010), and in some studies, midwives' attitudes indicated lack of support for intervention and strong support for alternative birth settings to hospitals (Klein et al., 2009). Yet midwives are simultaneously required to follow local NHS policies, which are usually controlled by obstetric concerns (Kirkham & Stapleton, 2004). A midwife's role can become that of the servant of the doctors and the institution (Cronk, 2010), resulting in midwives policing each other to make sure everyone stays in line. They can also be seen as forcing women into vaginal birth, and away from caesarean births (Churchill & Francome, 2009). Alternatively, midwives can be positioned as being in conflict with doctors, organisational policies, and with other midwives (Tew, 1995), and taking the woman's side, or they can be seen as the go-between for women and the institution, negotiating between those with the expert knowledge (doctors, especially Consultants) and those with the theoretical power to make decisions (women) – a position which also negates the midwife's own expert knowledge. These competing models can cause internal tension for the individual midwife as she balances the competing models of birth. Tension can also arise between professionals as these models come into conflict, and this is exacerbated by the hierarchical nature of the relationship between obstetricians and midwives (Kirkham & Stapleton, 2004).

These tensions between professionals are reflected in women's accounts, as they experience differing pressures to make choices about their pregnancy, labour and birth (Jomeen, 2012; Oakley, 2005). The assumptions underlying the choices recommended by the professionals can also be internalised by women – that normal birth is something to be achieved, or that wanting a normal birth is having an unrealistic expectation (Shub, Williamson, Saunders & McCarthy, 2012). The dynamic between the various health care professionals, local policies, and the labouring woman influence the choices women make and hence the ways birth is managed (Kingdon, Neilson, Singleton, Gyte, Hart, Gabbay & Lavender, 2009; Martin & Kasperski, 2010; Simpson, James & Knox, 2006).

As shown above, two competing models of birth exist within the NHS services women receive. Most women will be exposed to both models through the care they receive, and will have to make decisions about antenatal, intrapartum and postnatal care against this confusing background. In this context, the level of real choice that women are able to exercise must be questioned.

2. 4 Issues relating to choice

Under UK law in relation to consent to medical procedures (GMC, 2008), and NHS policy on Maternity Care and Informed Consent (NHS, 2012), pregnant women in the UK have the freedom to decide where to give birth, who can attend the birth, and whether to accept or decline any interventions offered. The role of the medical staff, set out in the policies cited above, is to offer monitoring, information, advice, and to offer access to interventions if appropriate (NHS, 2012; GMC, 2008). Except in rare cases relating to mental capacity and involving Court Orders (RCOG, 2006), the pregnant woman is the only person who can make a choice about what should happen during labour or birth (Beech, 2014; Birthrights, 2013b).

This is not the experience of most women giving birth in the UK. Kirkham and Stapleton (2004) found that women reported that they were offered choices, but the way in which the choice was offered created a strong feeling of being 'allowed' or 'not allowed' to make choices about antenatal care, labour, interventions and birth. Whilst this research is 13 years old, it appears that the situation remains largely unchanged. Hallam, Howard, Locke and Thomas (2016) report that women talked postnatally about the importance of being an 'active' mother who made decisions about her care, and how

> 'communication style and compassionate care either enabled or prevented women from adopting the position of 'active' mother' (p.175).

The discourse of choice may have resulted in women being given more information about possible choices, but they are still expected to defer to the 'expert' opinion of midwives or doctors (Jomeen, 2012). There is strong evidence that both midwives and obstetricians pressure women into making the choice that they feel is the correct one (Jomeen, 2012; Kitzinger, 2006; Kirkham & Stapleton, 2004; Stapleton, 2004; Levy, 2004).

Women's criteria for a successful or unsuccessful birth may not be as simple as the obstetric or midwifery model (Eaton, 2014; Oakley, 2005). It may or may not include 'normal birth' as desirable. Some women are very keen to have a normal birth (Jomeen, 2012; Gamble, Creedy, Moyle, Webster, McAllister & Dickson, 2005; Hildingsson, Rådestad, Rubertsson & Waldenström, 2002), but for others a 'successful birth' may be one where they have been able to obtain a planned caesarean section, without medical indication (Hofberg & Brockington, 2000; McGrath & Ray-Barruel, 2009). Similarly, whilst almost all pregnant women would want

their baby to be born alive, women may have additional criteria for a successful birth, such as the health of the baby, their own physical and emotional wellbeing, their long-term recovery and health, future fertility and the experience of the birth (Eaton, 2013; Oakley, 2005).

Feeling in control of decisions, and having genuine choice, is a common desire expressed by women (Jomeen, 2012). 'Better Births' (NHS, 2016) sets out an ambitious strategy in relation to this, which includes

> 'Choices being made available to all woman in terms of antenatal care and postnatal care; and of the type and place of birth even if it means crossing traditional boundaries' (p.8)

This policy aim shows that the idea of women having control of their choice is central to current maternity policy. However, this does not reflect current practice. The report later acknowledges that this aim does not reflect the current situation:

> 'There has been a longstanding expectation that women should be given a full choice of place of birth: home birth, midwifery unit and obstetric unit, and this is endorsed by NICE guidelines. However… it is not happening everywhere. Of the women surveyed, 25% were aware of all 4 options for place of birth, a further 40% were aware of 2 or 3 options and 33% had one choice only. (NHS, 2016, p.32)'

Indeed, the existing situation is that the discourse of choice may lead to conflict between the medical care providers and the birthing women is acknowledged, as demonstrated by this 'Key message' from the RCOG Expert Advisory Group Report (2011)

> 'While choice is supported in principle, there is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services.' (p.4)

Lowden (2012), in discussing this report from RCOG, describes how the existing paradigm of birth within the UK health services can come into conflict with individual women's own paradigms of successful birth, and the pressure that can be brought to bear on women to comply with the medical view. This conflict is not necessarily limited to the health arena. In the UK, there

have been three Court order caesarean sections carried out against women's wishes within the last eight years. In addition, in 2012, a pregnant woman had to go to the European Court in order to establish her right to choose the circumstances in which she would give birth (Harman, 2012). The respondent in this case was the Hungarian Government, but the ruling gave to women the human right to choose the circumstances in which they will give birth across the whole of the European Union. In the UK, judicial review proceedings were threatened against a London NHS Trust in 2011 after it suspended its home birth service. Facing this threat, the Trust reinstated homebirth services and used independent midwives to cover its staff shortfall (Birthrights, 2013c). When women are taking their maternity care providers to Court to establish their rights about how to birth, there can be no doubt that there is conflict between the medical and legal views of birth, and what some women want.

2. 5 Expectations of women to handle knowledge

Women's knowledge of their own bodies is not considered to be as valuable as the detail provided by monitoring equipment, or as valuable as the knowledge held by the experts (Kirkham & Stapleton, 2004; Oakley, 2005; Berg, 2010). In some aspects of maternity care, women's own internal knowledge comes to be seen as suspect, for example in tensions over establishing the estimated due date (EDD) of a baby. In determining the EDD, women's reports of the date of conception, or date by menstrual cycle are often overruled by the dating from ultrasound scan (Oakley, 2005).

Rather than relying on intuition or an innate sense, women are expected to weigh the evidence presented to them by the experts, and then make the decision that is correct for them. If they make a decision in line with the advice received, and the outcome is negative, the woman can expect to receive compassion and sympathy (Blanchard & Bourgeois, 2014). If the woman makes a decision against medical advice, whether that is to have an elective caesarean or to have a home birth after a caesarean, she faces censure (Kitzinger, 2006; Jomeen, 2012). Should this lead to an adverse outcome, the woman can expect condemnation (Mamamia, 2012). If her decision leads to an outcome which is positive, she is viewed as 'lucky' rather than having made a good decision (Kirkham, 2004).

2. 6 Factors affecting conflict and trust in relationships during labour

In the UK, all women receive intrapartum care from a midwife, who has a legal obligation to attend a birth, if requested to do so by the woman – an obligation which is not placed on other maternity medical professionals such as obstetricians. The woman who is giving birth has the right, and the theoretical power, to choose to accept or decline the midwife's advice. But if anything goes wrong, the midwife knows that she will be held accountable (NMC, 2016; Fullbrook, 2008). This legal position for midwives, of having to attend a woman, not being able to compel her to follow advice, but being subject to investigation if she does not, may also give rise to additional tensions during labour and birth (Dauphinee, 2004).

The work that midwives' do incorporates practical and clinical skills, but also includes a great deal of emotional work in building relationships with women, and providing them with individualised support (Drach-Zahavy, Buchnic, & Granot, 2016; Rayment, 2015; Hunter, 2011; Hunter & Deery, 2005). In addition to the legal obligation to attend a labouring woman, and the potential for litigation, midwives must deal with the challenges of the emotional work inherent in supporting several women giving birth at the same time, who may need very different things. The demands placed on midwives to initiate intimate relationship quickly, maintain those relationships, respect women's choices whilst promoting normal birth and concurrently operating within the local policies frequently lead to exhaustion (Rayment, 2015; Hunter & Deery, 2005).

A great deal of mutual trust is required to make this relationship work well, within the difficult legal framework that exists in the UK (Hunter, 2011; Kirkham, 2010; Levy, 2004). In the current dominant model of maternity care in the UK, it is usual for a midwife and mother to meet only during labour, and the woman may experience a change, or several changes in midwife, as shifts end and begin. This makes building such a trusting relationship, very quickly, quite difficult. Midwives who feel strongly supported by their organisation are more likely to view women's integrity as important (Hunter, 2011; Hunter & Deery, 2005), and so support their right to make decisions, whilst those who feel unsupported by their organisation are likely to practice from a risk-averse model of care which holds women's views as less important (Thompson, 2013; Hall, Tomkinson & Klein, 2012).

If this relationship is not successfully built, tension and even conflict may arise between the woman and the midwife (Drach-Zahavy, Buchnic, & Granot, 2016; Thomson, 2013; Dauphinee,

2004). Whilst women hold the legal power, the midwife holds the expert knowledge and skills, and can present information in a way which strongly influences a woman's choices (Beech, 2014; Levy, 2004). At the same time, a midwife has a responsibility to ensure that the woman she is caring for is making an informed choice, and if she has only just met the labouring woman, assessing that can be very difficult. If a woman is agreeing to a course of action the midwife feels is advisable, the midwife may be more likely to assume that the consent is informed, than if the woman makes a choice the midwife thinks is inadvisable, or even dangerous. Walsh (2008) describes this as midwives offering 'informed consent rather than informed choice' (p.499) acknowledging women have been given information by the midwife, but with a strong expectation that they will comply with the advice, and an ever present threat of being 'a bad mother' if they decline the advice.

Conflict during labour may also arise between the midwives and the obstetricians, due to the differing philosophies of birth each holds (Reiger, 2008; Levy, 2004; Tew, 1995). In this situation, a midwife may find they are supporting a labouring woman to make a choice which the midwife believes is correct, but which a more senior member of staff (such as an obstetrician or another midwife) thinks is inadvisable, or even dangerous. The midwife may find ways to appear to agree with the obstetrician, but use delaying tactics or negotiate slightly different alternatives, in order to support the woman's choices (Hollins Martins, 2007; Levy, 2004). Whilst this support allows women to have their wishes taken into account, it models for the labouring woman (and her birth partners) that the obstetrician is the only one who determines what choices are to be made (Reiger, 2008; Tew, 1995). Alternatively, midwives may feel the pressure of the social hierarchy in the hospital setting is so strong, that they ignore the views or choices of the woman, instead following local policies, or the instructions of senior colleagues and act in ways that are contrary to the woman's wishes (Hollins Martins, 2007).

Physiologically, surrendering to the physicality of birth is an important part of labour (Odent, 1994). It is perhaps not surprising then that some women will want to hand over choice and control at certain points in labour and birth (Kirkham, 2010; Jomeen, 2010). For the relinquishing of choice and control to be positive, the woman must be handing over her power on her own terms, at the point she determines is right for her (Jomeen, 2010). The person to whom she gives that power must be someone she feels understands her wishes, who is emotionally capable of bearing the burden, and with whom she has a reciprocal relationship of trust (Attarha, Keshvarz, Bakhtiari & Jamilian, 2016; Thompson, 2013; Raphael-Leff, 2005). The woman must feel cared about and cared for in order to successfully hand over choice and control (Jomeen, 2010). The

way in which choice is framed legally and by organisational policy does not necessarily support women to hand over this control, in this way, and so the importance of an underlying relationship is not formally recognised.

This leads to the paradox of choice facing pregnant women within the NHS Maternity Services, where choice is explicitly stated as important, but where there can be an unstated 'correct choice'.

2. 7 Traumatic birth

In the previous section, a worst-case scenario of what women in the UK might experience when giving birth was outlined. This model includes high intervention, with unknown care-givers who are themselves working under pressure, where women are narrowly positioned within competing paradigms of birth, and where women's views may come into conflict with organisational policy or practitioner perspectives (Bones, 2007). This is not the experience of all women giving birth within the UK, but it is the realistic experience of some. For the women who do give birth in these circumstances, it is hardly surprising that a high number of them experience giving birth as traumatic. This trauma may come from the woman sustaining a serious physical injury during labour (Grekin & O'Hara, 2014), which has a higher rate of occurrence with interventions (Ampt, Patterson, Roberts & Ford, 2015), and being affected psychologically by this injury for a long time afterwards. Or the trauma may be purely psychological (Ayers, Bond, Bertullies & Wijma, 2016; Kitzinger, 2006; Beck, 2004b). The care women receive during labour has the potential to cause psychological trauma, if it is perceived by the woman as inhumane, uncaring, humiliating or intimidating (Ayers, Bond, Bertullies & Wijma, 2016; Ayers, 2014; Elmir, Schmied, Wilkes & Jackson, 2010). This perception of care can cause trauma even in otherwise normal births (Thompson & Downe, 2010).

It is recognised that up to 30% of women in the UK experience childbirth as a traumatic event, with many of them going on to experience some form of anxiety, depression, or post-traumatic stress disorder following childbirth (Yildiz, Pelin, Ayers & Phillips, 2017; Ayers, Bond, Bertullies & Wijma, 2016; Slade, 2006). The links between events in the intrapartum period, and postnatal mental wellbeing are not well recognised. Whilst post-natal depression has been recognised and treated for many years, postnatal anxiety and PTSD linked to childbirth have only been recognised more recently (Ayers, Bond, Bertullies, Wijma, 2016; Ayers & Pickering, 2001; Creedy Spochet & Horsfall, 2000), and quantitative research into this subject has only been undertaken

very recently (Grekin & O'Hara, 2014). This is in spite of the informal recognition of the link between events during childbirth and postnatal mental health by those such as Beech and Robinson (1985) nearly 30 years ago. Along with others such as Kitzinger, they have spent nearly three decades bringing women's distress following traumatic childbirth into the public eye. Yet until 1994, when Criterion A was redefined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), it was extremely difficult to diagnose PTSD occurring as a result of childbirth.

There are some divisions about the level of true PTSD experienced by women who have had traumatic births. But where PTSD after childbirth does exist, evidence indicates that it can be profoundly life affecting and of great longevity (Yildiz, Pelin, Ayers & Phillips, 2017; Kendall-Tackett, 2014; Slade, 2006).

Debates continue about the most useful ways to conceptualise and further investigate why women are traumatised by childbirth, how to prevent this where possible, and how to treat it where inevitable. Contemporary research into traumatic childbirth has developed into an array of different focuses, as shown in Table 1 below.

Table 1 – Current focus of childbirth related PTSD research

Research focus	Examples of research
What makes childbirth traumatic?	(Simpson & Catling, 2016; Slade, 2006; Beck, 2004b; Kitzinger, 2004)
Why do some women develop PTSD whilst others do not?	(Yildiz, Pelin, Ayers & Phillips, 2017; Ayers, Wright & Ford, 2015; Leeds & Hargeaves, 2008;)
What is the best treatment for traumatic birth/childbirth related PTSD?	(Thomson & Downe, 2016; Robinson, 2007; Small, Lumley & Toomey, 2006; Gamble et al, 2005; Robinson, 2002)
How can traumatic childbirth be prevented?	(Ayers, Bond, Bertullies, Wijma, 2016; Quinn, Spiby & Slade, 2015; Kendall-Tackett, 2014; Saisto, Ylikorkala & Halmesmaki, 1999)
Understanding the construct of PTSD	(Ayers, Bond, Bertullies & Wijma, 2016; Ayers & Olander, 2015; Grekin & O'Hara, 2014; Ayers, Harris, Sawyer, Parfitt & Ford, 2009)

2.8 Subsequent births

Whilst medical and academic debates and research continue, women who have experienced a traumatic birth have to make decisions about whether to have further pregnancies and births. Thomson and Downe (2010) point out that there are very few professional support services available to help women after a traumatic birth and prior to a subsequent birth.

Some women develop secondary tokophobia[2] after a traumatic delivery, and may go to great lengths to avoid childbirth in the future, including tubal ligation, their partner having a vasectomy, not engaging in sexual activity, or having terminations (Elmir et al, 2010). Other women may try to conceive only after having arranged a specific birth plan, including an elective caesarean birth (McGrath & Ray-Barruel, 2009). There is a substantial body of research investigating caesarean sections carried out at maternal request, in the absence of medical indication, and a previous traumatic birth experience does seem to be a highly influential factor in creating some of this need (Kottmel, Hoesli, Traub, Urech, Huang, Leeners, & Tschudin, 2012; Kringeland, Daltveit, & Moller, 2009; Nieminen, Stephansson, & Ryding, 2009; Tschudin Alder, Hendriksen, Bitzer, Popp, Zanetti, Hosli, Holzgreve, & Geissbuhler, 2009; Hofberg & Brockington, 2000).

For some women, specific kinds of midwifery care after a traumatic birth, and during a subsequent pregnancy may provide the support they need to have a positive birth experience (Beck & Watson, 2010; Lemay, 2001). Other women may want midwifery support, but feel it is unavailable within the NHS system. Those women may choose to opt out of the NHS medical maternity services entirely, and find alternative support to achieve the birth they want, for example by using an Independent Midwife (Edwards & Kirkham, 2012). Alternatively, some women may choose to have an unassisted birth, either because they feel that the midwifery care they would like is unavailable, or because they believe any midwifery care would risk a repeat of the traumatic birth they previous experienced (Feeley & Thomson, 2016; Edwards & Kirkham, 2012)[3].

---

[2] 'Secondary tokophobia is defined as morbid fear of childbirth developing after a traumatic obstetric event in a previous pregnancy. However, it could also occur after an obstetrically normal delivery, miscarriage, stillbirth, or termination of pregnancy' (Bhatia & Jhanjee, 2012, p.158)

3 There are other reasons for choosing not to have any medical care during birth, but these decisions are made as a positive choice based on a set of beliefs, rather than a lack of available care or a fear of a repeated trauma. Throughout this thesis the two are distinguished by the terms used – unassisted birth equates to a decision to not have medical staff present because of a lack of desired

When a subsequent birth results in a desired outcome, it has the power to be a healing experience (Thomson & Downe, 2013; Beck & Watson, 2010; Lemay, 2001).

2. 9 Conclusion

Childbirth in the UK at the beginning of the twenty-first century is physiologically no different to childbirth throughout human history. The rise of technological interventions that are available to ensure babies are born alive is different, and has significantly altered the context within which women in the UK and developed world give birth. Technology has contributed to the current dominance of the medicalised model of childbirth, and invented a different socio-cultural context for birth. Women are making decisions against a background of cultural proscription about the behaviours and beliefs allowable to them as pregnant bodies, whilst also being faced with the paradox of choice which is not free choice, but which they are required to participate in as though it were. The support known to be successful for women in this situation – continuous care from a knowledgeable, trusted, and previously known individual midwife (Kirkham, 2010) is very rarely available. These factors all contribute to the potential for childbirth to be experienced as traumatic. The effects of experiencing childbirth as traumatic are life-changing and long-lasting (Kendall-Tackett, 2014; Leeds & Hargreaves, 2008; Slade, 2006), for the mother, and also the father (Elmir, 2013) and the care giver (Rice & Warland, 2013). Traumatic birth is a developing area of research, and the full consequences have not been explored. One potential gap in the research is how women who have experienced childbirth as traumatic this deal with subsequent issues of fertility, and potential pregnancies and childbirth.

The discourse of choice in pregnancy and birth is already a complex interplay of paradigms of pregnancy, technology and cost. Women who have previously experienced a traumatic birth bring a range of other additional factors to each decision they make about fertility, pregnancy, and birth. Logically, when someone has experienced a trauma, it seems likely that they would try to avoid that experience again. However, this may not be true for women who have experienced a traumatic birth. Women who have experienced a traumatic birth may choose to experience pregnancy and birth again, but may make choices or decisions to try to avoid a recurrent traumatic experience. There already exists a large body of literature relating to traumatic births, which can be used to answer some of these questions. A systematic review of

---

care, and freebirth to a freely chosen birth which is not attended by medical professionals. These terms are not ideal, but serve to distinguish meaning in this context.

this literature will be carried out, to find out what is already known about the choices women make about future fertility, pregnancies and births, when they have previously experienced a traumatic birth. This review forms the following chapter.

Chapter 3 – Literature review

As the previous chapter demonstrated, experiencing a traumatic birth is a significant issue for some women. This experience can have an impact on many areas of their lives, including decisions about future fertility, and choices that women make about conception, pregnancy, birth, and the early postnatal period. To investigate this further, a systematic search was conducted to identify literature about choices women make in pregnancy and childbirth, when they have previously experienced a traumatic birth. This section of the thesis aims to give an overview of published works on the subject of subsequent decisions about pregnancy and childbirth. The chapter provides a critique of the existing literature relating to fertility, pregnancy and birth after a traumatic birth. Revealing the gaps in this literature lays the foundation for the research study presented in this thesis.

Much of the traumatic birth literature relates to physical trauma to the baby, or physical trauma to the mother's perineum. Separating out the literature on psychological trauma was a lengthy task, especially as physical trauma can result in consequent psychological trauma.

3.1 The role of the literature review within Constructivist GTM research

Grounded theory methodology (GTM) sets out not to test existing hypotheses, but to aid 'the discovery of theory from data' (Glaser & Strauss, 1967, p.1). Engagement with existing literature *prior* to primary data collection is characteristic of most strategies of inquiry, but Glaser and Strauss (1967) argue explicitly against this, on the grounds that data should be deliberately privileged above existing theoretical concepts, and that engagement with the existing literature may affect how the researcher processes the data they have gathered: 'An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study' (Glaser & Strauss, 1967, p.37). However, as GTM has become a more popular way of conducting qualitative research, it has developed into a constellation of methods, rather than a single prescriptive one[4]. Each variety of GTM approaches the question of prior knowledge, and therefore engagement with the existing literature, in a slightly different way, depending on how the production of theory is viewed within the methodology.

---

[4] These developments are discussed in greater detail in Chapter 6 – in this Chapter the concern is solely with the impact that these developments have on the role of Literature Review.

This thesis adopts a Constructivist GTM approach. Within this approach, data is not viewed as being generated passively by the researcher, rather data is seen as being co-produced by the researcher and the participants, through their interactions during the interview. Therefore, data is not considered as a pure source of theory-in-potentia, untainted by the researcher's own views, as it is in Glaser and Strauss' original 1967 work. Instead, data necessarily includes the researchers' own views, and is affected by their positionality. When the data is no longer viewed as a source that must not be contaminated by preconceptions, much of Glaser and Strauss' original argument for not engaging with the existing literature as way of preserving the purity of the data are removed (1967).

If the argument for not contaminating data by reading the existing literature is removed, the arguments for not conducting an early literature review become moot. In later explications of GTM, Strauss and Corbin do not recommend dissociating from the literature, but engaging with it and using it in 'all phases of the research' (1990, p.56). They claim that engaging with the existing literature can help the researcher to identify what is important to the developing theory.

Charmaz herself argues that a late literature review is usually more beneficial to the researcher, as it allows them to focus on the data rather than the literature (2000). However, alongside this argument, she acknowledges the practical situation for the researcher, who may be subject to forces other than research methodology (Charmaz, 2006; Charmaz, 2008). The practical considerations are summed up by Dunne:

> 'From a purely pragmatic viewpoint, the idea of postponing a literature review until data collection and analysis is well underway is simply unworkable for many researchers. This is particularly true for PhD students, whose research funding, ethical approval and progression through the doctoral process may all be heavily dependent upon producing a detailed literature review prior to commencing primary data collection and analysis' (2011, p.111).

A further methodological reason for conducting an early literature review is put forward by Dunne, who argues that GTM is a methodology often put forward as being useful

> 'for topics which have been subject to relatively little research and about which there is a paucity of knowledge. However, this leads to a practical conundrum articulated by

McGhee et al. who ask, 'but how can this paucity of knowledge be ascertained unless an initial review of literature is undertaken?' (2011, p.113).

This argument is one which has resonance for this research. In order to discover what choices women make in pregnancy and birth, after previously having a traumatic birth, it is important to establish what is already known about such choices. Therefore, this literature review will be carefully defined, and limited to assessing what is currently known, and what is not known. The rationale for presenting the evidence and understanding the key concepts on traumatic birth, prior to generating data, is to look for omissions within existing knowledge.

It is envisaged that by examining the choices women actually make during a subsequent pregnancy, this will not only add to existing knowledge about traumatic birth, but will do so from an internally located women's perspective, rather than from a practitioner or policy viewpoint. It is also hoped that choices which take women out of the gaze of most practitioners, such as the choice to freebirth, to have a completely unassisted pregnancy, or to opt out of NHS services and employ independent care-givers, will be able to be explored in a way that is not usual in the existing literature. It is the aim to present this new knowledge in a way that could be used to inform midwives' and other birth professionals' practice and policy, and to highlight areas where further research would be useful. The conclusions drawn from this review will lead to the refinement of the research questions to be investigated, and inform the aims and objectives of the study.

3.2 Research question

The question for the systematic literature review was:

'What choices do women make about subsequent pregnancies and births, when they have previously experienced a traumatic birth?'

3.3 Scoping search

An initial scoping search of the Turning Research Into Practice (TRIP) database was carried out to establish whether this research question had already been addressed in a systematic way. The intention was to identify papers dealing with psychological trauma, a concept which has only been recognised relatively recently. In order to generate these results, the terms *birth

AND trauma* NOT perine* were used, and the date range from 1998 to 2013 was specified. The date range was chosen to eliminate work that was over 15 years old, firstly as maternity services are a rapidly changing and evolving service, and so research before this point might have less applicability to women's contemporary experiences. Secondly, research into psychologically traumatic birth is a developing area of research, with the first primary research paper on the subject being published in 1998. Childbirth-related PTSD (which much of the current birth trauma literature investigates) was not possible to diagnose until the publication of the revised guidelines in the DSM IV in 1994. Therefore searches that included primary research older than this would have had a focus on physical trauma.

The search produced 27 results. Of these, 15 were immediately rejected because they dealt with physical trauma to the urogenital region and a further ten were rejected because they dealt with physical trauma to the infant

This left two articles,
1. Pentadic cartography: mapping birth trauma narratives
2. Helping parents cope with the trauma of premature birth: an evaluation of a trauma-preventive psychological intervention

Neither article included a systematic literature review.

From the initial scoping search, a list of prominent researchers in the field of Birth Trauma emerged. After the search, they were identified and contacted individually. The list consisted of:
- Professor Pauline Slade
- Professor Susan Ayers
- Professor Cheryl Beck
- Sheila Kitzinger

This contact led to access to a literature review of the fear of childbirth, which was also read as part of the scoping exercise.

From literature revealed by the scoping exercise, the terms of reference for the systematic literature review were drawn up. The question to be asked of the literature was refined, and the search strategy to identify literature which would answer the question was devised.

3.4 Methodology

The literature was subjected to a textual narrative synthesis (Economic and Social Research Council National Centre for Research Methods, 2014). Textual narrative synthesis is an approach which has been found to be particularly useful in synthesising evidence from different methodologies (Lucas, Arai, Baird, Law & Roberts, 2007), which was useful in this literature review, as the studies varied in both size and methodology. Textual narrative review is also useful for this study, as it describes gaps in the literature, both by showing where evidence is absent and by making an evaluation of the strength of evidence in different areas. For the purposes of this study, identifying gaps in the literature was a priority, and so this was a useful framework to employ.

Lucas et al (2007) provide a detailed guide on how to conduct a robust thematic synthesis, alongside a worked example. They identify a series of three steps to be undertaken, and give details of the key tasks and points of consideration for each step. The first step is to identify which literature is to be included in the synthesis. Once this is completed, commentaries on each study are prepared, and the literature is grouped according to the commentaries. A synthesis is then performed upon each group of commentaries.

Identifying suitable literature

The first step is to identify suitable literature for inclusion in the synthesis. Thomas and Harden (2008) recommend searching both research databases, grey literature, and hand searching references to ensure that all relevant literature is included. Only studies dealing with primary data should be included.

A search strategy was devised to identify suitable literature. The aim of the search strategy was to gain an overview of research papers which mentioned the decisions made by women about pregnancy and childbirth, when they had previously suffered birth trauma. Of particular interest were sociological and psychological approaches to these choices, as it was desirable to gain access to a diverse body of knowledge and access a corpus of published works that crossed disciplines. For this reason, a search strategy using Cochrane, PsycINFO, CINAHL and Medline databases was employed. It was recognised that after a traumatic birth, many women would experience fear of childbirth – secondary tokophobia – which would be a dominant factor in decisions they made. The search strategy would need to include the literature on fear of

childbirth. Only sources in English were to be included and a search strategy of terms below was used.

birth AND trauma NOT perine*
*birth AND fear

Initially results not from the UK were automatically excluded, because models of maternity care in different countries vary. However, in preliminary searches it was found that some prominent researchers in this area were not UK based, and were therefore producing highly relevant research that was being excluded. Moher, Liberati, Tetzlaff and Altman (2009), stress that a literature review is an iterative process, and that

'reviewers may need to modify their original review protocol during its conduct' (p.339).

The criteria for inclusion in this literature review was amended, and in all searches, results that were not from the UK were only included if they were highly relevant. The criteria used to determine this was that both birth trauma, childbirth PTSD or another synonym, and previous or subsequent births were mentioned in the title, keywords or abstract of the article.

From this literature search, further key authors emerged. The aim of a literature search is 'to locate all relevant studies (Thomas & Harden, 2008), in order to prevent bias. Therefore, the list compiled after the scoping search was extended, and a second search of the databases was performed for works by these authors:

- Ayers, Susan
- Beck, Cheryl
- Driscoll, Jeanne
- Jomeen, Julie
- Kitzinger, Sheila
- Slade, Pauline
- Watson, Sue
- Wijma, Barbro

These names were applied to the search strategy; the purpose was to recover and include literature which mentioned decisions women had made about fertility, putative future

pregnancies, and childbirth after suffering birth trauma, or decisions women were making at the time of the research, based on previously experiencing birth trauma.

Once duplicates had been removed, a total of 4,134 sources were identified in the initial searches. The titles and keywords of these articles were systematically evaluated, and were excluded if they dealt solely with trauma to the baby, or if they related to physical trauma only. This reduced the total to 323 journal articles, reviews, letters, book chapters and commentaries. The full abstracts of these articles were then read, and sorting criteria were applied to find the articles most relevant (Thomas & Harden, 2008). The criteria were selected to obtain the studies most likely to comment on subsequent childbirth in relation to a previous traumatic childbirth. From reading the abstracts, it was noted that literature which had a longitudinal view, commented on previous maternity experiences, or mothers choosing a non-standard care pathway in this pregnancy was more likely to reflect on the relationship between previous and subsequent experiences of childbirth. Studies which were primarily concerned with the treatment of a specific diagnosable condition, or which were published before traumatic birth was generally recognised, were less likely to discuss the relationship between one experience of giving birth and a further pregnancy. The criteria used to ensure relevance to the research question are set out in Table 2 below:

Table 2 – Criteria for relevance of literature

Raises relevance if mentions:	Lowers relevance if mentions:
Previous childbirth	Treatment
Longitudinal study	Diagnosis or diagnostic criteria
Predictors of childbirth	Measuring mental health
Maternal request for non-medical lower-segment caesarean section (LSCS)	
Birth history	
Choosing not to use NHS services	
Literature review	
Longitudinal study	

This resulted in a total of 57 articles, research papers, letters and other sources for inclusion that were then read in full to ensure their relevance.

These articles were then subjected to an appraisal of quality of the research. A reviewing matrix which could evaluate both qualitative and quantitative research papers was devised, based on Creswell's mixed methods appraisal tool (Creswell, Pluye, Robert, Cargo, Bartlett, O'Cathain, Griffiths, Boardman, Gagnon, & Rousseau, 2014) (Appendix 1). Each article was reviewed, based on both the relevance of the study to the research question, and also on the methodology employed. Articles which were not based on primary research, such as opinion pieces, secondary analyses and meta-analsyes, were separated out. Broad methodological criteria were used for methodological inclusion, but articles were excluded if the evidence presented appeared anecdotal, or the only evidence presented was the author's own experiences. 37 articles were excluded from the literature review in this process. These articles were used to inform the background chapter to the thesis.

This left 20 articles which contained primary empirical data, were highly relevant and directly applicable to the question asked of the literature, and which were methodologically rigorous. This provided a good evidence base for the review that was both methodologically diverse and of an appropriate quality.

Reference lists of these 57 papers (including those which did not contain empirical data) were hand searched to identify additional relevant original research. This method is referred to as backchaining (Downe, 2008). This resulted in the identification of eight potential further papers, six of which were of sufficient quality and relevance for inclusion. In addition the eight prominent authors in the area of traumatic birth or birth choice (listed above) were contacted to identify other relevant publications that might not have been retrieved, but no further papers were identified with this approach. A grey literature search also revealed no further papers. The process of the literature search is detailed as a flowchart in Figure 1 on the following page.

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart for literature review (Moher, Liberati, Tetzlaff & Altman, 2009)

4,134 articles retrieved

Excluded papers not apparently relevant to the after effects of traumatic childbirth

323 papers remained

Abstracts read, sorting criteria applied

57 papers

Full articles read, sorted for relevance, then review matrix applied to each

20 articles

37 articles identified which are of high quality, but contain no empirical data

Hand searching of references of remaining articles

Hand searching of references of these articles

8 further papers retrieved. 1 was excluded for methodological reasons, 1 was not available in English. 6 further papers included

Grey literature search, and authors approached directly

No further papers discovered

26 papers included in Literature Review

3. 5 Results

The search strategy process outlined in the previous section resulted in the identification of 26 papers to be included in the textual narrative synthesis. 13 of the studies were qualitative, whilst the other 13 employed quantitative methodologies. 11 of the articles were based on retrospective studies, and one on a retrospective chart review. Eight were cohort studies, three were longitudinal, two were qualitative narrative studies, and one was a cross-sectional study.

The literature identified in the literature search is presented on the following pages.

Study commentaries and grouping

Once the initial stage of identifying suitable literature is completed, Lucas et al's (2007) second stage involves the preparing of commentaries for each study that is to be included. Study commentaries should draw out the pertinent content details of the specific study. This allows studies to be grouped according to content, rather than by methodology (Lucas et al, 2007). It is acknowledged that studies may well overlap groups, and pertinent data from one study could therefore be included in more than one grouping.

Commentaries should also engage with quality issues. Thomas and Harden (2008) recommend that the quality of the research should be assessed. Only research which is of sufficient quality to 'avoid drawing unreliable conclusions' (Thomas & Harden, 2008, p.45) should be included. The quality of each piece of literature had already been established, using a reviewing matrix based on Creswell's mixed methods appraisal tool (2014). A summary of the quality issues was included alongside the commentary.

All the studies included in the literature review were of a sufficient relevance and quality to merit inclusion, but some were more rigorous than others. Forssen's work (2012), relies on recall of memories that are decades old, which may raise issues of accuracy, and the focus of the research changed part way through the study. This change in focus was in response to the emerging data, which has both positive and negative effects in terms of quality. The change shows that the authors were reflexive about their findings, but at the same time means that the focus altered between the early interviews and the later ones. Edward and Kirkham's study (2012) was conducted primarily for a journal article, rather than as an academic piece of work, which resulted in some lack of clarity about methodology, which in turn made analysis of the rigorousness and quality of the article more difficult. The inclusion of this study is important

though, as it was the only piece of literature identified which discussed intentionally giving birth without medical attendants (now known as 'freebirth'). The quality of Saisto, Ylikorkala and Halmesmaki's study (1999) is good, but the conclusions were not fully supported by the data. For example, the authors make the assumption that every operative delivery is necessary and unavoidable. The authors also assume that women have an unrealistic idea about how childbirth should be personally fulfilling, but present no evidence of this in their study. The solutions proposed were also not supported by the evidence presented, and the authors use emotive language which is perhaps inappropriate.

A commentary was prepared for each study chosen for inclusion in the literature review. On the basis of these commentaries, studies were grouped together by content. In a textual narrative synthesis groupings are determined by the subject of the studies included, rather than by methodological commonalities (Lucas et al, 2007). The commentaries drawn from the studies were then further summarised, and these summaries are included in Table 3 on the following pages, alongside any quality issues identified.

Table 3 - Summary of studies included in the literature review

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
1998 UK	Allen, S. A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology,* **16**(2-3), pp. 107-131.	In the first stage a self-report questionnaire was used, and the Revised Impact of Event Scale was used to measure responses. The second stage consisted of a semi-structured interview, which was transcribed and subjected to first open coding and then axial coding, using Grounded Theory methodology.	223 women were asked to participate in the first stage at 10 months postpartum, 145 agreed to initial screening. 26 women were eligible for involvement in the second stage, and 20 women did participate.	This study comes from a period when childbirth-related PTSD was just beginning to be recognised. It provides a picture of the variables that affect the process of dealing with birth trauma. It also investigates some of the consequences of birth trauma	- Study is from some time ago - Only relates to future childbirth choices in terms of fear
2006 UK	Ayers, S., Eagle, A. and Waring, H. The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study.	Semi-structured interviews	6 women suffering from clinically significant PTSD	To establish the long-term effect of traumatic birth on women's relationship with their partner and child	- Only looked at relationship with child from traumatic birth, not other children in the family - Small sample - Compares women to before and after childbirth, rather than comparing traumatic childbirth to non-traumatic childbirth

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	Psychology, Health & Medicine, Vol 11(4), pp. 389-398				
2004 UK	Bahl, R., Strachan, B., Murphy, DJ. Outcome of subsequent pregnancy three years after previous operative delivery in the second stage of labour: cohort study, *British Medical Journal*, 328, 7435, pp. 311-311.	Cohort study from two hospitals, with a combined total of circa 10,000 deliveries a year. The study was conducted by means of a single postal questionnaire	A follow up study from 393 women who had operative deliveries in theatre during the second stage of labour. 283 women responded	What was the mode of delivery for a subsequent pregnancy, three years after the operative delivery?	• Although the overall study is quite sizeable, individual groups, such as the number of women attempting VBAC (for example) are quite small (18)
2004 International	Beck, C. T. Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, 53, 216–224.	Descriptive phenomenological study of written experiences, mostly submitted via email attachment (two submitted by post). The stories were analysed using Colaizzi's method of data analysis	Self-selecting sample of 38 women, from New Zeland, USA, UK and Australia	The study aims to describes women's experiences of what their lives are like after a traumatic childbirth, and how the associated PTSD has affected them.	• The nature of the sample may be quite biased – all women are linked to one organisation, and are computer literate with access to the Internet • The international nature of the study, across countries with different birth paradigms and practices has the potential to make conclusions harder to draw

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
2006 International	Beck, C. T. The anniversary of birth trauma: Failure to rescue. *Nursing Research*, *55*, 381–390.	Descriptive phenomenological study of written experiences, mostly submitted via email attachment. The stories were analysed using Colaizzi's method of data analysis	Self-selecting sample of 37 women.	The aim of this study was to determine the essence of mothers' experiences regarding the anniversary of their birth trauma	• The nature of the sample may be quite biased – all women are linked to one organisation, and are computer literate with access to the Internet • The international nature of the study, across countries with different birth paradigms and practices has the potential to make conclusions harder to draw
2010 International (mainly US)	Beck, C.T. and Watson, S., Subsequent childbirth after a previous traumatic birth. *Nursing research,* 59(4), pp. 241-249.	Self-selecting internet sample, who wrote their birth stories. The written texts were then analysed	35 women.	What is subsequent birth after traumatic childbirth like?	• The nature of the recruitment and the requirement to write a birth story may have limited participation to certain women • The stories are written between one and 13 years later, and memories of childbirth change over time • Difficult to compare internationally as birth practices and legalities are different
2012 UK	Edwards, N. and Kirkham, M., Why women might not use NHS maternity	Self-selecting sample. Used informal interviews	5 women who freebirthed but had some antenatal care	Why do women choose freebirth? What is it about the NHS services that lead them to reject them?	• Study says it is about non-NHS care, but only covers freebirth, not Independent Midwifery • Small sample

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	services. *Essentially MIDIRS,* **3**(9), pp. 17-21.				• None of these women had an unassisted pregnancy – which (anecdotally) the majority of freebirthers do. Therefore may be unrepresentative
2003 Australia / International	Fenwick, J,. Gamble, J., and Mawson, J., Women's experiences of Caesarean section and vaginal birth after Caesarean: A Birthrites initiative, *International Journal of Nursing Practice* 2003, 9, 1, pp. 10-17,	Self-selecting sample, questionnaire delivered electronically or by post.	Fifty-nine women completed and returned a questionnaire between the months of January and July 2001. Fifty-five women had experienced LSCS and 29 had experienced a VBAC. Seven women had been unsuccessful in their attempt to have a vaginal birth after a previous LSCS.	Descriptive research of women's experiences of repeat unplanned CS, and VBAC.	• Non-representative sample
2012 Sweden	Forssen, A.S.K., Lifelong significance of disempowering experiences in prenatal and maternity care: Interviews with	Interpretative phenomenological design, consisting of a series of semi-structured interviews	Twenty elderly women, most of whom were interviewed three times, two of them four times, one five times, and seven of them twice.	The research initially focused on women's experiences of work, both paid and unpaid. In this context, the authors categorised childbearing, breastfeeding and child rearing as work. However, they found that the way women talked about their	• Small scale • Although research is contemporary, the women gave birth some decades ago (1934-1966) • Altering the focus of the research part way through may

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	elderly Swedish women. *Qualitative health research,* 22(11), pp. 1535-1546.			experiences of disempowerment during pregnancy and birth was significant in itself, and so altered the focus of the research.	have consequences
2001 Australia	Gamble, J., and Creedy, D., Women's preference for a LSCS section: incidence and associated factors, *Birth,* 28, 2, pp. 101-110	Cohort study, using questionnaire	310 women 36-40 weeks pregnant recruited from one antenatal clinic	How do women prefer to give birth? What factors are associated with this?	• Older study • Numbers of women preferring CS due to previous birth experience not huge
2002 Sweden	Gottvall, K. and Waldenstrom, U., Does a traumatic birth experience have an impact on future reproduction? *BJOG: An International Journal Of Obstetrics And Gynaecology,* 109(3), pp. 254-260.	Prospective cohort study, involving retrosepctive statistical analysis of the largescale Stockholm Birth Centre Trial, correlated to centrally held factual data on births.	Altogether, 1230 women were enrolled in the Stockholm Birth Centre Trial, which evaluated women's childbirth experiences. Multips and those who had experienced miscarriage were excluded, leaving 617 women.	What is the effect of a traumatic first birth experience on future rates of childbearing? What is effect on the time between births?	• Only interested in what happened if first birth was traumatic

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
2011 Sweden	Hildingsson, I., Nilsson, C., Karlstrom, A. and Lundgren, I., A longitudinal survey of childbirth-related fear and associated factors. *Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns,* 40(5), pp. 532-543.	Population-based study, involving four longitudinal surveys. Based on one county council area in Sweden. Survey was not solely about childbirth-related fear, but about pregnancy and childbirth in general	697 women who had returned all four surveys. 135 reported fear of childbirth at some point in pregnancy.	To investigate the prevalence of childbirth-related fear from pregnancy to one year after childbirth, and to identify factors associated with being 'cured' of childbirth-related fear.	• Looked only at those who were cured of childbirth fear, versus those who had experienced fear when pregnant and continued to have fear a year later. Did not look at those who had gained in fear, having not previously had fear (there may not have been any? Maths unclear)
2002 Sweden	Hildingsson, I., Radestad, I., Rubertsson, C., and Waldenstrom, U., Few women wish to be delivered by caesarean section , *BJOG,* 2002, 109, 6,	Cohort study, attempted 100% population sample of ante-natal clinics	3283 women	How many women want to give birth by LSCS, and what is it that characterises those women?	• Does not provide a multivariate analysis of the factors of 'previous birth experience' with 'mode of previous delivery' and 'preference for a LSCS'.

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	pp. 618-623, Wiley-Blackwell, England				
2000 UK	Hofberg, K. and Brockington, I., Tokophobia: An unreasoning dread of childbirth. A series of 26 cases. *The British Journal of Psychiatry,* 176, pp. 83-85.	A series of unstructured interviews were conducted over two years, along with direct questions about mental health history, obstetric history, childhood abuse, rape, contraceptive methods and sexual relations	26 women, referred by obstetricians and psychiatrists at two different hospitals in the West Midlands (one more was referred but declined to take part)	To classify tokophobia. Identified three classifications: • Primary tokophobia stemming from adolescence • Secondary tokophobia after a previous birth experience • Tokophobia as a symptom of pre-natal depression Pregnant women with tokophobia who were denied their chosen delivery method showed higher psychological morbidity than those who achieved their desired birth	• Small scale sample • Sample limited in diversity
2012 Switzerland	Kottmel, A., Hoesli, I., Traub, R., Urech, C., Huang, D., Leeners, B. & Tschudin, S., Maternal request: a reason for rising rates of LSCS section? *Archives of*	A retrospective chart review of the indications of all CS performed at a tertiary care clinic in Switzerland in 2002 and 2008. Statistical tests were performed	884 women who had had a CS in either 2002 or 2008, who came into contact with the specified clinic.	To evaluate the prevalence of CS, and the indications, especially those related to maternal request. CS were categorised into • medically indicated prior to onset of labour • medically indicated during labour	• Although efforts were made to exclude non-maternal request CS, it is known that women can be led/forced into requesting a CS. Methodology is not able to take account of this • Previous traumatic delivery will only have been recorded if women mentioned it, and

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	Gynecology and Obstetrics, 286(1), pp. 93-98.	to identify significant differences.		• maternal request plus obstetric factors • maternal request, one previous CS, no other obstetric factors • previous traumatic birth • maternal request, no medical indications	consultant recorded it as a factor • Previous CS is categorised separately, but there is likely to be some cross-over from previous CS to previous traumatic delivery • Two previous CS was categorised as 'medically indicated', which is an arguable categorisation
2009 Norway	Kringeland, T., Dalveit, A.K. & Moller, A., What characterizes women in Norway who wish to have a caesarean section? *Scandinavian Journal of Public Health,* 37(4), pp. 364-371.	Analysis of the data from the Norwegian Mother and Child Cohort Study	55,859 women were surveyed between the years 1999 and 2006.	Describe the characteristics of pregnant women who wish to have a LSCS. At 30 weeks of pregnancy, one out of 10 women in a sample of Norwegian women would choose a LSCS. Negative experiences from previous pregnancies and fear of giving birth are two of the strongest factors associated with a wish for a LSCS.	• Negative birth experiences are often associated with operative or instrumental deliveries, which are associated with medical problems in subsequent pregnancies. Cross tabulations of previous negative birth experience and medical issues were not available • Negative, positive and all right birth experience are not defined
2009 Australia	McGrath, P. and Ray-Barruel, G., The easy option? Australian	Descriptive phenomenological study consisting of	20 women at one hospital, 13 of whom had a previous	A qualitative study designed to explore, from the mothers' perspective, the decision-making	• Small scale, single recruitment site • It is not possible to differentiate

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	findings on mothers' perception of elective Caesarean as a birth choice after a prior Caesarean section. *International journal of nursing practice,* 15(4), pp. 271-279.	open ended interviews. The data was 'freely' coded, and organised by subject headings.	unplanned LSCS, and seven of whom had had an EC. None had a medical indication for a repeat CS. 16 women chose an EC, two had a VBAC, and two attempted VBAC but ended up with CS	experience with regards to subsequent birth choice for women who have previously delivered by LSCS. Specifically, the findings in this article present the perspective of the mothers who opted for elective LSCS. Eighty per cent of mothers in this study chose elective LSCS for reasons of fear and the desire to retain some control over the birthing process. For many, this decision is made prior to or early in pregnancy without any openness to consider other possibilities.	between the women whose first LSCS was an emergency LSCS or an unplanned LSCS
2003 UK	Murphy, D., Pope, C., Frost, J. & Liebling, R., Women's views on the impact of operative delivery in the second stage of labour: qualitative interview study, *Bristish Medical Journal,* 2003, 327, 7424, pp. 1132-1132,	Purposive sampling, using semi-structured interviews	27 women who had had an operative delivery between 2000-2002	Women's experience of operative delivery in the second stage of labour. Focused on how prepared women felt for operative delivery, the perceived usefulness of a birth plan, their understanding of why operative delivery was needed, their views on debriefing after delivery, and their preferences for future pregnancy and delivery.	• Women already knew researcher

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
2007 UK	Nicholls, K. & Ayers, S. Childbirth-related post-traumatic stress disorder in couples: A qualitative study, *British Journal of Health Psychology* 12, 491–509	Qualitative interviews with individuals. Transcripts then subjected to thematic analysis.	6 couples, where at least one partner had clinically significant symptoms of childbirth-related PTSD.	To explore the effects of childbirth-related PTSD on the relationship between a couple, and with their child	• Small sample • By the nature of the design, the study compares relationships to before and after childbirth, rather than comparing traumatic childbirth to non-traumatic childbirth
2009 Sweden	Nieminen, K., Stephansson, O. & Ryding, E.L., Women's fear of childbirth and preference for caesarean section--a cross-sectional study at various stages of pregnancy in Sweden. *Acta Obstetricia et Gynecologica Scandinavica,* 88(7), pp. 807-813.	Cohort study, involving repeated surveys, data subjected to various statistical tests	1,635 women. 254 had intense fear of childbirth, 93 had such an intense fear it was classed as tokophobia.	What characterises women who have a fear of childbirth, and women who prefer a LSCS?	
2008 Hong Kong	Pang, M.W., Leung, T.N., Lau, T.K. & Hang Chung, T.K.,	Longitudinal prospective study. Women were asked	501 women took part antenatally. 418 were valid to be contacted	What is it about first births that can move some women from preferring a vaginal birth to a c section?	• The study group contained too few women with a complete data set who preferred elective

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	Impact of first childbirth on changes in women's preference for mode of delivery: follow-up of a longitudinal observational study. *Birth (Berkeley, Calif.),* 35(2), pp. 121-128.	about preferred method of delivery before having their first baby, and then again at six months postpartum. Univariate and multivariate analyses were performed to demonstrate characteristics of women who had moved from preferring vaginal birth to elective caesarean	for the second survey, of which 259 women responded.		LSCS at term and had undergone a planned vaginal birth. • One location offered elective LSCS at maternal request – the other did not • The size of the sample meant the number of women preferring LSCS at term, but vaginal birth at six months pp was too small to draw conclusions
2013 UK	Rice, H. & Warland, J. Bearing witness: Midwives experiences of witnessing traumatic birth. *Midwifery* 29 (9), pp. 1056-63	Qualitative descriptive interviews, analysed thematically	10 registered midwives, who were either practicing or recently practicing were interviewed about their experiences of traumatic births	What are midwives' experiences of witnessing traumatic births? And to determine if they are at risk of negative psychological sequelae similar to those in other caring profession	• Small numbers • Some midwives were no longer practicing
1999 Finland	Saisto, T., Ylikorkala, O. & Halmesmaki, E., Factors associated	Cohort study, with a matched control group. Used medical	100 women in a second pregnancy, who were referred to a	What are the factors that correlate with a fear of childbirth that is only	• The conclusions drawn from the study are based on some questionable assumptions,

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	with fear of delivery in second pregnancies. *Obstetrics and gynecology,* 94(5), pp. 679-682	notes, demographic data and interviews	consultant for maternal-request LSCS because of fear of childbirth, where they had not had a fear of childbirth in the first pregnancy	developed after a first experience of childbirth?	including that there are no avoidable or unnecessary operative births, that feto-pelvic disproportion is easy to observe, that all antenatal preparation classes are of equal merit and sufficiently prepare women for childbirth, and that women have unrealistic expectations of a fulfilling experience of childbirth (with no evidence from the sample about what women's experiences were) • Emotive language is used in the conclusions – the researchers are 'disappointed' that women reported fear of delivery ward staff
2012 Norway	Storksen, H., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M., The impact of previous birth experiences on maternal fear of	Cohort study using two questionnaires at 17 and 32 weeks.	1357 parous women at a specific hospital	What is the impact of both objective obstetric complications and subjective experiences from previous births on maternal fear of childbirth?	• Unclear whether women who intended to birth at home were included

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	childbirth. 2012, *Acta et Gynecologia Scandinacvica* 92, pp. 318-24				
2010 UK	Thomson,G. & Downe,S. Changing the future to the past, women's experiences of a positive birth following a traumatic birth experience, *Journal of Reproductive and Infant Psychology,* 28, 1, pp. 102-112,	Interpretative phenomenological study, using unstructured interviews. Data collected in two phases – first phase retrospective, second stage with women who were pregnant at time of interview.	14 women	How do women prepare for, plan and internalise a positive birth after a previous traumatic birth? What does the experience of a positive birth, when a previous birth has been traumatic, mean to the woman who experiences it? How are her feelings of trauma, and symptoms of PTSD affected, in comparison to the feelings and symptoms of women whose childbearing ended with a traumatic birth?	• Small scale • Recruitment was from just one site, and through a Consultant Midwife, limiting diversity of population, and potentially introducing gatekeeping • No women were included who had wished to have future children, but been infertile, or who had had abortions when becoming pregnant unintentionally – all women had chosen to be pregnant/not have future children
2009 Switzerland	Tschudin, S., Alder, J., Hendriksen, S., Bitzer, J., Popp, K.A., Zanetti, R., Hosli, I., Holzgreve, W. and Geissbuhler, V., Previous birth experience and birth	Cross-sectional study as part of another ongoing study – randomised controlled trial of psychological interventions when a non-medically indicated LSCS was	All pregnant women attending one of two hospitals, or seeing one of 30 obstetricians, within a three month period were eligible for recruitment (if	What effect does previous birth experience, and birth anxiety, have on a woman's wish to have a non-medically indicated LSCS.	• Numbers are quite small

Year and country	Author and citation	Design	Sample	Focus of research	Limitations of study
	anxiety: predictors of caesarean section on demand? *Journal of psychosomatic obstetrics and gynaecology,* 30(3), pp. 175-180.	requested	German-speaking). 195 women who had delivered a baby before returned surveys		

The final step in Lucas et al's (2007) textual narrative synthesis is to collate and synthesise the grouped commentaries. A narrative exposition of the grouped commentaries is then devised, and is related back to the individual studies that formed part of the grouping.

Using Lucas et al's (2007) framework, common themes were identified, and studies were grouped according to these themes, resulting in thematic groupings which included a mixture of qualitative and quantitative studies. The results from the synthesis are presented below. The findings from the review are interwoven with the discussion of the implications.

3.6 Discussion and findings from literature review

Longevity of effects

A strong and relatively consistent body of evidence illustrates the potential negative psychological impact of childbirth and the enduring impact that this can have on women (Forssen, 2012), fathers (Nicholls & Ayers, 2007), their children (Allen, 1998) and family and friends (Ayers, Eagle & Waring, 2006; Beck, 2004a). Consequences of traumatic birth include enduring mental health problems (Forssen, 2012; Beck, 2004a), compromised maternal infant relationships (Nicholls & Ayers, 2007), poorer quality marital relationships (Ayers, Eagle & Waring, 2006) and concomitant depression in partners (Nicholls & Ayers, 2007). A traumatic birth in particular has been highlighted as a factor likely to result in deleterious outcomes. In terms of psychological consequences, between 2-6% of women are reported to experience perinatal PTSD (Ayers, Harris, Sawyer, Pariftt & Ford, 2009; Beck, 2004). Traumatic birth can also impact significantly on a woman's satisfaction with and reflection on her birth experience (Beck, 2004). In a study amongst elderly Swedish women, Forssen (2012) identified that recall of the birth experience was recounted with both clarity and detail of memory, even decades after the experience. The level of detail included things such as the perfume a midwife wore, or the patterns on the curtain, highlighting the acuity with which women absorb their labour and birth experience. Especially significant is that negative experiences of childbirth were also remembered with this level of painstaking detail, and were given most emphasis, particularly those involving prenatal and maternity care encounters.

The longevity of the effects of a traumatic birth means it may impact both short and longer term outcomes for the mother and baby. In the short term, mothers may struggle to bond with their

babies (Nicholls & Ayers, 2007) and suffer extreme exhaustion (Ayers, Eagle & Waring, 2006). Women may also experience changes in their mood, and engage in negative behaviours such as avoiding going out of the home (Ayers, Eagle & Waring, 2006). Avoiding leaving the house may result in difficulties in maintaining friendships (Ayers, Eagle & Waring, 2006), which could reduce access to social support networks, which are thought to aid women's recovery from a traumatic birth (Allen, 1998). In terms of engaging with the traumatic birth, women may either need to talk exhaustively about the experience (Beck, 2004a), or avoid it entirely (Allen, 1998). Beck and Allen independently report that neither of these strategies appear to increase mothers' psychological wellbeing, and may rather signal that women need some external help in processing the trauma they have experienced.

Longer term consequences include difficulties in the relationship between the woman and her partner, including the breakdown of the relationship, and a lack of sexual intimacy (Nicholls & Ayers, 2007). This may be compounded by how the mother perceives her body in the case of an operative birth (Ayers, Eagle & Waring, 2006). For the mother and child, longer term consequences may include either avoidance or over anxious attachments (Ayers, Eagle & Waring, 2006). If a mother has experienced difficulties in leaving the house, and has become alienated from her friends, she may experience social isolation on a longer term basis (Beck, 2004a). Difficulties in processing negative emotions associated with the birth may eventually turn into long lasting anger, anxiety, depression and even suicide ideation (Beck, 2004a), which could then be reinforced by social isolation or the breakdown of a relationship with a partner.

It is feasible to suggest, therefore, that the embedded nature of this recall, particularly in the light of a negative experience or a perceived traumatic birth has the potential to affect future reproductive decisions throughout the rest of a woman's life. In particular, the longevity of the effects of traumatic birth may affect a woman's decisions about whether to resume a sexual relationship (Nicholls & Ayers, 2007), whether to conceive (Hildingsson, Nilsson, Karlstrom, & Lundgreen, 2011; Ayers, Eagle & Waring, 2006; Gottvall & Waldenstrom, 2002; Beck, 2004a; Allen, 1998), what antenatal care to accept (Thomson & Downe, 2010) and how to give birth (Kottmel et al, 2012; Kringeland, Daltveit & Moller, 2009; Fenwick, Gamble & Mawson, 2003; Hoffberg & Brockington, 2000). Women who have experienced a traumatic birth may choose not to talk about their negative experiences for many years afterwards (Forssen, 2012; Allen, 1998). The implication of this is that the decision not to talk about a traumatic birth may contribute to the fear of future

childbirth (Allen, 1998), which in turn may affect either the decision not to have any more children, or the length of time between pregnancies. Indeed, national cohort data in Sweden demonstrated that negative experience of first birth made women less likely to have a future child, with a clear gradient, in that the more negative the birth experience seemed to the woman, the less likely it was that she would have another pregnancy. Women who did have a further child had a longer interval between pregnancies (Ayers, Eagle & Waring, 2006; Gottvall & Waldenstrom, 2002).

For women who do feel able to pursue subsequent pregnancies, the enduring and profound effects of a traumatic birth may influence how they choose to give birth in the future. By reviewing 884 LSCS sections performed at one clinic in Switzerland in either 2002 or 2008, Kottmel et al (2012) found that the number of LSCS performed in the absence of a medical indication and solely due to previous traumatic birth experience nearly doubled. The choice of how to give birth has important consequences, including maternal psychological wellbeing, and the physical health of both the mother and baby.

Physical and emotional health during subsequent pregnancy

Evidence is emerging that a traumatic birth has an effect on a woman's wellbeing in subsequent pregnancies. Women may experience great psychological upheaval, which can be most pronounced in their first pregnancy subsequent to a traumatic birth (Thomson & Downe, 2010). Women use extreme language to describe their emotional states during a subsequent pregnancy, fear, terror, anxiety panic, dread and denial (Beck & Watson, 2010). These harrowing emotions originate in women's fears of a repeat birth experience (Thomson & Downe, 2010; Beck & Watson, 2010).

One consequence of this fear is a high rate of women requesting a non-medically indicated LSCS (Kottmel et al, 2012). If this request is not granted, women can become very distressed, and experience a significant impact on their mental health, including developing post-natal depression, PTSD and experiencing bonding problems with their baby (Thomson & Downe, 2010; Hofberg & Brockington, 2000). This is also true for women who had felt traumatised by having a previous LSCS, and who were facing difficulty in negotiating the vaginal birth after caesarean (VBAC) they wanted (Beck & Watson, 2010; Fenwick, Gamble & Mawson, 2003).

Remaining in a highly charged and negative psychological state for a prolonged period during pregnancy has other consequences for women. Physical wellbeing can be affected by the

psychological upheaval, as is shown by women reporting that they experienced panic attacks as their pregnancy progressed closer to their estimated due date (EDD) (Beck & Watson, 2010). Other physical effects of the psychological upheaval include sleeplessness, and difficulty in eating (Beck, 2004a), both of which in turn have a negative effect on psychological state. Hypermesis gravidarum has been reported far more often amongst pregnant women who have previously experienced a traumatic birth than for the general population of pregnant women (Hofberg & Brockington, 2000). Whilst the relationship between psychological state and physical health is a debated area, Hofberg and Brockington (2000) postulated that the cause of the rise in hypermesis gravidarum was a psychosomatic reaction to the psychological upheaval.

Maintaining both physical and psychological well-being during pregnancy are important, as birth is physically arduous, regardless of the mode of delivery. Caring for a newborn is draining both emotionally and physically. Approaching such a major change in life in suboptimal condition has implications for the postnatal wellbeing of both mother and child.

Antenatal care choices

Very little emerged from the literature about the antenatal care choices women make in a pregnancy subsequent to a traumatic birth.

Pregnant women face a whole host of choices about the routine or non-specialised antenatal care on offer. This includes regular screenings such as blood and urine tests and ultrasound scans, along with choice of caregivers, choice of information sources, decisions about health care during pregnancy, classes for birth preparation, and lifestyle choices. There is a significant research gap into whether a previous traumatic birth affects the choices women make about any of this kind of antenatal care. Antenatal care decisions, usually to do with lifestyle, are mentioned in passing in a minority of studies (Beck & Watson, 2010; Thomson & Downe, 2010), but no research has examined antenatal decision making after a previous traumatic birth in a systematic way. Thomson and Downe's (2010) study identified that the women who were experiencing psychological upheaval during a subsequent pregnancy were engaging in very specific behaviours, including information gathering, selection of care-givers, and lifestyle choice. These behaviours are one way of making choices about antenatal care. In this context, antenatal care in the form of hypnotherapy and alternative birthcare are referenced, but the study did not include information about other antenatal care decisions.

This research gap is surprising given that women experience both specific physical and psychological health needs during subsequent pregnancies (Thomson & Downe, 2010; Beck & Watson, 2010; Hofberg & Brockington, 2000). The need for specific antenatal support, not directly related to birth choices, is demonstrated by the specific needs that pregnant women with a previous traumatic birth evidently have. These needs include the high number of women with secondary tokophobia who experience hyperemesis gravidarum in subsequent pregnancies (Hofberg & Brockington, 2000). Women also need specific support for their psychological needs. This need may be demonstrated by women behaving in ways which are different to how other pregnant women behave, often in reaction to psychological difficulties during the pregnancy (Thomson & Downe, 2010). This suggests that women who have experienced a previous traumatic birth may need specialised antenatal care, but there is no existing literature that demonstrates how women utilise even the routine antenatal care on offer.

Who provides the care is also an important aspect of antenatal care provision. Research from Australia in 2003 indicated that the most important factor for women attempting a VBAC (after a traumatic first LSCS) was continuity of carer, and that this continuity was important throughout pregnancy, not simply in the intrapartum period (Fenwick, Gamble & Mawson, 2003). Taken together, this research suggests that women who have previously experienced a traumatic birth are experiencing specific needs antenatally, and are acting in ways to try to fulfil those needs. In the absence of systematic research, the choices they are making to fulfil those needs are unknown, and no assessment can be made as to whether those choices are successful.

Conceiving again

A common path following a traumatic birth, described in the literature, is the avoidance of the possibility of re-experiencing the trauma, in this case by avoiding pregnancy (Bahl, Strachan & Murphy, 2004; Murphy, Pope, Frost & Liebling, 2003). Women may choose to make certain that they do not conceive again by arranging sterilisation for themselves, or vasectomies for their partners (Beck, 2004a; Hofberg & Brockington, 2000). Other women choose less permanent methods of contraception, but may avoid conception every bit as carefully. Women's fear of childbirth after a previous traumatic birth may be so extreme that they avoid conception even when access to family planning information and contraception is extremely difficult to obtain (Forssen, 2012). Some literature reports that where women have accidentally conceived after a previous

traumatic birth, they have felt they have no option but to have a termination, because they are unable to face giving birth again (Hofberg & Brockington, 2000). These women all experience secondary tokophobia, but remain hidden, because they are not coming into contact with the maternity services.

Women who do choose to have a subsequent child often leave a longer gap between pregnancies (Gotvall & Waldenstrom, 2002; Saisto, Ylikorkala & Halmesmäki, 1999). This has a significant effect in a number of ways. Women with a larger gap between children will be older themselves during the subsequent pregnancy. There are number of potential complications associated with conception and pregnancy in women over 35, including higher stillbirth rates, and the health of the baby (Kenny, Lavender, McNamee, O'Neill, Mills & Khashan, 2013). Even in the absence of complications these women will be categorised as high risk and managed within that framework, which evidence suggests comes with a higher likelihood of interventions and maternal mortality (Kitzinger, 2006).

In some studies, many of the women who do become pregnant subsequently then chose to have permanent contraception for themselves or their partner, after having the subsequent baby (Hofberg & Brockington, 2000; Beck, 2004a). This suggests that the fear of childbirth has not been removed by the subsequent pregnancy, but that the desire for another child was so strong that the mother was temporarily able to overcome it in order to complete her family.

Elective caesarean births

There is a significant body of research into maternally requested LSCS for births following a traumatic birth experience, perhaps because these women are easy to identify (Hildingsson et al, 2011; Tschudin, Alder, Hendriksen, Bitzer, Popp, Zanetti, Hosli, Holzgreve & Geissbuhle, 2009; McGrath & Ray-Barruel, 2009; Kringeland, Daltveit & Moller, 2009; Kottmel et al, 2009; Pang, Leung, Lau & Hang Chung, 2008; Fenwick, Gamble & Mawson, 2003; Hildingsson, Radestad, Rubertsson & Waldenstrom, 2002; Gamble & Creedy, 2001; Hofberg & Brockington, 2000; Saisto, Ylikorkala & Halmesmäki, 1999). In order to give birth the way they choose, these women must request that their antenatal care provider to refer them for Consultant-led care, and then find a Consultant who will agree to carry out a non-medically indicated LSCS. In some NHS Trusts, women must also undergo a course of counselling before a Consultant is able to agree to their request. This process not only makes these women visible, but raises their profile amongst a range of health professionals, which may be one reason why so much research exists about this cohort. Another factor in the

abundance of research is the controversial updating of the NICE guidelines for Intrapartum Care at the end of 2011, to give women the option of a non-medically indicated LSCS if they have a fear of childbirth, which is not relieved by specialist perinatal mental health interventions.

In the population as a whole, few women would choose to give birth by LSCS (Hildingsson et al, 2002). Interestingly, multiparous women are more likely to desire an LSCS than nulliparous women (Gamble & Creedy, 2001). These women have not all experienced previous obstetrically complicated births. Instead they have a range of previous delivery experiences, including previous LSCS sections, instrumental deliveries, spontaneous vaginal deliveries in hospital, and spontaneous vaginal deliveries at home. Having an obstetrically complicated previous birth does increase the likelihood of a maternal request for an LSCS, but not all women with this history will prefer to give birth by LSCS. What distinguishes the multiparous women requesting a non-medically indicated LSCS is a fear of childbirth, and a subjectively negative previous birth experience (Storksen, Garthus-Niegel, Vangen & Eberhard-Gran, 2012).

Maternally requested caesarean births are a topical issue, with much attention being given to the subject. Labels such as 'too posh to push' abound (McGrath & Ray-Barruel, 2009). Women who request an LSCS after a previous traumatic birth do not usually do so lightly (McGrath & Ray-Barruel, 2009). However, it may be the only way that some women who have experienced a previous traumatic birth can contemplate giving birth, and they may have no willingness to consider other birth options (Hofberg & Brockington, 2000). When women in this situation are denied access to an elective LSCS, it can be psychologically devastating (Hofberg & Brockington, 2000).

If caesarean birth only impacted maternal psychological health, the literature is clear that it would be beneficial to allow multiparous women with secondary tokophobia the right to an LSCS in the absence of any medical indicators. However, caesarean births do have other consequences, including higher maternal death rates (Tew, 1995), poorer AGPAR scores for babies (Mander, 2007), and financial implications for an already stretched health service (Saisto, Ylikorkala & Halmesmäki, 1999; Mander, 2007). For women who plan further pregnancies, the implications on future fertility and health of future foetuses is also a consideration (Mander, 2007).

Birth choices

The focus of much of the literature about birth choices began with maternally requested LSCS, and then explored whether women were able to obtain their birth choice, and the impact of this. Literature about other birth choices is scarcer. This means conclusions drawn are more tentative.

From the small amount of research that has been conducted, it seems that subsequent to a traumatic birth, women who achieved a spontaneous labour, an unassisted vaginal delivery, and did not use strong pain relief such as opiates or epidurals expressed the greatest satisfaction with their birth experience (Beck & Watson, 2010; Fenwick, Gamble & Mawson, 2003). Some studies suggest that achieving this 'normal birth' after a traumatic experience can be more than simply satisfactory, it can help to heal some of the psychological wounds of the previous trauma (Beck & Watson, 2010). For some women this is a deeply redemptive experience, and this seems to be particularly the case where women have birthed at home, or in home-like settings, with minimal intervention (Beck & Watson, 2010). However, for others it can re-ignite the previous wounds, as after such an intensely satisfying experience, the woman realises anew the full extent of the loss she experienced in her traumatic birth experience (Beck & Watson, 2010).

Not all the literature agrees that the psychological benefits of a normal birth are so high. In some studies, birth experience via elective LSCS and birth experience via vaginal delivery have been equally as positive (Tschudin et al, 2009). This difference may be partially accounted for by the exact nature of the comparison – in the cases of a healing birth experience which was described as transcendental, the births did not include induction of labour, augmentation of labour, or strong pain relief (Beck & Watson, 2010). In Tschudin et al's study (2009), in which elective LSCS and vaginal birth were found to have equally favourable satisfaction scores, the births were all in hospitals. The only categories used in the research were LSCS and vaginal deliveries, with no differentiation made between unmedicated spontaneous deliveries and vaginal deliveries which included a high level of intervention or operative vaginal deliveries. The information about interventions is not included, so it is impossible to determine whether this is a true comparison. Whilst the satisfaction scores in Tschudin et al's (2009) study were equal, the redemptive element reported by women who had experienced a normal birth in Beck's studies is missing.

Where women have experienced a traumatic birth, but then do become pregnant again, and have a positive subsequent birth experience, their reports of that experience are extremely positive, irrespective of the mode of delivery (Beck & Watson, 2010; Thomson & Downe, 2010).

Where there is agreement in the literature is that when a previous birth has been traumatic, if a subsequent birth involves either an instrumental vaginal delivery or an emergency LSCS, satisfaction scores are very low, and there is a high chance that the subsequent birth will also be experienced as a traumatic event (Beck & Watson, 2010; Tschudin et al, 2009; Hofberg & Brockington, 2000).

The choices that women make in choosing antenatal care may be connected to the birth they have. The choice of place to birth will also have a significant effect on the experience they have (Beck & Watson, 2010). Whilst these choices are by no means the only factors in predicting birth outcome, they are likely to be significant. Understanding what influences a woman's choice of place to give birth, what she is trying to achieve by making that choice, and whether she succeeds, would enable caregivers to support women's choices more effectively.

Confusion over definitions

There is relative consensus within the literature about the factors which contribute to a birth that is experienced as traumatic by the woman giving birth. These include previous experiences (Kringeland, Daltveit & Moller, 2009; Nieminen, Stephansson & Ryding, 2009), previous mental wellbeing (Pang et al, 2008), events during birth (Saisto, Ylikorkala & Halmesmäki, 1999), care received (Beck & Watson, 2010) and feelings of control (McGrath & Ray-Barruel, 2009).

This consensus of contributory factors does not extend to a consensus about the definition of traumatic birth. A variety of terms are used interchangeably by those working in this area. Although 'traumatic birth' is the most commonly used, 'birth trauma' (Beck & Watson, 2010), 'PTSD/PTSS following childbirth' (Ayers, 2004) and 'traumatic delivery' (Gottvall & Waldenstrom, 2002) are also used. The lack of a common terminology results from the lack of a definition of traumatic birth.

Traumatic birth cannot be defined solely based on the method of delivery. Emergency operative deliveries are often linked to a traumatic birth experience, but not every emergency operative delivery is experienced by the mother as traumatic (Bahl, Strachan & Murphy, 2004). Normal vaginal deliveries can also be experienced as traumatic (Forssen, 2012). Nor can a traumatic birth be defined

neatly by psychological sequelae. The consequences of a traumatic birth can include psychological conditions, such as PTSD (Beck, 2004a) and secondary tokophobia (Hofberg & Brockington, 2000), but not every woman who has experienced a traumatic birth develops either psychological condition (Ayers, 2004). Rather, a traumatic birth is defined by the person who has subjectively experienced it as such, just as a 'good birth' is (Thomson & Downe, 2010).

3.7 Conclusions

There is a consensus throughout the literature that traumatic births are a significant issue affecting women today (Allen, 1998; Beck, 2004a; Hofberg & Brockington, 2000;). Experiencing a traumatic birth can have a significant impact on a woman's life, especially in relation to choices about fertility (Edwards & Kirkham, 2012; Hildingsson et al, 2011; Beck & Watson, 2010; Thomson & Downe, 2010; Ayers, Eagle & Waring, 2006; Bahl, Strachan & Murphy, 2004; Gotvall & Waldenstrom, 20020, although the degree of impact will differ from woman to woman. The quantitative studies show the scale of the issue (Kottmel et al, 2012; Hildingsson et al, 2011, 2002; Nieminen, Stephansson & Ryding, 2009; Pang et al, 2008; Bahl, Strachan & Murphy, 2004; Gotvall & Waldenstrom, 2002; Gamble, & Creedy, 2001; Saisto, Ylikorkala & Halmesmäki, 1999), whilst the qualitative studies demonstrate the nuances of the individual women's experiences (Forssen, 2012; Beck & Watson, 2010; Nicholls & Ayers, 2007; Ayers et al, 2006; Beck, 2004a, 2006; Allen, 1998).

The evidence about choices made in subsequent pregnancies is limited, and skewed towards certain elements, notably the choice to have an elective LSCS (Kottmel et al, 2012; Tschudin et al, 2009; Kringeland, Daltveit & Moller, 2009; McGrath & Ray-Barruel, 2009; Nieminen et al, 2009; Pang et al, 2008;; Hildingsson et al, 2002; Gamble & Creedy, 2001; Saisto, Ylikorkala & Halmesmäki, 1999). Where evidence does exist in the literature about choices made in pregnancy, this tends to be a by-product of the study, rather than the focus of the research (Beck & Watson, 2010; Thomson & Downe, 2010; Gamble et al, 2003). It is unclear why this gap exists in the research, but it is possible that it is influenced by the dominant medicalised model of birth and maternity. As has already been noted, much of the literature from a midwifery or obstetric background focuses on the easily identifiable women who request elective LSCS, which is of necessity a medical event. From a maternity services view, once a woman has been discharged from the midwife's care, the birth is over. Any subsequent psychological difficulties might necessitate medical treatment by the GP, or a referral for psychological support, but these are interventions which move the mother into services

other than maternity services. From a Maternity Service viewpoint, the mother may therefore be invisible between discharge following a birth, and conception of a subsequent baby. This may be one factor influencing this gap in the research.

Most of the remaining literature comes from a background of psychology or psychiatry, and is concerned with diagnosable conditions, such as PTSD, treatments for such conditions, and what effect interventions have on recovery from a traumatic birth (Nicholls & Ayers, 2007; Ayers et al, 2006; Beck, 2004a; Hofberg & Brockington, 2000; Saisto, Ylikorkala & Halmesmäki, 1999; Allen, 1998). This viewpoint is again from a medical model. Women who have experienced a traumatic birth, but do not currently have a diagnosis of a mental health condition occupy a liminal space – they are no longer patients within the maternity services, and are not patients through a diagnosable condition. Perhaps this is why there is a dearth of literature from a maternity services perspective which examines women's lived experiences and choices once the traumatic birth is over.

This situation is confounded by the lack of a defined concept of traumatic childbirth, which makes it difficult to draw the literature together. In order to take the proposed research further, it is first necessary to have a clearly defined concept to examine. A concept analysis of traumatic birth will draw together the literature included in this review, and other literature, and aim to provide clarity over the definition of traumatic birth.

Chapter 4 – Concept Analysis of Traumatic Birth

As shown in the previous two chapters, experiencing childbirth as a traumatic event is a factor that has been highlighted as contributing to poorer psychological outcomes for mothers. Up to 30% of women in the UK experience childbirth as a traumatic event, with many consequently going on to experience some form of anxiety, depression, or PTSD following childbirth (Ayers, 2014; Slade, 2006). It is already known that there are lower birth rates amongst those who have experienced a traumatic birth (Gottvall & Waldenstrom, 2002), and higher rates of elective caesarean section amongst those women who do have more children (Kottmel et al, 2012). What is not fully known is what other choices women make during pregnancy and birth, when they have previously experienced a traumatic birth. In order to understand what choices such women make, getting to the root of what their common experience was, and defining what is meant by a traumatic birth, when it is not defined elsewhere, is an essential first step.

A body of literature about traumatic birth already exists, and the term is widely used by authors investigating theories and models of causality (Ayers, 2014; Boorman, Devilly, Gamble, Creedy & Fenwick, 2014; Slade, 2006; Creedy et al, 2000; Allen, 1998). However, there are competing models within this literature about what constitutes a traumatic birth. In their meta-analysis of traumatic birth Elmir et al (2010) begin by saying:

> 'There is no consistent definition of traumatic birth and no systematic way to assess birth trauma, and the terms birth trauma and traumatic birth are used frequently synonymously' (p.2142).

A psychiatric model of traumatic birth exists as childbirth-related Post-Traumatic Stress Disorder (PTSD), and is defined through the DSM-5 (American Psychiatric Association, 2013). This definition relates more to the appraisal of the event, and the individual's reactions to the event, rather than the event itself. Conversely, the medical definition of traumatic birth, as it is widely used in the literature, relates to the mode of delivery (operative birth) and the event of birth only, yet it is evident from the literature that not all women who have an operative birth will be traumatised by it (Bahl et al, 2004; Murphy et al, 2003). Adding to the confusion is the fact that there is no single term used in the literature, instead a variety of terms are used, with slightly differing meanings (shown in Table 4 overleaf):

Table 4 – Terms used in the literature to describe concept being analysed

Birth trauma
Traumatic birth
Difficult birth
Traumatic experience of childbirth
Negative birth experience
Partial Post-traumatic Stress Disorder (PPTSD) resulting from childbirth
Post-traumatic Stress Disorder (PTSD) resulting from childbirth
Post-traumatic Stress Symptoms (PTSS) after childbirth

The latter two of these terms are most clearly defined, in that they have diagnostic criteria attached. However, whilst PTSD and PTSS are potential consequences of a traumatic birth, not all traumatic births result in a woman experiencing either condition. Childbirth related PTSD is often undiagnosed and because of this, researchers may use cohorts that include those with a diagnosis alongside those without (Beck & Watson, 2010) and terms are often confused and used interchangeably (e.g. Beck, 2009).

Hence, the concept of 'traumatic birth' is meaningful within the literature relating to childbirth, but is generally poorly defined. There is therefore a need to conceptualise the concept of a traumatic birth, distinct from diagnosable conditions that may result from the experience, or the mode of delivery. In this situation concept development is needed to clarify the concept (Walker & Avant, 2011), refine meaning and direct future application. This chapter aims to clarify what is meant by 'traumatic birth' through a concept analysis, using Walker and Avant's model (2011).

4.1 Method

Concepts form the foundation of applied theory in the social sciences (Morse, Mitcham, Hupcey & Cedras-Tason, 1996). A concept is a mental image of a phenomenon or experience, with a meaning that can be communicated to others and understood. A concept analysis is a deductive process that analyses the existing usage of a concept, identifying and refining shared meaning (Walker & Avant, 2011). In order to analyse a concept, it needs to be broken down into simpler elements to establish their internal composition. Walker and Avant (2011) provide a model for undertaking this process, the goal of which is to bring to light the attributes of a particular concept and clarify its meaning.

Walker and Avant's (2011) framework relies on literature-based evidence and ensures that the uses of the concept are not just limited to nursing and medical literature, but facilitate sources such as dictionaries, thesauruses and research papers. This method is not without criticism, with some authors arguing that it does not add to the knowledge base, and is instead only an intellectual idea (Rogers, 1993), and others saying it does not create a strong enough theoretical basis for further work (Morse, 2000). Other methods have been proposed – evolutionary concept analysis (Rodgers, 1993), simultaneous concept analysis (Haase, Kline Leidy, Coward, Britt & Penn, 1993), utility method (Morse, 2000), principle-based method of concept analysis (Penrod & Hupcey, 2005), and hybrid model of concept development (Schwartz-Barcott & Kim, 1993). However, the Walker and Avant model has been selected for this research because it is the most widely utilised within nursing and midwifery research, and it has specifically been used in a perinatal context to analyse concepts related to traumatic birth (Spiteri, Borg-Xuereb, Carrick-Sen, Kaner & Martin, 2013; Allan, Carrick-Sen & Martin, 2013). Overall, this method is deemed rigorous, logically structured and appropriate to the concept being analysed.

Traumatic birth is a concept that is relatively new in the research and midwifery literature, and one for which meaning has not fully coalesced. Using Walker and Avant's (2011) framework, this chapter will explore what different writers mean by traumatic birth, to develop an accurate understanding of what is being discussed. This method involves using a series of eight steps, which have been summarised in Table 5 below:

Table 5 – Process of Concept Analysis

Step	Process	Purpose
1	Selection of a concept	Define what is being analysed
2	Determine the aims and purposes of the analysis	Identify why the analysis is useful
3	Identify all the uses of the concept	Understand how the concept is currently used (includes literature review)
4	Determine the defining attributes	Analyse what features lie behind the current usage
5	Constructing a model case	Create an exemplar of how the concept is currently used
6	Constructing borderline, related, contrary, invented and illegitimate cases	Demonstrate that the concept is narrow enough to exclude mis-usage
7	Defining antecedents and consequences of the concept	Explain what happens prior to and after the concept to make the usage valid

8	Empirical referents	Check definition of concept for external validity

4.2 Results

Step 1: Selection of a concept

The literature already contains a wide range of terms, which are used in sometimes overlapping or contradictory ways. The first stage in the Concept Analysis is therefore to decide which term should be selected. Examining the list of terms currently used in the literature, there exists a choice of at least eight overlapping but slightly different concepts which could be analysed (see Table 4). Some of these terms name specific psychological conditions which can result from a traumatic birth, but exclude women who do not develop these conditions. These terms were therefore ruled out. Walker and Avant (2011) recommend analysing concepts where the meaning is unclear, and not strictly defined. On this basis, all terms with diagnostic criteria were ruled out. Consideration was then given to whether the term was narrow enough to be conceptually useful. Terms such as 'difficult birth' and 'negative birth experience' have a wide applicability and encompass a wide range of birth experiences, which may or may not be experienced as traumatic (Sorenson & Tschetter, 2010; Soet, 2002). This means that defining either of these terms would not add to the understanding of traumatic birth, and on this basis these terms were excluded from selection. With these terms excluded, the potential terms available were 'traumatic birth', 'traumatic experience of childbirth' and 'birth trauma'. A brief review of the literature was undertaken to determine which term was used most consistently. On this basis, the concept of 'traumatic birth' has been selected for analysis.

Step 2: Determine the aims or purposes of analysis

The lack of a clear definition of a traumatic birth results in difficulty both for those conducting research on traumatic births, and those providing services to women affected by traumatic birth. In the research arena, this leads to a reliance on either self-definition, or third party definitions. Where stricter criteria are used, the only existing definitions are those which result in the diagnosis of a mental health problem to identify who has been affected by a traumatic birth. This makes comparisons between populations difficult, and therefore leads to potential lack of reliability in comparing the effectiveness of prevention of trauma, or treatment for those who have been traumatised. In clinical practice, the lack of a clear and defined concept may create barriers for women wishing to access services, as they may have experienced a traumatic birth which has not resulted in a diagnosable mental health problem. This can lead to inappropriate diagnosis, and to

treatment which is at best ineffectual, but potentially harmful, whilst leaving women's real needs unmet (Kitzinger, 2006; Hilpern, 2003). Defining the concept will therefore facilitate comparisons across studies dealing with prevalence, prevention and treatment after traumatic births, highlight areas for future research, and may enable targeted support and assistance for those experiencing or at risk of a traumatic birth.

Step 3: Identify all uses of the concept

Once the concept has been selected and the purpose of the analysis has been defined, the concept is broken down into its component words, so that the individual words 'traumatic' and 'birth' can be examined separately. The terms are then re-joined, to provide a single definition. The analysis then progresses to examine how the concept as a whole is currently used in the literature. Initially this stage utilises as wide a range of sources as possible, including dictionary definitions, academic and medical literature, and common usage sources (Walker & Avant, 2011).

Birth

'Birth' is a relatively simple concept to understand. It is a specific event, and is defined in the Oxford English dictionary as

'The emergence of a baby or other young from the body of its mother; the start of life as a physically separate being' (p.209).

In conjunction with 'give', 'birth' can also be used as a verb to describe the process of the event:

'Give birth to (a baby or other young)' (p.209).

Two other uses of birth are given in the Oxford English Dictionary: 'The beginning or coming into existence of something' and 'A person's origin, descent, or ancestry' – but for this analysis only the first two uses of the term 'birth' are relevant – a specific event that involves the emergence of a baby from a mother, and the process associated with this event.

Traumatic

'Traumatic' is a more difficult concept to define. Beginning with the root word 'trauma', the Oxford English Dictionary contains two definitions:

1. 'A deeply distressing or disturbing experience'
2. 'Physical injury' (p.907)

As an adjective 'traumatic' can relate to either of these meanings, but refers to the distress and disturbance caused by either the psychological or physical injury. In the context of birth, trauma can arise from medical interventions, whether or not they cause physical injury, or from the care received. Therefore psychological consequences are always involved in the concept of 'traumatic', regardless of whether physical injury is involved.

Traumatic birth

The enduring nature of the distress is a matter for consideration. Clearly it should last past the end of the birth itself, but does it also outlast all the physical consequences of the birth, when some of those might last for years, or even be permanent? In the definition of PTSD and PTSS which are lucidly related to a traumatic birth, the minimum duration for symptoms is given as one month (American Psychiatric Association; Criterion F, DSM-5, 2013). It may be feasible therefore to tentatively advance this timescale as a minimum for the duration of distress in the case of traumatic birth. If untreated, or ineffectively treated, there is unlikely to be a maximum duration to the psychological distress caused by a traumatic birth. Turning again to the definitions used for PTSD, the UK NICE Guidelines (2005) recognise that many individuals presenting with symptoms of PTSD will have experienced them for many months or even years. Existing literature on traumatic childbirth also demonstrates that the psychological distress may last a woman's entire life, and never be resolved (Forssen, 2012).

When these concepts are put together the following definition can be proposed:

> *The emergence of a baby from the body of its mother, in a way which may or may not have caused physical injury. The mother finds either the events, injury or the care she received deeply distressing or disturbing. The distress is of an enduring nature.*

At this point some consideration must be given to what constitutes the timeframe of 'birth'. The beginning of birth could be conceptualised as the onset of labour, but for women who are induced, or birth their baby through a pre-labour caesarean section, the beginning of labour does not mark

the beginning of birth. It is therefore proposed that the beginning of birth be taken to be either:

1. The onset of labour, or
2. The admission to hospital for medical intervention intended to begin birth

Using the Oxford dictionary definition above, the end of birth would occur when the baby had emerged from the mother's body. In midwifery and gynaecology, the birth is seen as complete when the placenta has been delivered. In the case of a caesarean section, a woman will still be cared for in the Recovery Room, following the delivery of the placenta and the stitching of the incision. From the literature, none of these definitions seem to fit with women's experiences, in which the care received is as important, if not more important, than the medically significant events (Storksen et al, 2012; Allen, 1998). It is proposed that the end of birth be conceptualised for the purposes of this analysis as the end of the care received from medical professionals, maternity staff, and other birth workers (e.g. doulas) in direct relation to the episode of birth. In practice, this might mean when a midwife who has attended a homebirth leaves the home, or in a hospital delivery it would mean when a woman is discharged from the Labour Ward or Midwife Led Unit, either to return home, or for admission to the Postnatal Ward. This definition of the timeframe of birth fits the literature, but is an area in which future development could be helpful.

Using this timeframe, the usage advanced above is consistent with the definition based on the separate terms that was advanced above.

The next component of this step is to search the literature on 'traumatic birth'; to evaluate whether the definition arrived at fits the ways in which the concept being analysed is used in practice.

Literature search

In Walker and Avant's (2009) method of Concept Analysis, a literature search is not a specific step in the process. Instead it forms one part of the larger step of identifying all the uses of the concept that can be found in the literature, to examine consistency of the definition that has been advanced. However, a search strategy using Cochrane, PsycINFO, CINAHL and Medline databases was employed, for dates between 1998 and 2014, to ensure the inclusion of literature from a wide variety of sources. Studies over 15 years old were excluded as the aim was to examine contemporary uses of the concept. This time period was chosen as Allen's work in 1998 and Saisto Ylikorkala and

Hamlmesmaki's in 1999 mark a point in the literature when the concept of traumatic birth was beginning to be used. With the publication of the updated DSM-IV-TR the following year, the diagnosis of PTSD relating to childbirth became possible, and the literature relating to traumatic birth increased (American Psychiatric Association, 2000). The keywords used for the search were 'traumatic' and 'birth'; only sources in English were included.

The search returned 92 potentially relevant papers, after duplicates were removed. Following the reading of all abstracts, one article was excluded as the full text was only available in Persian and one was removed because it was no longer available. This left 90 papers which related to traumatic birth in some way. Of the papers, 68 were concerned largely with the sequelae of a traumatic birth, rather than what was actually meant by 'traumatic birth'. These 68 papers were used to inform the consequences of traumatic birth, whilst the 22 dealing with the births themselves were used to inform the defining attributes. The 22 papers dealing with the births themselves included a meta-ethnography of traumatic births (Elmir et al, 2010), and the 68 papers dealing with the sequelae of traumatic birth included one meta-ethnography of Beck's work (Beck, 2011), and a meta-synthesis by Fenech and Thomson (2014). An updated search in June 2015 added an additional two papers to the Concept Analysis, and an additional nine to the papers on the sequelae and consequences section of the analysis. A list of this literature is included in Appendix 5 - Literature informing Concept analysis. These papers were analysed, and the results interwoven with the findings from the original analysis. This is shown in Figure 2 overleaf.

Figure 2 – Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)

flowchart for concept analysis (Moher et al, 2009)

```
┌─────────────────────┐          ┌─────────────────────┐
│ 110 papers retrieved│          │  14 papers retrieved│
│  through database   │          │ through other sources│
│     searching       │          │                     │
└─────────────────────┘          └─────────────────────┘

                ┌─────────────────────┐
                │   92 papers after   │
                │  duplicates removed │
                └─────────────────────┘

┌─────────────────────┐  ┌─────────────────────┐  ┌─────────────────────────┐
│ 47 papers retrieved in│ │ 92 papers screened by│ │ 2 papers removed as no longer│
│ updated search June  │  │  reading abstracts   │  │ available (1) or full article not│
│ 2015, and screened by│  │                      │  │   available in English (1)  │
│  reading abstracts   │  └─────────────────────┘  └─────────────────────────┘
└─────────────────────┘

┌─────────────────────┐  ┌─────────────────────┐  ┌─────────────────────────┐
│11 full text papers read│ │ 90 full text papers read│ │ 68 papers removed, as they dealt│
│for eligibility, 9 dealt with│ │   for eligibility    │ │with the sequalae of traumatic birth│
│      sequalae        │  │                      │  │    rather than the concept  │
└─────────────────────┘  └─────────────────────┘  └─────────────────────────┘

┌─────────────────────┐  ┌─────────────────────┐  ┌─────────────────────────┐
│ 2 additional papers  │  │22 papers reviewed for│  │ 68 papers reviewed to inform│
│ reviewed for Concept │  │  Concept Analysis    │  │ antecedents and consequences│
│ Analysis, 9 reviewed to│ │                      │  │   element of the Concept    │
│ inform antecedents and│ │                      │  │        Analysis             │
│   consequences       │  │                      │  │                             │
└─────────────────────┘  └─────────────────────┘  └─────────────────────────┘
```

In literature that does define the actual experience that constitutes a traumatic birth, a range of different experiences are revealed. Earlier papers refer almost exclusively to physical trauma having occurred to the mother or baby (Lesianics, 2005; Oliver, 2005; Saisto Ylikorkala & Hamlmesmaki, 1999; Ryding, Wijma & Wijma, 1998) and this usage is similarly reflected in popular understandings of traumatic birth:

'Birth trauma (BT) refers to damage of the tissues and organs of a newly delivered child, often as a result of physical pressure or trauma during childbirth. The term also encompasses the long term consequences, often of a cognitive nature, of damage to the brain or cranium '. (Wikipedia)

Some of the papers identified in the literature search focused on this kind of physical injury to the mother or baby (McKinlay, Grace, Horwood, Fergusson, Ridder & MacFarlane, 2008). In many other

cases the trauma is presumed by researchers to be implicit in the mode of delivery (Rowlands & Redshaw, 2012; Oliver, 2005), in particular for unplanned caesarean section (Van Reenen & Van Rensburg, 2015; Lesanics, 2005; Ryding, Wijma & Wijma, 2000; 1998;), but also for instrumental vaginal delivery (Gamble & Creedy, 2005; Parker, 2004).

There seems little disagreement that severe physical injury to either mother or baby, and unplanned operative births have the potential to be psychologically traumatic as well as physically injurious, although research shows that unplanned operative births do not always result in maternal psychological trauma (Van Reenen & Van Rensburg, 2015; Boorman et al, 2014). In more recent years, it has become common to use the term 'traumatic birth' for a wider variety of experiences. The notion that the birth experience *per se* irrespective of physical injury or intervention can be traumatic is not a sudden development. Kitzinger (2000), highlighted the manifestation of PTS symptoms in women following normal birth and Robinson (2002) reflected that home-birth can cause PTSD 'when a midwife is set on giving a hospital birth at home' (p.43). Both authors reinforced Beech's and Robinson's (1985) findings that the consequences of this distress can last for a great many years. Yet the number of researchers using traumatic birth in this way were relatively few, until more recently when psychological trauma unrelated to physical injury began to emerge as part of a discourse on whether childbearing women can experience PTSD. Childbirth related PTSD is now generally accepted, although the criteria for diagnosis remain under discussion (Ayers, McKenzie-McHarg & Slade, 2015; Stramrood, Huis in 'T Veld, Van Pampus, Berger, Vingerhoets, Schultz, Van Den Berg, Van Sonderen & Paarlberg, 2010; Vythilingum, 2010; Ayers, Jospeh, McKenzie-McHarg, Slade & Wijma, 2008).

It is also now increasingly acknowledged that women without PTSD can experience clinically significant distress following childbirth. Beck (2004b) posited a definition for birth trauma centred round the mother's psychological rather than physical experience:

> 'An event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror' (p.28).

The terminology used to describe the experience of these women has fluctuated over time, as researchers have grappled with defining and naming women's experiences. Initially, terminology

remained closely related to the clinical terminology of PTSD. Where women have symptoms of PTSD, but the symptoms had not lasted long enough to qualify, or the birth was not physically traumatic, terms such as partial PTSD (Stramrood et al, 2010), Post-Traumatic Stress Symptoms (Simkin, 2006), or Post Traumatic Stress Experience (Simkin, 2004) have been used. Where clinical terminology was inappropriate, more general terms, such as distress (Moyzakitis, 2004), negative birth perception (Sorenson & Tschetter, 2010), and trauma (Soet, 2002) were also used. Despite the differences in language, all of these terms were describing a potentially similar phenomenon: a sub-clinical psychological reaction to an event or care experience which occurred during birth.

A paper by Ayers et al (2008) marked a seminal moment in the area of traumatic birth, as it explicitly acknowledged the existence of women without PTSD who experienced clinically significant distress following childbirth that is not necessarily related to physical injury. This reflected a change that occurred in the literature from just a short time before the publication of this research – the usage of 'traumatic birth' in much of the literature widened to include psychological distress in the absence of severe physical trauma or operative births. Terminology continued to be inconsistent though, with some authors using the term birth trauma (Kitzinger & Kitzinger, 2007), some using traumatic birth (Ayers et al, 2008), and some using the two interchangeably (Beck, 2009). In addition, wider terms such as negative birth experience continue to be used (Sorenson & Tschetter, 2011).

There has been a more recent acknowledgment that psychological trauma can occur to other people who are present at a birth. In particular the woman's partner can have a psychological reaction to a traumatic birth (Ayers & Nicholls, 2007). Midwives and other health professionals present at a birth can also experience a similar reaction (Beck LoGiudice & Gable, 2015; Davies & Coldridge, 2015; Rice & Warland, 2013; Weston, 2011). This is an emerging area of research, with a paucity of literature, and so defining the characteristics of the experience of a traumatic birth in someone other than the mother is currently difficult. Further commentary on this subject is outside the scope of this research. It is acknowledged that a birth which did not cause psychological distress to the mother, but did cause significant distress to someone else present is still a traumatic birth. There may be further consequences for the witness in this case that are not covered within this concept analysis.

'Traumatic birth' is therefore used in the literature to refer to a birth where there has been:

1. Physical injury to the baby and resulting psychological distress, and/or

2. Physical injury to the mother which results in psychological distress, and/or

3. Fear of physical injury to mother or baby and associated psychological distress, and/or

4. Psychological response to the experience of birth, including care received, which causes psychological distress of an enduring nature

Step 4: Determine the defining attributes

Having identified the way that 'traumatic birth' is used in both contemporary society and academic literature, the next stage is to understand what attributes define a traumatic birth, to create greater precision in the analysis of the concept.

The defining attribute of 'birth' is that a baby must have been within the mother's uterus, and emerged. If the baby has not survived, it must be of a gestation where survival was possible, in order to fulfil the criteria of a birth rather than a miscarriage.

The mother must have been traumatised by what happened during the process of the baby being born. This injury could be physical, occurring to either the mother or the baby, but must result in psychological distress that lasts after the birth. The trauma could be purely psychological, or could include both physical and psychological aspects. Psychological trauma could arise from care during the birth, including brusque or unsympathetic care, or inability to obtain interventions or analgesia the woman feels is necessary, or from experiencing interventions the woman feels are unnecessary. Psychological trauma could also arise when a woman has experienced a previous traumatic experience, including sexual abuse, and events that occur during the birth vividly remind her of these experiences. The long-lasting nature of the distress is one attribute which separates the concepts of 'difficult birth' or 'negative birth experience' from a traumatic birth. Why some women experience short-lived distress, and for others the distress continues is not fully understood, though it may be related to how the woman processed the events either as they happened, or to feeling emotions such as horror and intense fear during the events (Beck, 2004a), or how she processed them afterwards (Van Reenan & Van Rensburg, 2015; Ayers et al, 2015), and whether the events are reinforced or balanced by other events of new motherhood (Beck, 2009).

The defining attributes are therefore:
1. A baby has been born

2. Events and/or care during the birth caused significant distress and trauma to the mother as

they unfolded. The trauma could be

a). Physical and psychological

b). Psychological alone

3. The distress from the trauma must be long lasting

The attributes must all be present to fulfil the criteria for a traumatic birth. Using these defining attributes, it is then possible to construct cases which include all, some, or none of the attributes. The purpose of this stage of the analysis is to test the application of the newly defined concept.

Steps 5 and 6: Constructing a model case, and constructing borderline, related, contrary, invented and illegitimate cases

The next step in Concept Analysis is to identify a series of cases, and apply the defining attributes to them to check for 'fit'. These include model cases which show the concept being applied in an exemplary way, and then a range of other uses, including borderline, related, contrary, invented and illegitimate cases. The cases are based on the full inclusion, partial inclusion or exclusion of the defining attributes, which in turn have emerged from the literature. For this analysis, the cases relate to whether a woman has become a mother through a traumatic birth, and how this might relate to her future choices about pregnancy and birth. The purpose of identifying these cases is to check that the definition of the concept can be applied appropriately. The exact purpose of each case is summarised from Walker and Avant (2011), and shown in Table 6 below:

Table 6 – Summary of purpose of cases in Walker and Avant's method of concept analysis

Case	Purpose
Model	An example drawn from the literature which fits the definition of the concept exactly
Borderline	An example drawn from the literature which includes most of the defining attributes of the concept, but excludes one attribute. This case should be used as a test to help tease out the nuances of the defining attributes
Related	An example drawn from the literature which contains some of the elements being studied, but not all of them, demonstrating the concept can be used accurately to differentiate between related cases
Contrary	An example from outside the literature which is a clear example of 'not the concept', which helps to define what the concept is
Invented	An invented example which demonstrates the applicability of the concept to cases which have not happened
Illegitimate	To be used when a concept has alternate meanings

- Model

A mother is told her baby's life is at risk and given unwanted medical interventions including an episiotomy without adequate anaesthesia. She does not feel in control, and is distressed by both the threat to her baby's life, the pain and the physical injury incurred through the episiotomy. She feels medical staff are brusque and uncaring in their attitude towards her. She has lasting physical effects from the episiotomy, and feels traumatised when thinking back over the birth. She wishes she had made different choices, and feels that the perceived removal of her choice was traumatic, as well as the lasting physical trauma from the episiotomy.

- Borderline

A mother is told her baby's life is at risk and advised that she needs medical interventions she does not want, including an episiotomy. She feels respected by those caring for her, and in control of the decisions, and decides to have the advised interventions. She experiences distress at the threat to her baby's life, and at having interventions she would have preferred not to have, and describes the birth as difficult. But the care she received, and feeling in control of decisions protects her from being traumatised by the events. On reflection, she feels she would have made the same choices again, and trusts that she would have been supported by those caring for her in whatever decisions she had made.

- Related

a). A mother has minor perineal grazes from giving birth. They are tender for a few days, but cause her no lasting problems or distress.

b). A mother is told her baby's life is at risk and is given medical interventions which she welcomes.

- Contrary

A mother has an empowering and satisfying birth experience and is very happy with it.

- Invented

A solitary pregnant alien finds herself on Earth. She cannot explain her needs and does not receive appropriate care as she gives birth. Her expectations of what should happen during birth are not met, and things happen during the birth which surprise her and which she did not expect. She is unable to understand what is happening. She and her baby suffer no major physical harm, and live, but the mother is distressed and traumatised by what happened.

- Illegitimate

No illegitimate uses of the concept of traumatic birth were found.

Considering these cases demonstrates that the definition of the concept of 'traumatic birth' can be applied appropriately; this shows that the defining attributes identified were consistent with the current usage of the concept.

Step 7: Defining antecedents and consequences of the concept

Once a definition has been arrived at, and has been demonstrated, the next step is to identify the necessary antecedents and consequences of the concept – that is, what must have happened prior to the concept under study, and what are the unavoidable things which happen afterwards? In the Walker and Avant (2011) method of concept analysis, antecedents and consequences are the things which must *all* have happened, in order for the concept to be applied appropriately. These are detailed in Table 7 below.

Table 7 – Necessary antecedents and consequences of a traumatic birth

Necessary antecedents	Necessary consequences
Conception occurred, and A fetus developed to the point where it was viable, and A viable baby was birthed, and Physical and psychological, or psychological harm alone, occurred to the mother during the events or care received during the birth or as a direct result of the events of the birth	The woman has become a mother, and A baby has been born, and The psychological distress experienced lasts beyond the immediate delivery

It can immediately be seen that many of these necessary antecedents and consequences apply to all births. Because of the nature of the concept under investigation, there are also a number of antecedents and consequences which are likely, but may not *all* have happened. These potential consequences are however part of what sets a traumatic birth apart from other closely linked concepts, such as a difficult birth. The nature of a traumatic birth is that the distress a mother experiences is long-lasting, and that this long-lasting distress has potential important consequences; it is therefore necessary that a mother has experienced *some* of the potential antecedents and consequences in order for a birth to be defined as a traumatic birth. The Walker and Avant (2011) method does not include analysing likely antecedents and consequences, but it has been decided to adapt the model slightly to the nature of the concept being reviewed. These potential

antecedents and consequences are shown in Table 7a below:

Table 7a – Potential antecedents and consequences of a traumatic birth

Potential antecedents	Potential consequences
Physical harm to mother or baby	Development of diagnosable psychological
Warned of potential harm to mother or baby	conditions such as PTSD and post-natal anxiety or
Death of baby	depression
Operative birth	Difficulty with infant-maternal bonding
Medical intervention	Lower rates of breastfeeding
Haemorrhage	Marital/relationship difficulties or breakdown
Lack of care	Difficulties in sexual function or relationships
Care which is perceived as uncaring, unsupportive	Difficulty maintaining existing friendships or
or inhumane	forming new ones
Experiencing high levels of pain during labour,	Distress on anniversary of birth
and not being able to obtain analgesia	Distress when encountering people, places, or
Having choice removed by the actions of a person	phenomena which remind mother of the birth
(rather than events)	
Not holding baby immediately after birth	
Existing psychological condition	
Previous sexual abuse	
Previous traumatic experience	

Step 8: Empirical referents

The final step in the Walker and Avant (2011) model of concept analysis is to define the empirical referents of 'traumatic birth'. Empirical referents are

> 'classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself' (p.46).

With a traumatic birth, a necessary antecedent is that the mother experienced the birth, or specific events during the birth, as traumatic. The referents for this would be that she has experienced deep distress or disturbance, and that this continued for a significant period of time afterwards. An

additional referent would be that she describes the birth as a traumatic experience. This does not have to be a literal use of language; negative terms such as upsetting, traumatic, distressing, horrific might also be used (Beck, 2006b).

Other referents may be present, for example sometimes the mother will avoid discussion of the birth, or discussion of other people's births. She might also avoid returning to the physical location of the birth, or experience anxiety if she needs to return there. She might experience flashbacks to the birth, or vivid re-imaginings of it, or have nightmares about it. Related psychological conditions might develop; common ones are PTSD/PTSS, anxiety disorders, depression, conversion disorder and bonding/attachment difficulties (Reid, 2011; Sorenson & Tschetter, 2010; Simpson, 2008; Rowan, Bick & Bastos, 2007; White Matthey, Boyd & Barnett, 2006; Parker, 2004). Absence of these latter referents does not indicate an absence of a traumatic birth. Whilst psychological wellbeing is often affected by a traumatic birth, it appears to be possible to have experienced a traumatic birth, to experience clinically significant levels of distress, but not to have a diagnosable pathological outcome (Ayers et al, 2008).

4.3 Discussion

Traumatic birth, and its negative sequelae, have only begun to be properly recognised within the last 15 years. A picture is emerging of a group of women who are living with the long term negative sequelae of traumatic births, enduring consequences such as longer term mental health problems (Forssen, 2012; Beck, 2004a), compromised maternal infant relationships (Nicholls & Ayers, 2007), poorer quality marital relationships (Ayers et al, 2006) concomitant depression in partners (Nicholls & Ayers, 2007) and challenges to future reproductive decisions (Fenech & Thomson, 2014). These women may be left without access to appropriate services that can offer treatment or support, because the distress they are experiencing does not fit the diagnoses available. Not all women experience all these issues, but experiencing long term distress, and enduring consequences, is one of the defining differences between a traumatic birth, and other closely related concepts such as a bad birth or a difficult birth. Because women who have experienced a traumatic birth may experience a variety of different enduring sequelae, the adaptation to the Walker and Avant (2011) model was deemed appropriate, in order to include a range of potential consequences, as well as the necessary consequences.

The literature emerging from the study of traumatic birth is breaking new ground, and dealing with concepts which have not been acknowledged previously. At the moment, a variety of terms are used to describe the experience of a traumatic birth, and they are used interchangeably (Beck & Watson, 2010; Ayers et al, 2008; Kitzinger and Kitzinger, 2007). 'Traumatic birth' is used quite loosely in the literature, to describe a number of different, but related, experiences. These include physical injury to mothers and babies and psychological responses to the events of or care received during birth.

The recognition that bystanders, especially women's partners and health professionals, may also experience traumatic births challenges the idea, posited in some literature, that mothers find birth traumatic because of unrealistic expectations (Shub et al, 2012).

Examining the literature, it becomes apparent that trauma in the form of physical injury can lead to a birth being traumatic, but it is not a necessary condition (Thomson & Downe, 2010; Kitzinger, 2006). In the case of physical injury to either the mother or baby, the experience becomes traumatic because of the psychological distress caused by the injury (Harris & Ayers, 2012). In other cases, the experience has not involved any physical injury, but something has occurred during the birth which has been deeply disturbing and distressing, usually to the mother (Harris & Ayers, 2012; Beck & Watson, 2010). It is also the case that women who have previously experienced a traumatic event, including sexual abuse or a previous traumatic birth, can experience events during birth as traumatic, because they remind them of the previous traumatic experience. This potential is made more probable if the woman perceives the care she receives to be insensitive (Gottfried, Lev-Wiesel, Hallak & Lang-Franco, 2015).

Models of the causal factors in traumatic birth are beginning to emerge. There are a number of predisposing factors identified by Soet, Brack and Dilorio (2003), expanded on by Slade (2006), and subsequently discussed as a predictive model by O'Donovan, Alcorn, Patrick, Creedy, Dawe and Devilly (2014). These predisposing factors make it more likely that a woman will experience birth as traumatic. An operative birth has long been recognised as a factor which may influence whether a birth is traumatic or not, as has delivering a very premature baby, where there are concerns for survival and long-term disability. A woman's previous experiences, including having been sexually abused or having experienced other traumatic events may also be a significant factor in how she responds to the events of birth (Gottfried, Lev-Wiesel, Hallak & Lang-Franco, 2015). However, the care received by a labouring woman has been observed to be one of the greatest factors in the

incidence of traumatic birth (Soet, Brack & Dilorio, 2003). With the right care, women can experience deep distress and disturbance during the birth, including physical injury to themselves and their baby, and still not experience the birth as traumatic (Beck, 2004b). Conversely, women can have births in which no interventions were used, there was no physical injury to anyone, the birth might even have been at home, but the woman has still come away from the birth traumatised, because of poor care. The factors which make care good or bad are not fully explored in relation to traumatic birth, but themes that are emerging relate to the relationship between the midwife and the woman, whether the woman feels in control of decisions, and feels her wishes are respected (Elmir et al, 2010). Postnatal care, and wider postnatal support, also appear to play a role in whether a woman who has experienced a traumatic birth goes on to develop a diagnosable psychological condition (Quinn, Spiby & Slade, 2015; Iles & Pote, 2015; Ayers, Wright & Ford, 2015). The diversity of causal factors in a traumatic birth are one of the reasons that the adaptation of Walker and Avant's model was deemed appropriate, through the inclusion of potential antecedents to a traumatic birth.

This emerging picture of traumatic birth as a complex process in which there are opportunities for intervention to reduce or exacerbate trauma, challenges the literature which focuses on mode of delivery as the greatest signifier of traumatic birth. Women's subjective experiences of care may be more important in whether a birth is traumatic than any objective account of the events (Garthus-Niegel, von Soeat, Volrath & Eberhard-Gran, 2013). Women's knowledge about and perceptions of their experience and their feelings may therefore be the most expert information available in identifying traumatic births. This potentially poses a challenge for predictive modelling and standardised tools to determine which women are at greater risk.

For the experience to be a traumatic birth, the distress must be long lasting, in some cases for years (Forssen, 2012). A birth which causes distress that is short-lived might be categorised as a difficult or negative birth, but is not a traumatic birth as defined in this analysis. What causes the distress to be short-lived or long-lasting is not fully understood, but may be about the care received, the way a woman processes the distress (Van Reenan & Van Rensburg, 2015), or an interplay of the two. Women who experience a traumatic birth may go on to develop associated psychological conditions, such as mood and anxiety disorders (Beck, 2009), PTSD/PTSS (Leeds & Hargraves, 2008). However, these conditions, and the nature of their relationship to a traumatic birth, are not well-recognised, and may be under-diagnosed (Leeds & Hargraves, 2008). Conversely a birth can be

traumatic, and the mother may experience sub-clinical distress, but not develop a subsequent psychological disorder (Elmir et al, 2010). There is no literature which systematically addresses the question of why some women experience a traumatic birth, and suffer distress, whilst others subsequently develop associated psychological conditions, but it may point to the spectrum nature of traumatic birth.

Objectively, in incidences of traumatic birth, the single physical event present in all cases is that a baby has been born. The trauma comes from the mother's subjective response of some form of psychological distress, which is enduring. For some women this results in a diagnosable psychological condition, for others it does not. For those women for whom a traumatic birth does not result in a diagnosable psychological condition, experiencing a traumatic birth may still have significant, negative and long-lasting consequences.

The definition of traumatic birth arrived at in this analysis challenges the medical model of a traumatic birth as being primarily related to the mode of delivery. It also poses challenges to a rigid interpretation of traumatic birth as necessarily resulting in a diagnosable mental health difficulty, such as PTSD or post-natal depression. That a group of women exist who may experience after effects from a traumatic birth, whilst not being diagnosed with a specific psychological condition is a point which is beginning to be explicitly recognised in the literature (Coates, Ayers & de Visser, 2014). This analysis has shown that some women may experience birth as traumatic, and have long lasting consequences from this trauma. Their distress may be based either on the events that have occurred during the birth, or the care received, or an interplay of the two. The trauma may result in a diagnosable psychological condition, or it may not, but even in the absence of the development of such a condition, the consequences for the mother and those around her may be of a severity and duration which requires support. This group of women are currently under-represented in the literature on traumatic birth, and may not be able to access services which rely on the existing models of traumatic birth or diagnostic categories.

4.4 Conclusions

'Traumatic birth' is a term currently used widely yet inconsistently in the existing literature. This chapter has sought to conceptualise the term 'traumatic birth'. Notwithstanding the complexities of the concept it seems feasible to conclude that a traumatic birth can be described as:

> 'The emergence of a baby from its mother in a way that involves events or care which cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature' (Greenfield, Jomeen & Glover, 2016).

Chapter 5 – Study Rationale

The previous three chapters illustrate what is already known through the literature about choices in pregnancy after a traumatic birth. In Chapter 2 it was established that whilst birth in the UK is very physically safe for women and babies (CMACE, 2011), there is a potential for tension and conflict between women and HCPs during the perinatal period (Yildiz, Ayers & Phillips, 2017; Ayers, 2014, Slade, 2006). This potential for conflict arises from a number of different sources. Tension exists between models of birth as a normal event (usually associated with midwifery models of care) (Berg, 2010; Klein et al, 2009), and as risky medical event which necessitates managing (usually associated with obstetric models of care) (Kirkham, 2010; Oakley, 2005). This can lead to conflict between different HCPs, which the woman may then be exposed to (Kirkham & Stapleton, 2004; Tew, 1995). Differing constructs of a 'good birth', and therefore of a 'bad birth' too, can lead to conflict between the woman and the HCPs caring for her, especially in the intrapartum period (Eaton, 2013; Oakley, 2005). These conflicts are intimately bound up with the concept of choice within Maternity Services. Chapter 2 examined the increasing attention given to women's rights to make choices over the past few decades, as expressed through strategic Government Maternity policies (NHS, 2016; RCOG Expert Advisory Group Report, 2011). However, it has been noted that the rhetoric of choice did not currently match women's lived experiences (NHS, 2016; Jomeen, 2012). Women may now expect to make informed choices about their care, but find that they are sometimes unable to do so (Hallam, Howard, Locke & Thomas, 2016; Jomeen, 2012; Kirkham & Stapleton, 2004). Choices are sometimes not removed explicitly, but rather through the use of language and gatekeeping by HCPs (Jomeen, 2012; Kitzinger, 2006; Kirkham & Stapleton, 2004; Stapleton, 2004; Levy, 2004). At the most extreme point, the removal of choice can result in women taking legal action against Maternity Services during pregnancy in order to secure their right to choose where to give birth (Birthrights, 2013c; Harman, 2012).

5.1 Existing knowledge about choices after traumatic births

Against this background, it is not surprising that up to 30% of women in the UK experience childbirth as a traumatic event (Ayers, 2014; Slade, 2006). The literature suggests that the prevalence of postnatal PTSD in relation to childbirth is around 4.0%, but that over 18% of women in high-risk groups may develop PTSD postnatally (Yildiz, Ayers & Phillips, 2017). A brief overview was given in Chapter 3 about what is already known about women who experience birth as a traumatic event, and what current directions in research on this subject are. At the end of Chapter 2, it was noted

that what is not known is what choices women make when they have previously experienced a traumatic birth. The bulk of Chapter 3 therefore established what is already known specifically about the choices women make in pregnancies subsequent to a traumatic birth, through a review of the existing literature. The question for the systematic literature review was:

'What choices do women make about subsequent pregnancies and births, when they have previously experienced a traumatic birth?'

The textual narrative synthesis of the literature (Lucas et al, 2007) established what was already known about the choices this group of women make. Women who have experienced a traumatic birth are less likely to give birth in the future, and if they do give birth, are likely to have longer intervals between births (Ayers, Eagle & Waring, 2006; Gottvall & Waldenstrom, 2002). Women may arrange permanent contraception for themselves or their partners (Beck, 2004a; Hofberg & Brockington, 2000). If these women do choose to have further children, they are more likely to request a caesarean birth (Kottmel et al, 2012). Sometimes this fear of birth is clinically diagnosed as secondary tokophobia. For women who experience secondary tokophobia, being denied their chosen way to give birth can have a profoundly negative effect on their emotional wellbeing (Hoffberg & Brockington, 2000). This is true regardless of whether the woman wishes to have a non-medically indicated caesarean birth (Thomson & Downe, 2010; Hofberg & Brockington, 2000), or make another choice, such as a vaginal homebirth after a previous caesarean birth (Beck & Watson, 2010; Fenwick, Gamble & Mawson, 2003). Some literature has found that a positive subsequent birth experience can have a profound psychological effect, and has been variously described in the literature as 'redemptive' or 'healing', especially if the birth happens at home or in a home-like environment, with minimal interventions (Beck & Watson, 2010).

5.2 Defining of the concept

The literature review also revealed an immediate difficulty with the literature search question, which was discussed in Chapter 3. This difficulty is the lack of a common definition of the term 'traumatic birth'. In order to formulate the research question, it was necessary to first establish what exactly the term 'traumatic birth' meant. Chapter 4 addressed this difficulty, by analysing what the concept of a traumatic birth is, and proposing a definition:

'The emergence of a baby from its mother in a way that involves events or care which cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature' (Greenfield, Jomeen & Glover, 2016, p.266).

Defining the concept of 'traumatic birth' prior to formulating the research question was essential. Without this definition, there would have been a lack of clarity in the topic being researched. Furthermore, the defining of the concept assisted in producing specific inclusion criteria for participants, in terms of the previous experience that pregnant women had to have undergone in order to be eligible for the research.

5.3 Formulation of the research question

The textual narrative synthesis revealed a number of research gaps. Two significant gaps were identified, and combined together to formulate a research question. The first gap was the lack of information about perinatal choices outside of the intrapartum period. Only one study had addressed antenatal choices, and in this study antenatal choices were included in an incidental way, not as the main focus of the research. No study had examined postnatal choices. The second gap related to how birth choices other than non-medically indicated caesarean births were made by women. Whilst there was literature which asked about women's birth choices, it was largely retrospective, and assumed an unproblematic act of making a choice about method and place of birth. From the combination of these gaps in the literature, the research question to be addressed in this study was proposed. That question is:

'What choices do women make in pregnancy and birth, when they have previously experienced a traumatic birth?'

This chapter has summarised why the existing usage of the term 'traumatic birth' was identified as problematic for this research. It has further shown how the defining of the concept assisted in the formulation of the research question. The literature review led to the identification of the gaps in the existing literature, which led directly to the devising of the research question. The following two chapters explain the methodological approach that underpins the research, and then provide specific details of how the research was designed and carried out.

Chapter 6 – Methodology

This chapter will present the methodological approach taken in the research, and the rationale for this approach. A constructivist grounded theory (Charmaz, 2014) approach was used, underpinned by feminist research principles (Doucet & Mauthner, 2006; Stanley & Wise, 1993). As demonstrated in Chapter 3, little is known about the choices women make in pregnancies subsequent to a traumatic birth. Grounded Theory Methodology (GTM) is a well-established approach to develop theoretical models grounded in empirical data where there is not an existing body of research or set of theories (Hutchinson, Johnston & Breckon, 2011). In addition, the act of making choices is a social process, and making choices in relation to pregnancy and birth involves constructing a shared meaning about which decisions are a choice, and the significance of choice. Therefore 'making choices' as a subject lends itself well to a Constructivist Grounded Theory approach, as demonstrated by a number of studies that have successfully adopted this approach (Burge & Jamieson, 2009; Holmberg & Wahlberg, 2000).

There is a significant history of using a feminist approach to explore issues related to childbirth, dating from Oakley's seminal work 'Women Confined' (1980). This is a well-established approach when dealing with issues of choice, control and power in childbirth (Kitzinger, 2006; Oakley, 1980). Choice was the central subject of this study, and the ability to exercise choice is inherently linked to issues of control and power. It is therefore appropriate to underpin the Constructivist Grounded Theory with feminist research principles, developing theoretical models which come from women's lived experiences, and which aim to improve women's lives.

The chapter begins with a statement of the epistemological position of the researcher. This is followed by an exploration of what it means to conduct feminist research, and how utilising feminist research principles has affected this research project. Next, an overview of the development of grounded theory is provided, to contextualise the methodological discussions later in the chapter. This is followed by an in-depth discussion of the principles of constructivist grounded theory, and finally the strategies applied to enhance methodological and interpretive rigor are detailed. The chapter then concludes with a methodological evaluation.

6.1 The importance of epistemology

In any research project, there is an interwoven relationship between the position of the researcher, the research question specified, the methodology chosen, the methods used to collect data, the data produced and the analysis methods used (Gubrium & Holstein, 2001).

The methodological approach taken to any piece of research encompasses a theory of how research should be conducted, based in philosophical ideas about the subject under study, and competing ideas about the best way to find out about that subject (Outhwaite & Turner, 2008). In turn, this theory informs both the processes of data collection and of analysis. The methodological and philosophical background in which the research is situated will therefore determine to a great extent the particular methods of data collection and analysis which are selected for use, and how they are deployed (Outhwaite & Turner, 2008). The chosen methods will then generate data, and the content of this data will direct the potential ways of analysing the data produced, from which conclusions may be drawn.

With this process in mind, thought must be given to defining the underlying epistemological and philosophical positions of the research. Only then can a methodology be devised which fits these positions. Clarifying the research methodology in this way is particularly important when 'sensitive topics' are the subject of the research (Renzetti & Lee, 1993). Renzetti and Lee state

> 'ignoring the methodological difficulties inherent in researching sensitive topics is... socially and scientifically irresponsible because this ignorance may potentially generate flawed conclusions on which both theory and public policy subsequently may be built' (1993, p.11).

Therefore in this section the positions which underlie the research question will be explored first, and a methodology will then be proposed which is congruent with these positions.

6.2 Epistemological position

This research is based in a constructivist approach to knowledge. Constructivist researchers begin with an understanding that 'social reality is multiple, processual and constructed' (Charmaz, 2014, p.13). This means that there is no objective external reality to be understood; rather, there are

multiple social realities, each of which is 'real' to the person experiencing it (Charmaz, 2014). The only way to access these stories in for the researcher to elicit them from the individual in some form. However, what the researcher elicits through such discussions in not a pure and neutral version of the social reality of the participant, it is a social construction, which the researcher and participant have jointly created. Therefore, the researcher's own beliefs and social reality are an integral part of the research process, and must be examined and understood alongside the participants', making a reflexive approach a necessity.

This stance is linked to a social constructionist approach, and the two approaches have significant areas of overlap, but whereas

> 'Most constructionist investigations address the question of *how* social reality is assembled' (Gubrium & Holstein, 2008, p.5)

constructivist renderings of the world allow the *why* questions to be addressed (Charmaz, 2008). Social constructionism's focus is on the processes of creating a social reality, whilst constructivism allows a focus on either the processes, or the reasons that an individual assigns to the processes. The researcher is interested in the social experiences of women making choices about pregnancy and birth, and is interested in understanding both *why* women make these choices, and *how* they implement their decisions, leading to an epistemological stance which is more constructivist than constructionist.

Alongside this understanding of the world, the researcher has a deep interest in issues of gender and power and how they influence women's childbearing experiences. This research is located in the belief that women make the choices that seem to them to be likely to provide the best outcomes in their individual situation (Jomeen, 2010; Beech, 2003). These choices may or may not be the choices advocated by healthcare professionals, official guidance from Government bodies, or those people around the woman.

Having established the epistemological position of the researcher, the next three sections will now examine how this position influenced the selection of a feminist Constructivist Grounded Theory methodology.

6.3 Feminist perspective

There is no one feminist approach to epistemology, methodology, and no one set of feminist research principles. Currently, feminism involves a multiplicity of rapidly evolving and shifting political theories, which in turn influence researchers' epistemological positions and methodological choices. Doucet and Mauthner (2006) say that the term 'feminist research' has overtaken older notions of specifically feminist epistemologies or methodologies, and define feminist research as

'the work that feminists do when they take on either qualitative or quantitative research that is driven by, and aimed toward, a desire to challenge multiple hierarchies of inequalities within social life' (p.36).

According to Skeggs (1994), feminist research is distinct from non-feminist research because it

'begins from the premise that the nature of reality in western society is unequal and hierarchical' (p.77).

The epistemological position underpinning this is fundamentally feminist. The research question was formulated to examine women's experiences of pregnancy, birth and choice from the point of view of the individual woman. In exploring a woman's individual encounter with her chosen provider of maternity services, the only account sought in this research is that of the woman. The research does not aim to provide triangulation by seeking the views of the care provider, or an (arguably) objective account of the pregnancy through reference to medical records. It is this aspect of the research which dictates that a feminist philosophy is needed – in giving voice and weight to women's own accounts of their experiences, the research is fundamentally of a feminist nature.

This thesis is further located within a feminist philosophy, in that it emerges from a belief that women have the right to choose where and how to give birth, and that women retain bodily autonomy whilst pregnant. Combining this core belief in women's autonomy with the research intention to seek women's views of their experiences, it would be difficult to address the research question without utilising a feminist perspective.

If a feminist perspective to the research is adopted, feminist principles of research practice must then be utilised throughout the research for consistency, and the avoidance of internal dissonance. In the absence of a definitive feminist orthodoxy, and the consequential methodological pluralism that exists, it is necessary to examine feminist research theory and actual feminist research to draw out common characteristics and underlying beliefs. Feminist scholars have embraced particular characteristics in their work, and drawing these together can provide a framework for other feminists who want to produce feminist research. Perhaps the most fundamental underpinning of feminist thought is an understanding that women's own accounts of their experiences are a suitable subject for study (Ussher, 1999). Following on from this belief is a recognition that the relationship between researcher and researched is by its very nature a relationship of power and imbalance, as women's accounts of their experiences are mediated by the researcher. With this recognition, the role of the feminist researcher comes to include both acknowledging and addressing the power imbalance, to create a more equitable relationship (Oakley, 2016). Some researchers take this idea further, and suggest that research which is truly feminist should produce knowledge which challenges the systems and structures that are oppressive to women (Brook & Hesse-Biber, 2007), or that can be practically used to improve women's lives (Oakley, 2016). These principles are summarised by Kelly, Burton and Regan in the idea that feminist research takes the position of being research 'on, with and for women' (1994, p.28). These are the set of underlying feminist research principles which will be used in this research.

Having established these underlying principles, the proposed research must now be examined to ensure that it fits with feminist research theories. In order to do this, Stanley and Wise's key themes of feminist theories will be used to evaluate the knowledge that the research question seeks to generate. Stanley and Wise (1993) highlight three key themes of feminist theories that should inform feminist research:

1. The belief that women are oppressed
2. That the 'personal is the political', that is '[t]he personal and the everyday are both important and interesting and ought to be the subject of inquiry'
3. That there is a developing feminist consciousness from such inquiry

The proposed research incorporates all three features, though to differing extents. Women's perception that they experienced a lack of care during labour is highlighted as a cause of traumatic birth (Talbot, 2014; Beck, 2004b), and is in itself a form of oppression. However there is stronger

link between the proposed research and the second and third themes described by Stanley and Wise.

In relation to the second theme, few experiences in life can be said to be more personal than giving birth, and birth is also an intensely political issue. There is a political agenda around the extent to which women should have choice in maternity care and birth. The extent to which women are able to exercise in practice the theoretical choice they have, and furthermore whether that choice is properly informed is equally political and contentious (Chippington Derrick, 2012; Lowdon, 2012; Jomeen, 2010; Houghton, Bedwell, Forsey, Baker & Lavender, 2008; Jomeen, 2007; Beech, 2003). In seeking to document and understand the choices women make during pregnancy and birth, this research engages with the political agenda of choice, and the personal lived experience of the women involved in the research.

In relation to Stanley and Wise's (1993) third theme, the development of a feminist consciousness about maternity care has been ongoing for several decades (Kitzinger, 2006; Beech, 2003; Thomas, 2002; Oakley, 1980). This research seeks to add to the continuing development of this awareness of birth as a political matter of importance, profoundly affecting everyone in society, but especially affecting birthing women.

Having concluded that the proposed research meets Stanley and Wise's criteria for feminist research, it is now possible to examine the methodology that informed the research.

In line with the feminist principles outlined above, the study adopted a methodological approach that accepts and incorporates subjectivity – that is, individuals' feelings and experience and how they make sense of them. Subjectivity was viewed as central to the research process, as advocated by O'Connell Davidson and Layder (1994). This meant that women's accounts of their own experiences and feelings were the subject of the research, and were viewed as intimately connected. There were no attempts to corroborate any objective events of the pregnancies or births, because objective events were not the subject of the research. Rather, what women perceived as having happened was accepted without question by the researcher as the woman's perception. In interviews, the researcher then explored how these perceived events made the women feel, and crucially what choices the women made in reaction to their perceptions.

It is this inclusion of subjectivity that attempts to redress what feminist research perceives to be a male dominance in research to date (Oakley, 2016). Rejecting the idea that subjectivity and objectivity can be divorced from each other is one way in which feminist researchers can begin to address the power imbalance in the research relationship. Maynard (1994) states that not acknowledging the subjective involvement of the researcher in research has led to 'weak' notions of objectivity

> 'because they include the researchers' hidden and un-explicated cultural agendas and assumptions' (p.19).

The transparent discussion of subjectivities as part of the research process validates the data collection process and the analysis of such data. Acknowledging that the researcher, as well as the research participants, influence the research process is fundamental to the feminist approach of adopting a non-hierarchical research relationship, regardless of the specific research method adopted (Oakley, 1980). This acknowledgement allows for a discussion of the influence of gender and/or power relations on the research process and outcomes. In this research, the issues of power are discussed in relation to women's feelings of choice and control, and the support they received or did not receive.

Robson (1993) suggests that 'confinnability' is 'the corresponding concept' (p.663) to objectivity moving the focus away from the researcher to the 'case study' itself. He suggests that providing the researcher can provide a clear audit trail of evidence about how the research has been carried out, which an 'outsider' could follow if required, this provides evidence for confinnability.

Feminist research practice also requires the researcher to be sensitive to the impact of the research process on the participant, as well as on herself as interviewer. This sensitivity to the research participant is not simply the domain of feminist research practice but is an essential aspect of any good research practice. However, it is a key consideration given the woman-centred and political focus to feminist research practice. As Kelly, Burton and Regan (1994) point out

> 'We need to take much more seriously the potential for harm, that participation may be more of an intrusion/imposition/ irritation/responsibility than a benefit' (p.29).

In this research, the impact of the research on the participant was considered at all stages of the research. To be recruited into the study, women had to have experienced a traumatic birth. However, retelling traumatic birth stories is controversial, and some studies suggest it can have a negative impact on women (Ayers, Claypool & Eagle, 2006). Therefore, the information given to potential participants prior to recruitment made it clear that it was not necessary to tell the researcher details of the traumatic birth. This was also reiterated directly by the researcher during the screening interview. The inclusion criteria were devised to avoid asking women for details of their previous birth(s), by giving them a definition of a traumatic birth, and asking for confirmation that they had a birth experience which fitted this definition. The questions and prompts used in the interviews also steered women to talk about their current pregnancy and forthcoming birth, and the researcher avoided asking for the details of how they had previously given birth.

The impact of being involved in the research was also considered throughout the interviews. The researcher paid careful attention to women's visible emotions, and if women appeared distressed at any point, the researcher interrupted, and offered a break, or a change of topic. The impact of the publication of the research was also considered, and when journal articles or conference presentations were drawn from the research, these were circulated to women, prior to the article or presentation being finalised. One participant did discuss with the researcher something she asked the researcher not to share with her (the participant's) husband. The researcher decided that if this information was published and directly quoted, it would not be attributed to the participant who it had come from, and that the reasons for not attributing this information to a specific participant would be explained in the text.

Feminist research principles were therefore identified as an important underpinning to the methodology. The following two sections will firstly contextualise GTM as a whole, and then explore Constructivist Grounded Theory in more detail, in particular examining the fit between the methodology and the underpinning of feminist research principles in this research.

6.4 Grounded Theory Methods

GTM is a methodology with a long history, which is used across many disciplines in the social sciences, and particularly within healthcare (Benoliel, 1996). The central goal of all GTM approaches is to generate theoretical analyses, rooted in the data generated from the research (Charmaz, 2014). Furthermore, GTM methodologists

'value grounded theory studies for informing policy and practice' (Charmaz, 2014, p.134).

The decision to use GTM for this research was therefore based in a desire to generate theories about women's experiences of making choices in a pregnancy and birth subsequent to a traumatic birth – theories which would be likely to have practical and policy applications to improve women's lives.

Emerging first in the 1960's in reaction to the low esteem in which qualitative research was held (Kenny & Fourie, 2014), GTM has subsequently evolved substantially, and divided into a 'family of methods' (Bryant & Charmaz, 2010, p.12) bearing mutual resemblances, rather than a discrete set of methods that share clear and precise elements. Therefore, it is critical to contemplate the historical context and philosophical perspective in which grounded theory is being discussed when trying to make sense of the literature pertaining to this approach. The remainder of this section will give an overview of the development of GTM, before moving onto a rationale for why a constructivist grounded theory approach has been adopted for this study.

Historical developments within GTM

GTM is the brainchild of Glaser and Strauss, two sociologists who began working together in the 1960's. Their disenchantment with the methodologies utilised at the time centred around the focus given to using data to verify pre-existing hypotheses, and the consequently lower importance given to using data inductively to generate new theories. Additionally, they argued that this led to a dearth of theoretical ideas that were actually based in empirical research. Their frustration led them to design a number of distinct methodological techniques. They stipulated that data collection and analysis should be undertaken simultaneously, through the specific procedures of theoretical sampling, coding, constant comparison, saturation and memo writing. They argued that if these exacting techniques were followed, as data is collected, coded, compared, and organised into increasingly abstract categories, theoretical ideas will begin to emerge. Their book 'The Discovery of Grounded Theory' (Glaser & Strauss, 1967) was published upon request, and was considered revolutionary, as it offered an alternative for social scientists who wished to combine theory construction with social research. The strength of GTM continues to be the opportunity it gives researchers to produce robust and astute hypotheses grounded in research.

Kenny and Fourie (2014) identify three different grounded theory models: Glaser's (1978) Classic Grounded Theory (CGT), Strauss and Corbin's (1990) qualitative data analysis (QDA), and

constructivist grounded theory (Charmaz, 2000). The initial divide between Glaser's CGT and Strauss and Corbin's QDA can be seen as arising from their different academic backgrounds and philosophies. Strauss' background in symbolic interactionism led naturally to his reconfiguring on the central idea of the researcher 'discovering' theory into a more nuanced idea of the researcher 'deducing' theory from a rigorous systematic analysis of the data, whilst Glaser continued to develop CGT based on his original ideas. Over time, the two forms of GTM have continued to develop in increasingly divergent ways as other researchers have developed concepts further, particularly Corbin through her long academic partnership with Strauss, and other forms of GTM have been advanced.

Constructivist Grounded Theory draws on both Glaser's CGT and Strauss and Corbin's QDA, and merges many of their methodological ideas and specific techniques with a constructivist understanding of the world. Charmaz (2008) describes constructivist grounded theory as a

> 'method that begins with inductive enquiry, adopts a comparative logic, invokes abductive reasoning and emphasises interaction' (p.132).

This explanation is strongly influenced by the methodological guidelines articulated in Classic GTM (Glaser & Strauss, 1967), but marries this with an understanding that researchers are not separate from their theories, rather they form them through their interactions with research participants and research perspectives (Charmaz, 2008).

The three models discussed by Kenny and Fourie (2014) are considered the main grounded theory methodologies widely used in academic research. Other authors have identified a number of less known variants of grounded theory, such as Clarke and Friese's (2007) identification of Situational Analysis and Bowers and Schatzman's (2009) incorporation of Dimensional Analysis as forms of GTM. Fernandez (2012) calls for the recognition of feminist grounded theory as a specific model of GTM based on Wuest's (1995) work, although Wuest herself discusses the compatibility of different GTM models with feminist perspectives, and does not argue for a separate specifically feminist form of GTM.

Women's choices in pregnancy and birth are complex and influenced by both their unique circumstances in the present, and their unique experience of a previous traumatic birth. The

methodological decisions guiding this research needed to address this. Having scrutinised the main approaches to grounded theory, Constructivist Grounded Theory was identified as the approach that best addressed the research question. The following section will advance the rationale for this decision, and consider the implications of adopting this methodology.

6.5 Constructivist Grounded Theory

It has long been argued within feminist research on birth and the transition to motherhood that women construct the story of their childbirth. Some constructs are of 'a good birth' (Talbot, 2014), whilst other constructions are of 'a bad birth', or 'a traumatic birth' (Simkin, 2006; Beck, 2004). What all births have in common is that this constructed story is carried with the woman through decades of their lives (Talbot, 2014; Forssen, 2012; Simkin, 2006; Oakley, 1980). Thomson, Kehily, Hadfield and Sharpe (2009) argue that the birth story played a role of almost summarizing the woman's emotional, psychological and practical world at the time, while Talbot (2014) describes birth stories as a 'constructed… prism for their changing lives' (p.1).

From the literature, it is apparent that a traumatic birth is a subjective experience. Objective events during the birth play a part in whether a birth is traumatic or not (Storksen, Garthus-Niegel, Vangen & Eberhard-Gran, 2013; Saisato, Ylikorkala & Halmesmaki, 1999; Allen, 1998), and good care can be a protective factor in preventing trauma (Talbot, 2014; Murphy, Pope, Frost & Liebling, 2003), whilst poor care can be in and of itself a traumatic experience during birth (Beck, 2004b), but they do not define which experiences will be classified by which women as a traumatic birth. The concept analysis, which is drawn from the literature on traumatic birth, is clear that the long-lasting distress a woman feels is the crucial defining factor in determining whether a birth is traumatic. Birthing women therefore can be said to construct their 'birth story' from both the objective events, the feelings they have about these events, and the perceptions of the care they receive (Beck & Watson, 2010; Beck, 2004b; Allen, 1998).

Concrete events happen as women make choices about pregnancy and birth. A scan may be accepted or declined. A non-medically indicated caesarean birth may be requested by the mother or not. A midwife may be called to a homebirth or may not be called. But the reason that those observable choices are made are complex, and subjective. They depend upon the reality of the situation as constructed by the woman, rather than having an observable basis in a 'real' reality.

Epistemologically, a relativist approach, which acknowledges the validity of each individual woman's point of view fits best with the subject under study. Constructivist Grounded Theory is a relativist approach, in that it acknowledges the subjectivity of experiences. Conversely, GTM approaches based on Glaser's CGT, or Strauss and Corbin's QDA, have been criticised for their positivist assumptions (Charmaz, 2014, 2002; Bryant, 2003, 2002). Both approaches hold the view that there is an external objective reality, which does not fit with the constructed nature of the central concept – traumatic birth – under investigation. Additionally, Strauss, Corbin and Glaser all position the researcher as a neutral figure within the research context, who can lay their values to one side, in order to report on this objective reality (Charmaz, 2014). This position is difficult to reconcile with the feminist principles of research, which demand that attention is paid to the relationship between the researcher and those they are eliciting data from.

Constructivist Grounded Theory does not see the constructs that a research subject creates as something which a researcher can neutrally and objectively report on. Rather, Constructivist Grounded Theory researchers argue that the researcher and the participant together construct a shared reality during the process of the research (Charmaz, 2014). Comparing this view with the feminist principles underlying the research, it can be observed that there is a shared emphasis on considering the view, role and power of the researcher situated within the research. For both Constructivist Grounded Theory and feminist research, the focus on the role of the researcher is not carried out to take emphasis away from the subject of the research, but to create clarity as to whose voice, whose views, are being reported upon, and to ensure that the voice of the research subject is given weight and power.

This understanding of the role of the researcher as an active partner in creating meaning does not indicate that Constructivist Grounded Theory is unreliable, or not a robust research method. Rather it encourages an ever greater reflexivity of the part of the researcher, with open acknowledgement of the researchers' own views and biases. This approach acknowledges that the theories generated by GTM are constructed, not discovered (Charmaz, 2014). Taking this further, it is argued in this research that the acknowledgement of the constructed nature of theory can allow space for the research subject to have an active involvement in the co-construction of theory, rather than being relegated to the sole role of data provider. From a feminist perspective, using research to allow women to generate their own theoretical understandings of their experiences is an expression of

the view discussed before that feminist research is research carried out 'on, <u>with</u> and for women' (Kelly, Burton & Regan, 1994, p.28, emphasis added).

A Constructivist Grounded Theory approach was therefore a good fit with the epistemological position underpinning the research question – that traumatic birth is an experience which is subjective (but nonetheless real to those who experience it), and the meaning of this experience is constructed. Furthermore, there is a good fit between Constructivist Grounded Theory and feminist research principles in bringing the role of the researcher into the fore, paying attention to the views and beliefs of the researcher, and scrutinising the relationship between researcher and researched, as they jointly construct meaning in the course of the research.

Choosing Constructivist Grounded Theory as an approach commits the research to exploring the experiences of the participants, and producing theories which are grounded in the data produced through this exploration. It also has an impact on the practical choices about methods of recruitment, data collection and analysis which are necessary. These are explored in the following chapter.

In the previous sections of this chapter, there has been an exploration of the two central methodologies employed in this research project – feminism and Constructivist Grounded Theory. The next sections in this chapter are devoted to examining the methodological challenges and consequences that arose from selecting these two methodologies to explore the research question. The first section will deal with the particular issue of conducting longitudinal GTM research, whilst the subsequent section will examine an issue which should be considered in all qualitative research; reflexivity. The chapter then concludes with a methodological evaluation.

6.6 Longitudinal GTM

This section deals with a methodological issue affecting this research which rarely occurs – using a well established methodology in a way which is unusual. The research was a longitudinal study, with interviews being conducted with the same cohort over a period from 12-20 weeks of pregnancy, until four-eight weeks postpartum. Interviews with individual participants may therefore take place over a maximum period of eight-nine months.

Longitudinal GTM is an emerging and relatively rare methodology, but it is the most appropriate one to explore this research question. There is an immediacy and richness of data that can be collected by asking women about choices as they are making them, which would be lost if instead women were asked about potential future decisions, and would equally be lost if women were asked to reflect on choices they have made after the consequences of those decisions were known. Using interviews spaced over a period of time allowed data to be collected about what choices women were aware of, why they made the choices they did, and how successful these choices were felt to be by the women in retrospect. For these reasons, a longitudinal study was appropriate. In the absence of an established body of published literature that unpicks all the methodological underpinnings of an emerging methodology, the most robust way of handling such queries is to critically examine how other researchers who have used the same methodology have dealt with these issues.

Most of the important theoretical concepts of GTM – such as using initial and then focused coding to develop theories rooted in the data, memo writing, and concurrent data collection and analysis – can be applied to a longitudinal study without issue. The exception to this is the concept of saturation. The quantity of data collected when using GTM is not pre-determined, but continues, along with concurrent analysis, until saturation is reached. Saturation is reached at the point when no new theoretical concepts are being generated by the data collected. The most theoretically robust way to apply the concept of saturation to a longitudinal study might be to continue to complete final interviews with the first set of participants, and then consider recruiting further participants. However this was not a practical proposition in this research, as repeated rounds of recruitment, spaced eight months apart, had the potential to lead to a research study of many years. This spacing would also have created the potential for theoretical problems; as the policies and practices around maternity care shift continuously, including participants in the same study who had given birth some years apart would have meant that the context in which they were making choices had changed, but the data was being analysed to produce a single coherent theoretical framework.

Although there is little literature on the theoretical basis of saturation in longitudinal GTM studies, there are a few pieces of research which have been carried out using GTM in longitudinal research. Details of available studies were collated, and the published articles from each were read, focussing on methodological issues. Two studies were selected as being of a high quality, being published in

peer-reviewed journals, and having aspects of the research which were similar to the proposed research on choices after a traumatic birth. These were Lalor, Begley and Galavan's (2008) 'A grounded theory study of information preference and coping styles following antenatal diagnosis of foetal abnormality', and Gray and Smith's (2000) 'The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study'.

One author from each of the studies was contacted, and the issues of longitudinal GTM were discussed, in one case via e-mail (Gray, 2014), in the other via a telephone interview (Begley, 2014). Both researchers confirmed that they had not identified literature which dealt with the theoretical basis of longitudinal GTM, and then described how they had approached the issue of saturation. In both cases, they had applied the concept of saturation to the first set of interviews, continuing to recruit until no new theoretical concepts were being generated by the data collected at this point. In one case, this level of saturation worked for subsequent interviews; at each interview point the researcher found that saturation was achieved using the initially recruited group of participants. In the second study, during the last round of interviews, a new issue arose in one of the last interviews. To explore this issue, the researcher then applied the concept of theoretical sampling, separately from the main data collection method of individual longitudinal interviews. A group of participants who fitted the criteria for that interview were recruited, and were interviewed as a focus group, exploring only the specific issue which had arisen. The decision to conduct a group interview rather than individual interviews was both a pragmatic choice and a methodological one, in that the researcher was interested in the shared meaning the group made of the specific issue.

Following these examples, in this research the concept of saturation was applied to the first set of interviews. Participants were recruited until no new theoretical concepts were being generated from the data collected in the first interview. In the subsequent two rounds of interviews, once the initial and theoretical coding stages were completed, a further question was asked – has saturation been reached in this set of interviews? If new issues had still been emerging, theoretical sampling would have been used to explore these specific issues only, with women who were recruited for a single, individual interview. The eligibility criteria for these participants would have been the same as for involvement in the main research, with the addition of a criterion that they were at the appropriate stage of pregnancy for the interview. However, saturation was actually achieved at each interview stage, using only the originally recruited participants.

As stated at the beginning of this section, longitudinal GTM is a rarely used methodology, and the challenges that arose from its use are therefore not challenges which all research faces. The next section moves on to deal with an issue facing all qualitative research studies – reflexivity, before this chapter concludes with an evaluation of the methodological approach taken in this research.

6.7 Reflexive research

'Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process' (Robert Wood Johnson Foundation, 2008, p.483).

When Glaser and Strauss first claimed reflexivity as an essential component of GTM, it was not a commonly adopted technique within qualitative research. Qualitative methodologies have developed over time, and reflexivity can now be seen as 'the defining feature of qualitative research' (Banister, Burman, Parker, Taylor & Tindall, 1994, p.192). All researchers who use reflexivity as a tool do so in order to identify and acknowledge their own standpoint and views, in order to 'enhance the trustworthiness, transparency and accountability of their research' (Finlay, 2002, p.210). However, once a researcher's views have been identified, different theoretical backgrounds advocate the researcher use reflexivity in different ways – to bring their views to the foreground for discussion, to rigorously attempt to remove them from the data, or to process the reflexive account in some other way.

Approaches to reflexivity vary widely, and can be categorised in a variety of ways. Finlay (2002) identifies five different approaches qualitative researchers take to reflexivity, examining how they fit within different methodologies. The categories Finlay uses are one of many ways of dividing up reflexive approaches, but her categorisation is especially useful in this context as it covers the intent of different reflexive approaches, rather than focussing simply on the mechanics of undertaking reflexive practice. Table 8 overleaf summarises Finlay's analysis of the strengths of each approach, and common criticisms.

Table 8 – Approaches to reflexivity (adapted from Finlay, 2002).

Approach	Fundamental characteristics	Strengths	Criticisms
Introspection	Personal reflections are assumed to provide data regarding the social/emotional world of participants, allowing the researcher to better understand the context of the participants. Personal revelation is not seen as an end in itself – rather, as a path towards interpretations of data	- Acknowledges the link between knowledge claims and personal experiences	- Focuses on the researcher, not the participants or the data
Intersubjective reflection	The researcher considers themselves in relation to others, focussing on mutual meanings emerging within the research relationship. This can be in relation to both the researcher's emotional investment in the research, and the perception the participants have of the researcher	- Considers the impact of the researcher on the production of data	- Researcher may assume or claim knowledge of participants' subconscious motivations
Mutual collaboration	Participants are involved in reflexive dialogues during data analysis, and may be involved in the research as co-researchers. Researchers own experiences can also be positioned as data within the research, depending on the methodology adopted	- Opportunity to present multiple, conflicting views - May offer participants the opportunity to have ownership of the research	- Can disguise power imbalances in researcher/participant relationship - Inclusion of many 'researchers' can dilute focus
Social critique	Concerns centre around the power inherent in the positions of researcher/researched, and how these positions may be reinforced by gender/class/race/status.	- Recognition of multiple, shifting researcher/participant positions	- Can become preoccupied with power at the expense of the research
Discursive deconstruction	Attention is paid to the language used by both researcher and participant. Attempts to present accounts of self or actions through the use and/or manipulation of language	- Can powerfully expose underlying issues	- Data can lose meaning - Infinitely regressive

	are unpicked, in order to uncover underlying and sometimes subconscious motivations		

The approach to reflexivity adopted is intrinsically linked to the methodological choices which are made. Constructivist Grounded Theory and feminist research both have strong positions on the purpose of reflexive practices in research, and the decision to use a Constructivist Grounded Theory methodology, underpinned by feminist research principles will therefore affect the reflexive approach of this research. The positions of both on the purpose of reflexivity will now briefly be examined in turn, after which the rationale for the reflexive approach of this research will be presented.

Reflexivity in feminist research

Feminist researchers have been at the forefront of those drawing attention to the importance of reflexivity for many decades (Oakley, 1981), and it is generally taken as a point of consensus that reflexivity is an essential component within feminist research (Doucet & Mauthner, 2005). Feminism's central concern to improve the lives of women (Oakley, 2016) links to concerns described by Finlay (2002) as 'social critique'. Reflexivity is highlighted as an important research tool by feminists in data analysis, and in knowledge construction more generally, as a way of acknowledging and dealing with the complex power dynamics of research relationships (Mason 2002; Pidgeon & Henwood, 1997; Olesen, Droes, Hatton, Chico & Schatzman, 1994), which may otherwise reproduce gendered power relationships (Oakley, 1981). In this context, reflexivity acknowledges that all knowledge bears the impress of the social relations entailed in its production, including the complex power relations between researchers and research participants; issues described by Finlay (2002) as 'introspective reflection' are therefore a common consideration for feminist researchers.

However, as Doucet and Mauthner (2006) point out, there is amongst feminist researchers a degree of theoretical diversity within the concept of reflexivity itself, from which they identify three key themes of debate; the scope of reflexivity; the impact of reflexivity on knowledge claims; and the reflexive positioning of the researcher within the research. These areas of debate are multi-layered, and may be overlapping – for example, discussions on the scope of reflexivity are necessarily limited by the researcher's partial and incomplete awareness of the range of influences that affect their research. Mauthner and Doucet (2003) also touch upon the choices that the researcher makes in

positioning themselves within the research, as in Reinharz's (1997) work, 'Who Am I,' in which she reflects on her '20 different selves' (p.5). Debates within feminist research extend as far as the name of the term itself. Naples (2003) promotes the use of the term 'reflective practice', arguing that a reflex is an unconscious response, whilst a researcher engaged in reflective practice is deliberately raising their consciousness, however Bondi (2009) argues that 'reflexivity involves something more than reflection' (p.327). Therefore, different feminist researchers may adopt different approaches to reflexivity, which may fall under one or more of the categories identified by Finlay (2002).

These debates within feminist research suggest that practising reflexivity effectively is 'difficult and complex' (Bondi, 2009, p.328). When reflexivity is such a core concern, this level of nuanced debate should not be a surprise – rather, there are so many debates because of the central place that reflexivity holds in the feminist research canon. However, the proliferation of competing ideas does make it difficult to summarise a single consensus view on the practice of reflexivity within feminist research. Rather, the conclusion that can be reached is about the purpose of reflexivity, which Wise and Stanley (2008) argue is thus:

> 'producing accountable feminist knowledge requires analytical means of looking reflexively at the processes of knowledge production, rather than bracketing or dismissing such things as unimportant in epistemological terms' (p.242).

Reflexivity in Constructivist Grounded Theory

Charmaz (2014) echoes the main thrust of Stanley and Wise's argument, declaring that:

> 'if we are not reflexive, our research analyses may… reproduce current ideologies, conventions, discourses and power relationships' (p.228).

Reflexivity, in Constructivist Grounded Theory, is not an optional extra. Rather, it is positioned as an essential tool, in much the same way that it is positioned within feminist research. Charmaz (2014) argues that

> 'researchers… are obligated to be reflexive about what we bring to the scene' (p.228)

when we design, carry out, and analyse research. However, whereas in feminist research the abundance of theoretical debates about reflexivity make it difficult to pin down what exactly reflexivity is, the purpose of reflexivity within Constructivist Grounded Theory is currently perceived as being reasonably straightforward. Constructivist Grounded Theory promotes a clear view that the primary purpose of reflexivity is to enable a researcher to identify their preconceptions, described by Finlay (2002) as 'introspection'. This is achieved firstly by heightening the researcher's own awareness of their position, in order that they can critically analyse their own contribution to the data generated from interactions with the participant. And secondly, this focus explicitly acknowledges the researcher's views, which in turn provides the reader with a sense of the analytical lens through which the researcher has viewed and analysed the data (Mills, Bonner & Francis, 2006).

Constructivist Grounded Theory discussions about reflexivity tend towards pragmatic discussions on how to 'do' reflexivity. Grounded theorists in general argue for the inclusion of reflexive practices at all stages of the research process, from deciding on a research topic, through data collection, analysis and publication (Mey & Mruck, 2007). However, within Constructivist Grounded Theory, Charmaz (2014) argues that

> 'reflexivity… holds special significance in focused coding because these codes shape our analyses' (p.231).

Charmaz argues that, whilst preconceptions can affect the researcher at every stage of the research process, preconceptions at this delicate stage of the analysis process raise the potential to force data into preconceived codes, or existing theories, wittingly or unwittingly. Therefore, it is at this point that reflexivity must be engaged in most strongly.

Reflexive approach adopted in this research

> 'Grounded theorists have much to learn from reflexive feminist research accounts'

argues Olesen (2007, p.132), and indeed, as has been shown above, there is a good fit between the ways in which Constructivist Grounded Theory and feminist research view reflexivity. Both consider reflexivity to be an integral part of any research project. Drawing from the traditions of both, this section will set out the rationale for the reflexive approach adopted in this research.

All five of the forms of reflexivity identified in Table 8 could be utilised by feminist researchers, but not all are essential for a piece of research to be considered feminist. Examining the purpose of reflexivity within feminist research traditions, there are two forms of reflexivity which must be employed. Feminist researchers' concerns with the inherent and complex power relations between researcher and participant mean that intersubjective reflection is a fundamental form of reflexivity which must be involved in the production of feminist research. Arguably, a degree of introspection is a requirement for intersubjective reflection, but introspection as a standalone form of reflexivity is not a necessary requirement for a research project to be considered as feminist. Stanley and Wise's (1993) three feminist research principles outlined in section 5.3 directly relate to the second essential form of reflexivity. If feminist research has to produce positive change in the lived lives of women, it is necessary that such work involves a social critique which takes into account gender and other societally positioning aspects of women's lives. It can immediately be seen that these two forms of reflexivity, although described separately by Finlay (2002), have a large area of overlap, in that both take account of the potential power and positional relationships that exist between the researcher and the participant.

Constructivist Grounded Theory's focus on the preconceptions the researcher brings to the research invoke a requirement for introspection at all stages of the research, from the design of the research to publication. The underlying belief in the constructed nature of reality also encourages researchers to engage in social critique, whilst the understanding that the research process itself is what creates the shared reality of the research data contains an invitation to at least some degree of intersubjective reflection, to understand how power differentials might influence the co-construction of this reality.

Reflexivity in this research will therefore draw jointly from the three perspectives described by Finlay (2002) as introspection, intersubjective reflection, and social critique. Figure 3 provides a map of how these elements will fit together to form the reflexive approach of the research.

Figure 3 – Reflexive approach adopted in this research
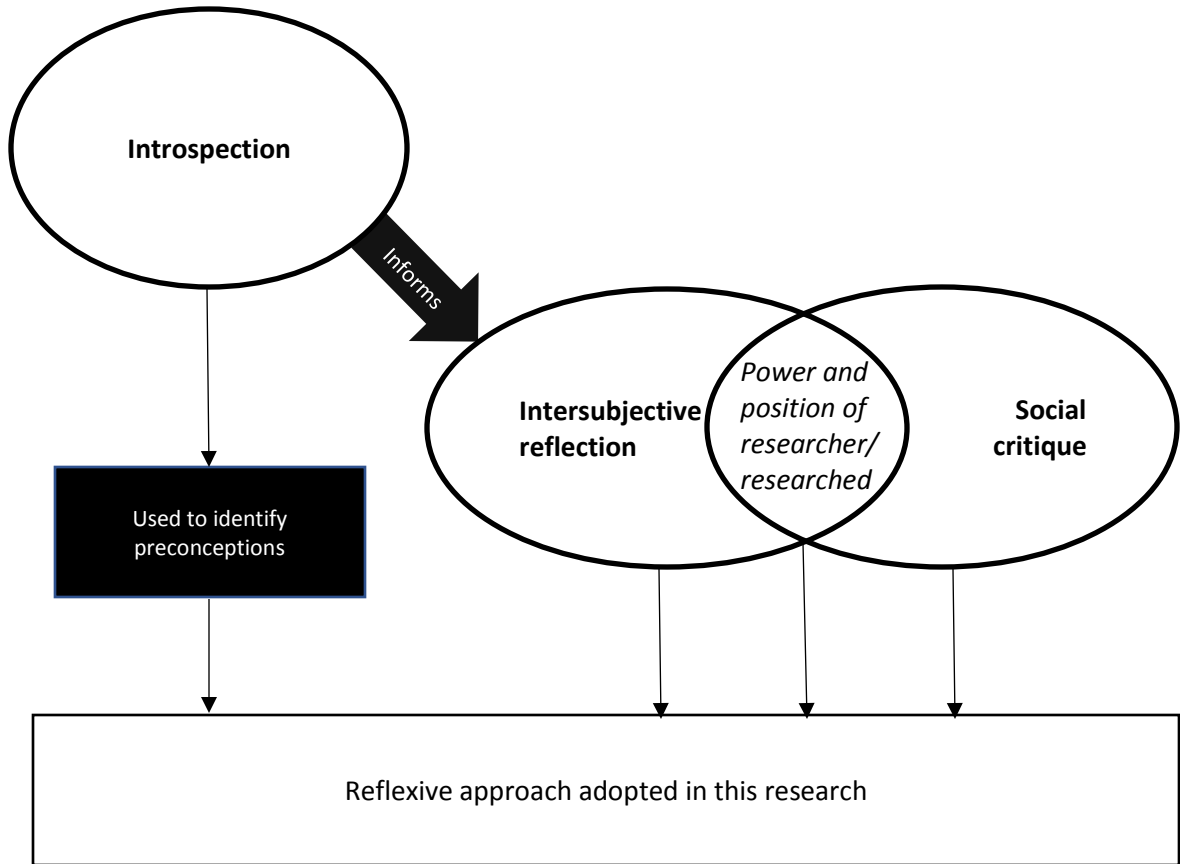
Birks and Mills (2011) present the constructivist grounded theorist with a series of consciousness-raising questions to ask themselves in order to think about power differentials that might exist in the research relationship and to ensure a conscious, ongoing commitment to participant-driven research:

1. How is this [person] like me?
2. How [are they] not like me?
3. How are these similarities and differences being played out in our interaction?
4. How is that interaction affecting the course of the research?
5. How is it illuminating or obscuring the research problem?

This series of questions is a good start for a purely Constructivist Grounded Theory research project, but it does not incorporate all the influences identified in the model above for this piece of research.

Therefore, this series of questions were adapted for this research, to take account of the model above. The questions will be:

1. Who am I
   a. In relation to the research question?
   b. As I present myself to the participant?
   c. In what I am thinking about the research data?
2. What do I think
   a. About the subject of the research?
   b. About the ways I am like/unlike this individual participant?
   c. About the data?
   d. What informs these thoughts?
3. How do I feel
   a. About the individual participant?
   b. About the data?
   c. How are these feelings influencing what I do?
4. How am I acting
   a. Towards the participant in setting up the interviews?
   b. During interviews?
   c. In handling the data?
   d. In developing codes and categories?
5. What effect are my actions having
   a. On interactions with participants?
   b. On the development of codes, categories and theories?
6. How are all these factors illuminating or obscuring the research problem?

These consciousness-raising questions were applied on a regular basis, both before the research design was applied, as part of the data collecting process, and during the analysis processes. Regular reflection on these questions, and the issues arising from the answers to them, was facilitated by the use of a reflexive diary, and as part of the memo writing process.

Reflexive statement

A central part of the reflexive approach adopted in this research is acknowledging the position of the researcher. This statement outlines the researcher's personal experience, as relevant to the research.

The researcher is a woman, and also a mother. She has experienced pregnancy, labour and birth within the UK, and through this has had a range of personal relationships with HCPs. The researcher also works as a doula, a breastfeeding counsellor, and an Infant Massage instructor. In these roles, she has worked directly with pregnant women and new parents who have had a variety of experiences of maternity care. In these roles she has also worked alongside obstetricians, midwives,

counsellors, lactation consultants, other doulas and birth workers, and has observed a range of different practices. Some working relationships have been very short term, whilst others have become long-standing professional relationships. Others have developed into friendships outside of the immediate work context, resulting in her social network including a high proportion of midwives, doulas and other birth workers. In approaching this research, the researcher therefore brings her own personal, professional and social positions to the research.

This chapter has established the epistemological position of the researcher, and situated the methodological direction of the research within that context. The reflexive position of the researcher within the research has also been described. The next chapter will take these theoretical ideas, and provide further in-depth details about the practical methods used to put these ideas into practice, and carry out the research.

Chapter 7 – Research methods

The previous chapter outlined the epistemological position for the research, and detailed the underlying theoretical basis and principles on which the study was based. The rationale for adopting a feminist Constructivist Grounded Theory approach was explored. This chapter will now set out the practical methods employed in the research, showing clearly the continuous relating of research question to methodology to research method. The chapter will first set out the design of the research, and outline the study procedure that was used. It will then set out the ethical considerations of the research, before moving into an explanation of how the data collection and analysis were carried out. Finally, the role of reflexivity throughout the research will be discussed.

7.1 Research design

The research was designed as a longitudinal GTM study, covering the period from early pregnancy to the early postnatal period. The research was designed to capture women's views and experiences throughout the perinatal period. The research was designed to enable investigations about when during pregnancy women made choices, to establish whether choices changed through the perinatal period, and to construct theories relating to these issues. To achieve this, the perinatal period was divided into three sections for the purposes of this research, and each period was then defined in relation to the pregnancy or birth:

- Early/mid pregnancy (12-20 weeks gestation)
- Approaching birth (32-36 weeks gestation)
- After birth (four-eight weeks postpartum)

The division into these three specific periods was informed by the intention to capture women's views at an early stage of pregnancy, and to gain insight into their intended choices for this pregnancy. As birth approached, finding out whether women had continued with their intended choices or not was important, as was discovering whether their birth choices remained the same as birth became imminent. The postnatal interviews were intended to capture reflective data from the women, shortly after the birth, but when they had had a little time to process the events of the birth. This allowed for the research question to be fully addressed, through gaining an insight into choices intended, choices made, and women's reflections upon their choices.

The significance of the prenatal period was also considered, as previous research notes that women may make decisions about pregnancy and birth prior to conception (Beck & Watson, 2010; Gottvall & Waldenstrom, 2002; Gamble & Creedy, 2001; Hofberg & Brockington, 2000). Including women prenatally would have raised both greater practical and ethical issues. The significance of this period was not felt to be as great, for the purposes of this study, as the perinatal period itself, as research shows that this cohort of women do not always have fixed choices prior to conception, and may frequently alter decisions during the course of pregnancy (Beck & Watson, 2010; McGrath & Ray-Barruel, 2009; Hofberg & Brockington, 2000).

<u>Participants</u>

The research was designed to recruit a sample of 8-10 women, each of whom would be interviewed three times, resulting in 24-30 interviews. When using GTM, the goal is to achieve a saturation of data, which makes specifying an exact sample size at the outset of the research problematic. The scarce literature that does advance a view on appropriate sample size suggests that this is an appropriate initial number – Creswell (1998) suggests 20-40 interviews, and Morse, (1995; 2000) suggests 30-50. These views on sample size all relate to single timepoint GTM, as there is no literature which addresses appropriate sample size within a longitudinal GTM study. Given the highly specific nature of the population being studied, and the high emotionality of the subject, the sample size was selected as being both small enough to be attainable, large enough to be sufficiently rigorous and achieve saturation at timepoint 1, and an appropriate size to generate a useful but manageable quantity of data.

The inclusion criteria for the screening interview were:

1. To have previously experienced a birth which:
   - The woman describes as a traumatic birth when asked whether the birth was traumatic
   - Fits the definition of a traumatic birth as defined in the Concept Analysis;
     'The emergence of a baby from its mother in a way that involves events or care which cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature'.
2. To have had a live baby from the traumatic birth
3. To be between 12-20 weeks pregnant at the point of recruitment to the research
4. To be over 18 years old
5. To be fluent in both written and spoken English

6. To be willing to participate in the research

The exclusion criteria were:

1. Women who have experienced a stillbirth or neonatal death were not eligible for the study, as the researcher did not feel she had the experience to interview women who may have experienced this additional level of potential bereavement
2. Women who were less than 12 weeks pregnant were not eligible to enter the study until 12 weeks of pregnancy
3. Women who were planning to give birth outside the UK were excluded, because Maternity Care systems and legal frameworks around childbirth vary significantly between different countries

<u>Interviews</u>

In-depth semi-structured interviews were the major research method adopted. This decision was based both on the fit between interviewing and the feminist Social Constructivst GTM approach adopted, and on the practicalities of conducting research with this cohort. Charmaz (2014) argues that, for a number of reasons,

'intensive qualitative interviewing fits grounded theory methods particularly well' (p.28)

Firstly, intensive interviewing focuses attention on a specific topic, whilst allowing the interviewee and interviewer an open-ended space in which to co-construct views about and meanings of that topic (Charmaz, 2014). Secondly, interviewing offers a useful way of conducting an

'exploration of an area in which the interviewee has substantial experience' (Charmaz, 2014, p.28).

This view is shared by Hesse-Biber (2007), who states that interviewing is considered a particularly valuable feminist research method precisely because 'researchers can use [interviews] to gain insight into the world of their respondents' (p.114). The question to be addressed in this research question was not only that of naming the choices that the women made, but involved an exploration of their reasons for making such choices. To address such issues, the research method chosen had

to have the ability to elicit women's insights into their experience, which made interviewing a good fit.

Thirdly, Charmaz (2014) argues that using unstructured or semi-structured interviews allows the researcher to gain an 'in-depth understanding' of a specific set of issues rather than 'theory testing [a] set of goals' (p.32), or taking a whole life history. Choices women make after a traumatic birth is an area which has not been extensively researched, and the research question therefore aimed to provide exactly this kind of in-depth understanding. Equally, the research sought to focus on a particular section of the women's experiences, rather than their whole lived experience. On this basis, semi-structured interviews were the most appropriate research tool to utilise.

The decision to use Skype to conduct interviews was made on several grounds. Firstly, in practical terms Skype or telephone interviews saves travel time compared to face-to-face interviews, and therefore opens up more possibilities in terms of geographic access to participants (Seitz, 2016). Given the very specific inclusion criteria, it was considered likely that recruiting sufficient numbers of participants, at the correct stage of pregnancy, could present challenges. Therefore, choosing an interview method which widened geographical possibilities gave an advantage. Secondly, this research was with pregnant women who already have a child, and it seemed reasonable to assume that these very characteristics might mean that participants had to cancel some interviews at short notice. Had the researcher been travelling a number of hours to interview the participants face-to-face, cancelling and rescheduling interviews would have been disruptive (Seitz, 2016).

These two considerations meant that telephone or Skype interviewing had advantages over face-to-face interviews. Practical benefits have also been documented for telephone interviews (Holt, 2010). However, telephone interviews do not have the visual advantage that Skype interviews have by establishing a synchronous visual interaction between the researcher and participant (Seitz, 2016). Given the intimate and emotive subject of this research, this visual interaction was considered important. Furthermore, Skype interviews can feel more comfortable because they occur in the participants' own private spaces, but without the intrusion of the researcher into that space (Seitz, 2016). Hanna (2012) describes this as both the researcher and participant being able to

'remain in a "safe location" without imposing on each other's personal space' (p.241).

This can have the effect of both the researcher and participant feeling 'less nervous' and 'less pressured' compared to being in person (Hanna, 2012, p.242). Deakin and Wakefield (2014) also point to the health and safety benefits of Skype for both interviewers and interviewees, and found that Skype interviewees were more responsive than in a number of their face-to-face interviews. Based on these considerations, it was decided to conduct all interviews via Skype.

With the format and method of conducting the interviews decided, the last design consideration were the interview questions themselves. Charmaz (2014) recommends the production of an interview guide, which can be a flexible tool that allows the conversation to flow, rather than being a proscriptive list that must be covered. A common difficulty in using an interview guide in a constructivist grounded theory interview is that the questions the researcher asks may

'inadvertently force interview data into preconceived categories' (Charmaz, 2014, p.39).

To avoid this, Karp (2009) suggests that the interview guide should resemble a list of the fundamental issues that the researcher wishes to cover. Taking this advice, the research question was broken down into four open questions, which were as simple as possible. This allowed the participant to direct the interview towards their areas of interest. Seitz (2016) discusses the difficulties posed when a researcher asks very intimate or challenging questions via Skype. This was a consideration in determining the wording of the questions. The questions were in any case designed not to be challenging, and not to demand justifications or explanations from the participant (Charmaz, 2014). This allowed the participant to choose when and whether to venture into intimate territory. These questions were:

1. What choices are women aware that they have?
2. What choices are they making?
3. What is their thinking about these choices?
4. How do they feel about the choices they are making or have made? (taken from Interview Schedule, full schedule presented in Appendix 3)

Charmaz (2014) further suggests that a good researcher should let the participant

'set the tone and pace, and then mirror what seems comfortable to him or her' (p.30).

This has implications for constructing the body of the interview guide. A set list of detailed questions would direct the tone of the interview. However, to have no questions or prompts to ask could lead to difficult pauses, and can lead to the researcher becoming 'rattled or derailed' (Charmaz, 2014, p.30). Therefore, the four fundamental areas were listed on a sheet for the researcher, with further suggestions for open questions listed below. These questions were deliberately not numbered, to encourage the researcher to treat them as a menu of potential questions to be asked to help the conversation continue, rather than a list to be worked through. Following the pilot interview, this was supplemented with a list of prompts about what 'choices' might include, should that be helpful.

Lastly, if the participant is to set the pace of the interview, not all subjects may be covered in a set amount of time. On this basis, rigid end times were not set for the interviews. Rather, participants were given an approximate idea of how long an interview might take, and were allowed to dictate how long was spent discussing each fundamental issue within the interview.

Diaries

As well as capturing women's views at significant points during the perinatal period, there was an intention to capture data continuously throughout the pregnancy, to enable the researcher insight into exactly when different choices were considered by women. It was intended that this occurred in the form of a diary to be kept by the participants. Whilst data generated by GTM is most usually interview and observational data (Stern, 2007), some proponents of GTM have described it as a methodology which can be used with any data (Charmaz, 2014; Stern, 2007; Glaser, 2005). Charmaz (2014) discusses in detail the inclusion of documents as data in a Constructivist Grounded Theory study. She differentiates between extant and elicited documents, noting how the involvement of the researcher means that elicited documents are co-constructed, and specific to the shared reality constructed between the researcher and the participant.

Criticisms of the use of elicited documents include the lack of relationship between researcher and participant, and the inability of the researcher to 'follow up on a statement, encourage a response, or ask a related question' (Charmaz, 2014, p.35). However, in this research, the longitudinal nature of the research meant that these criticisms could be incorporated to improve the research design. Participants were not asked to begin their diaries until after the first interview, when the research relationship was already established. Diary data was collected before the two subsequent interviews, allowing the researcher to ask follow up questions, and probe issues further.

When documents are used as data within GTM, they can be used as either a primary or supplementary source of data (Charmaz, 2014). In this research, the intention was that the diaries were treated as a supplementary form of data. This decision was made in recognition of the time pressures faced by pregnant women, who already had an existing child to care for, which meant attrition rates were likely to be particularly high for the diary keeping element of the research. Therefore, designing the research so that the interview data was the primary source of data increased the resilience of the research, in that a low participation rate in the diary keeping element of the research would not invalidate the research.

7.2 Study procedure

This section outlines the way the study was planned. Significant deviations from these plans are discussed in the section entitled 'Data Collection' below.

Recruitment

Recruitment was conducted in two ways. In the first route, the call for participants was advertised through a group of non-NHS networks, that engage with pregnant women, who often self-identify as having experienced a traumatic birth. These included the Association for Improvements in Maternity Services, Doula UK, Association of Radical Midwives, homebirth groups, Birth Choices groups, and Independent Midwives UK. Members of these groups were given information sheets to distribute to women, and advertisements to place on their websites. It was made clear to women that feedback about whether they had contacted the researcher would not be provided to the person who had given them the information sheet.

The second route involved direct online recruitment. This was carried out by the placing of advertisements on on-line forums, some generic online parenting forums, and some specifically aimed at women who have experienced birth trauma (including Mumsnet, Netmums, the Birth Trauma Association, International Caesarean Awareness Network, Birth Crisis, Natural Mamas and their related Facebook groups).

From both recruitment routes, women contacted the researcher, and any questions they had were answered. Those who had not received an information sheet from a third party were sent one. After

this was received, women who wanted to be involved in the research contacted the researcher, and were taken through a screening process before being enrolled in the research (women who had already received the information sheet were taken straight to the screening process).

Initial contact

The initial contact involved a telephone call between researcher and participant, which was always initiated by the woman. During the initial call, a précis of the information from the information sheet was given verbally to the potential participant, stressing that participation was voluntary. If the phone call was initiated as a result of third party having given information to the woman, it was emphasised that feedback would not be given to the third party about whether the woman chose to participate in the research or not.

Information given to women included a description of the time commitment involved, and a discussion of the facilities needed for the interview (internet connection, Skype, a place where the interview would not be overheard). Information about the purpose of the research, who the researcher was, and their University affiliation was also given. A brief eligibility check was carried out, checking the participant's:
- Age
- Pregnancy and gestation

Information sheet

The information sheet contained details of the research, and is included at Appendix 2.

Screening interview

Seitz (2016) details many of the difficulties involved in interviewing via Skype, when compared to face-to-face interviews. Technical problems, such as lagging caused by poor internet connectivity, insensitive or badly placed microphones, and unfamiliarity with the technology present the greatest problems. Experiencing technical problems at moments of emotional personal revelation can become an emotional barrier (Seitz, 2016). Therefore, in this research, a deliberate decision was therefore made to conduct screening interviews via Skype. This allowed the researcher and participant to both check the technology worked, establish where the microphone needed to be, and become familiar with speaking to each other in this way. The researcher could also check

background noise levels in the participant's home, and that the recording equipment worked. In this way, some of difficulties associated with Skype interviewing were ameliorated.

Screening interviews took participants through the full inclusion and exclusion criteria listed above. Participants were asked to read the definition of a traumatic birth during the interview, and confirm they had experienced a previous birth which fitted this description. The rest of the inclusion and exclusion criteria were then presented as questions by the researcher.

At the end of the screening interview, women were told whether they were eligible for inclusion. All the women included in the study met the traumatic birth criteria. The only reason any woman was excluded from the research as a result of the screening process was gestation of pregnancy. If the woman was too far on in the pregnancy to be included, she was thanked, and the reason she could not be included was explained. If she was too early in her pregnancy, this was discussed, and if she wished to proceed in a few weeks' time, a first interview was planned for a time when she would be at the right gestation for inclusion. In this case, a reminder text was sent the day before the planned interview. If a woman was eligible for immediate inclusion, a first interview date and time were planned.

Consent to participate

After the screening interview, women were sent a Consent Form (Appendix 6). This could be completed and returned by email, or by post. At the beginning of each interview, consent, confidentiality and the right to withdraw from the study were revisited. The researcher asked the participant questions one to four from the Consent Form, and received verbal affirmation of each question. The participant was then asked if she would like to go ahead with the interview. Consent was audio recorded, but not later transcribed.

Interviews

The interview schedule was developed to capture women's views at different points in pregnancy, whilst also being sensitive to time constraints that were likely to be faced by pregnant women who already had at least one child. The interview points were carefully chosen by the researcher in consultation with the research supervisors, and discussed with the University of Hull Ethics Committee. The first interview needed to be conducted before the midway point of an average pregnancy, to capture women's views in early pregnancy. However, the risk of miscarriage is

greatest in the first trimester of pregnancy (before 12 weeks gestation), and many women also chose not to announce their pregnancy until this point (NHS Choices, 2015a). Therefore, the first interviews were not conducted until after 12 weeks gestation, but were conducted before 20 weeks gestation. The second set of interviews were intended to capture women's views approaching the birth, but needed to be conducted before women might have given birth. A singleton pregnancy is considered full term from 37 weeks (NHS Choices, 2015b), therefore all interviews needed to be conducted by 36 weeks pregnant. To allow for scheduling, a four week window was used, meaning that interviews were conducted between 32-36 weeks gestation. Discrepancies in gestational dates between the woman's calculations based on Last Menstrual Period, and sonographer's estimates are relatively common, and it was decided that where a discrepancy existed, the woman would be asked to select the dates she felt was most accurate to base the interview schedule on. For the postnatal interviews, it was important to capture women's views as soon as was practicable following the birth. However, it was also important not to interfere in a family's adjustment to the new baby, and to be sensitive to the fact that women need time to physically and emotionally recover from birth, and that establishing breastfeeding may take time. For these reasons, a window of four to eight weeks postnatally was chosen.

The recruitment process and interview were piloted. A modified advertisement was placed on the same websites as were to be used in the full research, and removed as soon as an appropriate volunteer had come forward. The potential participant made contact by telephone, and was given the same information as future participants would be given, with the additional information that this was a pilot for the full research, and that she would only be involved in one interview. The pilot participant had to meet all of the inclusion criteria, except the gestation criteria. She had to have experienced a traumatic birth, and had to be pregnant at the time of the interview. The participant who took part in the pilot interview was 38 weeks pregnant at the time of the pilot interview. The experience of conducting the pilot interview led to some minor changes in the wording of the prompts, and to the decision to conduct screening interviews via Skype to establish that the technological connection between the researcher and each specific participant worked.

The interviews were semi-structured, with the researcher asking a series of open ended questions, which could be followed by prompts if necessary. A copy of the interview questions and prompts is included at Appendix 3. The interview structure remained the same for all three interviews, with prompts only changing in grammatical tense after the last interview.

<u>Diary</u>

The diary was designed to be as easy to fill in as possible. It was provided to participants in both electronic and paper-based formats, with the aim of maximising participation (Santafe, 2011). The interviews followed a semi-structured design, and the diary replicated this by asking open-ended questions. Diaries are more likely to be completed when they are not seen as onerous by participants (Santafe, 2011). Therefore, as few questions as possible were asked, and they were written in a simple format. The diary format is included at Appendix 4. The diary was given to participants to complete at the end of the first interview. Participants were asked to complete the diary weekly, giving as much or as little information as they wished.

The study procedure is presented in diagrammatic form overleaf, as Figure 4 – Flowchart of study procedure.

Figure 4 – Flowchart of study procedure

```
┌─────────────────────────────┐        ┌─────────────────────────────┐
│ Potential participant        │        │ Third party provides         │
│ telephones researcher in     │        │ information sheet to          │
│ response to advertising.     │        │ potential participant. If     │
│ If eligible and consenting,  │        │ interested, potential         │
│ is sent information sheet.   │        │ participant telephones        │
└─────────────────────────────┘        │ researcher                    │
                                        │                               │
                                        │ If eligible and consenting,   │
                                        │ screening interview is        │
                                        │ arranged.                     │
                                        └─────────────────────────────┘

        ┌─────────────────────────────────────────┐
        │ 2-5 days after initial contact, telephone │
        │ call to see if participants would like to │
        │ be involved.                              │
        │ If consenting, eligibility screening /    │
        │ information giving booked.                │
        └─────────────────────────────────────────┘

        ┌─────────────────────────────────────────┐
        │ Initial information giving/eligibility    │
        │ screening interview carried out.          │
        │ Subsequent interviews booked, diary       │
        │ format discussed, and diary given to      │
        │ participants.                             │
        └─────────────────────────────────────────┘

┌──────────────────────────────┐     ┌──────────────────────────────┐
│ Interview 1 carried out       │     │ Diary completed weekly.       │
│ before midpoint of pregnancy  │     │ Entries collected by          │
│ (12-20 weeks).                │     │ researcher at each interview. │
└──────────────────────────────┘     │                               │
                                      │                               │
┌──────────────────────────────┐     │                               │
│ Interview 2 carried out at    │     │                               │
│ before birth (32-36 weeks).   │     └──────────────────────────────┘
└──────────────────────────────┘

        ┌─────────────────────────────────────────┐
        │ Interview 3 carried out postnatally (4-8  │
        │ weeks postpartum).                        │
        │                                           │
        │ Final diary entries collected.            │
        └─────────────────────────────────────────┘
```

7.3 Ethical considerations

This research raised a number of matters for careful ethical consideration. Four specific areas of risk were identified. Firstly, working with any group of participants who are vulnerable requires sensitivity, and women who are pregnant are arguably vulnerable even in a straightforward pregnancy. Having experienced a traumatic birth might mean participants were emotionally vulnerable, and the fact they were pregnant again might have exacerbated this vulnerability. Talking

with the researcher about their pregnancy might have evoked strong emotions, and if the discussion had strayed into discussing the previous traumatic experience, it is possible that participants could have re-experienced that trauma.

Secondly, participants might have looked to the researcher to answer questions about their care, or affirm choices they were making (Oakley, 1980). The researcher was not a medical professional, and only had access to the participants' interpretation of the information they were given, meaning this kind of interaction could have risked women receiving incorrect answers, advice, or affirmation about choices from the researcher.

Thirdly, some participants were recruited by being given information by those involved in their care, which carried a potential risk of coercion or pressure to become involved in the research. And finally, if older children had been present during the interviews, hearing about their births, they could have internalised negative messages if these births were traumatic.

To limit the risks identified above, participants were reminded of their right to withdraw at the beginning of each interview. Prior to the interviews, a list of organisations who could provide additional support for women who had experienced traumatic births was compiled, including contact details. Women were sent this list, along with the Information Sheet, prior to recruitment into the research. If a participant was becoming distressed by the interview, the researcher used her judgement to offer the participant a break and check that they wished to continue, and considered in this time whether the interview should be ended. If women became distressed, at the end of the interview, the researcher reminded them of the list, offered to resend it, and offered to discuss which organisations might be appropriate for a woman to contact. All incidents of distress, and the researcher's response, were fully discussed with the research supervisors prior to a further interview with any participant taking place.

Oakley (1981) discusses the feminist researcher's dilemma in withholding information from participants when participants ask questions of the researcher, or ask for their opinion. In examining the ethical issues that might arise in this research, the potential for this situation to arise was recognised. The researcher's background in perinatal care, and her access to research and expertise through her supervisors and the University meant there was the potential for participants to look to her to answer questions about their care, or affirm choices they had made. To mitigate this risk,

the role of the researcher was clearly explained to participants, and the researcher remained vigilant about the potential for comments made in the interview to influence women's decisions.

On three occasions, ethical dilemmas of this nature did arise. On two occasions, the participant reported during the interview having received information from a healthcare professional, which they believed to be true, but which the researcher was aware was not correct. One participant had

> 'talked today… to the Consultant… asking if, that the cord could be delayed and stuff but she said no' (Alice, 2)

Alice reported that the Consultant had said optimal cord clamping was not possible with a caesarean birth. The researcher was aware that the National Institute of Clinical Excellence (NICE) Quality Statement says:

> 'Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat' (NICE, 2015)

This Quality Statement covers both vaginal and caesarean births. This occasion, and a similar occasion in which a participant reported receiving information about Intrauterine Growth Restriction which they believed to be correct, but the researcher was aware was incorrect, presented an ethical dilemma. Firstly, what was reported was the participant's own report of the information that they had received. The possibility existed that the participant had misunderstood the information, or was wilfully misreporting the information. Therefore, the researcher commenting on these matters, with only partial information about the context in which the participant received the information, might have added to a situation of misunderstanding between the participant and their healthcare providers.

On the third occasion, the participant stated their own belief that although 'I would like a named senior obstetrician' to perform her caesarean section, but 'that is not what the NHS provides so I didn't bother [requesting it]' (Rachel, 3). However, the researcher was aware that another participant, Alice (who had a similar birthing history) had requested and got exactly that care – a senior named obstetrician had performed her surgery, within the NHS. In this case, providing the information that this care was available in some cases would not have risked interference in the

relationship between her and her healthcare provider, as the assumptions were Rachel's alone. However, providing this information might have raised Rachel's expectations that this care would be available to her, which the researcher was not in a position to guarantee.

For these reasons, the researcher did not respond to the participants with any different information, and also did not challenge the participant's expressed views.

Ethical approval for the study, based on the procedure outlined above, was sought from the Faculty of Health and Social Care Research Ethics Committee at the University of Hull, and was gained on the 27th January 2015.

7.4 Data collection

This section sets out the practical experience of conducting the research. It covers the details of how the study procedure was implemented, difficulties that arose with the implementation, and how these were dealt with.

Recruitment

Participants were recruited from April 2015 until September 2015. In total, 12 women were recruited to be interviewed. One woman withdrew from the study before her first interview, due to difficulties with time. Another changed her mind about being interviewed after recruitment. Another woman lost her baby after recruitment, but before the first interview. The data set is therefore drawn from interviews with nine women, each of whom was interviewed three times – a total of 27 interviews.

One woman who had experienced a stillbirth did apply for inclusion in the research. She had experienced a live birth since the loss of her first baby, and was clear that the stillbirth was not the birth she perceived as a traumatic birth, rather it was the subsequent birth which was a traumatic experience. After discussion with the research supervisors, she was enrolled into the research.

All the women recruited to the study were White British, and all described their sexual orientation as heterosexual. Four women were married, five were living with a partner. Numbers of previous pregnancies ranged from one to four, with a mean of two. The women's ages ranged from 24 to 43

at the time of recruitment. None of the women described themselves as having a disability, but five of them had a formal diagnosis in relation to their traumatic birth.

<u>Data collection</u>

All participants completed all three interviews (one interview was ended slightly early, due to the participant's child injuring themselves at nursery, however the only outstanding point from this interview was the planning of a date for the subsequent interview, which was then completed via email later). All the first and second interviews were conducted within the timeframes set. Two postnatal interviews were conducted outside of the timeframe. In one case this was due to a mistake over when a baby had been born, and the interview was conducted at two weeks postnatally. In this case, once the mix up had been identified, the participant was asked if she'd prefer an interview a few weeks later (the main reason for not interviewing before four weeks being to avoid pressuring a mother with a new baby). She chose to go ahead with the interview at this stage. One interview was delayed until nine weeks postpartum, as the baby had been readmitted into hospital several times.

All interviews were conducted via Skype, except for one participant who did not have a strong enough internet connection to facilitate this. Interviews with this participant were conducted via the phone. Interviews lasted between 42 minutes and one hour 53 minutes, with most interviews lasting approximately an hour. Overall, subsequent interviews were slightly longer than first interviews, but the difference was of a few minutes only in most cases.

Diaries were also issued to participants, who had agreed to complete them weekly. However, the rates of completion were extremely low (only one participant completed a full diary, and two others completed a few entries). It was therefore obvious by the second interview that diary data was unlikely to be substantial enough as a data source to be included in the research. Therefore the diaries that were completed were read by the researcher as contextual materials, but were not explicitly included the analysis. Where diary entries had been completed and contained points of interest, the researcher used these points to ask supplemental questions in the subsequent interviews.

As was discussed in the previous chapter, theoretical saturation is an important concept in GTM. It is described by Charmaz as

> 'the point at which gathering more data about a theoretical category reveals no new properties nor yields any further theoretical insights about the emerging Grounded Theory' (2006, p.119).

Saturation was considered at each interview point. In the design of the research this created some hypothetical difficulties, for example if saturation was reached in the first two sets of interviews, but not the postnatal set. Re-recruitment at that point would have added around eight to nine months to the length of the data collection, and was therefore not a practical proposition. A decision was taken to achieve saturation in the first set of interviews. If saturation was not achieved at subsequent interview points, supplemental interviews would used, with participants consisting of women at the appropriate stage of pregnancy. These interviews were intended to be one-to-one interviews, but the potential for small group interviews was also included in the research design to allow maximum flexibility, in recognition of the fact that longitudinal research includes a level of unpredictability.

Theoretical saturation in the first set of interviews was reached with nine participants. At this point, although women had a multitude of different previous birth experiences, and a wide range of plans for this pregnancy and birth, no new categories were emerging from the data in the initial coding. In the subsequent sets of interviews, theoretical saturation was reached earlier, before the interviews with all participants had been completed. This may have been because the topics discussed in the interview at each timepoint followed on from each other, and therefore the categories that emerged from the second and third interviews had a relationship to the categories from the earlier interviews. Another influence may have been the developing relationship between the interviewer and the participants, and the familiarity of the researcher with participant's history from the first interview, which may have enabled more data to be gathered in subsequent interviews.

Despite reaching theoretical saturation before the completion of the interviews with all participants approaching birth and postnatally, interviews with all nine participants were still carried out. Whilst

the last three interviews (approaching birth) and last two interviews (postnatally) did not add 'new properties nor yield any further theoretical insights' (Charmaz, 2006, p.119), completing the interviews did allow longitudinal comparisons to be made for each participant, reflecting forward and back along their pregnancy and birth journey. It also added a richness to the data, particularly in the case of the postnatal interviews – where new categories were not emerging, but existing categories were found across a range of different birth experiences. Completion of the interviews also allowed the researcher to engage in theoretical sampling (Charmaz, 2006) with the direct involvement of participants; not simply checking emerging theoretical ideas against data generated by participants', but directly discussing aspects of emerging theory with participants in relation to their own experiences.

7.5 Data analysis

Analytic processes in GTM begin simultaneously with data collection, and follow an iterative process of coding and recoding to produce analytic categories and eventually to advance theories. Therefore, the analysis described in this section was begun before the completion of the data collection described in the previous section. Further data collection occurred after initial coding and production of analytic categories were produced, to check the validity of the categories used, or to answer areas of emerging interest about which insufficient data had been previously gathered.

For this research, the process described by Charmaz (2014) was followed:

1. Reading and re-reading the data
2. Initial line by line coding, noting specifically
    a. Actions
    b. Processes
3. Development of analytic categories
4. Searching for variation in the categories or process
5. Constructing theory

All interviews were conducted and transcribed by the researcher. This led to a familiarity with the exact words spoken by the women, as well as a heightened awareness of tone, pauses and inflections which are difficult to capture fully in transcribed texts (Hesse-Biber, 2007). Each

transcript was re-read several times, and then coded line by line (Charmaz, 2014). As each transcript was coded, ideas of theoretical categories emerged, or previous ideas were refined and even discarded (Charmaz, 2014). These developments were noted in a second column, with theoretical codes from interviews with other participants shown in black, and potential theoretical codes from this interview shown in bold typeface. An example of this is shown in Table 9 below.

Table 9 – Worked data example

	Transcript	Initial coding	Analytical coding
MG	Oh right. Right okay. And, at this stage of your pregnancy, what are you thinking about your pregnancy?		
02	Erm, is it ok to feel a bit defiant?	Are her feelings allowed? 'Defiant'	Emotions about pregnancy **Seeking affirmation that feelings/emotions/choices are 'allowed'**
MG	Mmm.		**Feeling defiant**
02	Erm, I, I feel like I was incredibly bullied with [second baby]. When I was pregnant with [second baby].	Relating current feelings to experience of previous pregnancy 'Bullied'	Remembering previous experience Control Bullying
MG	Yeah		
02	And I'm, and whilst I talk the talk of you're not going to do that to me, I'm not going to be treated like that, while I was pregnant with her, I was so afraid that she would die too, that, I did as I was told in the end. Because I was so afraid, that she would die too. But this time, I have, I have (pause) a different mindset. I'm not in a negative place any more, and I feel incredibly hopeful	Telling the story of what happened last time. Relating poor treatment Fearful of death last time Persona she presented last time did not match actions This time – positive mindset 'Hopeful'	Control Saying what she could have done differently Remembering the story Telling the 'story' **Fear of death/catastrophe** This time will be different
MG	Mmm		
02	and positive, and more confident in my choices, that it won't happen again. And that actually I'll come out of it with another live baby.	This time more confident This time not fearful of death of baby	Different choices this time Changing views about birth

Once all transcripts had been coded in this way, a table of all the analytical codes generated in every interview from the timepoint was created. The analytical codes were then further grouped. An example of this is shown in Table 10 below.

Table 10 – Analytical code development example

Analytical codes	Grouping
1. Emotions about pregnancy	Feelings about being pregnant
2. Physical symptoms	Feelings about being pregnant
3. Physical symptoms linked to feelings about pregnancy	Feelings about 'the bump'
4. Remembering previous experience	Telling the story
5. Impact of new baby on family unit	Making plans for this time
6. Telling the 'story'	Telling the story
7. Impact of traumatic birth on early parenting	Telling the story
8. This time will be different	Making plans for this time
9. Cascade of interventions	Gathering and analysing information
10. Breastfeeding	Postnatal decisions
11. Previous lack of knowledge	Gathering and analysing information
12. Impact of traumatic birth on partner	Support
13. Sources of information	Gathering and analysing information
14. More informed this time	Gathering and analysing information
15. Power dynamic in choice	Choice and control
16. What choice means	Choice and control

Further theoretical ideas also emerged during this process, were noted in the reflexive diary, and saved for later consideration. An example of this is shown in Figure 5 below

Figure 5 – excerpt from reflexive diary

> **9th April 2015**
> *Have conducted 3 first interviews, transcribed 2, begun third*
> - Women who want Consultant-led care see midwives as the gatekeepers to that. What they want is a referral, and not a lot else. Concerns from them about being 'pushed' by midwives to a less medical choice, ie, not an elective c-section, or using a birth centre instead of hospital labour ward.
> - Women who don't want Consultant-led care feel they have to fight the midwives/be firm with the midwives to avoid a referral. They have concerns about midwives 'pushing' them down a more medical route – so far into a hospital birth rather than a homebirth, or into an attended birth rather than a freebirth.
> - What is the role of the Community Midwives in a birth after a previous traumatic birth? What is the role of the Community Midwives during that pregnancy? Can they successfully engage with women to provide anything other than routine tests? If not, why not? Is it a desirable role?
> - Community midwives quite peripheral in all interviews so far. Women's feelings towards them don't seem bad – more irrelevant really? Knowledge not sought from them at all so far. In pilot, interviewee says she said to her work colleagues she was going to see 'the chocolate teapots' every time she had a midwife appointment, reflecting how useless she felt they were.

The scarcity of longitudinal GTM research means there is a dearth of academic guidance around adaptations that should be made in a longitudinal GTM study to Charmaz's process described above (2014). Therefore, as discussed in the previous chapter, some decisions about analysis were made after discussion with two researchers who had themselves conducted longitudinal GTM research (Begley, 2014; Gray, 2014), rather than with reference to academic writings. Each interview was read and coded up to stage two individually. The interviews from each timepoint were then taken through stage three as a cohort of nine, rather than analysing all 27 interviews together. This decision was made because the issues that all women consider at different points in pregnancy are different, and so the same was likely to be true for this cohort. This means that the categories for the early antenatal period are different to the categories in the pre-birth interviews, which are different again to the categories used in the postnatal interviews. A guide was produced to indicate which categories remained constant throughout the three tranches of interviews, which had remained but altered, and which categories were newly emerging during the interviews at this timepoint. However, as women were recruited over a year, later interviews had already been carried out, coded, and analytic work had begun on those interviews before the last of the early antenatal interviews had occurred. Therefore, refinements to earlier categories were influenced by the analysis of data from later interviews.

The final stage of analysis, constructing theory, was not completed until the end of all 27 interviews. Activities which support theory construction, such as memoing, were carried out throughout the processes of data collection and analysis, but formal theories were not developed until all interviews had been carried out and analysed. This decision was made because, although the issues women were concerned about changed over time, and the analytical categories varied at each timepoint, there was an interrelationship between the three sets of data. Pregnancies involved women in a journey through different thoughts and experiences; thinking about the previous birth led to thoughts about the forthcoming birth, and later reflections on the birth. Theories needed to encompass the women's experiences as a whole. This was especially important if the research was to remain true to the underpinning feminist principles of being able to improve the experiences of women, in this case by having practical applications for those supporting pregnant women.

7.6 Reflexivity

The previous chapter established the purpose and rationale of reflexivity in qualitative research, and its specific function within a Constructivist Grounded Theory study, underpinned by feminist

research principles. Using Finlay's (2002) work, an approach to reflexivity was constructed which drew on introspective reflexive practices to identify preconceptions, and used this to inform introspective reflections, which combined with gendered social critiques to ensure the researcher remained aware of the power relationship between the researcher and the researched. This section gives details of how those principles were practically applied.

It is a prerequisite of reflexivity that the researcher understands themselves, in order to be able to position themselves in relation to the research. Therefore, prior to the design of the study procedure, the researcher had to consider who she was in relation to the research. Answers to this question had to cover her:

- Personal experience

- Professional experience

- Motivation to undertake the research

- Fundamental beliefs about the subject of the research

The answers to these questions were later collected together into a Reflexive Statement, which is included in the previous chapter.

This recognition of the researcher's own position was then used to help shape the research design. At the design stage, questioning how the researcher perceived herself, and how she might potentially be perceived by participants influenced the consideration of ethical issues that might arise.

Throughout the research, a reflexive diary was kept by the researcher, detailing issues that arose both during data collection, and during analysis. Issues recorded in the reflexive diary ranged from the researcher's interview techniques and practices, through the initial coding and focussed coding of the data, to the generation of theories. Where appropriate, issues recorded in the diary were then discussed with the researcher's supervisors, to determine if further action was required.

The use of the diary led to identification of occasions when the researcher might have assumed an understanding of the participant's views which may not have been justified, and allowed her to work to correct these occasions. To highlight this, an example is worked through below:

In the first set of interviews, Luna said

> 'she started talking about negotiating. And the, as soon as the words left her mouth, I thought there is absolutely no way I am negotiating with you. Because this is exactly what happened with [second baby], and what you just do is break me down… and I just wanted to run away' (Luna, 1)

During the interview, the researcher made the assumption that she and Luna had a joint understanding of why this was problematic for Luna, and moved on to other topics. After transcribing the data, in discussion with her supervisors, it struck the researcher that she had made an assumption that could not be justified. The diary entry reads

> 'Some bits – like 'negotiate' means run away from consultant care – I know too much of why that is, need to draw out from participant explicitly so that in analysis it isn't subtext. Remove my assumptions.

> Discussed with [supervisors] ways to interrupt to explore. To uncover in future – why is it a fight? What is your strategy for dealing with it? What could there be instead of a fight? What makes it so difficult to discuss choices, without risking losing power over them?

> It's a fragile thing for some women – I've made a choice, now I have to hold onto it and defend it.' (Extracts from Reflexive diary, 16th March 2015)

To rectify the immediate issue, the researcher asked a supplemental question at the beginning of the following interview

> 'There's some bits from the last interview that I want to explore a little bit more with you… you'd said that she'd said it's all about negotiation and, that the moment she said that you just wanted to run away. And what I wanted to ask you about with that bit, about why her saying negotiation made you feel like that? (Researcher, interview 2 with Luna).

The reflexive practice of keeping the diary, identifying issues, and addressing them enabled the researcher to not only correct individual mistakes, but through the process of identifying such

issues, to raise her awareness for the potential for such issues in the future, and to therefore avoid them.

With the research question clear, the underpinning methodology defined, and the research carefully designed, the research moved into the recruitment phase.

Chapter 8 – Introducing the women

8.1 Recruitment

Participants were recruited from April 2015 until September 2015. Initial interviews took place between these dates. 12 women were recruited to be interviewed. A number of other women expressed interest in the research, but chose not to become involved, or wanted to be involved but did not meet the eligibility criteria because they lived abroad, or were further on in their pregnancies than 20 weeks. Two women enquired about the research, and expressed an interest in being involved in the research but lost their babies before 12 weeks, the earliest point at which they could be formally recruited into the study.

Of the 12 women recruited into the research, one woman withdrew from the study before her first interview, due to difficulties with time. Another changed her mind about being interviewed after recruitment. Another woman lost her baby after recruitment, but before the first interview. The data set is therefore drawn from interviews with nine women, each of whom was interviewed three times – a total of 27 interviews.

All the women recruited to the study were White British, and all described their sexual orientation as heterosexual. All were living with a partner at the point of recruitment (although one was temporarily living with parents between house moves, with a partner who worked away during the week). Two women became single during the course of the research. Four of the women were married to the partner they lived with, one woman was married to a previous partner, but living with a new partner who was the father of her baby. The others had never married. The ages of the women at the time of recruitment are shown in Table 11 below.

Table 11 – Maternal age at time of recruitment (showing assigned participant number)
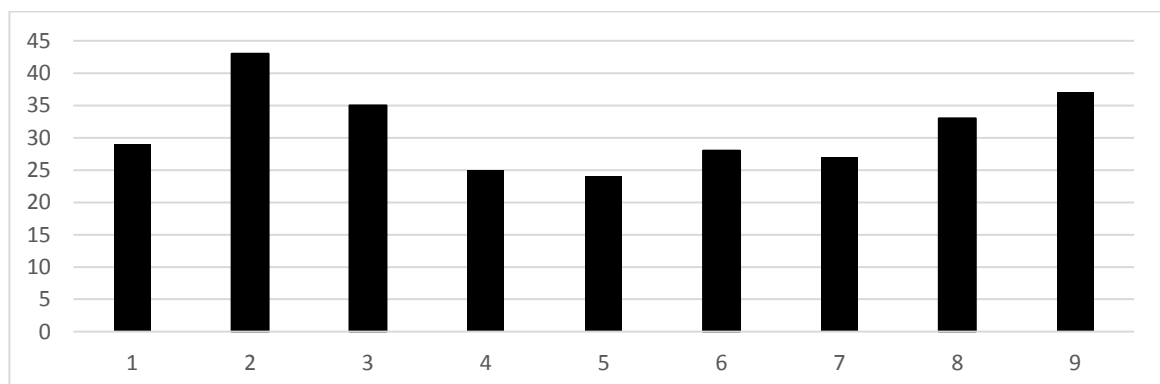
None of the women described themselves as having a disability, but five of them had a formal diagnosis in relation to their traumatic birth. This included one standalone diagnosis of post-natal depression (PND), one of post-traumatic stress disorder (PTSD), one of pudendal nerve palsy, and two women had comorbid diagnoses of PND and PTSD in relation to their previous traumatic birth.

The women had varied fertility and birth histories. The nature of the research meant that all the women had had at least one child before taking part in the research. Four of the women had just one child prior to this birth, three women had two children already, and one woman had three children, of whom one was not her biological child. However the number of previous pregnancies (one-four, mean two), showed that some of the women had experienced multiple losses before this pregnancy. For most of the women, the traumatic birth had been experienced with their current partner, but for two of the women the current pregnancy was the first child they had had with this partner. In one case this was the partner's first child, in another the partner had a child from a previous relationship.

8.2 Early antenatal interview

Nine women were interviewed in the early to midpoint of pregnancy. It was a requirement of the Ethics Committee of the University of Hull that no interviews took place before 12 weeks gestation, while the research methodology dictated that the first interview should happen before 20 weeks of pregnancy. This left an eight week window in which to conduct initial interviews with each woman. The spread of the point of initial interview is shown in Table 12 overleaf:

Table 12 – Weeks gestation at first interview
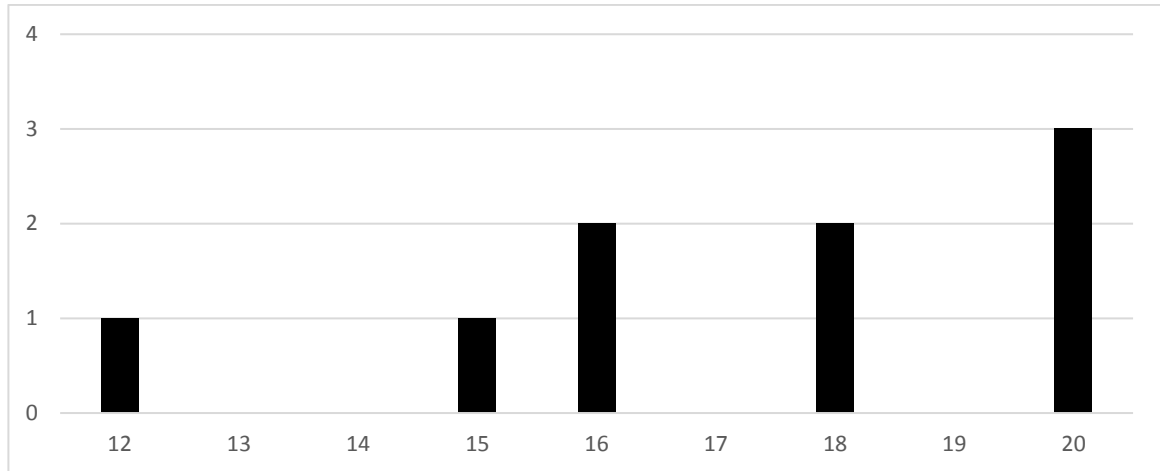
In this first interview, several of the women in the research reported physical health difficulties that were outside of the usual range of pregnancy discomforts. Two women had been diagnosed with hyperemesis gravidarum, and were suffering from it a great deal at the time of the first interview. Neither woman had suffered from it in previous pregnancies.

8.3 Pen portraits of the women

The women involved in the research had very different previous experiences of birth, different reasons why their previous birth(s) were traumatic, and different hopes and fears for their current pregnancy and birth. Below are given a few details about each woman's history, in order to provide context for the interview data in the following two chapters. The information is provided as it was relayed by the women themselves during the course of the three interviews, with identifying features removed.

Victoria

Victoria had one child, aged two at the time of the first interview. Her first birth had been in hospital, and she had been given an episiotomy. Her baby had jaundice after birth, which had required him to be readmitted to hospital at a few days old, and had led to conflicting advice about breastfeeding or formula feeding – a situation which Victoria found very stressful.

Luna

Luna had given birth twice before, but her first baby had died during labour. Her first birth had begun at home with an Independent Midwife, but she had transferred into hospital (at her request) during

labour. In her second pregnancy she had been hospitalised with pre-eclampsia, and had been induced.

Lea

Lea's previous birth had been in hospital, and had involved forceps and coached pushing. She had been extremely exhausted in labour, and had been given pethidine during labour. She had suffered with sickness throughout pregnancy, and had also experienced being sick repeatedly during her labour.

Alice

Alice had two children, both of whom had been born by planned caesarean section. She had a number of medical issues, both pregnancy related and non-pregnancy related. She had suffered severe haemorrhages some hours after both previous births.

Taylor

Taylor had one child, aged 8. She was pregnant with a new partner, who had no other children. Her first baby was born vaginally, after a long labour, in which she was given several doses of pethidine, before getting into a birth pool. She experienced repeated losses of consciousness whilst in the pool. She had patchy memories of both the birth and several months postnatally. Taylor had not breastfed for very long with her first baby, and felt guilty about this.

Becca

Becca had given birth twice, and also had a young step-child. Her step-child had been born prematurely, and had required an extended stay in NICU. This pregnancy was the first baby she and her new partner were having together. Her two birth children were both born by unplanned caesarean sections.

Quinn

Quinn had one child, who was born by unplanned caesarean section, after a transfer into hospital from a labour at home with an Independent Midwife. In her previous birth she had been examined by a male obstetrician who performed vaginal examinations without consent. Which left her feeling sexually assaulted. Quinn's first baby experienced weight loss after birth (whilst being breastfed),

and was readmitted to hospital under care of a paediatrician. Communication was problematic and left Quinn feeling she had been bullied.

Rachel

Rachel's first child was born vaginally, after a long second stage, which had left her with pudendal nerve palsy. Her second baby was born by planned caesarean section, carried out by a private Consultant. The incision had not been stitched well, and she had been readmitted to hospital to have the wound reopened and reclosed a few days after going home.

Halle

Halle's two previous children were both born at home, with NHS midwives in attendance. Her first baby was diagnosed as breech, and with IUGR at 38 weeks. She experienced pressure to accept induction of labour, and despite her clearly declining this, a number of dates for induction had simply been scheduled for her. Her baby was born at home at 42 weeks and six days, weighing eight pounds.

Chapter 9 – Findings from the first interviews

This chapter describes the conceptual categories emerging from the first set of interviews, which were carried out with women who were between 12 and 20 weeks into their pregnancy. This time period was chosen to capture their thoughts at a relatively early stage of pregnancy, but once the highest risk of miscarriage had passed.

The conceptual categories emerging from these interviews in the early antenatal period centred around the ways women were dealing with their previous traumatic birth, and their efforts to ensure that this pregnancy and birth was different to the previous one. The categories are shown in Table 13 below:

Table 13 - Categories from early antenatal interviews

Categories
Feelings about being pregnant
Feelings about 'the bump'
Gathering and analysing information
Making plans for this time
Choice and control
Support
Postnatal decisions

9.1 Feelings about being pregnant

The women interviewed experienced a fairly typical range of emotions connected to their pregnancies, from 'very very nervous' (Alice, 1) to 'apprehensive but, but you know excited' (Victoria, 1). The emotions women experienced were mixed, but all included some element of feeling 'quite anxious… quite worried' (Lea, 1). When these anxious feeling were explored later in the interviews, what was striking was how focussed the women's worries were. Women described very negative emotions thinking about 'the delivery aspect' (Taylor, 1), if they could indeed think about these issues at all - 'I still can't really think about… erm, birth side of things yet' (Lea, 1).

Usually, pregnant women experience a multitude of normal pregnancy worries, whereas in these interviews all the concerns expressed by women related to the birth. Not only was birth the sole

focus of real concern, the women interviewed shared one very specific worry about the birth, which quickly became the main feature of the early pregnancy interviews;

> 'my fears are that... the, my labour is going to end up being, how it, how it was last time' (Taylor, 1).

Some of the women in this group were experiencing issues which caused them worry in addition to the delivery itself – one woman was older and so she had concerns that 'my risks of chromosomal disorders were higher than a younger woman' (Rachel, 1), and at the same time her partner had

> 'unfortunately ... lost his job, and with it the private health insurance is gone and so I don't have that private health insurance any longer' (Rachel, 1).

For another woman, her

> 'job's ended... so I'm trying to job hunt before anybody realises that I'm too big and pregnant. Erm, and also we don't have anywhere to live at the moment. Cos we've rented our place out and we're looking at moving' (Lea,1).

This wider range of issues are the ones that would be likely to form part of the pregnancy concerns that a woman who had not experienced a traumatic birth might express. But for the women in this study, these worries were not the focus of their concerns. These issues were described by the participants as 'other stuff going on' (Taylor, 1) or 'the little stresses' (Lea, 1), and were seen as secondary to the women's main preoccupation, which was that this birth must be different to the traumatic birth or births that women had experienced; 'that it won't happen again' (Luna, 1).

Whilst most of the women experienced mixed feelings, with negative emotions clearly centred on the previous traumatic birth or births, one woman did not. She was positive about her pregnancy, but perhaps more moderately so than some of the other women interviewed. She expressed a range of normal pregnancy worries, such as the fact that currently her entire family had temporarily moved in with her parents, and discussed what it was going to be like being the parents of three very young children. She described how she 'almost forget[s] I'm pregnant', and only really noticed 'when I'm putting my clothes on' (Halle, 1). A notable difference between this woman and the others

was that she had had two previous births, the first of which was traumatic, the second of which was a very positive experience. Although one other woman had had a positive birth experience, the order of where the traumatic birth came was different, in that her first birth had been positive, and her second (most recent) birth had been the traumatic one.

For pregnant women who have previously experienced a traumatic birth, thinking about the impending birth in an early stage of pregnancy appears to provoke a great deal of anxiety and worry.

9.2 Feelings about 'the bump'

'Bonding with the baby' was not a topic which was raised by the researcher, but whilst discussing general emotions about pregnancy, five of the nine women interviewed talked directly about their feelings towards their unborn baby. In each case there was a sense that they were expecting some emotions which had not yet been experienced – 'there's a slight distance there' (Taylor, 1), 'I'm not finding I'm bonding that much with the pregnancy yet' (Lea, 1). This was 'very different' (Taylor, 1) to their first pregnancies – 'I don't think there was any distance with… my first pregnancy' (Taylor, 1).

Although these five women all identified a difference between how they felt about their previous pregnancies and this pregnancy, the reasons they gave were different. For one participant, with three other small children in the house, it was very much a practical matter:

> '[I don't have] any extra time to kind of devote to bonding with … bump sort of thing… I think it's just a case that I don't... I have to schedule in time to brush my teeth, y'know' (Becca, 1)

Another woman experienced a difference in emotions, but felt it was connected to the visible signs of pregnancy this time:

> 'I mean *sigh* it, it's, [bonding] taken a while to kick in with me cos I didn't really show very much very fast' (Victoria, 1)

A third woman reflected that it might be to do with the choice she had made about not finding out the baby's sex prior to birth:

> 'I'm not finding I'm bonding that much with the pregnancy yet… and I just, found it, easier to, deal with… it as a pregnancy rather than a product of a baby? … I think later along I… probably will regret not finding out [the baby's sex], but at the moment I'm just sort of, yeah, it's a pregnancy not a baby yet'. (Lea, 1)

For these women, the difference in how they felt about their current pregnancies was not obviously linked to their traumatic birth experiences, but to other factors in their lives. However for the remaining two women, the difference in their feelings was linked to the previous experience. For Alice, this difference seemed to occur because after her two traumatic experiences, she found it difficult to believe that both she and the baby would actually survive birth:

Alice	It's taken me a lot longer to… may be believe it's going to happen?
Interviewer	*Believe it's going to happen in terms of have a baby, or have the birth that you want, or…?*
Alice	[long pause] Just have a baby I think. I don't believe I'll have the birth I want'. (Alice, 1)

For Taylor, the distance between herself and her pregnancy was a conscious choice, made in reaction to her previous traumatic experience:

> 'I think there's a little bit of that defence mechanisms and such… I don't want it to have a catastrophic effect on my mental wellbeing so I'm just going to be a little bit more reserved at the moment' (Taylor,1)

Whether some women who have previously experienced a traumatic birth do have different feelings about their unborn baby is a subject that was beyond the scope of this research. However this evidence suggests it may a subject worth investigating in the future.

9.3 Gathering and analysing information

Every woman interviewed talked about information she had gathered about pregnancy and/or birth choices. Women were gathering information about pregnancy, birth and the early postnatal period in a deliberate way, and this information was collected from diverse sources. Most women were offered information by health care professionals, but most women also accessed information from other sources, in some cases to supplement the information given by health care professionals and in some cases to challenge this information and provide an alternate view for either the woman's personal use, or to present to the healthcare professional. The different sources of information are discussed below, along with an analysis of how women interpreted information from each source.

Information provided by health care professionals

Women described medical opinions and information they had been given by 'my midwife' (Lea, 1), both 'independent midwives' (Quinn, 1) and NHS midwives, 'the Head of Midwives' (Alice, 1), GPs (Quinn, 1), 'the [NHS] Consultant' (Alice, 1) and 'private Consultants' (Rachel, 1). Where women had sought this information out, and health care staff had made the time to talk to them, women were very appreciative – 'It was very reassuring to me' (Quinn, 1), and 'it… gave me a bit more confidence' (Alice, 1).

Another important source of medical information were the meetings some women had had following their traumatic births, either with the Consultant to discuss follow up care, or through a Birth Afterthoughts or 'Birth Reflections' (Taylor, 1) service

> 'the reflections appointment was… erm, amazing, informative. I found things out, about my first um, labour and, birth, that I didn't have… a clue about.' (Taylor, 1)

However, women were aware of not having been given all the information, or the correct information, or of having information presented to them in a less than optimal way in their previous birth by medical professionals. One participant commented

> 'my birth notes from last time, which I didn't see for, almost a year… said erm, latches but does not suckle… Nobody told me that' (Victoria, 1).

This experience of not being given the information she felt she needed by medical professionals in her previous birth had influenced where she looked to for information in this pregnancy. The participant went on to talk about how she 'was thinking of… expressing colostrum' (Victoria, 1) and had researched antenatal expression of colostrum via the internet, ordered herself a pump and small syringes, and planned to store milk in case of her baby having similar problems to her previous child. She was concerned because her first baby had suffered badly from jaundice and 'my birth notes from last time, which I didn't see for, almost a year… said erm, latches but does not suckle… And they, nobody thought to tell me that.' (Victoria, 1). When asked about whether she had asked the midwives for information about the expression of colostrum antenatally, she was surprised at the idea, as she hadn't considered them as a source of information. After some thought she said she 'probably wouldn't' (Victoria, 1) discuss it with them.

Another participant had sadly experienced her baby dying during labour. At the time,

> 'the Trust where [first baby] had been born, were saying it was the Independent Midwife's fault… she was temporarily suspended, even though she did nothing wrong. And… she was the scapegoat for what was actually something that was totally unavoidable…. and the way they manufactured lies, about her, and about my choices… and wrote it into official documents… the reports that the Trust wrote about … my, declining of … continuous monitoring, on the advice of my Independent Midwife, [they said] that caused his death… And it wasn't until [first baby]'s post-mortem came back at 16 weeks postpartum, that… … said categorically that he had had… a severe hypoxic episode between six to eight weeks before birth…. So even if he'd have been born, by caesarean, while I was in labour, he wouldn't have lived because, his brain was so hypoxic' (Luna, 1).

This experience led her treat any information given by medical professionals with a degree of distrust.

This experience of not having been given the information they needed last time led to some scepticism about medical information and opinions given this time, and also to women looking to gather information from other sources. So as well as gathering information from medical professionals, women were also gathering information from non-medical sources. These sources were extremely diverse.

<u>Written materials</u>

A large body of literature exists about childbirth, from academic research to self-help books to magazine article. A number of the women interviewed talked about using written materials to gather information about their pregnancies and birth choices. One interviewee's main source of information was 'medical research literature' (Rachel, 1). Other women preferred books as a source of information, and read a huge variety of them

> 'Birth Keepers… Birthing the Easy Way… Ina May's books… Laura Shanley's book… Gary Marther's book for… erm… birth preparation… Effective birth preparation by Maggie Howell… A few hypnobirthing books, erm, and I've got new… erm breastfeeding books' (Luna, 1).

Luna identified books as her main source of information in this pregnancy (her third), but this was unusual amongst the women interviewed. For most of the women who used written materials as an information source, this information was supplementary to something else. Sometimes written materials were used for preliminary information before deciding what other support to access, '[I've been] reading stuff about doulas… I've met a couple' (Alice, 1).

<u>Media</u>

In recent years, portrayals of birth on TV have become a phenomena, and connecting with others over birth and birth choices via social media has become much easier. In addition the changes in technology, such as the smartphone and the tablet mean there are a multitude of new ways for women to gather information about childbirth without leaving the house. It would be surprising if the women involved in the study had not used the media as a source of information about pregnancy and birth.

Several women recounted gathering information by watching TV programs which show different types of birth experience 'that home birth thing - the birth choices thing that was on [Home Delivery, ITV]' (Becca, 1). Along with TV programs, some had watched 'VBAC birth DVD' (Becca, 1). But women were selective in which media products they chose to use for information 'I don't watch Call the Midwife, I don't watch all that kind of, erm, One Born Every Minute, cos as far as I'm concerned it's like a horror film' (Luna, 1). Luna had instead chosen 'through careful consideration' to watch 'that,

erm, BBC programme a few weeks ago [Childbirth, all or nothing]' (Luna, 1). Before deciding to watch it, she had 'Read… what everybody was saying' in her 'trusted sources, like… the freebirth group, okay, so what are they saying about it… Erm, what are people like Virginia Howell saying?' (Luna, 1). She then watched the programme, and found it to be very useful in recognising 'my fear' mirrored in one of the women featured, which then allowed her to process her own feelings more effectively.

Other women were less selective in what they watched, but had strategies for dealing with 'negative' (Luna, 1) portrayals of childbirth. Becca described how she spent time 'shouting at One Born Every Minute' (Becca, 1), and further described watching the program and shouting at it as part of the way she educated her partner about her views and experiences of birth.

Lea made perhaps the most advanced use of technology as a source of information. She identified 'an app that my friend recommended called… what's it called, I'll have a look… erm, mind the bump' as one her sources of information.

Although women were using technology and the media to gather information, they were not relying on it as a source of completely factual information; 'of course that's just what the Internet says, just opinion not fact' (Luna, 1). Instead, during the interviews the women displayed an understanding that some accounts were biased, and had a healthy scepticism about their wider application, or relevance to the experience of the participant;

> 'I'm not really too keen on reading much online because I think… everybody has such a different story don't they. You can't take from other people's stories. Or the information changes' (Alice, 1).

Some of the women had used social media as a way to connect with other individuals, and to gather information from them, 'human milk for human babies [a breastmilk sharing Facebook page]' (Quinn, 1) and 'the freebirthing site [an Internet discussion board]' (Halle, 1). For some women this substituted for attending groups in person, for others social media was a way to find a local group they wished to connect to, and then to attend it.

<u>Groups</u>

Some women chose to physically attend groups, usually those local to them. Victoria had attended 'a homebirth group' because she 'had questions' (Victoria, 1) she wanted to ask about homebirth. She particularly wanted to ask questions relating to partner's experiences of homebirth, because she was 'having to sell the idea to [her husband] somewhat' (Victoria, 1). However, with a child already, she found the practicalities of attending the group quite difficult. These practical reasons were also cited by other mums as a reason they had not gone to groups to obtain information, even when they would have quite liked to.

Women who attended groups as a way of obtaining information found them quite useful, although after the homebirth group Victoria said there were 'still things I'd like to find out' (Victoria, 1). She was considering attending a 'positive birthing group' (Victoria, 1) a few weeks later, this time without her husband and toddler, in order to ask some further questions.

Some women were not able to attend groups due to other demands of life, including financial demands – 'there's a new pregnancy yoga class, but it's like £6 a week or something, and I just can't stretch to that.' (Becca, 1). Others had a general disinclination towards groups, but some women chose deliberately not to attend groups, and felt strongly that they were not a source of information that they wished to access. Luna felt that gathering information from groups that included antenatal education was not something she wanted to do because 'This is my third baby, I don't need to be told what will happen. I know what will happen' (Luna, 1). Yet at the same time, she was reading a lot of books about pregnancy and birth, so perhaps it was the type of information that might be given that was unnecessary or unhelpful, rather than information itself. This seems to be borne out by her later comment 'I don't like groups… Because they just talk too negatively' (Luna, 1). She also described avoiding groups because 'outside influence really affects… my balance' (Luna, 1) – something which she also said about an offered and declined meeting with a Consultant. For Luna, being able to select the type of information she exposed herself to was very important. Making these choices involved a pre-judgement about what information would be likely to come from a specific source, and a choice then to receive information from that source or not. This strategy was used to some degree by several women. Becca described not 'want[ing] to hear irrelevant stuff… [that] I already know' about guidelines for VBAC as one reason she had 'actually refused all consultant care' (Becca, 1).

<u>Individuals</u>

Women also gathered information from individual people. Sometimes these were people who were in their lives already, who proved to have some useful knowledge, such as 'my best friend [who] is a nurse' (Lea, 1), or 'one of my friends is a, is it BAMBI? Breast Support…' (Lea, 1). In other cases women sought out specific knowledge from professionals such as 'an osteopath' (Quinn, 1) or a 'doula' (Becca, 1). In these cases, the information flowed in a similar way to the information that the women gathered from health professionals, in that the women presented a specific question they had, and the individual gave them information in answer to the query.

Some women also sought out a more anecdotal kind of information from individuals, that was perhaps more like that gained from attending groups. This was gained by talking to 'other mums who had sort of traumatic births [and subsequent births]' (Lea, 1) or 'mums who have had a baby at [different hospital]' (Quinn, 1). In these cases the information flowed both ways, with mums recounting and exchanging stories, rather than posing specific questions.

In addition to this intentional gathering of information, women had also picked up further information from individuals in incidental ways between their previous birth and this pregnancy;

> 'I was interviewing a lady who was actually pregnant herself… and she said something that she, that was against having pethidine… It wasn't something that I'd looked into [until then, but then she researched the effects]. I discovered that… um, I think it's around forty percent of mums who have pethidine, actually have no pain relief, but there's a lack of control… feeling trapped, being paranoid... and it was like, that... that was me!' (Taylor, 1).

Women were seeking out other women's experiences and accounts of pregnancy, labour birth and the early postnatal experience, but were not treating them as wholly reliable sources of information. Where women came across information that was potentially unreliable, they were able to identify the difficulties of such information, and process it appropriately.

> 'it's … such a, niche view, I think, there's just no information about it so I, I'm not going to worry about why it happened' (Victoria, 1)

And even when the information received was not questionable, women were aware that anecdotal information about another woman's experience was not necessarily applicable to their own situation 'You can't take from other people's stories' (Alice, 1).

Rather, in seeking out other people's experiences, women appeared to be gathering a large amount of information, and then sifting through it to see what was applicable to them. What women said they were doing was looking for was somewhere to go for answers tailored to their individual circumstances 'I felt I had questions, more relevant to me' (Victoria, 1).

One consequence of this view of non-medical sources of information as being potentially biased, and generalist information rather than tailored individually, was that women then sometimes extended this view to information given by medical professionals too. Women did not unquestioningly accept that a medical opinion was correct. This seemed to emerge partly from the experience of sifting and analysing other sources of information

> 'the midwife… she was like, so, if your scar does rupture, which I said, yeah but that, y'know, that's a less than 1% chance, she was like, yes it will be catastrophic and you will both die, you won't make the ambulance, and I was like, not entirely sure that's entirely accurate…' (Becca, 1).

Women also framed what a medical professional said to them in the context of their previous experiences of having been given incorrect or incomplete information, and looked to verify that information from other sources, or from their own existing knowledge.

> '[the midwife said] they [the Obstetric team] assume you should go and give birth in that hospital, because you've seen the Consultant there. Which was… I'm thinking well that's not true either because, I, I, I'm entitled to get a medical opinion and could go elsewhere anyway' (Taylor, 1)

Every woman involved in the study had gathered a wealth of information about her previous experience, and her current choices, by the time of this first interview. The majority of this information related to birth choices, or the early antenatal period, rather than to the pregnancy. Women gathered information from a wide range of sources, and examined the information they

found in a critical manner. Most women began with information given to them by health care professionals, and then supplemented this with information from other sources. However as part of the previous traumatic birth experience, some women had experienced being given incorrect, incomplete or otherwise unsatisfactory information by health care professionals. This led to some mistrust in information that was given to them in this pregnancy. Applying a degree of critical analysis and scepticism to information they had gathered themselves from books, the media and other people may also have led women to apply the same evaluative techniques to information given to them by health care professionals. The wide range of information that women were gathering was then used by them to formulate their views about what they wanted to happen during pregnancy and birth this time.

9.4 Making plans for this time

Even at this early stage in pregnancy, most of the women interviewed were very concerned with making plans for the forthcoming birth. The information they had gathered directly informed their plans for this birth.

The act of planning

For some, the birth planning had started before they conceived

> 'I did also see a GP a few months before I started trying to conceive… then I said to her oh well I'd like a home birth' (Quinn, 1)

Another participant had talked a great deal to her new partner prior to getting pregnant, and only tried to conceive once he had understood her views on pregnancy and agreed her plans of how she would like to give birth

> 'before we decided to try and have another one we [self and partner] had a really frank conversation about how I'm pretty just… I'm basically just really shit at being pregnant and giving birth' (Becca, 1)

The planning for birth continued during early pregnancy. For some women, the choices they made about tests during early pregnancy were very connected to their later plans, especially if they felt

that choices they made could impact their choices about birth. This affected both whether women accepted or refused various services and tests that were offered:

'I… have agreed to erm thyroid testing every 10 weeks… That's not something that will exclude me from a home birth, that will not exclude me from, you know, any of the things I want to do' (Luna, 1)

'[the midwife]'s talking about referring me to the peri-mental, prenatal mental health just to make sure that everything's sort of okay… She said then if I do see the Consultant and I do want to have, the section it'll sort of help my case' (Lea, 1)

Some of the women had distinct preferences at this stage about they would like to give birth

'Electing for a caesarean is a very conscious choice, it's not really a choice when the choice is between having elective caesarean or risking permanent incontinence' (Rachel, 1).

But for most, there were elements of uncertainty

'At birth. I'm, I'm UNsure. I don't know [whether she would like a homebirth with NHS midwives, independent midwives, or a freebirth]' (Luna, 1)

For two of the women, not planning was important. They both expressed strongly that, although they had some preferences in how they birthed, they were refusing to plan. At the same time, both were making decisions about care, in one case the woman had declined Consultant-led care, and opted for a homebirth after two previous caesarean sections, and was very clear that if she did not birth at home, she was 'quite happy to go to hospital and have a c section' (Becca, 1), but not any form of induction or assisted delivery, because 'I've been there, twice, um, it hasn't worked, I don't dilate in hospital… not even all the drugs that they could throw at me got me in labour' (Becca, 1). In the other case, the woman was clear that she was 'not somebody that normally believes in… plans as such' (Alice, 1). Yet at the same time, she was drawing up a very detailed medical plan with her Consultant of exactly how the incision would be made during her caesarean section, how long she would stay in Recovery following surgery, and where she would be sent to subsequently, and how frequently her blood pressure, pulse, and so forth would be checked after surgery. She did at one

point describe this as 'the Consultant's… detailed plan for me', but the ownership was very clear, as she then said 'I don't think there are many choices that I can make to be honest', and reiterated that she herself was 'not planning' (Alice, 1). These two women appeared to have quite clear ideas about what they wanted and needed, but were strongly of the opinion that they were not making plans for birth. For them, actively choosing not to plan was important. Although their birth plans were very different, what they had in common with each other was that both had experienced two traumatic births previously. When asked about why not having definite plans was important, one answered

'So I'm not setting myself up to fail later on' (Becca, 1)

Content of plans

The women interviewed were planning a wide range of different ways to give birth, including freebirth, homebirth with independent midwives, homebirth with NHS midwives, hospital births, medically indicated caesarean sections, and non-medically indicated caesarean sections. No two plans were alike in terms of choice of birth. But what their plans did have in common at this early stage of pregnancy was a list of things that the women absolutely did not want.

What was viewed as unwanted was different for every woman. For some, a specific way of birthing was strongly not wanted. For Luna, a caesarean 'would never be, that would never be my choice. Never' (Luna, 1), whilst for Rachel 'a vaginal birth' for this baby was definitely not something she wanted. For others, specific interventions were not wanted. Taylor was extremely clear that 'absolutely desperately, I do not want pethidine' (Taylor, 1), whilst for Victoria, 'avoid[ing] an episiotomy' (Victoria, 1) was the main focus of her plans this time, and for Luna 'there are so many options that I will take over an induction aga… for this baby' (Luna, 1). And for some, it was about who was there at the birth midwives attending (Halle, 1), or what specific people did during the birth – 'no-one else is doing it [caesarean] this time' (Alice, 1).

These extremely strong wishes to avoid certain things at all costs frequently came directly from the experiences women had had during their traumatic birth(s) – 'There's no way I'm going through that again' (Luna, 1). Ensuring that this birth was 'not like last time' (Alice, 1) was the driving force behind the plans that the women were making. It drove how women searched for and analysed information

about their previous births, and about their current choices. By planning to refuse specific unwanted things, women sought to avoid a repeat of their previous experience

> 'and I just don't want to get in that state again… So I just think I need that control over the situation' (Lea, 1).

Many of the women acknowledged that planning for birth was difficult, because there are many unknowns 'you have to go with how it, goes along' (Alice, 1). But this negative planning (planning not to have certain births, interventions, and so forth) was a way women could regain control over their birth experience

> 'I need to be in control next time, because they took all the control away from me and left me very vulnerable and I need to have that control this time and my wishes respected in order for it to be a good experience. So that's why there's gonna be quite rigid birth plans' (Quinn, 1).

9.5 Choice and control

Most women talked about the choices they were making. They saw exercising their choices as the way to achieve the goal of having a birth that was different from last time

> '… the first time round I'd have done what I was told. I'd have just done what I was told and the impact of that is I'm saying do you know what, no. This, everything is my choice. It's my choice. It's my baby my body my birth. I don't want to do that, that's not going to happen this time.' (Taylor, 1)

Women were very deliberately making plans which they felt protected them best against any loss of choice or control they had experienced in their traumatic birth, particularly when an individual or individuals (rather than the naturally occurring events of birth) had removed that control from them. Losing choice or control due to natural events outside of anyone's power was upsetting, but women were not making birth plans to avoid those events in the same way. Luna had very sadly lost her first baby during labour, due to events beyond anyone's control. Her second baby was born with no

medical complications to the baby, but with multiple interventions during the pregnancy and labour. She said

'And in actual fact, I, this sounds really bizarre and I think to most people this is quite a strange thing to hear, is that I would rather go through another [first baby]… my trauma, comes from [second baby]'s birth, unfortunately… I feel like I was incredibly bullied with [second baby]. There's no way I'm going through that again…. Even if we get the same outcome as [first baby].' (Luna, 1)

Her devastation at losing her first baby was evident in the interview, but her plans for this birth centred around avoiding a repeat of her second birth, where she felt control had been removed from her by health care professionals, rather than by circumstance.

Other participants who had experienced more than one previous birth also had experiences of their choice and control being removed by events outside of anyone's control, and choice and control being removed by things they felt were in the control of medical professionals. For Alice, a last minute change of which doctor performed her caesarean, combined with a birth plan that was not followed, resulted in both physical trauma and emotional trauma. Her focus for this time was on controlling who carried out the operation

'the last time, they said a lot of things and they never happened … the Consultant's got to do it this time… I don't want it done by a junior who hasn't read the plan again' (Alice, 1)

Another participant had had a similar experience of having poor care during a caesarean:

'and I ended up being delivered by a locum who erm, made an absolute pig's ear of clearing up my wound… I suffered quite badly because I had to go to theatre, the wound got very badly infected because of not being closed properly' (Rachel, 1)

She explained the choices she had wanted to make to ensure she had more control this time:

'And the nice thing about having private health care cover is you could choose erm, choose the people that you wanted to look after you… I will choose if I could… to interview and pick people that you, you click with… You share a perspective with (Rachel, 1).

Her circumstance shad changed, and she now needed NHS care for her caesarean. This loss of control was concerning to her, not because she expected a lesser standard of care, but because she lost elements of choice in who carried out the operation, and lost the opportunity of building a trusting relationship, which in turn gave her more control

'You don't know these people they don't know you, they don't know that you're reliable… They don't know you can be trusted in something… I'd choose a different model of care if I could. For that reason.' (Rachel, 1)

For all the women, preserving their right to make choices and to have control where they could was extremely important. Where women were most scared of losing control depended on where they felt they had previously lost choice or control in their traumatic birth(s). Different women were using different strategies to try to preserve that control this time. Two women were using private healthcare at the time of interview, one in the form of Independent Midwives, one in the form of a private Consultant. One woman was choosing to have a mostly unassisted pregnancy, and intending to freebirth. Two women were intending to request non-medically indicated caesarean sections. Two women were hoping to have homebirths, probably with NHS midwives, but both displayed a great deal of anxiety about this. One said she was 'distancing myself physically' (Victoria, 1) from health care providers by choosing a homebirth. Luna described herself as 'avoiding avoiding avoiding' (Luna, 1) the midwives as much as possible.

For many of the women, exercising their right to choose was not described by them as a neutral act. Even at this early stage of pregnancy, many women were anticipating having to argue or even fight for their right to make the choices they wished to make. At this stage in pregnancy, few of the women were expecting that their right to make choices would be supported.

9.6 Support

Women's desire for support for their choices for this pregnancy was extremely high. It was mentioned multiple times in every interview, without exception. Often, discussions about what support a woman wanted this time stemmed from or led to comments about the support or lack of support she had received during her traumatic birth. Women wanted different support from different people involved in their lives.

Support from midwives and Consultants

At this early point in pregnancy, all the women were being offered care by midwives. Even for women who would definitely follow a path of NHS Consultant-led care in later pregnancy and in birth, the antenatal care up until around 20 weeks was provided almost solely by midwives

For eight of the women, midwifery care at this stage was provided by NHS Community Midwives, for one woman the care was provided by Independent Midwives. Yet in these first interviews, midwives seemed strikingly absent in what the women talked about.

In some cases this absence was due to what women wanted from their community midwives. Some women who wanted Consultant-led care described midwives as the gatekeepers to that care, particularly if the woman wanted a non-medically indicated planned caesarean birth. The support women wanted in this situation was a referral, and not a lot else. Once a midwife had done what the women wanted in terms of referring her, there was a perception that the midwives had no further role. In the pilot interview, the participant, who was having an elective caesarean birth said:

> '[I] say to my colleagues, "Just going to see the chocolate teapots" when I'm off to the midwives' (pilot interview)

This was the most negative way a woman wanting a non-medically indicated caesarean birth described her midwives, but it was a sentiment which was shared by other women;

> 'I think I've almost like bypassed the midwife' (Taylor, 1).

One woman felt the midwives weren't involved because of her previous health problems;

'Um, the midwives haven't really said too much to be honest. Quite a lot of them, I just think they just, they don't understand enough themselves, about why I've been ill, to sort of give advice.' (Alice, 1)

For these women, getting the all-important referral was very much on their minds at this stage of pregnancy, as it was the first step in their journey towards securing the birth they wanted. Some of these women also had concerns at this early stage of pregnancy that they might be 'pushed' by midwives to a less medical choice, for example, not having an elective caesarean section, or using a birth centre instead of hospital labour ward.

'I've been offered an appointment [with the community midwives at a VBAC clinic to discuss birth choices]… I will be going even knowing that I won't be a candidate for it, a vaginal birth. … because it's useful for me to erm, document it somewhere the reasons for the choice that isn't a choice.' (Rachel, 1)

However women who did not want Consultant-led care described feeling that they had to be firm with the midwives to avoid a referral. They expressed concerns about midwives 'pushing' them down a more medical route – for example into a hospital birth rather than a homebirth, or into an attended birth rather than a freebirth:

'then I said to her [Community Midwife] oh well I'd like a home birth. And she was like no way will you… and I just thought I'm not putting up with a fight with the NHS to have a home birth.' (Quinn, 1)

'they'll try anything they can to sway me the other way… kind of, more medicalised birth I guess.' (Becca, 1)

Other women felt pushed by midwives into tests they did not want, the results of which might lead to the women being further pressured into birth situations they did not want

'Erm… the nurse in the clinic, kind of did a bit of a sneaky thing what, which was, we would like to do, erm, er, an HbA1c. And I know you're not keen, but, can we do it anyway? And I

sort of went, *sigh*, you know what? I just want to go home, just take my damn blood and do it. And of course, it all came back fine, thank god. But, I did feel pushed into that' (Luna, 1).

This lack of support for women's informed choices is quite startling. The women involved in the research were all very clear that they wanted to make their own choices, and needed support to feel in control. Luna had

'already declined and said no I don't want it [blood test], but [the midwife] had written it on the form, and I… felt pressured at that point' (Luna, 1).

The removal of choice that happened in this instance, and the lack of support shown, had further reaching consequences than just whether that test was carried out or not. Luna described how this incident contributed to her deteriorating 'trust' (Luna, 1) with not just this midwife, but 'the lot of them' (Luna, 1). Her trust in midwives and obstetricians as a group had already been shaken by her first two births, and individual instances of a removal of choice such as this hampered the rebuilding of trusting relationships.

Only Luna had met with a Consultant at the point of the first interview. Another woman had initially had a private Consultant, but had moved into NHS care prior to the first interview, due to finances, and had therefore not yet met her NHS Consultant. Luna had been offered Consultant-led care, had refused it, had had appointments made and sent out to her anyway, which she had called and cancelled, and finally during a midwife's appointment

'I was offered, erm, to meet the obstetrician. Not have an appointment, but just meet her, because she was in the next room. And I, and I was feeling very confident that yeah yeah, I'll meet her, it'll be fine, and… So I did (Luna, 1)

Luna did not find this meeting helpful, as

'she started talking about negotiating. And the, as soon as the words left her mouth, I thought there is absolutely no way I am negotiating with you. Because this is exactly what happened with [second baby], and what you just do is break me down.' (Luna, 1)

For women the situation of either wanting a birth with less monitoring or interventions than might be recommended by local NHS policy, or women wanting an elective caesarean, the fear of being encouraged or forced down a path they did not want to take led to a sense of conflict with the midwife or midwifery team, and also affected women's emotional state profoundly:

'that anxiety became bad after I spoke to … she kept talking about a hospital transfer and things like that and it just freaked me out and that really sort of I cried for about three days after that phone call.' (Quinn, 1)

This sense of conflict may not have been based solely on anything that a midwife involved in this pregnancy had said or done. Rather, it seemed to come from previous negative experiences, which have left women feeling vulnerable in subsequent pregnancies. This is not to imply that the fear felt by women is unreal, or is based on something unlikely to happen – rather it is a fear based on their personal experience of a previous midwife, midwifery team or doctor. For one participant, the negative experience which led to her fear of future conflict happened during a debrief from her traumatic birth, before she was even pregnant again:

'I wasn't fat at the time or anything erm, but she sort of went on about how I was morbidly obese and how I would get gestational diabetes and I would get pre-eclampsia and you know, this would happen and that would happen, and you put your baby at risk and all this sort of stuff and I wasn't, I hadn't even started to try for a baby yet, and she was just really vile to me.' (Quinn, 1)

This vulnerability led to some women actively avoiding or keeping midwives at a distance, relegating midwifery care to a peripheral role:

'I feel a little bit more jaded and a bit wiser about things, and I, as I say I, I'd, I'm happier keeping my distance.' (Victoria, 1)

On the other hand, where a relationship with a midwife was good, this was very valued by women. What seems to have been most valued at this early stage of pregnancy was being listened to, and

the midwife respecting not the choices a woman was making per se, but the woman's right to be the one who made the choices

'Very supportive community midwife.' (Luna, 1)

Equally valued was having a midwife who a woman felt really understood her experience of trauma

'my community midwife is absolutely lovely… Um, and she had a lot of difficulty bonding with her son. Cos she had a difficult birth… And she had postnatal depression. So she understands from a midwife point of view but also from a, you know baby point of view… It's really nice to have someone who gets it.' (Lea, 1)

One of the women involved in the research received all her care from Independent Midwives at the point of the first interview. For this woman, the relationship with the midwives was crucial:

'it made me think you know what, these women know what they're doing I can trust … and that sort of helped me feel like I could do it again.' (Quinn, 1)

Support from partners

At the time of the first interview, all the women involved in the research were in a heterosexual romantic relationship with the father of the baby they were currently pregnant with. All but one woman lived fulltime with their partner, and the one who lived apart was doing so part-time and temporarily due to her partner's work.

All the women desired the support of their partner for their birth choices. Some felt they had it

'and he's, um, supportive to the point where it can be annoying.' (Becca, 1)

Whilst other women felt less supported in their choices at this stage of pregnancy;

'my husband with the best will in the world erm… wants to support me and I erm, and I, I am sure he, he does try, but… he's just got a different angle' (Victoria, 1)

Another woman felt that some of her birth choices were affected by her partner's abilities rather than his views. She would have liked to freebirth, but was choosing not to because

> 'my husband isn't very good in an emergency situation and you know something happens, something goes wrong it's me that deals with it' (Quinn, 1)

One woman felt it was easier that it was easier to manage any difficulties in her pregnancy with her partner away, due to how difficult he had found the traumatic birth;

> 'he's obviously quite worried about me … Cos I was so poorly last time… so he really panicked, and I think because I was so sick, and he had to go through that and hear that… I think it's almost easier that he's away a lot'. (Lea, 1)

Some of the women had worked hard to ensure their partner understood what they needed from them. This was particularly the case for the two women who were pregnant to partners they hadn't had a previous biological child with. In these cases, the women described how their view of pregnancy and birth were different to their partner's views

> 'he's still in that mindframe that if a professional said that sort of thing, they're right, they know best, they're the experts' (Taylor, 1)

> 'he owes his son's life to doctors, whereas… in my head, they're kind of interfering with what has caused the problems that I had… our experiences of childbirth are very different, um, and I was really scared that the choices that I make in this pregnancy would scare him.' (Becca, 1)

These two women worked hard to educate their partners about their previous experiences, because it was important to them that their partners understood their traumatic experiences. Interestingly, the two women were hoping to have very different births at this stage of the research (elective caesarean and homebirth), but the journey they describe going through with their partners was very similar.

<u>Support from friends and family</u>

What each woman wanted from family and friends, and what support was available, varied enormously. Women talked about both practical support, and emotional support in the context of their friends and family. Practical support included 'relying on my parents quite a lot for childcare' (Lea, 1) for some women particularly at points in pregnancy where women might be unwell or tired, or if a woman needed lots of medical appointments. It was also important for women to have someone 'that would have the kids for us' (Becca, 1) during the birth if a hospital birth was planned, because then 'my parents could look after her [first child], and [partner] could be with me in the hospital' (Lea, 1). Where a homebirth was planned, having someone 'coming round to be with the kids' (Halle, 1) was equally a needed form of support for some women. Women often talked about this kind of support being provided by family, although some women were reliant on friends for this support.

Practicalities played a big part in the availability of support from family. Lea and Halle and their children were living with parents at the time of the first interview, in Halle's case her partner was also living there, whilst Lea's partner was working away. In these cases, the practical day to day support the women received from family was clearly higher than the practical support women who lived at a great distance from family members received.

Emotional support from family members was discussed in different ways. Some women looked to family for quite a lot of emotional support, but most looked to friends to fill this role. Where family members and emotional support were discussed, it was usually in a negative context, in that women felt family members were emotionally unsupportive of the decisions they were making (including the decision to have more children):

> '[My mother-in-law was] disappointed that oh no, [there's] another baby. Because that's
> her attitude. You don't need more children. You've got plenty... So, so, she kind of doesn't
> have that positive view of having more babies. More grandchildren' (Luna, 1)

Family could also bring emotional pressure to bear in ways that affected women's choices. Lea's husband's family would have liked her to find out the sex of the baby she was pregnant with, but she chose not to, because

'there's pressure from family to have a boy… Erm, my husband is the only son with children… I think he's feeling the pressure even more so (laughs). You know, why did you not produce a boy?' (Lea, 1)

Women looked to friends to provide most of the positive emotional support they needed, and sometimes the practical support too;

'I would rather, my collective friends knew, rather than her [mother in law]… because actually, they'll be thrilled for me' (Luna, 1)

'I've got friends, um, that are, like… down here and y'know people and friends and that kind of thing that would have the kids for us and [friend] who's due in August, um, and is very much on my wavelength… so I'm feeling quite positive (Becca, 1)

When this emotional support from friends was unavailable, women missed it

'My best friend … was actually my birth partner when, [first baby] was born… she was a great support through the pregnancy last time but she's … just had a miscarriage herself… So I haven't, I can't really talk to her about the pregnancy at the moment, I've sort of, lost that support from her for a minute. So it's really difficult cos she's like why, my one sort of mummy friend who, who gets a lot of it.' (Lea, 1)

9.7 Postnatal decisions

When asked about postnatal decisions in this early interview, many of the women expressed surprise to be asked. One participant said she had not though about postnatal choices at all,

Interviewer   *'have you any erm, thoughts about postnatal choices at the moment?'*
Victoria   'Erm, no.'

She then went on to talk about the fact she was preparing to express colostrum, as there had been feeding difficulties after her last birth. She had already sourced all the equipment (pump, syringes) that she would need to do this, and researched when was the right time to begin expressing, and

how to store the milk. She clearly had very detailed postnatal plans, but crucially she did not identify these as choices, in the way that she thought about the choices she was making in pregnancy and for birth.

Another woman expressed the view that the postnatal journey was not necessarily about choice;

> 'Erm, again it's it's erm, I think it's important to people to, to, be… the postnatal course that you have is often not your choice. And so sometimes people get distressed about not being able to choose… Things they could have ever chosen' (Rachel, 1)

In the following conversation, she then talked about choices she had made about whether it was safe to use car seats that had been used for her older children for the new baby, passing on clothes from one child to the next, breastfeeding, needing a new car to fit the car seats in and maternity leave. Again, she had made a number of postnatal choices, but when asked about these alongside the choices she had made for pregnancy and birth, she did not perceive them as being in the same category.

Every woman, when given the prompts of what postnatal choices might include, did then indicate that she had made postnatal choices. But their reaction to being asked about postnatal choices was different to their reaction to being asked about antenatal and birth choices. This appeared to be because women did not classify these decisions as a choice – rather it was just what they intended to do, and women assumed that they could make such choices without the need for external permission and/or support that was needed for antenatal and birth choices. The postnatal choices women were making included immediate choices such as postnatal hospital stays, what to do with the placenta after birth, and the administration of Vitamin K. These postnatal choices all involved health care professionals (other than for the woman who was freebirthing), but there was no sense from the women interviewed that the right to make these choices might be denied by the healthcare professionals.

In the few instances where women were quick to respond to the initial question about postnatal choices, it seemed to be because they were making a choice which needed permission or acknowledgement from an external medical source; for example one woman was very concerned about her partner being able to remain with her if she needed to stay in hospital overnight after the

birth, and another was intending to decline all Health Visitor Services, but was aware that doing so could be difficult.

This view of postnatal decisions as being just what a woman intended to do, and not requiring her to make an active choice was in stark contrast to the views women expressed about the antenatal and birth choices they had. The difference seemed to centre on whether a woman perceived that she had an unquestionable right to make a choice, or whether that choice could be removed from her by someone else.

9.8 Summary

At this early stage of pregnancy, the women interviewed were dealing with their often complex feelings about their previous birth experiences, and making decisions about this pregnancy and birth. Women's overriding focus was on preventing this birth from being 'like last time' (Alice, 1). To avoid a repeat of their traumatic birth, women were gathering information from different sources, both about why their previous traumatic experiences had happened, and what their choices were this time.

Being able to make choices was important to all the women, but the choices that were important to each woman varied widely. For most women, having the ability to have a say in who cared for them in pregnancy and/or birth was important. For some women this meant choosing a specific individual, for others it meant knowing that the person who cared for them fully supported their choices. For all the women, it was important that those caring for them 'get it' (Lea, 1) – in other words that they understood the woman's previous experiences, and understood why that experience had been traumatic. This was a fundamental requirement towards rebuilding trust that had been damaged by the traumatic birth experience. When a woman's choices were not supported by any individual medical professionals she encountered in this pregnancy, her trust in all the medical professionals she might encounter through the course of the pregnancy and birth could be damaged. Support from family and friends was also important, and support from partners was seen as essential to having a non-traumatic experience this time by many of the women.

Chapter 10 – Update on the women

This chapter gives an update to Chapter 8 'Introducing the women'. It gives data on when the second, pre-birth interviews were carried out, in line with the information given about the first interview. It also gives a brief update on significant events which had happened to the women between the first and second interviews, to set the context for the following chapter.

10.1 Pre-birth interview

Second interviews were conducted with women at 32-36 weeks. This interview point was chosen to be as close to birth as possible, whilst minimising the chance of a participant giving birth before a second interview could be conducted.

Table 14 – Weeks gestation at second interview
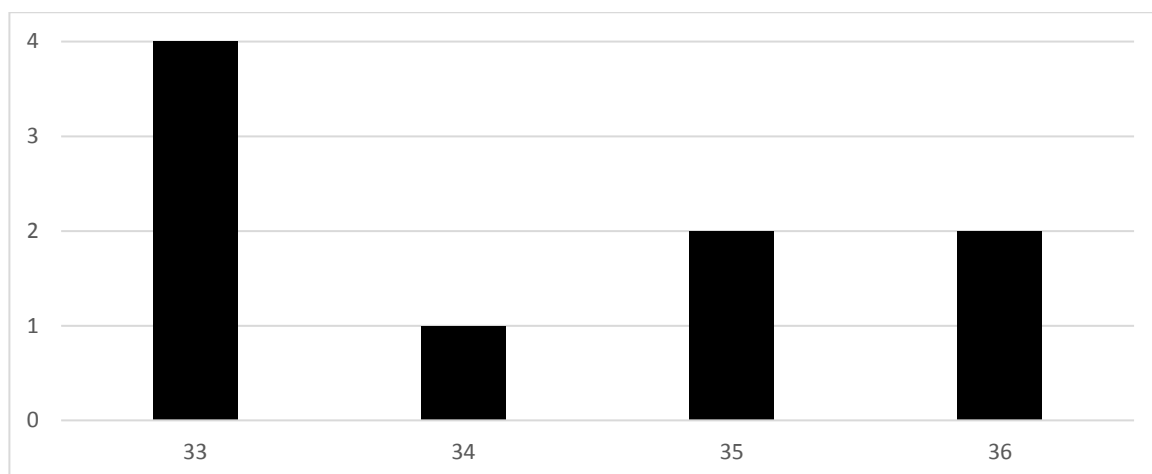
10.2 Pen portraits of the women

Between the first and second interviews, each woman had had different experiences of care, or of life events, which were relevant to the interviews. Brief updates are given below.

<u>Victoria</u>

Victoria had met with the homebirth team, and support for her homebirth plans had been agreed. She was harvesting colostrum, in case her new baby experienced jaundice and required readmission to hospital as her first had.

Luna

Luna had had difficulty arranging the care that she wanted within the NHS. She wanted a homebirth, but wished to avoid receiving care from specific midwives she had encountered when her first baby died during labour. She could transfer her antenatal care to a neighbouring Health Authority, but they could not provide cover for an out of area homebirth. She was unable to pay for an Independent Midwife as her partner controlled their financial resources and would not allow this. She had recently been offered free Independent Midwifery services, and was intending to transfer some aspects of her care. She remained unsure of whether she would prefer to freebirth, or have a midwife attend the birth.

Lea

Lea continued to experience hyperemesis gravidarium. She had moved to live with her partner some distance away, but had found the ill health, caring for their child, and social isolation difficult, and had moved back in with her parents, with her partner remaining in the house they had rented.

Alice

Alice had a date for the birth of her third child. She had had continuous care from one named midwife, and all Consultant appointments had been with the Consultant who would perform her caesarean surgery.

Taylor

Taylor had been able to arrange a non-medically indicated caesarean section, at the hospital where she gave birth to her first child.

Becca

By the time of the second interview, Becca was clear that she would like a homebirth. Her midwife was supportive, and Becca had declined Consultant-led care.

Quinn

Quinn was experiencing some difficulties in the communication between herself and her Independent Midwife. The relationship between Quinn and the second midwife was better, but Quinn was unsure whether she could transfer her care to the second midwife.

Rachel

Rachel had moved house, and so moved Health Authority. Her notes had not been transferred with her. This had resolved early difficulties over the date a caesarean should be carried out (based on the estimated due date from scans), as the only data available to the new Consultant was the private scan that Rachel had had. As the move had occurred towards the end of pregnancy, Rachel did not have long to establish a relationship with the midwife or Consultant involved in her care.

Halle

Halle, her partner and their children were still living with her parents at the time of the second interview, although a move into their own home was imminent. Halle continued not to have medical antenatal care, and was still intending to freebirth.

Chapter 11 – Findings from second interviews

The second interviews with women were carried out around four weeks before the beginning of the due period (33 weeks gestation), up until the beginning of the due period (37 weeks gestation). The aim in interviewing women at this stage of pregnancy was to capture women's thoughts as they prepared for birth.

In these interviews, some of the categories had altered slightly, for example women had moved from telling the whole story of their previous traumatic birth to a narrower focus on the specific things that went wrong, and to a focus on the responsibility for the things they identified as having gone wrong. Some categories remained constant, such as the need for support, especially from Health Care Professionals (HCPs) and partners. Other categories had disappeared, and some new categories had appeared. The main categories from these pre-birth interviews are shown below in Table 15:

Table 15 - Categories from pre-birth interviews

Category	Continuing, changing or emerging category
Focussing on what went wrong last time	Changing (from 'telling the story')
Dreaming and hoping	Emerging
Gathering and analysing information	Continuing
Struggling to say what you want, struggling to be heard	Changing (from 'choice and control')
Battles won and lost	Changing (from 'choice and control')
Making choices to get the birth you want	Changing (from 'choice and control')
Support and trust	Continuing
Plans for birth	Changing (from 'making plans for this time')

11.1 Focussing on what went wrong last time

In the first interviews, women had often told the whole story of their previous births. In these interviews, they focussed more on the specific things that had gone wrong in previous births. Many women spoke in a detailed way about how events had unfolded, often giving details of exactly where they were, and who was in the room when conversations had happened – for example Halle gave the exact dates that had been arranged for an induction, from 'Eight days before Christmas 2010' and up until 'day after New Year 2011' (Halle, 2), some five years before this interview.

This narrowing of focus onto what went wrong in previous births seemed to be very purposeful. Rachel talked specifically about the parts of the births that had caused physical trauma, in her first birth 'pushing for over two hours… [followed by] the use of forceps', and in her second birth the Consultant 'who failed to sew my wound up properly' (Rachel, 2). In doing so, she was focussing very closely on the part of the birth that had gone wrong, and examining in great detail what everybody involved could have done differently. She was explicit that doing this was, for her, a way of preventing 'the same thing happening again' (Rachel, 2).

Other women identified a number of factors that had contributed to their previous birth being traumatic. Lea focused on her 'exhaustion… from the low iron' and how the pethidine had 'absolutely spaced me out, I had no idea what was happening' (Lea, 2). A postpartum haemorrhage (PPH), which she now felt was largely caused by 'being told to push one big push and then doing that that really caused a lot of the tearing… and blood loss' (Lea, 2). She also had not consented to the administration of pethidine. By focusing on these elements of her previous traumatic birth, she was able this time round to put plans in place to avoid a repeat experience.

Many of the women felt that their previous traumatic birth was due in part to HCPs such as doctors, midwives and health visitors. A common thread emerging from the close examination of the stories was a lack of care, or being coerced into accepting something that the woman had not wanted. Lea explained that her 'original birth notes' recorded that she had 'consented to' pethidine, but she knew that 'they all knew I didn't want it' (Lea, 2). She also said 'I definitely… I did say last time but it was ignored, I do not want to be cut' (Lea, 2). These experiences had left her feeling that she had been misled, 'ignored' and 'bullied by the medical professionals' (Lea, 2).

For Becca, the traumatic birth began with a very small incident:

> 'I remember being told off by a midwife because she had done an examination and then when she came back … she was like can you just put some pants on … and I was like 18 it was really shaming actually' (Becca, 2)

The shame she felt at the time underpinned feeling uncared for during her long labour and eventual caesarean section. But now some years and two pregnancies later, she felt that the fault lay more with the midwife's words than with her behaviour.

Women also experienced other people exploring what had happened in their previous birth(s) with them, and implying that the previous traumatic birth(s) was their own fault. Rachel had a consultation with a Registrar, who 'actually left me feeling like she blamed me for the … adverse outcomes I'd had with my two prior deliveries', because they were the direct 'result of choices I had made' (Rachel, 2). Rachel was extremely clear that this blaming was led by the Registrar based on her own beliefs, not in reaction to Rachel blaming another, as Rachel herself felt she was 'not full of blame, I actually feel very well looked after' (Rachel, 2).

Her second birth was traumatic, and whilst Rachel felt this was because 'that surgeon really didn't take time and botched my wound', the Registrar she saw told her 'it was my fault for choosing to go to a private hospital and if I'd chosen to go to a public hospital it just wouldn't have happened' (Rachel, 2). This had not left Rachel blaming herself, rather she explained 'It just shows an incredible naivety… and er incredible arrogance from her' (Rachel, 2). As a result, Rachel decided 'I will choose not to see her again. She was dreadful' (Rachel, 2).

Some women attached some blame for the traumatic birth to their partner, either directly, or to a combination of the interactions between the partner and HCPs. Lea explains

> 'it is written in my notes that [her husband] consented to two or three things. I think, knowing what he is like in that sort of situation he would have said do what's best and again I don't count that as consent' (Lea, 2).

She felt that her husband should not have been asked for consent when she was still retained capacity to give or refuse consent. She comments that the HCPs 'seemed to take his word over mine which I didn't like', and said that this still 'makes me quite angry' (Lea, 2).

The close examination of the previous birth was therefore useful to women, in that it led them to make preventative plans for this birth. However it also caused some level of distress to many of them. Becca described dealing with this by actively 'the choices that I am making are just not to

panic' (Becca, 2). At the same time, thinking over the birth could reignited issues of fault, guilt and blame, directed towards HCPs, partners and women themselves, which were then carried into this birth.

11.2 Dreaming and hoping

Whilst women worried about a repeat of their traumatic experience, some of them also shared their dreams about what this birth could be like.

Luna was hoping to have this baby at home;

'I'll go into spontaneous labour before 40 weeks, yeah here we go I'm hopeful eh?... Erm, I basically ignore it but I carry on as normal, as normal can be… [Second child]'s with me… [partner]'s not gonna be … labour and will crack on and it'll all be good. I actually imagine … birthing this baby down the side of my bed' (Luna, 2).

Halle was intending to freebirth her baby, and said she felt she was 'a bit of an odd one in the freebirth world' because she was not a 'candles, lights… music-y… affirmations person' (Halle, 2). Instead her dream for this birth was

'watching rugby, then I'll go in pool, have the baby and probably watch Corrie' (Halle, 2).

Several women shared actual dreams they had had about birth. Luna had dreamed she 'gave birth on a bus… you know like a double decker bus they have a section behind the driver that is separate from the rest of the bus' (Luna, 2). For her, this dream embodied many of the things she was hoping for in her birth:

'Nobody touched this baby, nobody did anything to him… it was all me… there was no oooh we need to cut the cord, we need to do this that and the other. Somebody handed me a coat, I put a coat round this baby, … I held it to me with this coat wrapped around me and I was just left there' (Luna, 2).

These hopes and dreams felt significant. Most of the women interviewed were still talking, researching and planning in reaction to their previous negative experiences, with a focus on making sure 'this time is different' (Victoria, 2). For some of the women, this did not negate positive ideas of the upcoming birth, but this was not the case for all

> 'I keep having dreams where after I give birth, they take my baby away and I don't get to see my baby and things like that. So it's just things like that that really, you can tell how much these things play on my mind, and how much these things mean to me because I'm dreaming about my baby being taken away from me' (Quinn, 2).

Quinn very much wanted to 'be thinking about a good, magical home birth' (Quinn, 2). However, she was experiencing a great deal of anxiety, which she described as

> 'you just feel a dark cloud is coming right over you, and you're just sort of filled with dread…any time I felt anxious it feels like that' (Quinn, 2).

She articulates the culmination of those anxious thoughts.

> '…everything going wrong again and just ending up traumatised again, and then ending up with postnatal depression or something because, because it's all gone wrong and, and they've taken my baby away from me' (Quinn, 2).

In an effort to avoid these thoughts, Quinn avoided thinking about birth at all, but then experienced a feeling of loss as this meant she could not envisage the desired 'good, magical home birth':

> 'it's to the point where I try not to think about the birth so much that I'm not getting the enjoyment of thinking about the home birth because I just try not to think about the birth at all' (Quinn, 2).

11. 3 Gathering and analysing information

Some women were continuing to gather information in a very purposeful and determined way. For other women, these activities had slowed in pace.

Types of information gathered

For most of the women, the type of information being gathered had narrowed when comparing the first interview to the second. In the first interview, Taylor was gathering information relevant to her first experience, particularly about 'pethidine' (Taylor, 1), and about 'caesarean section over vaginal' (Taylor, 1). She had now made decisions about how she would like her baby to be born, and instead was now gathering information about 'choice of hospitals' (Taylor, 2).

Not all women had experienced this shift in the focus or amount of information they were gathering. Whether this shift had occurred, and the timing of it, seemed to be connected to agreeing of a birth plan Taylor expresses this view:

> 'I think this is just what I needed about having this appointment at 24 Weeks and her saying yes [to her birth plan]… I just felt like everything was okay and I could get on with being pregnant rather than being so caught up in … finding everything out' (Taylor, 2).

Difficulties in obtaining information needed

Several of the women interviewed were having difficulty in obtaining the information they needed. Taylor experienced practical difficulties in getting information she needed. Unsure of giving birth in the previous hospital, because 'what if one of them's [midwives involved in her care last time] still there and I bump into them?' she 'wanted to have a look round other hospitals' (Taylor, 2).This could be arranged from '31 weeks' (Taylor, 2), but the referral to a Consultant needed to be made at around 20 weeks. This meant that she had to make a decision about which hospital she wanted to have her baby in before she was able to look round the hospital. The information the midwives could give her about the hospitals was statistical, and 'not what I need' (Taylor, 2).

Quinn also experienced practical difficulties in trying to get information to help her decide which hospital to attend if the need arose. She wished to meet with the Supervisor of Midwives (SOM), but 'I've been waiting a month and a half to even get an appointment through erm, I'm still waiting on an appointment' (Quinn, 2). She could not arrange a meeting at either of the other two potential hospitals until this first meeting had happened, which at '33 weeks' (Quinn, 2) pregnant did not leave her a great deal of time to gather the information she needed from each hospital.

Other difficulties existed for women in getting the information they needed, which stemmed from their previous birth experiences. For Victoria, the one Positive Birth meeting she was able to attend turned out to be quite upsetting, because 'the theme of this meeting was when things go wrong I think' (Victoria, 2). Similarly, Taylor found attending groups to obtain information difficult. Having not managed to breastfeed with her first baby, and wishing to breastfeed this one, she eventually went 'with a friend' (Taylor, 2) to a breastfeeding group. This took a great deal of courage for her, because

> 'I hate being in groups of [pregnant women] it's such a horrible situation to be in and just waiting for someone to make a judgement, that I just didn't wanna be there' (Taylor, 2).

She was concerned that she would be judged for the aftermath of her first birth, particularly for 'having emotional difficulties… Mental illness' (Taylor, 2). She was also worried that people would tell her it was better 'to have a natural birth than it is for you to have a caesarean' (Taylor, 2). She did not want to go and talk in a group about her negative experiences because 'It's just not acceptable to talk about how it… affected you', but she also felt 'you're also quite taboo if you're just sat here' (Taylor, 2) not sharing experiences. 'Which means your only other option is to not go. Not be in that position at all' (Taylor, 2). When asked whether she had asked her midwives for this information, she said she hadn't, because

> 'There isn't time, there isn't staff …I need to sit down and talk … and I need that so that's that. There just won't be these resources' (Taylor, 2).

Taylor found going to groups to obtain information risky. Other women found other ways of obtaining information risky, because 'you read something every now and again and wish that you hadn't.' (Luna, 2). Gathering the needed information could have a negative impact, if women accidentally came across distressing information. Two women in particular had come across information about the same incident

> 'a case in America… a lady had been given an episiotomy… it was about 12 times or something insane, all the time without her consent, protesting and screaming that she didn't want it' (Victoria, 2).

Both had found this information whilst researching their birth choices, and both had found it very upsetting.

> *Interviewer*   *Did you finish reading the article?*
>
> Luna   I didn't no. I stopped. There was a video and I didn't click on the video either.

These examples show how women were cautious about accidentally exposing themselves to upsetting information. This caution may have resulted in self-imposed difficulties in obtaining the information they did actually need, but was something the women felt was necessary to protect themselves.

11. 4 Struggling to say what you want, struggling to be heard

Some women struggled to say what it was they actually wanted in this pregnancy and birth, other than for it to be different to their previous birth(s). Victoria described how in her previous experience, she 'didn't really have any say in what happened after I got to hospital' (Victoria, 2), which left her feeling 'like I'm doing it for the first time again, like a first timer who doesn't really know what she's doing' (Victoria, 2). This feeling made it difficult at times for her to actually know herself what it was that she wanted to happen.

Other women also recalled having found it difficult to say what they wanted during pregnancy and labour in their previous births, and talked about how that impacted on their articulation of their needs this time. Luna talked about her previous birth, in which she had found it difficult to say what she needed during labour 'I didn't have any control because I couldn't verbalise what I needed because I was afraid' (Luna, 2). During the interview she talked eloquently about her fear during labour

> 'I was bloody afraid, I thought she was gonna die too and I didn't verbalise it but all I'd ever known was to die' (Luna, 2).

Being unable to say what she needed during labour left her vulnerable, and relying on her negotiated birth plan to do the talking for her. She described the support she would have liked, and thought had been agreed before labour:

> 'everything I'd negotiated, the support, the no epidural, the environment stuff you know, I wanted my blessingway stuff put up… there wasn't space for it… people just kept coming in and I specifically requested, specifically, that they knocked… I still have the list now of my wishes, and they broke every single one of them, every single one' (Luna, 1).

Her frustration and continuing sadness at not having been able to make her wishes known is evident. And even when she was able to say that something was not okay, she felt it was unheard. During labour, she had also been allocated a midwife who smoked, but 'when I'm pregnant I literally cannot stand the smell of smoke, it makes me feel raged, enraged' (Luna, 1). She described how the midwife

> 'kept vanishing to smoke and coming back stinking of smoke and whenever this midwife left, they sent in somebody else just to sit with me, and I requested 4,5,6 times please can I have a different midwife and they did nothing about it. They kept sending the same one back in.' (Luna, 1).

This was an experience which reoccurred throughout the pre-birth interviews – women struggling to say what it was they wanted or needed, and when they did manage to verbalise their needs, they were sometimes left unsure about whether they had been heard.

11. 5 Battles won and lost

Not every woman interviewed experienced major conflict with their care providers. Some women's choices were accommodated easily by professionals who were very women-centred and sensitive to women's previous experiences. However even when there was no conflict during the appointment, women still talked about how worried they had been before the appointment that there would be a difficulty, and that they continued to worry about this for the future.

At booking, Victoria had told midwives that she would like a homebirth, and this had been positively received. She described the midwife she had seen as 'very pro-homebirth' (Victoria, 2). Despite this, she still imagined that expressing her choices during labour would 'feel like a battle' because 'you know the lack of consent thing is just a nightmare' (Victoria, 2). Prior to appointments, all but one of the women interviewed, worried about the potential for conflict and described preparing for appointments and meetings in a very thorough way. This often involved rehearsals of how conversations might go;

> 'I did have... a.... practice, of what I wanted to say to her the next time we saw her in response to that' (Quinn, 2).

When women had managed to get what they wanted, whether through winning a battle, or in the absence of any battle, their relief was palpable. There was disagreement between Rachel and her midwife over her estimated due date (EDD), as Rachel had had a private scan done, at a point which was more accurate for dating a pregnancy, but her midwife insisted on using the less accurate NHS scan date. When she had moved area and therefore hospital, '[Previous] Hospital have been so bad at information sharing, that information of their dating scan has not come across with me', and so the only date available was her 'private scan' which she had ' put… in my notes' (Rachel, 2). Rachel experienced 'frustration … [because] 'nobody actually listened to me [and]… had the crazy arguments' in which midwives told her inaccurate information about dating scans (Rachel, 2). Her relief at having won this battle was immense.

The only exception to this was Halle. She described how when she told her midwives at her first appointment 'I don't really want any paperwork, I just want this blood test done' they were 'a bit unsure… a bit like I don't know what to do, what do we say, what do we do?' (Halle, 2). Similarly when she asked for a scan 'they didn't know what to do with me really' (Halle, 2). However she did not feel any anxiety about this, she just called through to the SOM and asked for her results, which led smoothly to the SOM being 'aware of my intentions, fully aware' (Halle, 2), and her freebirth plans being fully supported. Halle's plans for her pregnancy and birth were perhaps the least common choice that any woman interviewed made, and yet she was the only woman interviewed who had not experienced concern before appointments about not being supported in the choices she wished to make.

Other women had not only had concerns about not being supported, but had experienced their choices being taken away. Some of these battles were lost in a way that made women feel their choices were given lip service, and HCP behaviours were actually then attempts to trick women into compliance. Becca explains 'I had said no growth scans … a couple of times' (Becca, 2). However on one of those occasions the midwife 'was like "oh I think you might be breech"' (Becca, 2). Becca described being suspicious at the time but the midwife had encouraged her to go for a scan, saying 'obviously you don't want to go into a breech birth without knowing' (Becca, 2). As a consequence Becca complied, the scan showed her baby as head down and also the right size. However, when Becca saw her notes, they said she had been referred for 'a growth scan, not a presentation scan' (Becca, 2). This left her wondering 'did you actually think he was breech or did you just want to bypass my no growth scans please?... I don't know whether I have been conned there' (Becca, 2).

Some battles had been lost more directly. Quinn's plan in case she needed an emergency caesarean section was 'if my baby needs resuscitating, about keeping it by my side, you know like a mobile resuscitaire to do it by the bedside so that I can still touch and things' (Quinn, 2). After an initial refusal of this plan, she compiled evidence about the 'better outcomes for the baby and it's better like less traumatic for the parents' (Quinn, 2), but was still told this was not possible. 'They actually said the reason they take the baby away is it's more convenient for them' (Quinn, 2). Quinn felt that this 'missed the point' because maternity care is 'not about convenience it's what's best for baby and mum' (Quinn, 2). As described above, she was having dreams in which her baby was removed from her, and felt very upset that her distress was ignored simply because of 'convenience' (Quinn, 2).

Quinn 'also said I didn't want baby cleaned up and wrapped and all of that, and they said no to all of that' (Quinn, 2). This was very important to her because after her last birth 'these are things that I didn't get last time that have still caused me a lot of anger' (Quinn, 2). The lack of dialogue, and the replies she was given further dented her (already damaged) trust in NHS maternity services to support her birth, and left her feeling unsure what choices she would make should she need to use these services:

> 'I can't get these things that are really important to me, okay so I'm sort of thinking am I going to be really irresponsible and even decline in an emergency for hospital? And that's actually where I am at, at the moment' (Quinn, 2).

Losing battles which were important to a woman, without a seemingly evidence-based explanation, left some women feeling that there were not appropriate services that they could use if needed, because the choices they wished to make would be denied when they were at their most vulnerable. It also provided a reinforcing loop of mistrust, and heightened women's sense that making choices in birth would be a battle.

11. 6 Making choices to get the birth you want

Women used the information they had gathered to make choices in this pregnancy. For some of them, their choices in pregnancy were made with a strong focus on obtaining the birth they wanted. This naturally included choices about method of delivery and location, but also included other antenatal choices.

Medical decisions

One of the antenatal choices women made was who to receive care from. The ability or inability to choose a caregiver was a concept that ran through many of the women's choices throughout pregnancy and birth.

For two women, the choice to use Independent Midwives during pregnancy was because they believed 'I'll just have… more right to choose' (Luna, 2). Conversely, Lea said 'This sounds really silly but I have requested that I don't have the same midwife' (Lea, 2). Initially, Rachel had hoped to be able to use the private healthcare insurance that came with her husband's job to select a Consultant individually to carry out her caesarean section. However, with the ending of this insurance, she was now using the NHS services, in an area that she had only just moved to. She desperately wanted to choose a surgeon but stated 'I really don't think that those considerations can be accommodated in the NHS can they?' (Rachel, 2). She still had a choice over which hospital to receive care from, and which Consultant to be referred to within that hospital, and asked advice from her midwife. The midwife 'said there's not really a choice and pretty much implied the obvious choice' (Rachel, 2). Coming into an area where she knew no other mums or professionals, Rachel found this advice helpful, and on this basis, made the choice to ask to be referred to this Consultant specifically, because

'I think when somebody has … telling personal view of one professional as the best and… the obvious choice… It's actually quite hard to take any other advice'

Some women were careful in selectively refusing tests which they believed might limit the support that was offered for their birth plans. Luna refused to have the standard blood tests, feeling that with her birth history

'if I ever chucked out glucose, or a bit of protein… I would be admitted and the baby would be born at hospital… and basically I'd have no choice' (Luna, 2).

Instead she agreed to a different form of the test

'I'm quite happy to do that because I know the HBA1C works so I know if two weeks before I have that test I completely cut out carbs so it's easily falsely fixed if you know what I mean?' (Luna, 2).

Other women had asked for additional tests as a direct result of their previous traumatic births. Quinn had arranged for more frequent blood tests to check 'my iron levels' (Quinn, 2) because of the PPH following her previous birth. The results had all shown 'my iron levels have come back good', but she was still choosing to take

'about one Spatone a day. But… I think in like a couple of weeks time I'm going to up it to two a day, cos it does say in pregnancy you take two a day'

and 'a supplement called NutriAdvance' (Quinn, 2). She was pleased with this choice and felt it was having the desired effect as 'Already I feel a lot more energetic and a lot better' (Quinn, 2).

Lea had also arranged for additional blood tests for iron levels when she began to 'feel really dizzy' (Lea, 2). When one then showed a low level of iron just a few weeks before her due date, she arranged with her GP to forgo the usual route of iron tablets and arrange 'an iron infusion tomorrow' (Lea, 2). Having experienced exhaustion due in part to anaemia in her first birth, ensuring she was not anaemic during this birth was very important. Lea identifies

'you can't go into labour as anaemic as you are because you are going to get exhausted and that is when… [you] start getting more complications' (Lea, 2).

Whether women were declining specific tests or requesting additional ones, the motivation for making antenatal choices that deviated from the standard NHS advised tests was the same – using the information the women had gathered to take control of this pregnancy, with the aim of ensuring this birth was not like the last.

Non-medical decisions

As well as making decisions about medical care, women were also making other decisions. Three women talked about the decisions they were making about clothes and birth. Although this may appear to be an objectively small choice, the decisions became a proxy for emotions associated with birth.

Two of the women involved in the interviews talked about being in denial that they were going to go through another birth, even at this late stage of pregnancy. Both conversations came up towards the end of the interviews, having spent almost an hour talking about the last weeks of pregnancy and the forthcoming birth. With both women, the conversation arose from a discussion of talking about what might be considered little choices, in one case talking about a going home outfit for the baby, the other from talking about what nightwear the mum would wear in hospital. Both women were having planned caesarean sections, and had agreed dates by this point. Both were happy to talk about the plans that were in place, and did not present to the interviewer as being in denial about what was going to happen, but both described their emotions when thinking about these objectively small and unimportant decisions as being 'in denial' (Alice, 2). When discussing getting ready for the hospital, Alice became very quiet, with long pauses in her answers. She said ', I've not packed my bag. I've not really bought anything yet…that sounds bad doesn't it?' (Alice, 2). She talked about how different this was from her previous pregnancies, and went on to say 'I'm still in denial this has happened, cos I think I've built up this… it's quite nerve-wracking… pretend it's not happening' (Alice, 2). Having had two previous births in which her life was at significant risk, it is perhaps not surprising that she felt 'a bit, a bit nervous about what could happen I suppose' (Alice, 2). This was something she said she hadn't discussed with her partner, because 'we don't really talk about it a lot cos we're both just as scared as the other' (Alice, 2). Her upset at talking about this

was evident, and the interviewer asked if she would like to switch subjects, which she said she would.

For Taylor, her pleasure in choosing the outfits for her baby was evident, but when the interview turned to a discussion of her own outfit, she said it 'should be really easy [but it] is actually hard work' (Taylor, 2). She could clearly explain what she practically wanted, and that this was not hard to find, but then described how she had been searching for some time for the right one. She said 'I know it sounds ridiculous' that she had 'looked online, looked in different shops, ended up going out of town' (Taylor, 2). She found her inability to find the right nightie frustrating, saying 'It's just a bloomin' nightie that's gonna be worn …. for two days' (Taylor, 2), but was also becoming visibly upset in the interview while discussing her search. She then explained why it meant so much to her

> 'this is what I'm going to be wearing this for… and then it's not even having the baby… what I'm going to be wearing in the hospital on that day… this is what I'm gonna be wearing when I hold my child (crying) … when I'm trying get up … when I shower and at times last time I felt … useless sort of thing' (Taylor, 2).

Choosing an outfit to wear was making her think of the things she would be doing in the outfit, things which last time had been unbearably hard and distressing.

Lea had made her decision that she would take 'an old nightdress which I know I want to throw straight away', but a lot was invested in the ability to throw away the nightdress immediately. She explained that in her traumatic birth, she had 'ended up staying in my clothes', and still had the dress that she had worn; 'I can't get rid of the dress but I don't want to wear it either' (Lea, 2). Equally she could not 'even… give it to a charity shop because I couldn't stand to see someone else in it' (Lea, 2). The dress itself had become a 'trigger', reminding her of her previous traumatic birth, and so this time her choice of what clothes went in her hospital bag was focussed on being able to 'just leave it [at the hospital] or get rid of it straight away' (Lea, 2).

For all these women, making what could be considered very minor choices was somehow bound up in acceptance of larger decisions, and was something all of them found very difficult to do, and upsetting to talk about.

11.7 Support and trust

Women's trust in those around them, especially HCPs, but also partners, families and friends, and even in their own bodies and minds, were affected by their previous births. The sense of heading into appointments ready to do battle came from experiences of having been failed previously. For most women, this had led to a degree of mistrust in HCPs.

This state of mistrust was not permanent for most of the women. Several described how trust had been built up slowly during the pregnancy. For Alice, having continuity of care had built this trust

> '[my] Midwife is the same person every time, she phones me up and, with the [test] results and it's been followed up a lot more' (Alice, 2).

Where the woman's lack of trust was within herself, this re-building of trust throughout the pregnancy was not possible. For Luna, her trust in herself was something quite fragile. She felt very strongly that 'my intuition speaks to me louder than anything I've ever known' (Luna, 2), but also talked about how much she felt the need to shield herself from outside influences, which could cause her to doubt herself. This was what she felt had happened in her last pregnancy

> 'I know that when I reached out for help, when I felt unwell, when I was 35 weeks with [second baby], when I had that wobble, I looked in the wrong place for help' (Luna, 2).

She spoke several times about her fear of a repeat experience that she would 'have a wobble… [and] reach out to the wrong place again' (Luna, 2) as this birth drew nearer.

> 'I needed support and kindness and hugs and love and somebody to hold my space what I actually found was a medical shit storm of shit' (Luna, 2).

Support from partners

When reflecting on the support they had, or the support they wanted from their partners this time, some women also talked about the support they had received from their partners in previous births. Others did not mention this. Those that did talk about it only did so in a negative context, when the

support they had received had been less than optimal, such as when Lea's husband had consented to interventions that she had already refused.

What women wanted from their partners in terms of support varied, but involved a partner who was willing to become informed about birth, and then support the woman to make the choices she wished to during birth. Becca felt strongly that she had this with her new partner;

> '[partner], as I said before, is just if I tell him to read something he will read it and take it on board and research' (Becca, 2).

Becca compared this to the support she had experienced from her previous partner is the birth of their two children, and felt 'It is just completely different' (Becca, 2). Offering unconditional support to the woman's plans was important, but on its own it was not enough

> 'He says do whatever you want and I'll support you. But I know I've said to him my fear, his fears, inadvertently fill my birth space' (Luna, 2).

Women needed their partners to understand their experiences, and their hopes and fears. Women found it difficult when their partner did not share their understanding of their previous birth experience

> 'he's still in this zone where all he knows is a difficult birth and he doesn't get the wider picture that most of them aren't' (Victoria, 2).

When partners expressed their views without this understanding, women found it difficult

> 'he thinks that he wants me to go to hospital, he wants me to have all the tests… He's a man and he doesn't know what it's like' (Luna, 2).

As illustrated, women had spent a lot of time gathering information to underpin their options for this time. This often meant they had a lot of information, whilst perhaps their partners did not. This difference in the information could make conversations about choices difficult, or directly affect the choices a woman made. Victoria, who was planning a homebirth, talked about how her husband's

lack of information about the risks had affected her decision not to use water for pain relief at home, saying

'[my] husband's not a big fan of the water … cos he thinks about the legionella's, about the health risks, but I don't think there are very many' (Victoria, 2).

Some women had put a great of effort into ensuring that their partners gained the information that women felt they needed:

'I have added him to some of the home births for dad groups and he is on slings and things and various things so he is being infiltrated via Facebook type crazy natural parenting women I guess. And he nods and agrees.' (Becca, 2)

Others found that, despite their best efforts, their partners were not willing or able to gather information about birth, and were not keen on the women's attempts to pass the information to them 'He is like who have you been talking to? Why are you doing all this weird stuff' (Lea, 2).

Where partners were not able to assimilate the information women would have liked, or were unable to offer the support for the choices women were making, women generally believed this was because of fear:

'He's not on board… He lets me do whatever I want but when I want his support he won't really give me that because he's afraid. I can only assume because we don't talk about it he's afraid that I'll die, that the baby will die too and the right way is going to hospital because that's what everybody does' (Luna, 2).

Several women expressed the view that the previous birth had been traumatic for their partner too. They had an understanding that if the partner had experienced the last birth as traumatic, they would have similar issues about control to the ones the woman herself had, 'because he is not around he sort of feels out of control with everything' (Lea, 2).

For two women, their partner feeling out of control led directly to conflict during pregnancy. Lea's partner was very set on choosing a name for their child that she strongly disliked 'So I don't know if

he sort of started it as a bit of an argument just to sort of make a point that I am the dad and I am going to help decide' (Lea, 2). For Luna, her partner's need to regain control impacted more directly on her birth choices

'funds are available but he will not allow me to employ an independent midwife… I guess money is the only form of control he has' (Luna, 2).

Other women were finding compromises they could make. Victoria was compromising on not using water for pain relief because of her husband's fears, and he had agreed to employing a doula, even though she felt 'he's not quite sure what to make of the whole doula thing I think' (Victoria, 2).

As well as emotional support, women valued practical support their partner was able to offer for the post-partum period

'he will do all cooking… he cleans… He's not a lazy husband or anything… And his cooking's lovely as well' (Quinn, 2).

Some women's partners were able to offer the full support women wanted, and in these cases, the positivity women felt about this was extremely clear 'and Joe has been really good… just brilliant… it's so different' (Becca, 2), and 'He's a very good husband' (Quinn, 2).

Support from family and friends

In the earlier interviews, women had talked about practical support and emotional support from family and friends roughly equally. At this point in pregnancy, many women's thoughts had naturally turned more to the practical support they might need during labour and/or birth, and in the immediate postnatal period. All the women had arranged care for their older children if needed during the birth. With a partner who was not particularly supportive of her birth choices, and a lack of faith in her midwives, Luna had made detailed plans for the support she needed from her friends

'my friend [name] knows that I'm gonna need help with the pool. Cos I can't get it up by myself as it were because I can't get the box of the thing, so erm, I'm gonna call her she's gonna come get the box down, put the pool out for me, fill it or even just attach the hose into the pool so I can literally just turn the tap on.' (Luna, 2)

Lea had chosen to move herself and her daughter back to her parents' house in order to get the practical support she anticipated she would need after the birth, saying she was

> 'back living at my mum and dad's… it is a lot easier down here because I have got more support, I was going to come back down to [name of area] and have the baby anyway' (Lea, 2).

Women also talked a little about difficulties they had had obtaining the emotional support they needed from friends and family. For some women, this support existed, but was through friends who were geographically distant from them

> 'I got a lot of support off the Internet. … but as good as that is it is not as good as having someone kind of hold your hand and tell you it's going to be ok' (Becca, 2)

For others, support was lacking from some family members or friends, and instead they experienced 'pressure from the in-laws' (Lea, 2), in this case to find out the sex of the baby before birth. Feeling some distance and lack of support from her partner already, for Lea 'it was just sort of another stress that we didn't need' (Lea, 2).

<u>Support from midwives and obstetricians</u>

For some women, even at this late stage of pregnancy, midwives seemed quite absent as either a source of information or of support. This absence was for several reasons.

Victoria felt this was because

> 'second time round you don't see people very often… so I've hardly… seen [a midwife]… booking in appointment at the hospital and then two visits to the midwife' (Victoria, 2).

This absence was not an insurmountable problem, but it left her with a number of unanswered questions. In the first interview she had talked about having questions about homebirth, this time she had other unanswered questions –

'I sleep on my back still which I don't think is ideal… but obviously I don't know if there's anything happening with the baby when I sleep on my back' (Victoria, 2).

This was not purely about information, as Victoria said 'I think she'll say if you're comfortable just carry on doing it', but that what she 'just wanted to get the nod if that was the right thing to do' from the midwife (Victoria, 2). Getting this reassuring support from a midwife was very difficult, because even in the two appointments she had had, 'you don't really get time to ask anything in-depth' (Victoria, 2). The need for this kind of reassurance was explicitly recognised by several other women: 'I think I kind of wanted her reassurance in a sense … that what I wanted was acceptable' (Taylor, 2)

In other cases, the absence of midwifery support was a choice that women had made. For Halle, this was a positive choice, but for other women, this choice came from a continuing deep mistrust of midwives. Luna explained that she 'Haven't seen the midwife since 24 weeks' (Luna, 2). Despite having been assigned a specific midwife by the Matron of the antenatal clinic 'specifically because of her approach to care' (Luna, 2). when she attended her appointment at 24 weeks, her assigned midwife had been off., Instead she was seen by a midwife who had been involved in her care when her first baby died, who then 'asked me lots of questions that I didn't wanna answer about [first baby]' (Luna, 2), and then 'coerced' Luna into further tests that she did not want Luna explained she

'would rather have been told when I arrived that [assigned midwife] wasn't available would you like to rebook? … [Luna] wasn't given the option and I felt bamboozled when this random midwife walked out and called my name, and I didn't have the guts to say that I'd rather see [assigned midwife]. I didn't have the guts. Cos I was on the spot' (Luna, 1).

Instead, she had cancelled her subsequent three appointments, and hadn't seen a midwife for 10 weeks.

In both these cases, the women would have liked more support from midwives, but were unable to obtain support on terms that were acceptable to them.

For other women, appropriate midwifery care was available and was welcome. Becca felt well supported by the 'Supervisor of Midwives', who had agreed to the birth plan she had drafted – 'it is not out of the realms of normal for them so she is happy to go ahead and support me' (Becca, 2). Although Alice's care was Consultant led and very medicalised, she had continuous care from a named midwife, which had been rebuilding her damaged trust. The named midwife was retiring a few days before her planned caesarean, so another midwife had been nominated to accompany her into theatre, and had also been building a relationship with her during her pregnancy

> 'the midwife in [city] the head midwife there, she phones me every month and she's gonna be the one that's coming in with me… she'll stay with me for the whole 12 hours [postnatally when Alice is being closely monitored]' (Alice, 2).

Having moved area, Rachel was now experiencing a different model of midwifery care, with 'one midwife… attached to the doctor's surgery… there's only one', rather than being seen by one of a team of midwives as she had been in her previous location (Rachel, 2). This gave Rachel 'the continuity of care which is a lovely thing to have', although she was also aware that this model meant 'there's not a great deal of choice for the local population' (Rachel, 2). Taylor had also had care from the same community midwife throughout the antenatal period. She said 'It's quite consistent', and when a problem arose during a Consultant's appointment in which Taylor's previously agreed elective caesarean was now refused, Taylor 'rang her [the midwife] in a complete state', and despite not being able to explain what had happened clearly, she found 'she [the midwife] was able to understand' and then proceeded to immediately resolve the situation, 'and then phoned me back five minutes later' (Taylor, 2). Without the recourse to this established trusting relationship with a midwife, Taylor might have struggled to resolve the situation of the practical plans for her birth with potential emotional sequelae.

For all these women, having care provided by only one midwife helped them build trust, and made them feel more supported in their plans for pregnancy and birth.

In the first set of interviews, only one woman was receiving care from an Independent midwife, whilst all the other women were receiving antenatal care from NHS midwives. By this interview, Luna was also intending to transfer her care to an Independent Midwife 'I know that I'll be calling her before Friday. Erm, to take over my care' (Luna, 2).

For the other woman using an Independent Midwife support for her plans was not forthcoming. At the most recent appointment, Quinn's Independent Midwife had refused to agree to her plans for monitoring during labour – 'I consented to having erm checks done on me' but 'wanted no heartbeat monitoring of the baby' during labour (Quinn, 2). The midwife had told Quinn that she could lose her registration if she agreed to her birth plan, whilst Quinn knew 'it's my legal right to decline what I want to decline' (Quinn, 2). The midwife had also asked her 'in front of [her husband]… how does [husband] feel about this? Erm, he has rights too, it's his baby too' (Quinn, 2). Quinn knew that these statements were not true, and hearing them

> 'rang alarm bells with me, because I know once the baby's inside me it's, it's, all the rights sort of lie with me' (Quinn, 2).

Like Luna, Quinn had assumed that an Independent Midwife, whose contract was directly with her as an individual rather than through the NHS, would be supportive of her birth plans. Quinn 'didn't expect that to come out from independent midwives and erm I was a bit shocked' (Quinn, 2). The lack of support and deteriorating relationship left her feeling

> 'I don't even have a supportive independent midwife and I'm paying over £4,000 what am I gonna do, and I just started really freaking out' (Quinn, 2).

Having hired an Independent Midwife, Quinn did not feel she had any choice but to try and mend this relationship. So in an attempt to heal the relationship with the Independent Midwife Quinn said

> 'I don't want to make you uncomfortable you know, if I have to have the foetal monitoring I'll have it' (Quinn, 2).

However, this unwanted and somewhat forced change to her birth plans left her feeling very unsupported, and she articulated

> 'It's just a shame that it really shouldn't have to be a case of her being reassured… It shouldn't have to be me saying you know what, it's gonna be alright, it's gonna be fine' (Quinn, 2),

rather 'It should be you know, the other way round if anything' (Quinn, 2). Because of this lack of support Quinn eventually hired a doula because she felt 'I need someone that fully supports me 100%' (Quinn, 2).

Women were also acutely aware of the possibility that on occasion, HCPs were giving opinions rather than information, and that the opinions of HCPs could be equally as biased as anyone else's opinions, and could be informed by personal and immediate experience rather than by a proper evidence base.

After having been refused an elective caesarean by a Consultant, Taylor discovered that he had arrived late to her appointment because he had been carrying out an elective caesarean which had not gone smoothly. She was very aware

> 'he was sort of saying well I've just seen a really negative side of having an elective caesarean' (Taylor, 2)

whereas she had 'looked at all the options' (Taylor, 2), and in that moment she felt that she was more objective than the Consultant she was talking to.

Receiving either personal opinions or incorrect information made women lose trust in their care providers. Becca was given incorrect information by a midwife 'she is the one that told me if I had a scar abruption then I would die, my baby would die' (Becca, 2), and Quinn was told by her Independent Midwife that her husband had rights over the baby before birth. Both women knew that these things were not factually correct information, and it led both of them to view other things that these particular midwives told them with a degree of scepticism. This loss of trust led to women feeling they could not 'rely on the support' (Quinn, 2) of those caring for them.

Rachel had a 'really bad consultation' with a Registrar.

> 'she just sort of implied it was my fault, keeping on pushing. She was asking me why I didn't just refuse to carry on... demand a section, saying she would've done that. I should've, because I am a professional. Then she looked at [second child]'s birth, and basically said it

was my fault for going private. Like that wouldn't have happened if I'd used the NHS. These things never happen in the NHS! Lots of blaming me.' (Rachel, 2).

The consultation left Rachel feeling that the Registrar 'was dreadful' and 'she just came across as extraordinarily naïve… and yet sort of unaware of her own naivety' (Rachel, 2). This could easily have resulted in Rachel experiencing the same loss of trust, and consequent feeling of being unsupported that other women experienced. However, Rachel perceived this as a problem with the individual person that she saw, not with the wider hospital, or with Obstetricians as a whole, and she was also able to approach other individuals to provide her care. She made an appointment with the Consultant, and was reassured that he anticipated her need to not be cared for by the Registrar – 'he sort of jumped the gun a bit and said well look next time you come back please do ask to see me' (Rachel, 2). The result of this was that Rachel's trust in the Consultant as someone who could care for her appropriately was improved.

Even with this increasing trust, Rachel was 'really missing the option to be able to choose individuals that actually provide you with care', because she was aware that when she went in for her caesarean section 'on the day it might end up being that particular registrar… but if it's out of hours it could be anybody' (Rachel, 2).

Support from doulas and other birth workers

Some women were also using doulas and other birth workers for support. This was always as an additional extra to the HCPs, and did not replace the services of the HCPs.

Women accessed this additional support for differing reasons, but all the reasons related to their previous experiences. Lea articulates that the additional support from the perinatal mental health team helped her 'feel more in control with the birth' (Lea, 2), whilst for Quinn, having a doula was important because 'I don't think she'll let me be pushed or forced into anything' (Quinn, 2). This is reinforced by Luna's view that a doula could offer 'respectful support' (Luna, 2). Interestingly, this additional support did not seem to raise the same anxieties in Luna as when she attended a midwifery or hospital appointment, specifically because the doula was not a HCP.

The support offered by these additional services seems to link to the need discussed earlier, displayed by many women, to be able to access small pieces of information for reassurance. Quinn describes the services she received from her doula,

> 'messaging me… and making sure I'm okay and you know anytime I wanna talk about anything she's been there' (Quinn, 2).

For Quinn, the doula's attitude towards birth was as important as the service she provided

> 'she's a very positive person when it comes to birth and things, and… she's… just really good, any time I've become negative about anything, she's been very good to then bring out the positive and then get me thinking more of that' (Quinn, 2).

For women who used birth workers for support, some of the information gathering activities of earlier pregnancy had shifted focus, to include information made available through these supporters.

11. 8 Plans for birth

Every woman expressed during the interview that her greatest hope for this birth was that it was not like the traumatic birth(s) she had experienced previously.

Many women wanted to use the birth plan as a tool to communicate with whoever attended their birth the specific things that they would not accept or consent to. Some women's birth plans also included things they would like, but the crucial part seemed to be what was not consented to.

For the women who chose to write down birth plans, how they as a patient were perceived was also considered. Victoria said she wanted to be very firm in not consenting to an episiotomy or to her baby being given formula, but also did not want to come across as an 'Obnoxious patient to the midwives' (Victoria, 2). Midwives having a positive image of her as a good patient was important, because she was 'not quite ready for free birthing yet' (Victoria, 2).

For other women, writing down birth plans was something they did not want to do. For some, this was because 'I'm secretive I'm not telling anybody what I'm gonna be planning cos I don't wanna be judged' (Luna, 2). In the first interview, Alice had been very clear that she did not want to make a plan, and this continued to be something she felt was an important protective strategy 'I haven't got a plan, I'm not very good at plans, it's not me as a person I just go with whatever happens… I think it leads to less disappointment' (Alice, 2). However she did at other times talk clearly about 'the Consultant's plan' (Alice, 2). A plan was clearly in place, and Alice expressed that she was happy with it during the interviews, but she did not see it as her plan.

Just making a birth plan was not enough for any of the women interviewed. Every woman had a sense that it needed to be agreed to by the HCPs involved in their care. For some women this need was very obvious, for example a woman wanting a non-medically indicated caesarean section definitely does need a doctor to agree to carry out the operation. However even for those planning a birth where legally all the choices are in the control of the woman, for example a homebirth, there was still a sense of needing agreement from HCPs. Securing this agreement seemed to be a fundamental precursor to building a relationship of support and trust.

Different women invested the power to agree birth plans in different people. For Taylor, who was planning a non-medically indicated caesarean birth, 'the Consultant' (Taylor, 2) or any of his Registrars could agree her plan. Whereas as far as Alice was concerned, only 'the Consultant herself' (Alice, 2) could put the plans for her caesarean in place, since the plan for was for this specific Consultant to carry out the operation. Other women perceived different HCPs to have the power to agree or refuse the choices they expressed in their birth plans.

Whoever the woman saw as being the person with the power to agree to her plans, once this agreement was received, it provided a huge sense of relief 'I felt really positive and… I instantly sort of relaxed' (Taylor, 2).

Conversely, if a woman presented a birth plan to a midwife or obstetrician, and they did not agree to it, she found this extremely difficult. When Taylor's birth plan for a non-medically indicated caesarean birth was refused by the Consultant, who said 'what happened last time would probably not happen again it's [vaginal birth] better for you' (Taylor, 2). Taylor's reaction was 'I completely

panicked completely freaked out and… I was saying, crying … get away from here, get away from this' (Taylor, 2).

Rachel felt unable to make many plans to get the birth she wanted 'I'm not really kind of in the position to make choices because of what's happened to me' (Rachel, 2). The things she had 'read… about… how to make a birth plan' felt irrelevant to her because they involved 'woolly, feely, pink fluffy stuff that you know, skin to skin and bonding, …. And dropping the drape… I'm not interested in any of that' (Rachel, 2). The plan she would have liked to make would have been solely 'the technical side of it sorted out. I want optimal conditions' (Rachel, 2). Like Victoria, Rachel was aware that HCPs might make judgements about her based on what was written in her birth plan, feeling that if you:

> 'demand some kind of choice that's not the norm…it can put people off and you can be regarded as obstructive or … demanding. And that again puts you at a disadvantage because people don't like patients like that' (Rachel, 2).

In both this feeling of being unable to plan, and her desire to have a specific person carry out the surgery, Rachel expressed very similar sentiments to Alice, who was clear that 'only she [the Consultant] is going to do it' (Alice, 2). For both women, having had complications with a previous caesarean, and now facing a repeat experience, being able to choose who 'wielded the scalpel' (Rachel, 2) was the only plan they really wanted to make. The difference between them was that Alice had been able to make this plan, whilst Rachel had not.

11.9 Summary

Women had spent much of the early antenatal period reflecting on their previous experience(s), and gathering and analysing information about why that birth was like that, and what their choices were for this birth. Once they had formulated those choices into decisions or plans about this birth, they needed very much to have someone agree those plans with them. Different women invested the power to agree their plans in different people – midwives, SOMs, or Consultant Obstetricians. If support for the plan was confirmed, women appeared to experience some relief. If a woman's choices were not supported, she experienced significant distress.

Each woman interviewed had lost trust as a result of her previous experiences. Some had lost trust in midwives and/or obstetricians in general, some in their partner's ability to support them, and some had lost trust in themselves. This loss of trust left women feeling unsafe and unsure. Women sought to rebuild trusting relationships, but whether they were able to do this depended on whether they were able to access appropriate care. What seemed to work for women in rebuilding trust was to have continuity of care from one person, usually a midwife, who 'gets it' (Luna, 2), who was accessible to the woman, and who was able to support her plans for this birth. However that relationship was fragile, and could be easily damaged, especially if the midwife gave inaccurate information to the woman. Where continuous care from a supportive midwife was not available, women were resourceful at finding the support they needed. Several women were employing doulas to provide this continuity of care and understanding, and others were accessing a range of care from other birth workers.

Women also needed understanding and support from their partners, but this was not always available. Some women felt that their partners had been too frightened by the previous birth to be able to offer the support they needed in this one.

Chapter 12 – Update on the women

This chapter gives an update to chapters 8 and 10. It gives data on when the final, postnatal interviews were carried out, in line with the information given about the first and second interviews. It also gives a further pen portrait of the women, explicitly about the circumstances in which each gave birth this time. These portraits are intended to set the context for the following chapter, which explores the data from the final interviews.

12.1 Postnatal interview

The final interviews with women were expected to be conducted between four and eight weeks after they had given birth. This period was chosen to capture the women's reflections about the choices they had made in pregnancy and birth whilst it was still a recent experience, but without interfering in the very early postnatal period. However, due to a mistake over when a baby had been born, one interview was conducted at two weeks postnatally. In this case, once the mix up had been identified, the mum was asked if she'd prefer an interview a few weeks later (the main reason for not interviewing before four weeks being to avoid pressuring a mum with a new baby). She chose to go ahead with the interview at this stage. One interview was delayed until nine weeks postpartum, as the baby had been readmitted into hospital several times. Once it became apparent that the interview could not happen in the four-eight week period, this was discussed by the researcher and supervisors. A decision was made to go ahead with the interview, so long as it was fairly shortly after that. For this woman, the admission and several readmissions into hospital were very much caught up in the emotional event of birth, and so the experiences she described in the postnatal period formed part of her experience of this birth. Table 16 below shows the point at which interviews were carried out:

Table 16 – Weeks postpartum at third interview
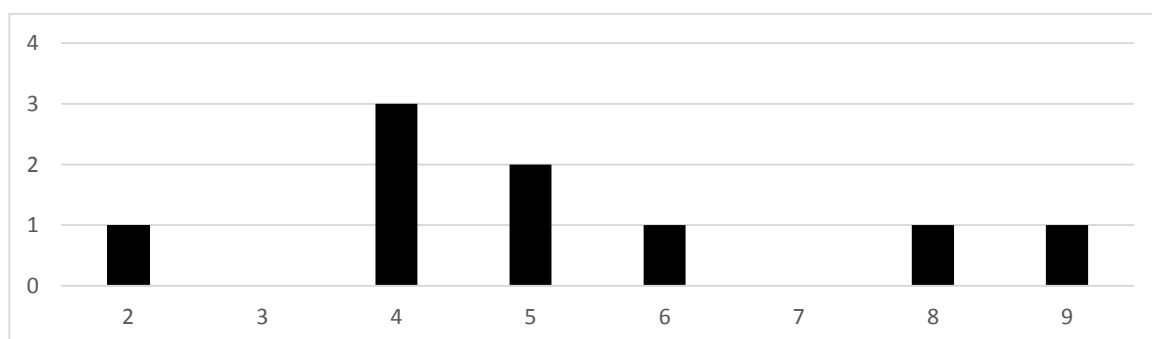
12.2 Method of birth

Some women had known prior to conception how they wished to give birth, and had kept to that view throughout the interviews. Some women had been unsure about how they would prefer to give birth in the first interview, and had decided during pregnancy. Other women's plans were more fluid, and changed during pregnancy as they came across new information, or felt differently supported. And some women's plans changed during labour. The ways women were planning to give birth at the time of the first interview, the second interview, and the ways they did give birth are shown in Table 17.

Table 17 – Plans for birth
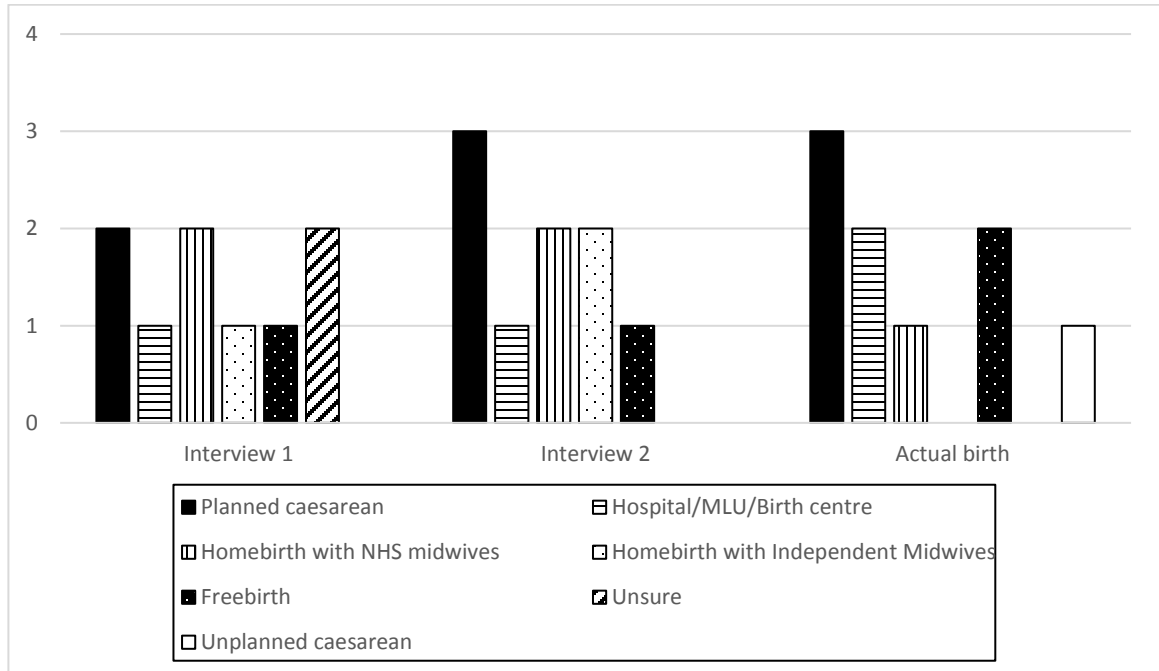
Victoria had planned a homebirth throughout pregnancy, and had her baby at home. Alice and Rachel had both planned their caesarean births throughout their pregnancies. Luna was unsure of whether she wanted anyone with her during labour, and if so, who, at the time of the first interview. By the second interview she had decided to have an Independent Midwife with her at home, and had her baby in hospital. Becca planned a homebirth with NHS midwives, and had an unplanned caesarean birth. Halle had planned her freebirth from before the first interview. Quinn planned to homebirth with an Independent Midwife, but had an unassisted birth at home. Lea was undecided between a vaginal birth and a caesarean birth at the time of the first interview, and had decided on the hospital vaginal birth that she had by the second interview. Taylor was planning a hospital birth

201

in the first interview, but was hoping a caesarean birth would be advised. By the second interview she was planning an elective caesarean birth.

12.3 Pen portraits of the circumstances in which birth happened.

<u>Victoria</u>

Victoria's baby was born after her estimated due date. Victoria was clear that she did not want an induction before 42 weeks in the absence of any medical indications one was necessary, but had accepted membrane stripping (known colloquially as a stretch and sweep) from the midwife. During the same appointment a telephone conversation had taken place between the midwife and the Consultant, which Victoria had overheard. The Consultant appeared to Victoria to be surprised that an induction had not been booked, and that Victoria was instead requesting an appointment to discuss induction versus expectant management, which made her anxious about attending the appointment.

In very early labour, Victoria had called the midwives out in reaction to her husband's anxieties about labour. This affected Victoria's confidence in herself. The midwives had then left, and she had called them out again when she was further on in labour. She had the homebirth she had planned for, attended by NHS midwives. Overall, Victoria found this birth a very positive experience.

Postnatally, Victoria noticed immediately when her new baby had signs of jaundice, and had been anxious because of her previous experience. She sought medical advice, and was reassured that her baby was fine.

<u>Luna</u>

At 38 weeks pregnant Luna discovered her partner had been unfaithful, and was intending to leave her for his new partner once the baby was born. He left the family home once the infidelity was discovered. This had an immediate impact on the choices Luna made in her plans for birth. Throughout pregnancy she had been intending to have a homebirth, but had remained undecided about whether to have midwives attend or not, as she did not want any of the midwives who attended her first birth (in which her baby died) or her second birth (in which she felt badly bullied) to come to her home. In late pregnancy she had found an Independent Midwife who had offered some support, but she had also been considering a freebirth. She now felt unable to proceed with

these plans, and decided instead to have a homebirth using NHS midwives. She made plans for this with the Head of Midwifery, her midwife, and her friends.

During labour, Luna was attended by a midwife who had been present at the birth of her first baby. Communication was difficult, Luna's blood pressure was rising, and a situation evolved in which there were two midwives, two Supervisors of Midwives, an ambulance crew, two of Luna's friends, an Independent Midwife (acting in a capacity as Luna's friend) and a GP from the local surgery in Luna's home. Luna was informed that she was at risk if she did not transfer into hospital, and that the GP was there to assess her mental competence.

After a time Luna decided to transfer into hospital. This was followed by the birth of her baby who had an Agpar score of one at birth. An hour and a half after birth, Luna experienced a postpartum haemorrhage, which was estimated at three litres in front of her ex-partner and her two year old daughter, neither of whom had been present for the birth, but who had come to visit Luna and the new baby.

Lea
Lea approached birth with a very detailed birth plan, drawn up between herself, her midwife, and the perinatal mental health team. An induction was scheduled for Lea, and in the week beforehand it was discovered that her iron levels were low. Her GP arranged for an iron transfusion in hospital. She then went into hospital for her planned induction.

Not all aspects of Lea's birth plan were followed – she was not able to have a side room because they were being painted, and there were staffing problems which led to Lea having to remove the prosotglandin pessary herself. However most of the plans were followed, and Lea gave birth using gas and air and hypnobirthing techniques. Overall, Lea found the birth a very positive experience. Lea then experienced complications in the third stage of labour and needed to have her placenta manually removed in theatre.

After having left hospital, Lea's baby was diagnosed with tongue-tie. The healthcare professional who divided tongue-ties was on leave, but arranged an appointment with Lea anyway. The procedure resolved the breastfeeding difficulties.

Lea and her partner had a difficult time after the traumatic birth of her first child. Following the most recent birth, Lea had remained at her parents' house with the two children, whilst her partner had returned to his home, and Lea had reached the decision that the relationship was now over.

Alice

Having previously experienced two births in which her life was at risk, Alice found the days before the birth very difficult. Alice had decided not to write down a birth plan; she saw the detailed medical and care plan that was in place as belonging to the Consultant, and she had chosen not to write down her own preferences for fear of disappointment. The week before her caesarean was scheduled, she did however meet with the midwife who would care for her on the day, and discuss things she would like.

Alice's planned caesarean went smoothly. The Consultant who she had agreed would perform the surgery was available on the day, and the birth went well. Alice was also able to experience many of the things she had discussed with her midwife, such as immediate skin to skin. Unfortunately some of Alice's choices were not carried out, such as no immediate weighing, and infant formula was bottle-fed to her baby.

Alice was certain her baby had a tongue-tie, based on her experience of her second baby's tongue-tie. This was refuted by several midwives, but Alice was finally able to have the referral she wanted, and her baby's tongue-tie was treated.

Taylor

In Taylor's one antenatal appointment with a Consultant, the Consultant had told her he did recommended she had a vaginal birth, and she had left the appointment distraught. Her midwife was able to quickly re-schedule the planned caesarean, but no further appointment was made with the Consultant, so she had no chance to ask about choices she would like to make. Instead, she worried about whether she would be able to make the choices she wanted to, right up until the day of the surgery. The community midwife was not able to advise on which choices could be accommodated in theatre.

Taylor had been concerned about the attitude she would experience from midwives and doctors in hospital. She found the reality was that she was well listened to. This experience left her feeling

extremely positive about the birth. Taylor experienced a dramatic change in how she felt about herself after the birth, as the anxiety she had experienced for the seven years since her previous birth disappeared. The difference was noticeable in the speed at which she spoke during the interview – in earlier interviews it had been hard to keep up with the speed at which she spoke, whereas in the final interview, she exuded a sense of calm and confidence.

Despite the extremely positive birth, Taylor did not wish to remain in hospital after the birth, and arranged to be discharged as soon as possible.

Becca

Becca had hoped for a homebirth after her previous two caesarean sections. She had had long pregnancies in the past, and expected this one to go over her estimated due date. Becca went into labour at over 42 weeks pregnant, but her labour did not go smoothly. In early labour, Becca went into hospital for a scan, accompanied by her midwife. Becca's midwife felt that it might be medically better for Becca to be in hospital, whilst knowing that Becca's choice was to be at home, and told her this. Becca trusted the midwife was genuinely willing to support her in either choice, and decided to stay in the hospital.

Becca experienced good care from everyone she saw during her labour and birth, other than one registrar, whose care Becca experienced as insensitive.

Becca gave birth at 42 weeks and five days gestation. In the end, this birth did end in another unplanned caesarean. However she felt extremely well supported in all the decisions she had taken.

During pregnancy, Becca had already made the decision to have permanent contraception, and having a caesarean birth had simplified how she exercised this choice.

Quinn

Quinn had hired an Independent Midwife in early pregnancy, but had described in the interviews how as time went on, the midwife had become less and less happy with supporting Quinn's birth choices. The relationship deteriorated, through a series of emails and texts, that resulted in Quinn's midwife withdrawing her care at 38 weeks gestation.

Quinn contacted the local Consultant Midwife, and arranged a meeting between herself, her husband, her doula and the Consultant Midwife. She was able to arrange this easily, and was pleasantly surprised at how her choices were respected. However one of Quinn's main reasons for hiring an Independent Midwife was to avoid having unknown carers at her birth, and switching care to the NHS at this point made this inevitable. Quinn decided, with the support of her husband and doula, to not call the midwives during labour unless there was a problem.

The unassisted birth went well. However after the birth Quinn needed to transfer into hospital for a manual removal of her placenta which had adhered to her c-section scar. It was extremely important to her that she was only examined and treated by a female. The midwives who had attended Quinn after her birth, and who were transferring her to the hospital were aware of this, and responded to it sensitively before they even left the house to go to the hospital, checking that there was a female Registrar on duty. At hospital, the consultant decided he did need to see Quinn, this was handled extremely sensitively: offering reassurances that he did not need to examine her, and obtaining her permission via the midwives to enter her room before coming to see her.

Quinn's baby was born with a tongue tie and struggled to breastfeed. No NHS services were available, and Quinn found a private Lactation Consultant to support her. However she experienced difficulties obtaining test results from her GP's surgery, because they had been requested by someone outside the NHS. Quinn's breastfeeding difficulties went further than just a tongue-tie, and at the point of the final interview a potential diagnosis of insufficient glandular tissue was being investigated.

The delay to accessing results, and then to treatment, resulted in readmission to the hospital for Quinn's baby, which was distressing to Quinn, as it had also occurred with her first baby. In hospital, Quinn experienced conflicting advice from Consultants about feeding.

After being discharged, Quinn experienced further difficulties with her GP's surgery, as she had not registered her baby with them or received a visit from the health visitor, because the baby had been in hospital. The entire experience caused a great deal of distress to Quinn, who was unable to understand why there was so little communication between the medical services. The lack of continuity of care postnatally caused Quinn to fear that her baby might be removed. It also left her concerned about becoming pregnant again.

Despite all of this, Quinn's relationship with her partner had improved following this birth. After her first birth, all sexual desire had disappeared, but following this birth, desire for her partner had returned.

Rachel

In the first two interviews, Rachel was adamant that she had no birth plan, and would not be writing one because she was certain that the things she actually wanted were not able to be provided. Instead of having a written plan, Rachel made a mental plan for herself, which involved not accepting pre-meds before the surgery, and sitting up on the theatre table to speak to the surgeon. She had rehearsed this scenario repeatedly, as a way of reassuring herself that the previous traumatic situation would not reoccur. Doing this in front of her partner had led to conversations with him about the previous birth, which had not been talked about before. This had led to greater understanding between them.

On the morning of her surgery, Rachel found that she was actually going to be operated upon by the Consultant that she had already had an appointment with, and her anxiety disappeared immediately. The Consultant had also arranged for an anaesthetist who had a similar professional background to Rachel's to be her anaesthetist during the surgery.

The Obstetrician who carried out Rachel's caesarean practiced a form of surgery sometimes known as natural caesarean, where the baby is lifted out of the incision and immediately placed on the mother, and the Obstetrician then changes his gloves before closing the wound. Rachel had not asked for this, in fact she had been clear that all her requests were around medical competence, but she was appreciative that the Consultant was so woman-centred that this had become his standard theatre practice.

Rachel's baby was born with a tongue tie, which was identified shortly after birth. Rachel's previous baby had also had a tongue tie, and she had managed to breastfeed without problems. She had therefore persisted in breastfeeding without having the tie divided for some time. When she did ask for the tongue-tie to be divided, the procedure was carried out on the same day, and relieved the breastfeeding problems immediately.

<u>Halle</u>

Halle was planning a freebirth, without medical assistance. Her pregnancy lasted until 43 weeks and five days, which caused some concern amongst healthcare professionals in her family. Halle experienced some pressure from her family to seek medical interventions. To offer them reassurance, Halle arranged a scan. She was pleasantly surprised not to experience pressure from the hospital or the midwives to consent to interventions she did not want, or to change her birth plans.

Halle had the unassisted birth she had planned at 43 weeks and five days gestation. Her birth went smoothly, and she called her midwives after the birth, to check her and the baby over. She enjoyed her birth greatly.

Chapter 13 – Findings from third interviews

The third and final interviews with women were carried out around four to eight weeks after their babies were born. This interview was intended to capture the women's reflections on the choices they had made in pregnancy and birth.

In these interviews, some of the categories had altered slightly, for example in these interviews women talked about the trust or lack of trust they had in those who were present at the birth, rather than talking about the support they wanted during the birth. Some categories had remained, including the battles women had won and those they had lost. Other categories had disappeared, and some new categories had appeared. The main categories from these postnatal interviews are shown below in Table 18.

Table 18 - Categories from postpartum interviews

Category	Continuing, changing or emerging category
Preparing for birth	Emerging
Battles	Continuing
Trust	Changing (from 'support and trust')
Little choices that were important	Emerging
Special treatment	Emerging
Postnatal	Continuing

13.1 Preparing for birth

The days before birth can be an emotionally mixed time for all pregnant women, but for the women involved in this research, there was also an added element of concern, which became overriding in the days before birth; that this birth should not be like the previous birth(s). Alice described how

> 'the build-up was horrendous. Quite overwhelming actually, more than my partner and I [had expected]' (Alice, 3)

This anxiety went beyond the normal worries pregnant women might have. For some women it became all-consuming

'the fear sort of eats you alive doesn't it, you can't think of anything else but that' (Alice, 3).

The feeling of build-up and dread was shared by women who were planning caesarean sections and those planning vaginal births. Additional stressors, such as those experienced by Quinn and Luna, added to the feelings of fear

'it was unreal how much stress I was under at that point and it was the opposite of what I wanted, this calm, you know, birth. So I was like what the fuck do I do?' (Quinn, 3)

From this place of anxious anticipation, birth plans became an expression of control. Most women had made plans for their birth, but for Quinn and Luna, the unexpected events in the days before birth meant these plans changed quite radically at the last moment. As a result of her personal situation, Luna decided not to freebirth, instead turning to the NHS to support her homebirth. For Quinn, circumstances immediately before her birth meant her decision changed in the opposite direction. Hiring an Independent Midwife was, for Quinn, in part to avoid 'having strangers at my birth' (Quinn, 3). Choosing to homebirth with the NHS at 38 weeks pregnant, this was now inevitable. So, with her partner and her doula Quinn agreed

'that we [would] probably have a birth before arrival… As long as I felt comfortable with that and I was like well I would rather not have them [NHS midwives] there unless I feel there is a problem and then call them out then (Quinn, 3)'

For those women whose birth plans changed immediately before birth, this created anxiety.

Other women approached birth with plans that had been set for some time. Many of the women had 'a really detailed birth plan' (Lea, 3). This had often been prepared with, or taken to and given approval by whoever the woman felt could agree or reject the birth plan. As discussed in the previous chapter, different women imbued different people with this power, from Consultant's to SOMs to the homebirth team. For many of the women, the birth plan assumed the role of a contract with their care providers of what would and would not happen. Lea described how hers detailed both lists of things she did not consent to, and

'these are the things that are likely to trigger Lea, and this is the support she needs' (Lea, 3).

Two of the women had been extremely clear throughout the interviews that they had not, and would not be making any sort of birth plans. Alice was clear that the medical and care plan in place was her surgeon's plan, not hers. She did not write a plan because of 'previous disappointment' (Alice, 3) in her last two births. The week before her caesarean was scheduled, she did however meet 'with the midwife that looked after me for the day' (Alice, 3). She discussed a lot of things with the midwife –

> 'I was speaking to her about a few things like that, saying that if this could happen it'd be lovely, but I didn't write an actual [plan]' (Alice, 3).

The need to protect herself from the disappointments she had experienced in her previous births was extremely strong for Alice.

Rachel on the other hand was adamant that she had no birth plan, and would not be writing one because she was certain that the things she actually wanted were not able to be provided:

> 'I would like a named senior obstetrician please, that would have been on my birth plan, I would like to meet this person beforehand but I know that is no point putting that down because that is not what the NHS provides so I didn't bother... It would have been like asking unicorns to wheel me down to theatre, you know, it just wasn't going to happen' (Rachel, 3)

Instead of having a written plan, Rachel made a mental plan for herself,

> 'I decided that I was going to make sure that I wasn't going to be given any type of pre-meds that might affect my ability to talk or make sense because no matter how anxious I was I didn't want to be given anxiety reducing drugs which might affect my ability to speak for myself' (Rachel, 3).

Whereas some women viewed their birth plan as a shield they could take into battle to be between themselves and healthcare professionals (HCPs), Rachel did not trust that anyone would read her plan

'if some random Obstetric Registrar comes in to do your caesarean they don't sit and ponder your birth plan, they honestly don't' (Rachel, 3).

Instead, Rachel felt the only defence against another traumatic birth that she had at her disposal was herself

'I needed to have it verbally ready to spring out when it was needed, and I needed to have it with a heck of a lot of emotional and power and confidence and commitment behind it' (Rachel, 3).

Women described rehearsing the potential arguments they might face in exercising their choices, and what they would say in whatever their particular worst case scenario was. Rachel describes doing this as,

'you know when you rehearse an interview and in order to prepare yourself you mentally rehearse to empower yourself and give yourself an idea of strength when you feel like you may not be able to muster it' (Rachel, 3).

These rehearsals had the appearance of a coping strategy, but the effects of this level of preparation were not wholly positive. Anticipating having to struggle to assert choices and maintain control raised women's anxieties. For Rachel, these rehearsals continued up until the day she was giving birth:

'I was ready before I even got anaesthetised… to make sure that I sat up on the operating table to give myself a bit of… power, to make sure again it was clear that I was not to be treated like someone should just shut up and take what they are given. I have got preferences and I have got preferences for a reason.   (Rachel, 3)

With plans made, or plans changed, or plans deliberately not made, and the last few days of pregnancy over, the women all gave birth.

13.2 Battles

In the days leading up to the birth, and during labour, birth, and the immediate postnatal period, some women experienced exercising their choices about birth as a battle. This was not a new experience, rather it was a continuation of some of the women's experiences throughout pregnancy. For Luna, the battles during pregnancy to avoid insensitive care, or to avoid tests and appointments with Consultants that she had already declined led into battles during birth. In labour, with two midwives, two Supervisors of Midwives (SOMs), an ambulance and crew, and a GP in her 'rather small house', Luna 'lost my temper with everybody' (Luna, 3). Luna's sense that this was a battle she couldn't afford to lose was particularly acute, as she was aware that the GP might 'section me' (Luna, 3) and that she would then lose the right to make decisions about this birth. She fought desperately to get the people she now saw as enemies trying to remove her rights to leave her house

> 'I just kept ranting I mean it, you're all standing there. I want you to leave my house. Go now! And nobody was doing anything. Nobody was moving and nobody was doing anything'. (Luna, 3)

Luna's experience of facing opposition to her choices was extreme, but she was not alone in facing it. Victoria's choice not to have an induction until 42 weeks was respected by her midwives, but not by all of those involved in her care. Her midwife made a call to the Consultant to arrange an appointment to discuss induction and expectant management with Victoria present, and she overheard the conversation,

> 'he obviously went what? It's not been induced? And she went no she doesn't want to be induced and he obviously thought that was bonkers. Crazy talk! Not wanting to be induced gosh! (Victoria, 3)

As Victoria's baby was born before the appointment actually happened, it did not affect her birth directly. But the indirect effect was to make her aware, again, that she might face opposition to her choices, and become concerned about a battle for control of her birth, should she attend the appointment.

Other women were supported in their choices, but did not know whether they would be supported until the last minute. On the morning of her surgery, Rachel found that she was actually going to be operated upon by the Consultant that she had already had an appointment with, and her 'anxiety' (Rachel, 3) disappeared immediately. In Taylor's one antenatal appointment with a Consultant, she had not been able to ask questions about the procedure of a planned caesarean, because the Consultant had told her he recommended she had a vaginal birth, and she had left the appointment distraught. Not knowing what choices she could make left her anxious, and preparing for battle over the things that were important to her. On the day of the surgery she explained what choices she wanted to make, and 'it was like yeah you can do this that's fine' (Taylor, 3). Even though Rachel and Taylor did not experience conflict during their births, they had prepared themselves for the battles they thought they might face, and therefore spent an extended period of time feeling anxious and anticipating conflict.

Other women faced small battles, having to insist on things they wanted, but managing to secure them. This seemed to be particularly the case where women wanted to go home from hospital earlier than usual. Entering a hospital, or remaining in hospital was a significant issue for many of the women, because the hospital was the environment in which they had experienced their traumatic birth. Some women 'didn't want to stay at all' (Taylor, 3). This uncomfortableness about being in a hospital environment did not seem to be acknowledged by those caring for the women in this study, and so women were left facing a struggle to assert their desire for an early discharge. Women described this in different terms to the battle for control, saying instead 'I had to push them' (Lea, 3) to be discharged, or describing asking 'every person I saw' (Taylor, 3) if they could be discharged.

Other women did not face battles to assert their choices, and instead were well supported to make decisions. Becca, was pleasantly surprised that 'there has just been not nearly as much fighting as I thought there would be' (Becca, 3). But even when women were supported, they still anticipated that HCPs would 'undermine me' (Becca, 3), and prepared accordingly.

13.3 Trust

The battle mentality arose from two sources – a build-up of fear and anxiety in the period before birth, and women's trust or lack of trust in those around them.

<u>Trust and HCPs</u>

Many of the women interviewed experienced mistrust of HCPs before birth, as a direct result of their traumatic birth. Alice and Rachel did not trust the HCPs enough to write down their plans. With her partner and doula, Quinn developed a

> 'code word for Entonox, which is right I really do want it now, which was Snow Leopard' (Quinn, 3).

Insensitive care in the days immediately preceding the birth affected women greatly. Quinn received 'a series of really aggressive text messages and emails' from her Independent Midwife in the days before she withdrew her care. The emails and texts would have been distressing on their own, but were made worse by the 'timing' which was 'really bad' because it was the 'three years' anniversary of Quinn's traumatic birth, and 'I was extra sensitive anyway' (Quinn, 3). Not only did this evoke feelings from the traumatic birth, but it meant Quinn 'spent all of [older child]'s birthday in tears because of her email' (Quinn, 3). Insensitive care at this vulnerable time eroded trust that had been built – in Quinn's case leading directly to her decision to freebirth.

Other women lost trust, or lost further trust, during labour. Luna had wanted her baby to be monitored in labour, but having experienced such a dramatic battle in early labour, did not trust the NHS midwives enough to allow them back into her home in later labour:

> 'I feel like I'm forgoing something that I actually want, because they're not supporting my decisions to say no' (Luna, 3).

However, when trust in one person caring for a woman was lost, it did not necessarily mean that trust in all HCPs had to be lost. Becca experienced good care from everyone she saw during her labour and birth, except for one 'registrar' who 'came in and did a VE and she was just awful' (Becca, 3). What was awful was not her medical skills, but that 'she was so dismissive' of the choices that Becca had carefully made (Becca, 3). The episode of insensitive care could have hindered Becca further, should she have received further care from the same person, but fortunately her midwife who was 'really lovely' rescued the situation;

'when she came back in the room she went are you alright? And I was like is it just me or is she really off and she went no, I didn't want to say anything but when I went out the room I banned her from the room and put in an official complaint with the consultant about the way she spoke to you'. (Becca, 3).

Trust and support in personal relationships

Those who experienced a lack of support, or even pressure from partners and family members talked about how this had hindered them. Sometimes this led them to have interventions they later regretted. Victoria felt ambivalent about the membrane sweep she had consented to 'I could've missed the sweep I'm sure it was probably about to kick off anyway' (Victoria, 3). She felt under a little pressure from her midwives to accept the intervention, but that

'I could've held my nerve the problem is... I didn't really have [husband] in agreement with ... minimal intervention. Erm yes I would've like to have held my nerve' (Victoria, 3).

Halle probably experienced the most obvious and direct pressure from her 'auntie', who was 'a senior midwife at [city]'. At over 43 weeks pregnant 'she was quite tearful when she rung up' and 'wanted me to go for a stretch and sweep and just to bring it on' (Halle, 3). When Halle explained that she would not consider that intervention at this stage her aunt

'asked if I would consider going for... a scan where they check the blood flow to the cord from the placenta... which I said I would, more to put her at ease than me' (Halle, 3).

Halle was able to be clear with midwives she encountered during her pregnancy about her intentions not to have interventions, but when the midwife was also her aunt, she felt she needed to find

'something I could do to just put her mind at rest because obviously your family are concerned for you'. (Halle, 3).

Factors that helped build trust

During pregnancy, the factor described by all women who experienced it as most useful was having continuous care from a single midwife, or two midwives. In some cases this was a plan put in place

deliberately, such as Alice's 'named midwife' (Alice, 2). In other cases this came about almost accidentally,

> 'I only had two midwifes throughout my whole pregnancy... it is not a one-to-one service but... the team consisted of about seven or eight [and I saw] the two that were assigned to my particular surgery' (Becca, 3).

This continuous care allowed a trusting relationship to be built between the woman and the midwives. It also allowed for women to have a full discussion of the choices they wished to make once, and not to have to repeat this conversation a number of times. With this model of continuity of carer in place, Becca was able to be 'very clear from the beginning that I wouldn't be accepting induction' and then have the same 'two midwives' see her at every appointment (Becca, 3). Knowing that the conversation about induction had already been had, the midwives 'were wonderful they were supportive all the way through' (Becca, 3). Having established a trusting relationship with the two midwives, Becca also found it easy to 'declined consultant, erm, appointments throughout' (Becca, 3), unlike Luna, who saw a number of different midwives, and early on in pregnancy felt she had been 'tricked' (Luna, 2) into seeing a Consultant and accepting tests she did not want.

This trusting relationship worked both ways, and helped midwives as much as it did women. With labour not going smoothly, Becca's midwife felt it might be better for Becca to be in hospital. The trusting relationship that existed allowed her to tell Becca 'if I wanted to go home that was fine she would come back with me or come and visit me later', but

> 'equally then if I wanted to stay... she had booked out this room for me... [and] I could come and go from there as I please, I didn't have to be in what they call established labour to do it' (Becca, 3).

Becca believed the midwife was genuinely willing to support her in either choice, and that she would be allowed to 'come and go' as promised, so she 'didn't feel like I was kind of trapped there' (Becca, 3). The trusting relationship meant that Becca's midwife was able to propose other options to Becca without making her feel her choices would not be supported. This was an extremely different experience to that of Luna and her midwife, who had a relationship of mistrust, based on their interactions during a previous birth. When Luna's midwife proposed changing the place of birth to

a hospital, without the guarantee of support for Luna's right to make that choice, the resulting situation was 'awful' (Luna, 3) and extremely distressing.

Another factor which helped build trust was when consideration was given to the things that the women themselves felt were important, especially in terms of scheduling appointments, procedures and surgery. For several of the women interviewed, the forthcoming birth was the 'first time' (Alice, 3) they had left their older child overnight. That child was often the baby who the traumatic birth had occurred with, and women who were planning a hospital birth were leaving that child to go back into an environment in which their previous trauma had occurred. It is unsurprising that having some choice and control in when appointments, procedures or surgery occurred was therefore important to the women. For Lea, choosing the day of the week for an 'iron transfusion' in hospital, and then also specifying the day of the week for her 'induction' that caused least disruption to her existing child was very important (Lea, 3). For both procedures she was able to choose a day when her child was 'at nursery' (Lea, 3) and was therefore less unsettled from her usual routine. Similarly, during the induction, Lea found 'the midwife' checking 'oh is anyone coming in with you', and on finding her husband was '20 minutes' away saying 'okay, well we'll get everything ready and we won't plug it in until he's here' a helpful acknowledgement of what was important to Lea herself (Lea, 3).

For most of the women birthing in a hospital, continuity of carer was not a possibility during labour. When a midwife 'handed over' (Lea, 3) to another midwife, what mattered was that information was passed from one midwife to the next, emphasising the things that were important to the women themselves, and that this was done in front of the woman. For Lea, observing the midwife who had been caring for her tell the new midwife 'the first thing you need to do is read [Lea]'s birth plan' was very reassuring. In this way, the midwife who was leaving could act as an advocate for the woman, without the woman having to prepare to assert her choices to an unknown reception.

Alongside the importance of handing over information from midwife to midwife, women stressed how helpful they found it if whoever was caring for them reading their notes and birth plans thoroughly

'she was sat in the room with me and [partner]… reading through my birth plan and everything, for quite a while… she really spent time reading my notes, finding out what the situation was and everything, which was really nice' (Lea, 3)

The experience of having been cared for sensitively and having had her choices respected remained with her, and when things went wrong 'it actually didn't panic me to go back into theatre like I thought it would' (Lea, 3). Good care may therefore be a protective factor against a potentially traumatic birth, even when a woman has had a previous traumatic birth.

With so much invested in birth plans, it was not just important to women to know that midwives had read them. If the birth involved a surgeon or an anaesthetist, and they read through the birth plan, that also built trust

'The consultant came in… he was lovely… he went through it with me and my whole birth plan and he was like yeah we can do that it is no problem, the anaesthetist was the same' (Becca, 3).

Not only was it important to women that information had been passed between HCPs, or notes and birth plans had been read, but that this had happened in front of them, so they knew it had been done.

13.4 'Little things' that were important

Discussion of birth choices often focus on choices around place of birth or method of delivery. These things were important to all the women in this research. However support for choices which might be regarded as little choices by HCPs, or even the women themselves, were equally as important in building or losing trust, and were therefore not actually 'little things' (Alice, 3) at all.

For several women giving birth by caesarean section, what happened during the procedure was important. Alice wanted to see her baby being born. The theatre team 'lowered the screen' so she 'saw her literally coming on out of my tummy which was really nice'. They also had the opportunity to get 'really nice pics of her actually coming out' (Alice, 3). This feeling of connection to the birth of her child, after two traumatic births, was, for Alice, 'really really important' (Alice, 3).

Not being separated from their baby, even for a few minutes, was extremely important to many of the women interviewed. In Taylor's case, this stemmed from having been separated from her first baby for some time after birth, and talking to the midwife as they went into theatre 'I was so like tearful thinking I just wanted him desperately to stay with me' (Taylor, 3). The midwife reassured her that 'unless there's something really serious' then her baby would 'only go… to be checked over' at the 'other side of the room' to her. But even that was too far for Taylor, who needed 'to be able to see him' (Taylor, 3) at all times. Her midwife listened, and 'changed the theatre' to be able to 'bring the little incubatory thing in over here so he was near me' (Taylor, 3). This small change made a 'world of difference' (Taylor, 3) to Taylor.

It is perhaps significant that this issue of having the baby with them before they are 'cleaned' or 'dressed', and not having them out of sight, was of greatest importance to women who were planning caesarean births (Alice, 3). These women knew that they would be physically immobilised, and therefore having agreed support for their smallest of decisions beforehand was crucial, because they would not be able to physically insist on them at the moment of birth.

Small things did not stop being important after the birth. It was important to all the women that their feeding choices were respected and supported. This did not only mean the choice to breastfeed or use formula, but littler choices. Alice was intending to breastfeed, but her baby's 'blood sugars were really quite low' (Alice, 3). Anticipating this, because it had happened in a previous birth, Alice had 'been like expressing… syringes to take with me', but the midwives refused to give these to her baby, and 'insisted that she had to have the formula' instead (Alice, 3). They also said 'we're gonna give it out of er the cups' (Alice, 3). Alice felt choice had been removed from her at this point, because she was still unable to move after her surgery, and could only say 'it's… not what I would've like to happen' (Alice, 3).

Other small things that were important were not related to medical aspects of childbirth at all, but to the wider experience of becoming a new mum or having a new baby. Choosing both the first name and surname for her new baby was especially significant for Luna. After her first baby

'died… we discussed, what we would call future babies and at the time, we agreed that any future boy would be called [name]' (Luna, 3).

The decision was made 'while we were having sex', but having discovered her partner's infidelity at a late stage of pregnancy, and then having been left by him, Luna could not use the name they had chosen 'because of the circumstances in which we agreed because it feels like a big massive fuck-off lie' (Luna, 3). The surname of the baby was also contentious. Luna and her ex-partner were not married. Her first and second child had the same surname as her ex-partner. In the final interview, Luna talked about how unhappy it made her that she had a 'different name' to her three children, and talked about her plan to change her name 'by deed poll' (Luna, 3). She was concerned that this would cause 'a shit storm' with her ex-partner, who would think she was a 'weirdo… stalker', but she felt that she was not taking 'his name', but rather 'taking the children's name' (Luna, 3).

Sometimes the little things that were important were very positive. Alice described how pleased she was that after she had had her baby 'the childminder' took her children 'downtown' and 'let them choose a big balloon for me' (Alice, 3). She had 'never had a balloon before' (Alice, 3) when she had given birth, and part of marking this birth out as a different and positive experience to her previous births was that she wanted to have one. She said 'I know it sounds stupid, but I really wanted one' (Alice, 3).

Other little things that were important were ambiguous still at the time of the final interview. Rachel had a scar that 'was raised' and looked like 'train tracks' after her revision surgery following her traumatic caesarean (Rachel, 3). In this birth, the surgeon had 'cut all of that away', 'chopped out all the' previous scar (Rachel, 3). Her scar looked different now, 'so the scar is not raised anymore it is sort of indented and all the little dots have gone' (Rachel, 3). She did not feel strongly that this was either positive or negative, instead she had subtle mixed feelings about it, describing that the 'visual reminder' of her traumatic birth had gone, but so had a piece 'of my history' (Rachel, 3). She described it as the surgeon having 'cut away all the old story' (Rachel, 3).

13.5 Special treatment

Several of the women interviewed felt they had received different, and better, treatment to that which other women might receive. They explained the reasons they felt they had received different treatment in several ways.

Two women's pregnancies continued for longer than normal. Halle gave birth at '43 [weeks] plus five [days]' (Halle, 3), whilst Becca who gave birth at 42 weeks and five days gestation and 'felt like the most pregnant person ever' (Becca, 3). Both women had had long pregnancies in the past, and both were expecting this pregnancy to last longer than 40 weeks. Both were aware that they might experience pressure to have an induction of labour, but neither did. Both women were very pleasantly surprised to be so supported, but felt that HCPs saw them as 'different to other people erm, not in a bad way just different like' (Halle, 3). Halle described how when she went in for a scan, already over 42 weeks gestation, and with 'reduced movements', she found the maternity staff were

'actually they were over the top, really really nice about it... they were really,
I'd say careful about what they were saying… aware of what I wanted I think (Halle, 3).

Halle was told that she would be offered an induction if she wanted, but that they knew she was intending to go home and continue with her plans to freebirth, and that this was supported. However while she was on the bed, other women were being treated in the same room, and were being treated very differently

'obviously curtains aren't soundproof and you can hear what they are saying to other people …and they said the next stage from here is induction… no one was really told that they can go home and have a home birth if you want' (Halle, 3).

Halle felt the difference in treatment could be about both her personality – 'I am quite opinionated about things that have happened or will happen', but also about the fact that she has a professional role in relation to the Maternity Services because 'I have sat on the maternity services committee' (Halle, 3).

Becca described the difference in how she was treated as 'being given celebrity status', in that she was not pressured to accept an induction, and was allowed to remain 'on the unit' in 'early labour' and to 'come and go as we pleased' (Becca, 3). Like Halle, she felt that difference in what was possible for her, and what other women experienced might have been that

'they just knew that I knew my stuff and that I was determined and that I probably had a bit of a don't mess with me sort of attitude... I had made my views quite clear beforehand so, I guess they knew they weren't going to get anywhere with me (Becca, 3)

Rachel also felt that she had received very positive and rather special treatment, in having the Consultant she had had an appointment with carry out her surgery. She had not been told this would happen, and had not requested it, but she thought

'he made a real effort to make sure that he was on duty and that it was him doing the surgery' (Rachel, 3).

In the one appointment they had, he had also mentioned a specific anaesthetist who had a 'similar [professional] background' (Rachel, 3) to Rachel, and this was the anaesthetist who was present during her surgery. Rachel talked at length about how reassuring and relieving she found this, and reflected that she felt it was

'probably as much professional courtesy as much as, erm, the needs of a patient' (Rachel, 3)

that the Consultant had arranged her caesarean to be when the staff rotas made this possible. But she also wondered if the Consultant could have arranged this not because she was a fellow medical professional, but in view of her previous trauma – because 'he knew what I went through before' and that

'he was aware that I had the specific need about not be left in the hands of a total stranger' (Rachel, 3).

13.6 Postnatal

<u>How women felt after the birth</u>
Following the latest birth, women had a range of reactions in how they now felt about their previous births. Women who had a positive birth this time experienced mixed feelings when reflecting on their previous births. For some, this experience helped them to heal from the emotional wounds

their previous births had left. After successfully breastfeeding her new baby, Taylor looked with a new, more forgiving perspective on what she had previously seen as her 'failure' to breastfeed her older child

> I definitely shouldn't have beaten myself up all that time with bottles, it just wasn't worth the, the negativeness that I put on myself then, not at all (Taylor, 3)

Conversely, some women found that having a positive birth this time made them more regretful about their previous birth. Comparing her first and second births, Lea felt

> 'it's definitely there sometimes; that feeling, sort of, well, why couldn't I have done more' (Lea, 3)

in her first birth. Similarly Halle said 'I just wish I had done it before', although she was clear that there was a specific reason she had not been able to have the birth she wanted either of the previous times – 'I didn't know enough' (Halle, 3). Not having enough knowledge had led her to go 'into my first birth with my eyes quite closed really', which meant she 'was probably talked into things that I shouldn't have been' (Halle, 3). In this way, a positive birth could be both healing, and also leave some women with more regretful feelings about their previous births.

For some women, this birth had improved their relationship with their partner. For Rachel, 'rehearsing' led to conversations with her partner about how they both had felt after the previous birth. She found that he 'hadn't really realised quite how let down I felt' (Rachel, 3). She saw the situation as 'this unexpected opportunity to revisit the whole thing both for myself and with [my partner]' (Rachel, 3), and found that talking about what had happened in the past brought them closer together. Quinn's relationship with her partner had also improved following her most recent birth. After her previous traumatic birth 'it took years for me to be able to have sex'. However

> 'since the birth… I actually feel like I want to have sex… I have the oh I want to have sex feeling' (Quinn, 3).

Two women experienced their relationship breaking down in late pregnancy or the early antenatal period, in ways which were directly connected to their previous traumatic births. Luna's partner

explained his infidelity and subsequent leaving of the relationship was because she had been 'depressed' following the death of their first baby during labour, and then 'wrapped up' in their second child (Luna, 3). Lea and her partner had a difficult time after the traumatic birth of her first child, attempting to 'just battle on and just kind of forget about it'. Following the birth 'I'm still at my mum's, with the two girls', and she had 'made a decision in my head now that I'm staying' and that she did not 'want him to come back' (Lea, 3). The effects of a previous traumatic birth could affect women's relationships with their partner even after a subsequent birth, regardless of whether the subsequent birth was a positive experience.

In these final interviews, several women talked about the guilt they had felt about their traumatic birth – 'things went wrong, and were horrible… I think I blamed myself a lot' (Lea, 3). Feeling guilt affected how women felt about themselves

> 'I was just so anxious, it was just, it would be like a really physical thing, it wasn't just I feel like this… that was life for seven years. Seven years I lived like that, my default being panic' (Taylor, 3).

When they had then experienced a positive birth, these feelings had the potential to undergo dramatic change, altering how women felt about themselves. For Lea, experiencing a positive birth was the turning point where she could 'think, yeah I need to let go of this guilt' (Lea, 3). For Taylor, the shift in how she felt about herself was even more dramatic 'I felt like a different person' (Taylor, 3). A few weeks after giving birth she

> 'was reading through some of my diary… and … it's crazy, I feel like I'm looking at a different person… who would've thought that effectively a 45minute experience could do that?' (Taylor, 3).

The difference was noticeable in the speed at which she spoke during the interview – in earlier interviews it had been hard to keep up with the speed at which she spoke, whereas in the final interview, she exuded a sense of calm and confidence. Taylor described this as feeling

> 'genuinely… like I've gone right back seven years of being… never quite right' and now being able to give herself permission – 'I've kind of gone okay you can actually start living life again without that holding over you, over everything' (Taylor, 3).

<u>Postnatal choices</u>

Throughout the interviews during pregnancy, women found it surprising that they were asked about postnatal choices. Many said they weren't making choices postnatally, or that they 'hadn't thought about it' (Victoria, 1), but then described what they intended to do. There was a sense that postnatal choices were not choices in the same way that pregnancy and birth choices were choices, because the women did not feel these choices required support from any external agency. In the postnatal interviews, women easily described postnatal choices they had made in relation to caring for their baby. No women described any postnatal choices they had made for themselves, other than Becca's choice to be 'sterilised' (Becca, 3) during her caesarean section.

A number of women experienced difficulties with breastfeeding. Over half of the women interviewed reported that their baby had been born with a tongue-tie that needed correction to establish successful breastfeeding. Sometimes this support was easy to access, but for a number of women, it was difficult. Alice felt she appeared to the midwives as 'a bit of a crazy woman' because she insisted a tongue-tie was present, based on her experience with 'my middle one had a tongue tie as well', whereas the midwife caring for her 'Said oh no, no, no, you haven't got one' (Alice, 3). Eventually she

> 'saw a different midwife who just kept banging on about it and then eventually gave me a referral' (Alice, 3).

13.7 Summary

The time immediately before the birth was a time of intense emotions for most women, regardless of whether a caesarean, vaginal, home hospital or freebirth was planned. Receiving sensitive care from a known professional who was supportive of a woman's birth choices was the one thing that helped women the most. Women were actively looking to identify those HCPs who they could trust to support them, and to build a relationship with those people. However the desire to trust was tempered by their previous experiences, which made them wary of trusting blindly. Where women encountered a lack of support from professionals, it had the potential to be devastating. Support from partners and family members was also very important, but a lack of support from these people about birth choices was rarely as devastating as a lack of support from a HCP.

Women prepared carefully for birth, with a focus on avoiding a repeat of their traumatic birth. Some women wrote these plans down, for others, writing the plans down felt unhelpful, either because they felt that what they wanted was not possible, or because they wished to protect themselves from disappointment. Women took a very active role in ensuring that those around them, whether partners, friends or HCPs, understood their previous experiences, and were willing to support the choices they wanted to make this time. For some women, this involved compromising their choices in order to secure the support of partners or HCPs. In some cases, this put strain on relationships, both with partners and HCPs – in some cases the strain was too great for those relationships to survive. For other women, preparing with their partners brought a renewed sense of closeness, and an opportunity to revisit unprocessed feelings from the previous birth.

A positive birth experience had the potential to be dramatically life changing, for both the women and their relationship with their partners. It could change how women felt about themselves, their previous experiences, and their partners.

None of the women interviewed in the research identified their most recent birth as a traumatic experience. However the research was conducted at a relatively early point postnatally. It may be that, as with diagnosable conditions such as PTSD, a traumatic birth can only be identified as such once some time has passed.

Chapter 14 – Discussion and theories emerging

The objective of a Grounded Theory Method research project is to

> 'develop an inductively derived grounded theory about a phenomenon' (Strauss & Corbin, 1990, p.24).

The previous six chapters offered a close examination of the different categories emerging from the data at each timepoint in pregnancy or after birth. This chapter situates issues arising from the data as a whole within the literature, and explores the theories emerging from this.

The process of coding, categorising and discussing the data constructed a picture of women moving through an internal emotional journey, as they progressed through the perinatal period. Many of the categories drawn from the data are interdependent. They combine together to suggest explanations of different aspects of this journey. From these combinations, two interlinked theories have been constructed. The first is the sense of the pregnancy and birth as a series of battles. The second is a theoretical model of the factors that support pregnant women who have previously experienced a traumatic birth. The two theories are discussed below. Finally, emerging from these theories is a model care pathway for pregnancy subsequent to a traumatic birth.

14.1 Battles for birth

Clausewitz on war

Algire (1995) uses the work of Carl Von Clausewitz, a nineteenth century military officer, to describe how rights in childbirth at a societal level have been fought for, and how they should be fought for in the future. In a series of eight treatises first published in 1832, Clausewitz sets out the nature and theory of war, how to strategically plan both offence and defence, and how to end a war. Algire (1995) describes his work as presenting

> 'concepts basic to any successful struggle from reclaiming conquered territory to reclaiming birth' (p.23).

and uses these concepts to present a sociology of childbirth in the context of society. However, Clausewitz's work is perhaps even more pertinent to the approach of women who have experienced a traumatic birth at an individual level.

Clausewitz describes war as a series of battles, none of which can determine the outcome of a war in isolation. According to Clausewitz, the goal of the force in entering the war determines how they should strategically plan the war, how they should carry out their battles, and what victory consists of. Battles cannot be fought except by 'mutual consent' of the opposing forces; however here he draws a distinction between offensive and defensive sides, commenting that if the offensive side 'regularly entrench themselves in their camps' (p.741), this can be seen as consent to enter battle by the defensive side – a factor which has significance for women battling with maternity services, as will be shown later.

Clausewitz draws a strong distinction between operational and strategic victories, viewing operational victories as a potential distraction from the achievement of strategic battles, unless they are underpinned by a solid strategic plan. He puts forward a strong case for strategic planning to be carried out in a way that is reminiscent of a game of chess, planning every potential move and counter move throughout the war, before the first battle is begun.

He also details the effects of a victory or failure in a single battle upon the opposing sides, arguing that the 'chief effect is upon the vanquished' who 'sink much more below the original line than the conqueror raises himself above it' (p.752). He paints a picture of the psychological preparations for war, the building up of the desire for victory, and then the crushing emotional effects upon the losing side, saying that the effect of losing a battle 'overpowers the imagination'. In this way he urges his readers not to underestimate the psychological effects of losing a single battle on the course of the entire war.

Clausewitz (1832) gave thought to what constitutes the end of war. He argues that the prevailing view that

> 'war is an act of violence to compel the enemy to fulfil our will, then in every case all depends on our … disarming [the enemy], and on that alone' (p.722).

However, he argues that the prevailing view of the goal of war is wrong, because

> 'the idea of a complete defeat of the enemy would be a mere imaginative flight, especially if the enemy is considerably superior' (p.723).

Rather than seeing the 'disarming of the enemy' as the sole successful end to war, Clausewitz defines a number of different possible ends to war, which are dependent upon the original aim of the war. Of most interest in this context is the end to a defensive war. Clausewitz (1832) comments on the

> 'innumerable instances of treaties in which peace has been settled before either party could be looked upon as disarmed' (p.752)

seeing peace by treaty as the successful end to a defensive war.

The following discussion uses Clausewitz's perspective to offer an interpretation of the findings from the research.

Childbirth as battle

There is a substantial history of viewing pregnancy and childbirth through metaphors relating to battle. As far back as 1980, Oakley divided women's postnatal experiences as creating 'victims and victors' of not only childbirth itself, but of the 'medical, social and economic contexts' that the women gave birth in (p.117). More recently, Lyerly, Mitchell, Armstrong, Harris, Kukla, Kupperman and Little (2009) have characterised pregnant women's bodies themselves as a complex and multi-faceted battleground between different social discourses about pregnancy and motherhood. In highlighting the different ways medical intervention, the body itself, and women's own values can be conceived of and discussed, they highlighted the moral battles that are fought over choices pregnant and birthing women make. Many of these choices are ones which the women involved in this research made, sometimes against medical advice, and sometimes whilst facing a battle to assert their right to choose. Looking specifically at birthing women who have previously experienced a traumatic birth, Thomson and Downe (2013) described their experiences as 'A hero's tale of childbirth', again invoking a warlike conquering image.

The findings from this research suggest that pregnant women who have previously experienced a traumatic birth approached their forthcoming birth as a war to be won or lost. However, the sense of engaging in a war was more than a metaphor. For the women involved in this study, the battle was a reality that affected them not only physically and emotional, but also affected how they viewed and interacted with those around them throughout pregnancy.

The potential outcomes women involved in this study were emotionally facing during pregnancy included: their own death (Alice); injury serious enough to require surgery (Rachel); and severe and enduring mental health conditions (Quinn and Taylor). Women feel they are facing these outcomes not because they have a skewed sense of reality, but because these outcomes are ones they have experienced, or come close to, previously.

The nature of the war

The nature of the overall war that these women were fighting – what they are trying to achieve – is deserving of some consideration. It may at first appear that delivering the baby via the method and in the location chosen could be considered victory, but the findings here demonstrate that this may not be the case. Women who gave birth in ways and circumstances they had not planned, or whose births included complications they had not anticipated or desired following the birth of the baby, did not all consider themselves to have lost the war. Rather, what appears to constitute victory for these women is that they were supported to make the choices they wished throughout pregnancy and birth. Losing battles during pregnancy could mean losing the war, even if women experienced the birth they had wanted, and conversely, winning (or better still not facing) battles during pregnancy could be perceived as winning the war, regardless of how and where the baby was born. This fits well with understandings drawn from the wider literature about the protective nature of empathic care during pregnancy and labour in reducing incidence of childbirth related PTSD (Ayers, Bond, Bertullies & Wijma, 2016; Connell, 2015; McKenzie-McHarg, Crockett, Olander, & Ayers, 2014).

Clausewitz defines a range of different positions for forces entering into a war. These include the destruction of the enemy to the point that their forces are annihilated; the overthrow of the enemy and the replacement of the regime; limited objectives in terms of offensive wars that involve seeking to gain only a specific part of an enemy's territory; and defensive positions in which the 'object was keeping possession' (p.754). In interviews, the women certainly did not speak of seeking to destroy

those providing maternity services to them, and nor were they seeking to overthrow those services. Rather, the overwhelming sense of being forced into battle arose when women felt their autonomy was under threat. Therefore, the kind of war women are engaged in is a defensive war, 'keeping possession' (Clausewitz, 1832, p.754) of their right to make decisions. This affects how women may approach the battles, and also how the war can successfully be ended.

War as a series of battles

Clausewitz describes war as a series of battles, none of which can determine the outcome of a war in isolation. This group of women experience pregnancy in a similar way, involving a series of small battles, each of which may confer advantage or disadvantage for the battle of birth. What constitutes a battle varies from woman to woman, and depends on her perception of her previous traumatic birth, and the events of the current pregnancy. For women who have experienced physical ill health in the previous pregnancy(s), medical tests may be a battle they face, against their own body. There is the possibility for every antenatal appointment to be a battle, and the women prepared for appointments accordingly. In interviews women described considering before appointments what might be discussed, offered to them or requested of them. They then prepared their arguments, so that they could fight for the outcome of the appointment that they wanted. Even when a woman discussed having had a positive antenatal appointment, it seemed to do little to alter her perception that the next appointment remained a potential battle. Women seemed to share Clausewitz's concern that territory gained in one battle's victory might be lost in the next day's defeat.

This sense of a series of battles was particularly strong when appointments were with different people – for example if antenatal appointments were with several midwives, or if a woman attended an appointment with a Consultant. An appointment with one person might have been supportive, and a woman might have felt that this person could be someone with whom she can form a treaty. However in most circumstances this potential alliance was only between the woman and the individual HCP – it did not extend to include the person she saw at the following appointment.

The identity of the enemy

In the literature around the battle metaphor for illness, it is frequently either the illness, or the body itself that is seen as the enemy (O'Brien, 2015; Hurley, 2014; Lane, McLachlan & Philip, 2013). Whilst pregnancy is not an illness, women who are pregnant are usually cared for by HCPs, and Maternity

Services are based in healthcare facilities. In literature on battling cancer, one argument put forward for the strength of the metaphor is that it gives the person the chance to 'identify with the powerful armamentarium of the physician-hero' (Hurley, 2014, p.311). For most of the women in this study, it appears that these roles were reversed, with the body (which the pregnancy is currently part of) being the ally, whilst Maternity Services, NHS policies or HCPs became the enemy. However as previous research shows, this is not the case for all women who have previously experienced a traumatic birth. For some women with secondary tokophobia, pregnancy may be the enemy, even though the outcome of pregnancy (a baby) is desired (Hofberg & Brockington, 2000). This difference might be related to the fact that all the women in Hofberg and Brockington's research strongly desired to give birth by caesarean section, whilst the women in this study desired to give birth in a variety of circumstances. The one woman in this study who did feel her body had failed in her previous birth, also felt failed by the HCPs around her, leading her to identify both her body and HCPs as potential enemies.

Clausewitz argued that both sides must consent to a battle existing for one to take place – in this case, the 'other side' of the battle are often HCPs, who are unaware that a battle is being entered into. HCPs are not consenting to enter a battle, do not see themselves as the woman's enemy, and are likely to believe they are entering into a caring relationship. However, Clausewitz also proposed that a defensive force may interpret the actions of a perceived offensive force as consenting to battle if they 'regularly entrench themselves in their camps' (p.741), and the findings from this research imply that this is potentially what is happening for this group of women. In attempting to make choices about birth, the women involved in this study frequently found that HCPs responses focused on national guidelines, local NHS policy or routine practice. This experience is not unique to the women in this study – other literature has reported on maternity HCPs 'increasingly technocratic set of practices' (Malacrida & Boulton, 2014, p.41), resulting in HCPs 'being complicit in ways of working and advising that incorporate a medical model' (Jomeen, 2007, p.19). This affects the information that women receive from HCPs (McAra-Couper, Jones & Smythe, 2011; Jomeen, 2007; Crossley, 2007; Barber, Rogers & Marsh, 2007). Women's choices included consideration of national and local NHS guidance, but also involved other considerations. Kukla, Kupperman, Little Lyerly, Mitchell, Armstrong and Harriss (2009) explain that

'Options that fail to minimize medical risks can still be the most rational choices, given other potential harms such as indignity, abandonment, or alienation, or benefits such as security, fidelity to loved ones, or a sense of comfort with one's own narrative' (p.36).

One of the categories that emerged from the pre-birth interviews was 'struggling to say what you want, struggling to be heard'. Women experienced HCP's responses to their choices being treated as less important than NHS policy. When this happened, a feeling of entrenchment could be engendered. The Maternity Service policy, or the established practice of a group of midwives and/or obstetricians therefore becomes Clausewitz's (1832) 'camp', and responses to women from HCPs which are rooted in the camp are perceived by women as giving the consent to battle. This in turn creates the sense for women that HCPs are a potential enemy. The results of this situation varied, from women seeking to avoid antenatal appointments, to women feeling unsupported by HCPs, and distressed by their exchanges with them.

This situation also impacts on HCPs, arguably having the greatest impact on community midwives. Hunter (2006) describes the additional emotional work midwives have to engage in when interactions with the women they are caring for are 'difficult'. Her findings indicate that this situation arises when 'boundaries of expected relationships between midwife and woman were disrupted in some way' (Hunter, 2006, p.274). She observes that interactions where midwives were most likely to describe women as 'difficult' occurred when women 'rejected exchanges' (Hunter, 2006, p.275) with the midwife. Hunter (2006) describes rejecting exchanges as covering a range of behaviours, from times when women were openly hostile to a midwife, or when they did not respond to friendly engagement, or when they rejected advice given by the midwife. A situation in which a woman perceives the midwife as an enemy is a disruption to the midwife's expectation of that relationship. Examining the categories of 'support and trust' and 'battles won and lost' from the pre-birth interviews, this can lead to women rejecting the advice or services offered. Hunter (2006) goes on to define the consequences for midwives of dealing with these 'emotionally difficult situations', which included midwives feeling 'overwhelmed and out of my depth', and notes that this situation also has an effect on mothers, as some

'midwives manage their emotions by self-protective strategies, such as professional detachment, distancing and task orientation... [which] inevitably affects the quality of care that women receive, and may explain the uncaring attitudes' (p.273-8).

Evidence in the 'Support' and 'Support and Trust' categories across all three groups of interviews showed that some women formed positive relationships with individual HCPs. The conversion of these relationships from potential enemy to ally occurred when a woman felt listened to, understood, and supported by a HCP. They also only occurred when a woman had consistent care from the same HCP.

None of the women in this study viewed their partners as enemies. However, some partners were viewed as allies by the women, whilst other women felt alone in their battles. Which role women saw their partners in depended on their partner's response to the woman's exercise of choice in pregnancy and birth.

Strategic versus operational victories

Clausewitz draws a strong distinction between operational and strategic victories. An operational victory is winning a battle, but unless that operational victory supports a larger strategic objective, it does not affect whether a war is more likely to be won or lost. Clausewitz postulates that having a strategic plan is fundamental to any chances of winning a war.

From the pre-birth interviews, the category of 'Plans for birth' demonstrated that each woman had a strategic plan. The overall aim of each plan was the same – that this birth was not like the last. However, the strategy each woman used to achieve this was different. Each woman's strategy was informed by her previous experience, and specifically was informed by the point at which she was traumatized in the previous birth. This point often involved a loss of control, or a loss of choice. That women wish to exercise choice and to remain in control of decisions during childbirth is well established in the literature (Bernhard, Zielinski, Ackerson & English, 2014; Jomeen, 2012; Jomeen, 2009), as is the connection between being able to make choices, and feeling in control during childbirth (Snowden, Martin, Jomeen & Hollins Martin, 2010). It is equally well recognised through national guidance that women have the right to make choices, and that facilitating choice should be a goal of Maternity Services (NHS England, 2016; Department of Health, 2007; NHS England, 1993). Indeed the first priority in 'Better Births' (NHS England 2016) is 'personalised care… [which] facilitates choice'. However, women's experience of exercising choice and control is complicated by many factors, including the events of childbirth (Meyer, 2013), the interaction between women and HCPs (Crossley, 2007; McCallum, 2005), and the context of giving birth within a medical system

(Malacrida & Boulton, 2014; Crossley, 2007). Whilst the discourse of choice has become stronger over time, Tew (2013) argues that this has not been reflected in women's experiences, and Cahill (2001) explicitly states that the previous four decades have brought about a

'steady erosion of maternal choice, control and satisfaction in relation to many aspects of pregnancy and labour' (p.335).

The women in this research were not making strategic plans in reaction to previous occasions when their choices had been removed by the events of childbirth, or occasions when they had chosen to surrender control to HCPs through positive interactions. Rather, as shown in the category 'Plans for birth' drawn from the pre-birth interviews, their plans for birth were designed in reaction to occasions when their choices had been removed from them by a HCP in their previous birth(s). These occasions were perceived in retrospect as a betrayal. Each woman's main strategic objective was to avoid a re-occurrence of that situation in this birth.

To achieve this objective, women had a strategic plan for this birth. Sometimes this included a written birth plan, but women's strategic plans extended beyond just a written plan. Their strategies incorporated how they conducted themselves in relation to HCPs, whether they requested, accepted or declined tests and other interventions throughout pregnancy, and how they interacted with partners, family and friends in relation to their pregnancy. Women's plans variously included; the method of delivery, the place of birth, individuals involved in the birth, the care women wanted during labour, and the model of care desired during the entire perinatal period. It is common for all pregnant women to make these choices, and to strategise to be able to implement them (Malacrida & Boulton, 2014) but for this group of women, these choices were invested with a much greater significance. As the data shows, women's strategic planning extended into their antenatal choices, as they worked backwards to consider whether accepting or declining specific tests would affect the support they received for their birth choices.

Most of the choices that women wished to make were difficult for them to assert without support. They therefore needed to form an alliance to achieve their strategic plan. Some women viewed their partner as an ally, and sought to ensure that their partner was fully informed as to the strategic plan, and of their responsibilities as an ally within that plan. If a partner did not understand the full importance of this to the woman, it caused difficulties. Other women had lost trust in their partner's

ability to be an ally, as a result of their previous birth experience, and did not seek to make them a part of the strategic plan in this way.

Effects of winning and losing

Clausewitz argues that, in every battle, the effect of a victory has a greater impact on the emotional wellbeing of the vanquished than the victor. All the women interviewed experienced interactions with HCPs, and sometimes partners or family and friends, which could be characterised as battles, some of which were directly described as such by the women. No woman won or lost every battle she faced. Winning the overall war has been defined earlier in this chapter as women being 'supported to make the choices they wished throughout pregnancy and birth'. Some of the women interviewed won the overall war, whilst other women lost. Women's responses to winning and losing the war, and winning and losing battles, were complex. Winning the overall war had a significant effect on some women's emotional wellbeing, a finding that is congruent with findings that a positive birth experience could be a redemptive birth (Thomson & Downe, 2010). For other women, the positive birth brought about a subtler change. The effects of having had a further negative birth experience were not explored in this study, but during the postnatal interviews, women who had experienced this showed signs of distress, such as crying or becoming angry when discussing their birth.

Winning and losing specific battles seemed to have a greater effect on many of the women than winning the overall war. This is supported by the literature that women who feel in control of external factors, such as 'what staff do to you' have a greater sense of satisfaction with their birth experience (Green & Baston, 2003), and have better perinatal outcomes, particularly in relation to emotional wellbeing (Ford & Ayers, 2011; Larkin, Begley & Devane, 2009; Ayers & Pickering 2005). Women's embattled feelings seemed to be moderated or heightened during pregnancy, depending on whether they felt well supported through each antenatal choice they made. This affected their emotional responses upon entering into labour and/or birth.

Ending the war

It is important to note that women did not make a conscious choice to go into battle, it is rather a consequence of their previous experience. The way out of the battle, into a situation where the relationship between woman and midwife can be a caring one was through trust, creating 'a treaty' (Clausewitz, 1832), and converting a potential enemy into an ally. As evidenced in the findings, what

each woman needed from the treaty is different, each woman had an idea of which HCP was able to agree the treaty with her. This was usually someone at a high level within the NHS Trust, such as a Consultant, the Head of Midwifery, or a Supervisor of Midwives. Women sought to secure a treaty at an early stage in pregnancy, which unfortunately is at odds with the workings of many NHS Trusts, which assume plans for birth should be made at the end of pregnancy.

For many women, the birth plan was the physical record of this treaty. It became a contract between the woman and every HCP that the woman met. Research amongst generic groups of pregnant women shows that many who formulate birth plans do so in order to exert some form of control over their experiences, to better communicate their wishes to HCPs (Kaufman, 2007; Perez & Lepsch, 2005; Brown & Lumley, 1998), or to create a strategic plan for birth (Malacrida & Boulton, 2014). However, this group of women appear to be unique in investing so heavily in the birth plan as a formal contract. The driving desire to have the birth plan agreed by a specific person also appears to be distinct.

The birth plan also served as a shield that women could take into battle with them. When serving as a shield, the birth plan needed to belong to the woman only. If the HCP suggested negotiating the birth plan, or constructing it jointly, this was not well received, perhaps because it could affect the efficacy of the shield.

In this study, some women who had had more than one traumatic birth, had used a birth plan in this way in the second traumatic birth, only to see it not be followed. For these women, the birth plan was perceived as a false shield, a treaty which would not be honoured, and which gave misplaced confidence. For these women, the birth plan could be another enemy. They resisted making one, because making one could cause harm, as it did last time. These women may then need a different way of recording the alliance between themselves and HCPs.

It is clear that ending the war is in everyone's interests, and that doing so requires the involvement of women, their partners, and HCPs. To understand how this battle mentality can be averted, the next section will turn to look at the factors which supported the women in their pregnancies.

14.2 Factors that supported women

For pregnant women who have previously experienced a traumatic birth, thinking about the impending birth in an early stage of pregnancy provokes anxiety and worry. For those supporting women in these circumstances, it is useful to identify interventions or ways of working which lessen this worry. These interventions serve to build some of the trust between woman and HCPs that is needed for women to exit the battle mentality. This section will therefore aim to draw together the factors that the women interviewed collectively found useful, and from this, propose a model care pathway for women who have previously experienced a traumatic birth.

Acknowledging the trauma

Women who have experienced a traumatic birth need their experience to be listened to, believed, and acknowledged, but may not have confidence in voicing their experience, because they fear it will be dismissed (Moyzakitis, 2004). The need for acknowledgement displayed by women in this study is consistent with Thomson and Downe's (2010) description that women involved in their research required validation of their distress. Having their experiences diminished or brushed aside as unimportant put women into a defensive space, where they had to fight in order to receive the recognition of their experience. Even worse were the times when women were told their traumatic birth was their own fault, either explicitly, or through other people identifying the women's choices or their physical bodies as the cause of the traumatic birth, a finding consistent with previous literature (Jomeen, 2010). When this message was mediated through an HCP, it had the potential to create ongoing difficulties for women in building a trusting relationship with any HCP met subsequently.

In some cases, the trauma that women had experienced came primarily from the care they had received in their previous birth. In other cases, it was the events of birth that were the primary cause of trauma, but perceptions of insensitive or unsupportive care had played a role too. In these cases, women needed the HCPs caring for them in their new pregnancy to acknowledge not only that they had had a traumatic experience, but that the care received from individual HCPs had formed part of that trauma. This finding is consistent with other literature in the field, such as Thomson and Downe's (2016) analysis of the support needed by women following a distressing birth, and Slade and Cree's (2010) recommendations for women who had had previously experienced a traumatic birth, in their proposed psychological plan for perinatal care. This finding also fits with the British

Psychological Society's briefing paper on the role of Perinatal Clinical Psychology (McKenzie-McHarg, Scott-Heyes, Slade, Burns, Jones, McGuinness, Sharp & Wittkowski, 2016)

Providing information

All pregnant women need access to good quality information about pregnancy and birth, available in a variety of formats (McCants & Greiner, 2016). Pregnant women who have previously experienced a traumatic birth are no different, but they may need more specialist information to assist their understanding of their previous experience. There are many ways this information could be provided, and different ways may be best suited to different women. One way in which many women in this research had obtained information was via the internet. Wald, Dube and Anthony (2007) describe how the advent of the internet has fundamentally changed the interactions between HCPs and patients into a three-way relationship, now involving the patient, the HCP, and healthcare information obtained via the internet. This contemporary kind of information can have disadvantages, as information may not be reliable, but they also note that it can result in more efficient appointments, as patients may arrive at appointments with a fundamental level of understanding, and that this can in turn lead to a more 'participatory decision-making model' and 'can add validity to the concept of informed consent' (Wald, Dube & Anthony, 2007, p.222). Given the high importance of participatory decision-making to this group of women, finding ways for HCPs to interact appropriately with information women have obtained via the internet would be useful.

Some women involved in this research received that information through a meeting with a senior midwife, often referred to as a Birth Reflections or Birth Afterthoughts meeting. These meetings are generally offered as a standalone appointment, usually held somewhere other than the hospital in which the birth occurred, in which the medical notes and the woman's own account of her experience are discussed. Explanations of aspects that were unclear at the time may be given, and alternative courses of action that could have been taken are discussed. In the interviews, women who had experienced these meetings generally found them useful, and found that some of their questions about what had happened, and what could be done differently in this birth were answered. However, after these meetings, women often continued to look for further information, and then had limited access to HCPs to discuss what they had found. Therefore, it would be useful for this group of women to have access to ongoing or repeat appointments of this nature. As discussions of what happened previously lead into discussions of what choices a woman wishes to make this time, a question arises of who should conduct these meetings. It may be that it is useful

to have them conducted by a HCP involved directly in the woman's care, rather than by a Head of Midwifery (HOM) or Consultant Midwife, or a joint meeting may be most useful. It is also important that HCPs assist women in finding reliable sources of information, and are prepared to review and discuss information that women bring to them. All of this does pose challenges to an already overstretched Maternity Services. However, if these interventions are able to reduce the numbers of women facing long term negative sequelae from a traumatic birth, savings may be made in other areas of health services.

There is mixed evidence about the use of debriefing meetings as an intervention after a traumatic birth. Some literature suggests that midwife-led debriefing can help women to process the events of a traumatic birth (Collins, 2006), whilst randomised controlled trials (RCTs) focussed on specific mental health conditions suggest women appreciate debriefing sessions, but in terms of psychological benefits, the evidence is inconsistent about whether debriefing reduces symptoms of PTSD or depression after birth (Baxter, McCourt, & Jarrett, 2014; Cunen, McNeill, & Murray, 2014; Peeler, Chung, Stedmon, & Skirton, 2013).

Debriefing for women who have experienced a traumatic birth is controversial, because of the links to PTSD. It is widely acknowledged that some women develop PTSD following childbirth (James, 2015; McKenzie-McHarg, Ayers, Ford, Horsch, Jomeen, Sawyer, Stramrood, Thomson, & Slade, 2015), and also that it is underdiagnosed (Yildiz, Ayers & Phillips, 2017; O'Donovan, Alcorn, Patrick, Creedy & Devilly, 2010). The result is that women presenting for a debriefing following a traumatic birth may or may not also have PTSD, and evidence for psychological debriefing following other types of traumatic events shows it can lead to increased PTSD under some circumstances (Rose, Bisson, Churchill, & Wessely, 2002). UK guidelines for PTSD treatment therefore explicitly state that debriefing should not be used (NICE, 2005), however whether this should apply to the midwife-led debriefing detailed above is difficult to determine, partly because of huge variability in what midwife 'debriefing' comprises (Steele & Beedle, 2003). Recent work by Sheen and Slade unpicks some of these issues, arguing a case for targeted debriefings, and specifying what these should involve. However, their work is primarily concerned with whether debriefing 'reduce[s] symptoms of PTS or depression', and/or whether it is 'efficacious… for women who experienced a traumatic birth' (Sheen & Slade, 2015, p.308-320). For the women in this study, engaging in a birth reflections meeting was not primarily intended to result in psychological or emotional improvement, but was used by the women as a tool to help them prepare for their forthcoming birth. As no evaluation of

birth reflections meetings as a tool for supporting a subsequent pregnancy have been conducted, it is difficult to know whether this is an effective tool. Further research to establish this would be useful.

<u>Building trust</u>

The pivotal issue throughout this research, around which all other issues interwove, was that of trust and mistrust.

Most of the women had entered their previous birth assuming that trusting HCPs was an appropriate behaviour. The traumatic birth had then served as what Holmes (1981) describes as a 'strain-test' for the trust invested in the relationship. In strain-test situations, one individual is highly outcome dependent on another person, but the actions that would promote the individual's own interests differ from those that would benefit the other. In the case of traumatic birth, the birth itself had provided the strain-test, but it was the actions, inactions, or even simply words of the trusted HCPs during that crisis had resulted in the women experiencing a loss of trust, as they demonstrated the priorities of the HCPs differed from the priorities of the women. The women had then lost trust in not only the specific individuals caring for them, but had come to the conclusion that trusting either HCPs as an entire group, or specific sub-groups such as midwives or Obstetricians, was unsafe.

Trust is both a much used and poorly defined concept in the social science literature. Goudge and Gilson (2005) define trust generally as

> 'a judgment in a situation of risk that the trustee will act in the best interests of the trustor, or at least in ways that will not be harmful to the trustor' (p.1440).

In a healthcare context, Østergaard (2015) has offered this refinement of Goudge and Gilson's definition:

> 'In this sense trust is a voluntary course of action which is taken in a situation without full information, based on the optimistic expectation that the trustee will do no harm to the trustor' (p.1047).

She argues that trust within a healthcare relationship is widely seen as fundamental, because trust has the potential to improve the working relationship between the HCP and the patient. Therapeutic collaboration between HCP and patient is a precondition for the production of health. She states that

> 'It is easier for the patient to disclose symptoms and to comply with treatment instructions if she or he has faith in the provider's sense of confidentiality, competences and respect' (Østergaard, 2015, p.1048).

It is a common finding that women who have previously experienced a traumatic birth may experience a lack of trust in those around them during a subsequent pregnancy (Beck, 2004a). Taking Østergaard's (2015) definition of both the nature and role of trust, it is easy to see why this would be. When women have had a traumatic birth, their faith in the provider's competences are necessarily damaged. This lack of trust poses a difficulty for HCPs caring for such women, as trust is fundamental to many aspects of healthcare (Carter, 2009), perhaps especially midwifery. Without a trusting relationship between woman and midwife, the midwife's ability to provide a caring role is limited (Gould, 2004). For these women, rebuilding trust with HCPs can only begin with an understanding that trust was previously given, and was betrayed, or even abused in order to coerce women (Gould, 2004). The midwife caring for a woman who has experienced a traumatic birth and has lost trust in midwives faces a difficult job, as the midwife must give this acknowledgement of the past, and at the same time, attempt to build trust with a woman who may present as highly suspicious of midwives, or of HCPs in general. Only once these two tasks are achieved can the midwife efficiently offer healthcare.

Simpson (2007) identifies 'trust-diagnostic situations' that occur in interpersonal relationships, in which the first individual notices whether the second individual

> 'Make[s] decisions that go against their own personal self-interest and support the best interests of the [first] individual or relationship' (p.265).

In the context of this research, a trust-diagnostic situation from the women's viewpoint could be characterised as one in which there is potential conflict between the interests of the woman and the HCP, or in any situation in which the HCP must act or speak in a way that shows whose interests

she is following. Having experienced a breach of trust in their previous birth, the women interviewed were highly alert in any potential trust-diagnostic situation. Any suggestion that a HCP's interests or views might not be compatible with the woman's own interests became a reason to immediately lose trust. This reinforced the women's previous experiential learning that HCPs were not to be trusted. Each time a HCP failed in a trust-diagnostic situation, the woman became more mistrustful of HCPs as a whole.

Simpson (2007) notes that these situations often occur naturally, but that people

> 'occasionally create trust-diagnostic situations to test whether their current level of trust in a partner is warranted' (p.266).

The findings from this research show that as well as being alert to naturally occurring trust-diagnostic situations, women did on occasion engineer situations in which they could test whether they would be supported by a HCP. When women engineered such situations, they frequently did so by making a request to a HCP which was perceived by the HCP as being unusual. It is noted in the literature that women who have had a previous traumatic birth are more likely to make birth choices which are outside the dominant paradigm of birth within their society (Thomson & Downe, 2010; Beck & Watson, 2010). Findings from this research suggest that one factor influencing this is that women are making such choices in order to engineer trust-diagnostic situations. One of the results of making a non-normative birth choice, however minor, is that a HCP has to articulate either support or a lack of support for the woman's right to make this choice. Therefore, the significance of non-normative birth choices (and the importance of unequivocal support for women's right to make such choices) should not be underestimated by those working with this cohort.

At the same time, the relationship between HCP and pregnant woman is not a situation of interdependence, with both parties having a similar level of vulnerability with regard to each other. Rather, the woman is dependent on the HCP for medical assistance and emotional support, whilst the HCP is in turn both dependent upon and accountable to her employer. Dealing with the woman's vulnerabilities first, even if a woman chooses to opt entirely out of the system by freebirthing, she is still dependent on the HCP to provide her with access to any antenatal or postnatal care she requires. She is also vulnerable to HCPs' perceptions of freebirth, for example should they believe that freebirthing is a safeguarding issue and report her to Children's Services (Feeley & Thomson,

2016). This dependence and vulnerability create a situation in which the pregnant woman has a real need to identify HCPs whom she can trust. At the same time, the HCP is dependent on their colleagues, their immediate managers, and their employer for their continued employment, and professional career.

If a HCP acts in a way which is not in accordance with their institution's policies and procedures, they may face disciplinary action. The vulnerabilities a HCP may face can therefore constrain their reactions to the woman they are caring for (Allan, Odelius, Hunter, Bryan, Knibb & Shawe, 2015). Marshall (2005) found that informed consent to procedures during labour was often seen as less of a priority than adhering to hospital policy, by both women and midwives. In 2010, Hollin Martin and Bull showed that 'midwives' decisions are profoundly influenced… [by] the presence of senior staff' (p.188). This effect was consistent even when the decisions made should not have been the choice of the midwife or the senior midwife, 'but the preference of the childbearing women' (Martin, Bull & Martin, 2004, p.128). These results relate to the influence exerted on the midwife's action by the presence of someone who is senior in the hierarchy, but a similar effect may occur even when others are not present.

This is not to suggest that all midwives are more likely to practice in line with their institution's policies than they are to support women's choices. Indeed, many of the women interviewed described receiving out of guidelines care, as a result of their informed choices. Work by Jefford and Jomeen (2015) identified that in some cases, midwives may even support women's choices to the point where the midwife compromises their own professional responsibilities, an issue they term 'midwifery abdication'. Jefford and Jomeen (2015) identify one cause of midwifery abdication as being the need to navigate being both

> 'accountable to the woman and her family… [and also] to the community, the
> organization, and the midwifery profession' (p.117).

The women interviewed were aware of this tension faced by the HCPs involved in their care. Women did not know how each HCP they met might react to this tension, and therefore prepared for the worst possible scenario (as they saw it) – that her choices might be undermined and removed – until the HCP had proved otherwise.

This research demonstrates the importance of developing a trusting relationship with HCPs for women. The single factor that had the greatest impact on this was continuity of carer. There is a wealth of literature demonstrating the positive outcomes for all pregnant women who have the same midwife throughout pregnancy (Homer, 2016; Tracy, Hartz, Tracy, Allen, Forti, Hall, White, Lainchbury, Stapleton, Beckmann, Bisits, Homer, Foureur, Welsh & Kildea, 2013; Leap, Sandall, Buckland & Huber, 2010; Warren, 2003). There is growing evidence that for pregnant women who have previously experienced a traumatic birth, continuity of carer may be even more beneficial (Thomson & Downe, 2010). The specific benefits to this cohort include avoiding re-traumatisation through the repetition of the traumatic birth story to multiple people, and in subsequent interactions, having confidence that their previous experience is already understood and acknowledged.

Literature which has examined the implementation of a caseload midwifery model has found that the model poses challenges in relation to midwives' personal lives (Jepsen, Mark, Nøhr, Fourear & Sørensen, 2016) and has greater associated costs (Stimson, 1995). The literature suggests that, for midwives, working in a caseload midwifery model requires a balancing of greater job satisfaction against the unavoidable impact on personal life. However, if this model is well supported at an organisational level, 'benefits [have been] found to outweigh disadvantages' (Jepsen, Mark, Nøhr, Fourear & Sørensen, 2016, p.103). To be successfully implemented, a caseloading model which provides continuity of carer requires an organisation to invest both additional finances to cover the initial costs of such a model, and additional resources to support the midwives engaged within it, with the understanding that the benefits will outweigh the costs over the longer term through reductions in pre-term births, infant loss, caesarean births, analgesic use, and mental health problems (Tracy et al, 2013; Sandall, Soltani, Gates, Shennan & Devane, 2013). This requirement for upfront investment may explain why only a minority of women currently experience such a model of care (Page, 2013). However, this research shows that for this cohort, without continuity of carer, trust that was carefully being rebuilt could be shattered by an insensitive interaction with a HCP who did not know the woman. Findings from this research show that when an individual HCP behaved in a way that broke a woman's trust, it was not only the trust in that individual HCP that was damaged, but the woman's ability to trust all HCPs. Therefore, the benefits of a continuous care model of midwifery for this cohort seem to be sufficiently well established to outweigh the potential cost and practical implications. However, within this system it is also important that if the relationship of trust does not build, women are able to change carer. Not being able to do so can

lead to deterioration in the relationship, with the result that the situation becomes unsafe for either the midwife or the woman or both. This is demonstrated in the postnatal interviews, when women talked about 'Preparing for Birth'. When relationships of trust had not formed, or had deteriorated, some women experienced significant emotional distress in the weeks before birth. Other women avoided antenatal care, or chose at the last minute to birth without midwives present, because they did not have an established relationship of trust. Other women (and the midwives attending them) experienced difficulties during labour, as a result of the lack of trusting relationships.

A system to ensure that all HCPs are aware of the need to provide sensitive care to this population, combined with training in perinatal mental health has been found to be useful (McKenzie-McHarg, Crockett, Olander & Ayers, 2014), although no women involved in this research experienced such a model.

Agreeing plans

Each woman interviewed had invested in a specific person who could agree or disagree to the birth plans she wanted. Who this person was varied, depending on the choices she wished to make. For women who wanted a caesarean section, it was usually the Consultant. For those wanting a homebirth, it might be the Homebirth Team, or the HOM. Once that person had agreed to support the birth plan, women experienced a sense of relief. Identifying who that person is, and facilitating the woman's access to them at an early point in pregnancy would be beneficial.

All the women interviewed talked about the importance of securing HCPs agreement to their antenatal care or birth plan. In some cases women did need consent to their plans for them to happen – for example Taylor's non-medically indicated caesarean birth could not happen without the agreement of a surgeon to carry out the operation. In other cases women were making choices which did not require consent in the same way, but the woman wanted some kind of official approval that her plans for birth had been discussed and specific support had been agreed, for example Luna's meeting with the Consultant Midwife. Many women mistakenly believe that HCPs have the power to 'allow' or 'not allow' specific choices in birth, and so seek approval for their birth plans on this basis (Beech, 2014). This was not a significant factor amongst the women interviewed, most of whom were very well informed, and knew that they were able to exercise choice in the method and place of birth, and who was present. The official approval they sought was not on the basis of being allowed to make certain choices, rather it was about pre-emptively ensuring support

for later choices. Women were anticipating a battle to assert choices, and preparing not to lose those battles. But they were also seeking ways out of this potentially adversarial position, and using their birth plans as a tool in escaping it. A birth plan which had received approval at a high level within the NHS structure could then be used as a contract between the woman and midwives. With this guarantee in place, women could relax. It is possible that securing this agreement at as early a stage of pregnancy as possible would remove uncertainty, and help women to feel less anxious earlier on. In turn this might facilitate the development of trusting relationships between women and HCPs, simply because there was a greater amount of low-anxiety time available in which to do so.

Those women who did not see the birth plan in this light included the two women who chose not to make any written plans. It is perhaps significant that these two women had both experienced two births which were in some aspect traumatic, and in each case had not had their birth plans followed in the second birth. Their experience led them to conclude that using the birth plan as a guarantee of support was a false reassurance that could lead to bitter disappointment. When a woman has previously experienced a traumatic birth, supporting her to develop her birth plan, and proactively affirming agreement to honour it may be even more important than it is for other pregnant women. When a woman has experienced more than one traumatic birth before their current pregnancy, understanding her reluctance to write a birth plan can be important, and finding other ways to elicit, record and facilitate choices may be key to avoiding a further traumatic birth. In this case, continuity of care from an experienced midwife, who can form a relationship with the woman, and come to understand what is important to her in this birth is indicated.

<u>Need for emotional care to continue in the postnatal period</u>

Some of the women experienced positive births, which appeared to have a positive impact on their emotional wellbeing. This finding is consistent with other literature, which terms subsequent positive births as 'redemptive births' and 'transformative births' (Thomson & Downe, 2010), commenting on the power of a subsequent birth to either heal or retraumatize women (Beck & Watson, 2010). However, some of these women also described how their positive experience had resulted in their re-evaluation of their previous traumatic experience. These re-evaluations resulted in some cases in an increased perception that the previous experience could have been different, and consequently, an increase in negative feelings such as anger, disappointment and sadness, as a result of this reframing of the previous birth.

Conversely, women who had had a further negative birth experience described symptomology including increased anxiety, uncontrolled worries, flashbacks, and distress when interacting with HCPs. Both groups of women expressed a desire for care to continue in the postnatal period, to support these emotional experiences. The support needed to be received from someone already involved in the woman's care, who the woman had already established a trusting relationship with. This would also avoid women having to recount their previous experiences again.

Theoretical model of factors that reassure

The factors above are all interlinked and interdependent: care from one midwife will not build trust if that one midwife denies that the woman's previous birth was traumatic; providing information to a woman will not help her make choices, if support for those choices is then denied. The factors are presented in the diagram overleaf as a theory.

Figure 6: Theoretical model of factors that reassure

Information

Easy access to good quality information about:
- traumatic parts of previous birth
- available options for this pregnancy and birth
- generic pregnancy and birth information
- psychological support available

A way of making plans for this birth

Having these plans agreed by the person/ people the woman believes has the power to ensure her choices are respected

Access to ask ongoing questions

Healthcare Professionals

A single nominated point of contact within the maternity services, (usually a midwife, in some cases an SOM or Consultant may be more appropriate)

Who can draw in maternity and psychological services

If either of these are not possible, a doula who offers continuous care, 'gets it', and supports the woman's choices may meet some of these needs

Being able to either:
- choose this person
- be matched with this person

This person must 'get it'

Personal relationships

Partner who:
- shares an understanding of the previous birth as traumatic
- supportive of woman's choices
- able to advocate for/support these choices with family, friends or medical professionals when needed

Woman is able to make choices about pregnancy and birth, confident they will be supported

250

14.3 Towards a care pathway

From the theoretical model presented above, it is clear that many of the factors that help women to feel reassured in their new pregnancies and approaching this birth are related to their interactions with HCPs. In the majority of cases, women are accessing NHS services. Therefore, an opportunity exists to positively intervene to improve women's experiences in this pregnancy. A specific care pathway could be put into place, one which puts into practice a model of care that has as a central aim building a relationship of trust between the woman and HCPs, alongside offering maternity care to the pregnant woman.

Identifying women

As most of the women will come into contact with NHS Maternity Services, accessing women is relatively easy. Identifying them may be more of a challenge though. As demonstrated in the Concept Analysis in chapter 4, specific interventions and types of delivery may be associated with higher rates of traumatic birth, but they do not necessarily lead to a birth being traumatic (Bahl, Strachan & Murphy, 2004). Conversely, a medically uneventful birth may be experienced as a traumatic birth by a woman, especially if she perceives that the care she has received was insensitive, uncaring, or involved the removal of her choices (Ayers, 2004). Women who have experienced traumatic births may have gone on to develop diagnosable mental health conditions such as Post Traumatic Stress Disorder or postnatal anxiety, but they may not develop such conditions, and even if they do, Ayers and Shakespeare (2015) suggest that up to half of the women with perinatal mental health conditions are not identified. Women who have experienced a traumatic birth may not use, or recognise, this term as applying to them, and may instead use other terms to describe their experience (Beck, 2004b). The first stage in the development of a care pathway for women who are pregnant subsequent to a traumatic birth is therefore to develop an appropriate screening tool. Slade and Cree (2010) suggest that

> 'several simple questions concerning perinatal experiences of fearfulness could be asked postnatally prior to hospital discharge' (p.195).

This would help identify women who might benefit from psychological interventions following a traumatic birth, but the same information could be used to identify women who might benefit in future pregnancies from the care pathway proposed below. Beck and Watson (2010) comment that we already have

'instruments available to screen women for Post-traumatic stress symptoms following childbirth' (p.243).

Perhaps assessing these instruments applicability to the wider category of traumatic birth is a starting point in the development of a screening tool, to identify pregnant women who have previously experienced a traumatic birth, and who would benefit from this Care Pathway.

Screening pregnant women to identify those who have had a previous traumatic birth can only be of benefit if an appropriate referral route and support services are in place to support women. This section will first examine the issues that arise from the idea of a screening tool, and then examine the support services that would need to be in place for women whom the screening identifies.

Beck and Watson (2010) refer to screening tools designed to identify postnatal PTSD symptoms, but do not reference their use with a pregnant population: other psychological screening tools are already in use for pregnant women. Whilst not specifically designed to assess for a previous traumatic birth, it has been suggested that tools such as the Whooley questions (NICE, 2007) may identify some of this population (Howard, 2016). The use of the generalized anxiety disorder 7-item scale (GAD-7) (DSM V) has also been proposed as a tool for identifying women in this category (Howard, 2016), due to the common symptomology of anxiety in women who have previously experienced a traumatic birth. An update to NICE guidelines in 2014 recommended the inclusion of the generalized anxiety disorder 2-item scale (GAD-2) as part of routine antenatal care. A positive score on this measure then indicates the use of the GAD-7, which research shows may represent a clinically useful scale for the detection of anxiety in perinatal women (Simpson, Glazer, Michalski, Steiner & Frey, 2014).

All the tools discussed above have been developed with the intention of identifying clinically diagnosable disorders. Another alternative would be to investigate the applicability of tools intended for use with the general pregnant population. The Birth Satisfaction Scale (BSS) (Hollins-Martin & Fleming, 2011), and the more recent and shorter Birth Satisfaction Scale – Revised (BSS-R) (Hollins-Martin & Martin, 2014) have been developed specifically to assess postnatal women's birth satisfaction. To avoid over-burdening midwives with full population screening, it is proposed that if

a woman screened positively on a universal measure such as the Whooley questions, that could then serve as an indication to use the BSS-R.

An appropriate screening tool should be used at as early a point in pregnancy as possible, perhaps at the first appointment with a midwife. Introducing screening tools may pose a challenge for midwives. When other screening questions have been introduced, compliance with introducing the tools has sometimes been low (McGlone, Hollins-Martin & Furber, 2016; Darwin, McGowan & Edozien, 2015; Wright, 2003). This has been variously attributed to; already overstretched midwives focussing on areas they perceive as being a medical priority (Wright, 2003); a lack of understanding of the purpose of the questions (McGlone, Hollins-Martin & Furber, 2016); a lack of robust training to accompany the screening tools (Jardri, Maron, Pelta, Thomas, Codaccioni, Goudemand & Delion, 2010); confidence in raising such issues with women at first meeting, and institutional barriers including time available to spend with women (Sanders, 2006). However, studies such as Mann, Adamson and Gilbody's (2015) research suggests that perinatal mental health screening has a high level of acceptability to women, with 93% feeling it was desirable to ask screening questions, and 97% feeling comfortable answering them. In the absence of screening and support for previous traumatic births, women will continue to experience standard NHS care, which, as this research shows, leaves some women locked into a battle with HCPs, with consequent negative results.

Specialist midwife

If a screening tool identifies a previous traumatic birth, then with the woman's permission, a referral should be made to a specialist community midwife who can provide antenatal and postnatal care, and care during labour and birth if possible. This midwife's focus would then be to work with the woman to understand her previous experience, and develop a plan to maximise the possibility that this birth was a different experience. This midwife would also need to act as a central point to pull in the support of other professionals and services across the maternity services. The midwife would need to have a high degree of autonomy in order to be able to effectively advocate for women's choices, whilst potentially working with people who were more senior to them within the hierarchy of the NHS. Hollins-Martin & Bull (2010) demonstrated that

> 'it may be difficult for midwives to support safe requests from women that conflict with what a senior person says' (p.223).

In this role, that ability would be essential. Hollins-Martin (2007) sets out an eight point plan intended to address these issues, and to enable midwives to support women's choices. Implementing this plan for these midwives could help to avoid some of the difficulties women in this study faced, when trying to assert their choices.

This proposed role incorporates that of caseload midwifery, which has itself been proved to benefit perinatal women (Forster, McLachlan, Davey, Biro, Farrell, Gold, Flood, Shafiei & Waldenström, 2016), but goes further than such models usually do in including the ability to draw in other support as required, rather than passing women over to other services. Other forms of support needed by the woman might include medical support for the pregnancy, such as Consultant care. Psychological care, which might involve counsellors, psychologists and perinatal mental health teams would be likely to be required in a high proportion of cases, given the evidence of the link between traumatic birth and anxiety, depression, or PTSD (Ayers, 2014; Slade, 2006). Slade and Cree (2010) advocate for a psychological care plan for the entire perinatal period, and for this cohort of women, such a plan could be invaluable. However, to ensure that the central goal of developing a trusting relationship between the woman is not diminished by the involvement of a range of different support services, the midwife should maintain a co-ordinating role.

The role is in essence that of a named practitioner – a model which has been proved to be of benefit to patients in both acute hospital settings (Kmietowicz, 2014; Francis, 2013), and more recently in nursing home settings (Mitchell & Strain, 2015). The literature from these fields suggest that benefits to the patients in these settings include reduced waiting times, decreased length of stay, improved patient satisfaction and increased cost-effectiveness of services (Stefanacci, 2015); it is expected that these benefits would also be experienced by this cohort.

Continuity of carer

Rowan, McCourt and Bick (2010) point to the fragmented nature of maternity services as a significant factor in women experiencing less than optimal care. This midwife would need to pull together the right combinations of support for each woman, to overcome such fragmentation. As demonstrated by the diversity of plans these women made, the specialist midwife would need to be able to arrange meetings between herself, the woman (and partner if appropriate) and a wide range of other HCPs, including Consultants and Heads of Midwifery. These meetings should be held as soon as a birth plan has been developed, to avoid women suffering anxiety that their plan might

not be agreed. The midwife might also need to call in specialist mental health services to support some women. Since the Royal College of Midwives issued a call in November 2015 for

'every maternity trust [to have] a midwife who specialises in maternal mental health at a senior level'

it would be expedient to explore how to ensure complementarity between these roles.

Women who were intending to freebirth or to use private HCPs for birth (including Independent Midwives and private Consultants), but were accessing some NHS services, should also be able to access this service if they wished.

Support for women's choices

During the pregnancy and birth, it is very important that women's choices are supported, and that they are not coerced into making the choices that HCPs feel they should make. Gould discusses how the culture of maternity services can lead to midwives using the trust women have in them to coerce them, and even withholding information in order to secure women's compliance (2004). She explains that this is unfortunately a far from uncommon experience. Little research has been conducted into whether these practices remain common in the years since Gould's work, but some groups of women continue to describe their encounters with midwives as involving 'bullying' (Dietsch, Shackleton, Davies, McLeod & Alston, 2010). The authors of this study commented at the time that their

'extensive search of the literature found no research specifically looking at bullying, harassment and abuse of women by midwives' (Dietsch, Shackleton, Davies, McLeod & Alston, 2010, p.53).

However, other studies have reported that women perceived the behaviour and actions of midwives as humiliating, believing that midwives held them in contempt, and did not believe them about what was happening at the time (Eliasson, Kainz & von Post, 2008). Therefore, even in the absence of more recent research specifically into the practices described by Gould, it seems that some women experience coercive control of their choices exercised by midwives. For all women, coercion of this

nature has the potential to be damaging, but for women who have previously experienced a traumatic birth, experiencing such behaviour is even more devastating.

Sometimes these actions come from a midwife's personal beliefs about the rights choices for a woman to make, often they come from a place of fear of personal and professional vulnerability if midwives support women's absolute right to make their own choices (Hollins-Martin & Bull, 2010; Hollins-Martin 2007; Gould, 2004). Another factor which affects midwives' actions is the fear of litigation. Symon's (2006) notes that defensive practice in midwifery was a direct result of midwives' awareness of previous cases where a mother had taken legal action after the birth of her child.

Postnatally

When a subsequent birth is a positive experience, it may be that it can truly be healing, in that it can have a positive effect on mental health conditions associated with the previous traumatic experience. However, even in these cases, women may experience a complex reaction to reframing the previous experience in light of the new experience. Therefore even women who have experienced a positive birth following their traumatic experience may need emotional support afterwards, perhaps ideally from the specialist midwife who oversaw their care during pregnancy.

If the subsequent birth is not a positive experience, it has the potential to re-traumatise. However, it may be possible only to identify traumatic births after a period of time has elapsed. From a practice perspective, this may indicate that women who have previously experienced a traumatic birth would benefit from continuing to have midwifery care for an extended period after a subsequent birth, with a particular focus on psychological wellbeing, and with established referral routes. This extended care could involve joint visits with the Health Visitor (if the woman chooses to use Health Visiting services), to assist the handover of care also involving the handover of a trusting relationship.

This chapter has discussed the implications of the findings of the research. It has developed existing theories on the perinatal journey of women who have previously experienced a traumatic birth, providing confirmation of other literature, and offering refinements and challenges to some work. From this, a model care pathway has been proposed. The following chapter will offer overall conclusions from the research.

Chapter 15 – Conclusions

This chapter considers the study as a whole, and begins with a methodological evaluation of the research. From this evaluation, the strengths and weaknesses of the research are highlighted and discussed. Practice recommendations and recommendations for future research are entwined in this study, and so are made jointly. Finally, the conclusions reached at the end of research are summarised, and the thesis concludes with reflections on how the researcher's positionality has changed as a result of the research.

15.1 Methodological evaluation

This chapter begins with an evaluation of the methodological approach taken in the research. Evaluation is a process which is centrally built in to GTM through Glaser and Strauss' (1967) work in the early formulation of GTM as a methodology. Glaser's (1967) original criteria of fit, work, relevance and modifiability have a long history of use as evaluative tools, which are used by the researcher at the conclusion of GTM research, prior to publication. However, Charmaz (2014) argues that judgement of the usefulness of Constructivist Grounded Theory should be based on 'the quality of the final product'. To this end, she sets out four new criteria for evaluation; credibility, originality, resonance and usefulness. These criteria embody the pragmatism that underlies a Constructivist Grounded Theory approach. Charmaz (2014) describes the inter-related nature of these criteria, explaining that a

> 'strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of the contribution' (p.183).

Rigour is sometimes considered as in-built in Grounded Theory approaches, through the use of the constant comparative technique, and theoretical sampling (Chiovitti & Piran, 2003). However, it is debatable whether the reader of the research can be given enough evidence about how these techniques were applied to come to an independent judgement about the rigour of the research processes. Glaser and Strauss (1967) originally emphasised two main criteria for judging the adequacy of an emerging grounded theory: that it fits the situation, and that it works, helping the people involved in the situation to make sense of their experiences and manage the situation better. However, these criteria have been criticised as not being a suitable demonstration of rigour, as the evaluative criteria would then be generated through the research process (Elliott & Lazenbatt,

2005). Charmaz's evaluative criteria do not include rigour as a specific measure. It is therefore appropriate to cast the net wider in searching for tools to assist in evaluating the rigourousness of the research. Beck's (1993) criteria for demonstrating rigour in qualitative research studies has been widely used by those conducting GTM research in the areas of midwifery, nursing and psychology (Cooney, 2011; Chiovitti & Piran, 2003). Additionally, Beck's primary area of current research is traumatic birth, and the criteria she specifies are therefore likely to be a good fit for this research. Beck (1993) suggests that the criteria which best demonstrate rigour in all qualitative research are credibility, auditability and fittingness. It is apparent that Charmaz's evaluative criteria and Beck's criteria for demonstrating rigour are complementary and fit well together, as credibility appears in both. Therefore, in order to evaluate the rigour of this study, auditability and fittingness will be evaluated, alongside the four criteria proposed by Charmaz.

This research uses Constructivist Grounded Theory as a methodology, but is underpinned by feminist research principles. Therefore, no evaluation of this research would be complete unless a feminist evaluative component was included. Referring back to Stanley and Wise's (1993) principles of feminist research, their third criteria is that there is a developing feminist consciousness from such inquiry. Other feminist researchers have gone further than this, and stated that feminist research should be conducted 'on, with and for women' (Kelly Burton & Regan, 1994, emphasis added, p.28). Combining these ideas together, the final category for the methodological evaluation of this research was arrived at – that the research should have the potential to have a positive impact on women's lives. The research was therefore evaluated against these five criteria, defined in Table 19 overleaf.

Table 19 – Methodological evaluation of research (based on Charmaz, 2014, and Beck, 1993)

Criterion	Questions used to evaluate the research
Credibility	• Has the research achieved intimate familiarity with the setting or topic? • Are the data sufficient to merit the claims? • Have systematic comparisons been made? • Are there strong logical links between the gathered data, arguments and analysis? • Has the research provided enough evidence for claims made, such that the reader can form an independent assessment, and agree with the claims?
Originality	• Do the categories offer new insights? • Does the analysis provide a new conceptual rendering of the data? • What is the social and theoretical significance of this work? • How does the grounded theory produced from the research challenge, extend or refine current ideas, concepts and practices?
Resonance	• Do the categories portray the fullness of the studied experience? • Are links drawn between larger collectives or institutions and individual lives, when the data so indicate? • Does the theory produced make sense to the participants? Does the analysis offer them deeper insights about their experiences?
Usefulness	• Does the analysis offer interpretations that people can use in their everyday worlds? • Can the analysis spark further research in other substantive areas? • How does this work contribute to knowledge, and to making a better world?
Fittingness	• Has contextual data, such as demographic information on the sample, study setting characteristics, the philosophy of care and/or other relevant local policy, been provided that is sufficient to enable the reader to understand the study context? • Is there a clear description of the sample, such as who was included, how and why?
Auditability	Has an audit trail been provided that details the researcher's: • Personal beliefs, values and assumptions? • Rationale for the research design, including a description of the research process, data collection process and sampling decisions? • Approach to analysis and generating theory?
Positive impact on women's lives	• Does the research demonstrate the potential to practically improve women's lives? • What impact has the research had upon the lives of the women involved in the research?

These questions were used to evaluate the methodological approach adopted in the research.

<u>Credibility</u>

The data for the research consisted of 27 interviews, the shortest of which was 45 minutes, the longest of which was just under two hours. This data provided the researcher with intimate familiarity with the topic of women's choices in pregnancy after a previous traumatic birth. That this data was sufficient was demonstrated by the fact that saturation was reached at each individual interview point, and in the data set as a whole.

Systematic comparisons were made between observations and categories, and both coding and defining and redefining of categories continued throughout the data collecting period. There are strong logical links between the data, the arguments presented, and the analysis of the data. The data is presented within the research in sufficient quantity to allow the reader to form an independent assessment.

<u>Originality</u>

The categories contained in this research build on those developed in previous research, offering new insights into the ways women make choices in pregnancy and about birth. In a similar way, the model care pathway developed from the research extends current arguments for specific aspects of care, such as one-to-one midwifery, and the importance of the birth plan. These aspects of care have a significant body of research behind them, but have not been combined before in this way, specifically in relation to the care needed by pregnant women who have previously experienced a traumatic birth.

The conceptualisation of this group of women's experiences in making birth choices as a battle, and the understanding that this a real experience, not a metaphor, is an original contribution to the field of traumatic birth research. The understanding produced in this work goes further than simply identifying that this is women's experience during interactions with healthcare professionals – it explores how this emotional response affects how women think about and prepare for such interactions. It also combines this understanding with a consideration of the development of trust and mistrust between women and healthcare professionals.

One of the strengths of the theory emerging from this work is that it shows that women may have similar motivations (such as avoiding loss of control), but based on their previous birth experience,

may make very different choices (freebirth or planned caesarean birth). This understanding that the basis of starkly different choices may be the same is a novel contribution to the field.

Resonance

The categories developed from the data portray a range of experiences, highlighting similarities and differences between different participants, and over time. Liminal experiences are included within the categories, and their difference is highlighted.

Most of the participants involved in the study received their primary maternity care via the NHS. Therefore, the links between individual lives and larger institutions, such as Community Midwifery teams, Midwife Led Units, Consultant teams, and hospitals are built into the research.

As papers have been developed from this research, they have been sent to the women who participated in the study. Feedback has showed that the theory developed from the research makes sense to the participants, and that understanding that their experiences were shared by other women was helpful to them.

Usefulness

The analysis offers interpretations that care providers can use to improve their everyday practice. It also offers interpretations that may directly benefit women, in identifying that their experience is one which is shared by other women, and being able to follow other women's stories through the research, to identify the factors that benefited the women involved in this research.

The research has offered new contributions to existing knowledge about women's experiences of making choices in pregnancy and birth. It has also offered contributions to knowledge about women's experiences of traumatic births. Equally, the research has revealed further knowledge gaps, providing ideas for future research into specific areas, such as whether a 'healing' subsequent birth produces a measurable psychological effect, and what the impact of compounding further traumatic births might be.

Auditability

The audit trail provided by Chapter 6 explains the epistemological position that influences the research design. From this, the decisions about research design, analysis, and theory generation are

explained. Chapter 7 then details the rationale for data collection and sampling, based upon the selected methodology. The researcher's own personal positionality is detailed in section 1.4. This is further developed into a reflexive statement which is included in Chapter 6. The decision making processes for the research are therefore highly auditable.

<u>Fittingness</u>

The study settings for the research varied somewhat as interviews were conducted by Skype. The decision to use Skype, and the context in which it was used (i.e. participant's own homes) are detailed in Chapter 7.

Inclusion and exclusion criteria for participants have been included, alongside a list of the places in which adverts for involvement in the study were placed, and a comprehensive description of the recruitment process. Demographic information for participants is provided briefly within Chapter 7, and then expanded in Chapter 8, to include pen portraits of the women, which give more detail. Details of women who enquired about the study, or enrolled into the study, but did not complete the interviews are also provided, which allows insight into reasons for non-participation.

For research to meet Beck's (1993) criteria for fittingness, it must 'fit' experiences outside of the study setting. The provision of the details of the study setting and demographic information enables the reader to the make an informed judgement as to whether this is the case. This research covered a diverse range of birth choices, from freebirths to elective caesarean births. The women involved in the study came from a number of locations within three countries of the UK, and experienced a number of different models of maternity care. This diverse group of participants may therefore assist in demonstrating fittingness in this study.

<u>Positive impact on women's lives</u>

The research has the potential to confer benefits directly to women, in the form of improved maternity care. Recommendations drawn from the research about the care pregnant women who have previously experienced a traumatic birth need are explicit in the provision of a specific care pathway. Central to this pathway is the development of a trusting relationship between the woman and her caregiver, and the woman and her partner. The research has demonstrated that these two relationships may impact on the woman's experiences of birth more than the concrete events of birth.

The research also contains several other recommendations for healthcare professionals, such as the early 'signing off' of a birth plan, and continuity of carer. These recommendations may be taken up independently by healthcare professionals, therefore benefitting women. There is also the potential for pregnant women who have previously experienced a traumatic to use the research directly themselves, in asking their healthcare provider to make specific provision for their care.

A common perception amongst participants in this research was that their experience was unique, and that this resulted in feelings of isolation, and a questioning of themselves about whether their choices were unreasonable or demanding. Feedback from the women who participated in this study showed that they had benefitted from an understanding that their feelings about and reactions to facing pregnancy and birth after a traumatic birth were shared by other women in similar situations. The publication of this research may therefore have a positive impact on women's emotional lives in demonstrating that their experiences and emotions are shared by a wider group of women.

15.2 Strengths of the study

The research was designed as a prospective longitudinal study in order to find out about women's experiences as they happened. The strength of a prospective qualitative study is the ability to capture contemporaneous data, which are likely to be more accurate than retrospective data (Euser, Zoccali, Jager & Dekker, 2009). Conducting a longitudinal study allowed insight into the way women's decisions altered over the perinatal period, rather than simply capturing intended decisions or past decisions at one particular point in their journey. The relationship between the researcher and the women developed throughout the interviews, making subsequent interviews easier to conduct, because a joint understanding of the woman's previous experience, and her general views about birth, were already established. It is surmised that this may have led to richer data being captured. Repeated interviews with the same researcher also allowed for follow up of unclear points from earlier interviews.

Longitudinal GTM is a relatively rare methodology, which gives rise to both strengths and limitations within this research. In employing this methodology, this study has also added to the body of methodological knowledge.

Recruitment to the study was successful, with the target sample size being met, and all interviews completed. The women involved had a wide range of birth preferences at the point of recruitment, from non-medically indicated caesarean birth, to hospital inductions, homebirths, freebirths, and the use of both private and independent maternity care providers. In the course of the research, the women also described a variety of different aspects of the previous birth that were traumatic. These variations added depth to the research.

The women also had a range of birth outcomes, both in terms of the place and method of birth, and in terms of whether they viewed the birth as a positive or negative experience. Previous literature in the field has often focussed exclusively on subsequent births which were positive. Through the use of a prospective research design, this study was able to capture a wider range of women's experiences. Importantly, the longitudinal nature of the data means it is also possible to understand, from the women's viewpoint, the factors that resulted in the specific birth outcome. This understanding has been fundamental to the development of the Care Pathway.

15.3 Limitations of the study

Although the study met its aims, some limitations have been identified. Firstly, as with much qualitative research, the overall number of participants was small. The dearth of other literature in this area meant that exploratory and in-depth data was required to investigate the research question. The small number of participants included was a necessary result of the nature of the data needed. The effect of the sample size is that the findings may not be able to be generalised to the entire population of pregnant women who have previously experienced a traumatic birth. In future, quantitative work could be utilised to assess this. If the practice recommendations made are implemented, it will be necessary to evaluate the success of the model proposed.

Whilst this research was not intended to provide a representative sample, it should be noted that the participants were all white, all identified as heterosexual, and all were living with a partner at the time of recruitment. This means that the experiences of all women are not captured in this research. It may be that women belonging to other ethnic groups, lesbian or bisexual women, and single mothers may have a different experience of pregnancy subsequent to a traumatic birth. Further targeted work to establish the choices these women make could be useful in the future.

The research question was formulated to examine the choices that women were making. In the development of the interview schedule, it was acknowledged that women can only make choices they are aware of being available to them. In the interviews themselves, it was quickly apparent that not all the participants were aware of all the potential choices that were available. However, women's ability to make choices can be limited by factors other than knowledge. This arose as an issue during the interviews, in that Rachel wished to have her caesarean section carried out by a private obstetrician, but was unable to access this due to a loss of private medical insurance through her partner's employment, and Luna wished to employ an Independent Midwife, but did not have the financial means, independent of her partner, to do so.

Social capital, as described by Coleman (1988) incorporates a number of interrelated measures, including income equality, social connections such as group membership, social trust or mistrust, age, education and access to education and employment, and family formation, which may affect outcomes for a community or individual. Specifically, poverty, group membership and social mistrust have been shown to be indicators of health inequality and mortality (Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997).

Social capital has been shown by Gold, Kennedy, Connell and Kawachi (2002) to affect teen birth rates in the United States, with those who had less social capital being more likely to become pregnant as teenagers. In a study in Tanzania in 2015, Semali, Leyna, Mmbaga, and Tengia-Kessy found that social capital played a significant role in determining where mothers gave birth, and who was present at the birth. Kritsotakis, Vassilaki, Chatzi, Georgiou, Philalithis, Kogevinas, and Koutis, (2011) measured the effect that social capital had on birth outcome, (in terms of preterm birth, small weight for the gestational age, fetal weight growth restriction, weight, length and head circumference), and found that lower individual maternal rates of social capital correlated to higher rates of preterm birth. Social capital therefore appears to play a role in determining when a woman becomes pregnant, where she gives birth, and the birth outcome. It is therefore likely that social capital, alongside knowledge and financial resources, affects the choices that are available to women who have previously had a traumatic birth. A deeper investigation of the role of social capital in determining the participants birth choices would have benefitted this research, and this may be an area where further research is indicated.

Longitudinal GTM is a relatively rare methodology, which gives rise to both strengths and limitations within this research. The limitations of using a relatively rare methodology are that there are few other studies to compare against. In this research, the potential difficulties of achieving saturation over a series of interviews was recognised, and a plan was put in place to address this if saturation was not reached in subsequent interviews. However, saturation was actually reached in subsequent interviews. What is impossible to know with such a limited pool of studies to draw from is whether this is usual in longitudinal GTM. Equally, it is difficult to know whether the concept of saturation should be applied in exactly the same way to a longitudinal GTM study, or whether additional concepts should be applied. Further theoretical development of longitudinal GTM, and further studies using this methodology might lead to improvements in robustness of the methodology.

The final limitation is that of the failure to collect sufficient diary data to include in the analysis. Whilst all the participants (except one) agreed to provide diary data, the amount of data provided was very low. Within the research, this was dealt with by using the interview data as the only direct data source for analysis, rather than as the primary data source, supplemented by the diary data, as originally intended. Instead, the diaries were read by the researcher for context, and issues which arose from the diaries were then brought up by the researcher in the following interview. The effects of this adaptation cannot be fully known, but it is possible that what has been lost is an understanding of the gradual changes in women's decision making.

Corti (1993) reports that the best way to maximise participation in diary collection is to recruit participants 'on a face-to-face basis, rather than by post'. This was adapted in this research to recruitment by Skype. Corti (1993) also suggests that

'Appealing to respondent's altruistic nature, reassuring them of confidentiality and offering incentives are thought to influence co-operation in diary surveys' (p.1).

Given that the respondents all completed a series of longitudinal interviews, it is thought unlikely that these factors were responsible for the low completion rates. Narrative reasons given for non-completion of the diary data during the interviews related to time available, and forgetting that the diary needed to be completed. It is possible that asking pregnant women who already have a child and busy lives to complete a weekly diary is simply unrealistic. This is a group who do not necessarily

fit that well into Alaszewski's (2006) depiction of a suitable diarist. If similar research was conducted in the future, consideration should be given to this possibility.

However, it is also possible that a different way of collecting diary data from women would have been more fruitful. In retrospect, the decision to collect diary data at the three interview points could have been a factor in the low rates of completion. Collecting diaries on a weekly basis, with a prompt from the researcher to ask women to submit that week's diary might have assisted.

15.4 Recommendations for practice and future research

This study has shown that pregnant women who have previously experienced a traumatic birth have specific needs throughout the perinatal period. Firstly, this cohort have the same needs in pregnancy as other pregnant women, but if those needs aren't met the consequences are less manageable for the women, and have the potential to be more damaging. Secondly, this group of women have additional needs, which stem from their previous traumatic birth. As a result of this, it is recommended that ways to identify this group of women are developed. It is crucial that, once women are identified, appropriate support services are in place. A care pathway is proposed for implementation. The core part of this care pathway is that the woman experiences supportive care from one single midwife. The findings from this research suggest that if this care pathway is implemented, it should support the development of trusting relationships between women from this group and HCPs. The likely consequences of this include a more positive birth experience, but are wider than this. Women in this research who were able to develop a trusting relationship with a single midwife also experienced improved emotional health generally.

To support these practice recommendations, research into which of the available screening tools is most appropriate, and demonstrates the highest level of identification of these women is needed. All of the women in this study were white, identified as heterosexual, and had a partner at the time of recruitment. Additional work with other groups of women should be undertaken, to establish whether the practice recommendations are appropriate for all women. If the practice recommendations are implemented, work to establish the effect of the recommendations upon midwives and other HCPs involved in this model of care would be useful.

The perinatal journey for the partners of these women was outside of the scope of this research. However, other literature does demonstrate that a traumatic birth has both a direct (Elmir & Schmied, 2016; Elmir, 2013) and indirect (Nicholls & Ayers, 2007) effect on women's partners. Further research to investigate the effect of a subsequent pregnancy on a partner could be helpful.

Women in this research described a positive emotional and psychological impact when they had a positive birth after a previous traumatic birth. This is consistent with other literature which describes such births as 'healing' and redemptive'. It would be useful to measure the impact of a positive birth on these women, using psychometric tools, to establish whether a positive birth could in fact a remedial effect on the distress caused by a previous traumatic birth. Further research is also needed into the effects of multiple traumatic births.

15.5 Conclusions

This study addressed the question

'What choices do women make in pregnancy and birth, when they have previously experienced a traumatic birth?'

Findings from this research show that pregnant women who have previously experienced a traumatic birth are often anxious to ensure that this birth is different from the previous experience. The choices they make about birth are likely to be connected to the points at which they felt they lost choice or control in the previous birth. To make these choices, women need access to good quality information about all the possibilities, and to have a trusted and consistent person that they discuss their potential choices with. These women's choices are more likely to be outside the dominant paradigm of birth in their society than the choices made by women who have not experienced a traumatic birth. From this research, a proposal is made that women may make non-normative birth choices both to retain control, and to engineer trust-diagnostic situations between themselves and HCPs. Despite the challenges that supporting women in this way (and potentially in their eventual choices) may pose for HCPs, ensuring this group of women are supported in their decision-making throughout the perinatal period is essential to ensuring that the forthcoming birth is a positive experience for women.

Choices during pregnancy may be focused on the effects of those choices for the birth. During pregnancy, women are wary about losing power and control, and may prepare for every encounter with a medical professional as though it was going to be a battle. From this study it appears that continually supporting a woman's right to make choices, and developing a trusting relationship, is an effective way to counter this fear. Receiving care from a single supportive midwife is an effective way to achieve this. Securing agreement from HCPs to the woman's plans for birth as early in pregnancy as possible benefitted this group of women. If agreement was delayed until later in the pregnancy, women continued to experience the care provided as a potential battle, and found developing trust in HCPs difficult.

Women's anxiety may increase markedly in the days before birth, requiring additional support from partners, HCPs, and complementary support services such as mental health specialists, psychologists, counsellors and doulas. In the absence of such support, women are likely to enter birth in a state of anxiety and fear, which has been linked to the development of childbirth related PTSD (Ayers, Bond, Bertullies & Wijma, 2016; Slade, 2006; Slade, 2000).

When women who have previously experienced a traumatic birth are pregnant again, an opportunity exists for sensitive intervention by medical professionals to ensure this experience is different, and in addition to potentially heal some of the damage from the traumatic experience. A model care pathway is proposed to provide this. However, if the care pathway does not fit a woman's choices (for example if she is choosing to freebirth and does not wish to have the involvement of medical professionals during pregnancy), then supporting her choices is likely to have a greater positive effect than a specific care pathway would.

15.6 Researcher's position at the conclusion of the research

This section details how the research influenced and changed the views and positionality of the researcher, in comparison to her views at the inception of the research process (outlined in section 1.5). It is a personal reflection, and is therefore written in the first-person.

The stories of pregnancy, birth, and the early postnatal period that the women involved in this study shared with me were varied in many ways. Women's previous births had been traumatic for different reasons, their hopes for their current pregnancy and forthcoming birth were different, and

the support they received to make the choices they wished also varied from woman to woman. Their births had different outcomes, both in terms of differing modes of birth, different places of birth, people present at the birth, and in whether this birth was a positive experience for the woman. It was a privilege to be allowed to share these journeys with the women. I was, and continue to be, deeply grateful to the women involved for giving me their time and trust in sharing their experiences.

The findings from the research have confirmed some of my earlier views. In particular, it does seem that women who have experienced a previous traumatic birth do have a fundamental need to create relationships of trust with those who care for them throughout the perinatal period. However, trust is a contentious issue for this group of women, due to their previous birth experiences. I have learnt that women may use or engineer situations so that they can test out whether they can trust those who offer support throughout the perinatal period. As I believed at the inception of the research, these women do benefit from a specific kind of care. From the research, I now know that the kind of care which is helpful is care which prioritises the ability to resolve issues relating to trust.

I have also learned that there are specific practicalities which can assist in developing this trusting relationship. These include continuous care from a single appropriate carer, and the early confirmation that birth plans or choices will be supported.

Before carrying out the research, I identified that the processes which women seemed to travel through had commonalities, regardless of the birth choices they wished to make. This has been confirmed by the research. Women in this study all went through a process of examining their previous experience in detail, in order to identify where the trauma occurred, where they could have made a different choice, and where they lost control of those choices. From the research findings, I have been able to understand this process in more detail, and also to suggest the purpose this process might serve. Women appear to be examining their previous experience in detail in order to make choices that would avoid the loss of control that they experienced previously. The findings from the research suggest that supportive care through this process could involve having access to a single appropriate carer, who can answer questions about the previous experience, discuss information women have gathered from a multitude of sources, and simultaneously provide confirmation that choices in relation to this birth will be supported.

Speaking to the women has altered my view of what makes a subsequent birth a positive experience. Mode and place of birth appears to have some significance, but to be secondary to the relationship between the woman and the HCP who is caring for her. If a trusting and positive relationship exists between the woman and a known HCP, it may provide protection against a further traumatic birth, and even ensure that the birth is viewed as a positive experience by the woman, regardless of the mode and place of birth. Equally, if there is a negative relationship involving mistrust between the woman and the HCP who is with her during her birth, the birth may be a negative experience, even if the woman gives birth how and where she chooses.

At the beginning of the research, I felt that it was important to collect women's own accounts of their choices, and their reasons for making these choices. The choice not to triangulate these accounts through the involvement of the HCPs caring for the women, or through documents such as Maternity Notes or scan results, stemmed from a feminist position that women were the experts in their own stories. This decision was not the result of a naïve belief that the women's own accounts would offer an objective truth; rather, it was influenced by my epistemological position that all such accounts of decision making in pregnancy are subjective, multi-faceted and complex. This position has been reinforced by the research, as I have talked with women who have expressed uncertainty about what choices they wish to make, or who have changed their minds, or who have made decisions based on the language and perceived attitude of a HCP, rather than on the supposed objective facts presented to them through medical tests and statistics. My belief at the beginning of this research that women's own sense-making of their decisions was worth studying has been strengthened through the observation of the similar journeys women have gone through, whilst seeking support to make very different choices about birth.

It is my hope that the learning I have gained from conducting this study can be utilised by birth workers, including doulas, midwives and obstetricians, to help us support pregnant women better, and to improve outcomes for pregnant women who have previously experienced a traumatic birth. I also hope that the learning I have gained can directly help me to improve how I work with women in the future.

References

Alaszewski, A. (2006). *Using diaries for social research*. London: Thousand Oaks.

Algire, T. (1995). On Clausewitz, battles and birth. *International Journal of Childbirth Education, 10*(2)

Allan, C., Carrick-Sen, D., & Martin, C. R. (2013). What is perinatal well-being? A concept analysis and review of the literature. *Journal of Reproductive & Infant Psychology, 31*(4), 381-398. doi:10.1080/02646838.2013.791920

Allan, H. T., Odelius, A., Hunter, B. J., Bryan, K., Knibb, W., & Shawe, J. (2015). Gatekeeping access to the midwifery unit: Managing complaints by bending the rules. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine, 19*(6), 652-669. doi:10.1177/1363459314567791

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology, 16*(2-3), 107-131.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Amnesty International. (2010). *Deadly delivery: The maternal health care crisis in the USA.* (). New York: Amnesty International.

Ampt, A. J., Patterson, J. A., Roberts, C. L., & Ford, J. B. (2015). Obstetric anal sphincter injury rates among primiparous women with different modes of vaginal delivery. *International Journal of Gynecology & Obstetrics, 131*(3), 260-264. doi:10.1016/j.ijgo.2015.06.025

Anderson, T. (2002). The misleading myth of choice: The continuing oppression of women in childbirth. *MIDIRS Midwifery Digest, 12*(3), 405-407.

Attarha, M., Keshavarz, Z., Bakhtiari, M., & Jamilian, M. (2016). The outcome of midwife-mother relationship in delivery room: A qualitative content analysis. *Health (1949-4998), 8*(4), 336-343. doi:10.4236/health.2016.84035

Ayers, S. (2004). Delivery as a traumatic event: Prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology, 47*(3), 552-567.

Ayers, S. (2014). Fear of childbirth, postnatal post-traumatic stress disorder and midwifery care. *Midwifery, 30*(2), 145-148. doi:10.1016/j.midw.2013.12.001

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine, 46*(6), 1121-1134. doi:10.1017/S0033291715002706

Ayers, S., Claypool, J., & Eagle, A. (2006). Birth trauma. what happens after a difficult birth? postnatal debriefing services. *British Journal of Midwifery, 14*(3), 157-161.

Ayers, S., Eagle, A., & Waring, H. (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health & Medicine* 11(4):389-98.

Ayers, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Posttraumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders, 119*(1-3), 200-204.

Ayers, S., Joseph, S., Mckenzie-McHarg, K., Slade, P., & Wijma, K. (2008). Post-traumatic stress disorder following childbirth: Current issues and recommendations for future research. *Journal of Psychosomatic Obstetrics & Gynecology, 29*(4), 240-250. doi:10.1080/01674820802034631

Ayers, S., McKenzie-McHarg, K., & Slade, P. (2015). Post-traumatic stress disorder after birth. *Journal of Reproductive & Infant Psychology, 33*(3), 215-218. doi:10.1080/02646838.2015.1030250

Ayers, S., & Olander, E. K. (2013). What are we measuring and why? using theory to guide perinatal research and measurement. *Journal of Reproductive & Infant Psychology, 31*(5), 439-448. doi:10.1080/02646838.2013.834041

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth (Berkeley, Calif.), 28*(2), 111-118.

Ayers, S., & Pickering, A. D. (2005). Women's expectations and experience of birth. *Psychology & Health, 20*(1), 79-92.

Ayers, S., & Shakespeare, J. (2015). Should perinatal mental health be everyone's business? *Primary Health Care Research and Development, 16*(4), 323-325. doi:10.1017/S1463423615000298

Ayers, S., Wright, D., B., & Ford, E. (2015). Hyperarousal symptoms after traumatic and nontraumatic births. *Journal of Reproductive & Infant Psychology, 33*(3), 282-293. doi:10.1080/02646838.2015.1004164

Bahl, R., Strachan, B., & Murphy, D. J. (2004). Outcome of subsequent pregnancy three years after previous operative delivery in the second stage of labour: Cohort study. *BMJ: British Medical Journal (International Edition), 328*(7435), 311-314 4p. doi:10.1136/bmj.37942.546076.44

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Philadelphia, PA: Open University Press.

Barber, T., Rogers, J., & Marsh, S. (2007). Increasing out-of-hospital births: What needs to change? *British Journal of Midwifery, 15*(1), 16-20.

Bassett, K. L., & Iyer, N. (2000). Defensive medicine during hospital obstetrical care: A by-product of the technological age. *Social Science & Medicine, 51*(4), 523.

Baxter, J. D., McCourt, C., & Jarrett, P. M. (2014). What is current practice in offering debriefing services to post partum women and what are the perceptions of women in accessing these services: A critical review of the literature. *Midwifery, 30*(2), 194-219. doi:10.1016/j.midw.2013.12.013

Beck, C.T. (1993) Qualitative research: the evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research*. 15, 2, 263-266.

Beck, C. T. (2004a). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research, 53*(4), 216-224.

Beck, C. T. (2004b). Birth trauma: In the eye of the beholder. *Nursing Research, 53*(1), 28-35 8p.

Beck, C. T. (2006). The anniversary of birth trauma: Failure to rescue. *Nursing Research, 55*(6), 381-390.

Beck, C. T. (2006b). Pentadic cartography: Mapping birth trauma narratives. *Qualitative Health Research, 16*(4), 453-466. doi:10.1177/1049732305285968

Beck, C. T. (2009). Birth trauma and its sequelae. *Journal of Trauma & Dissociation, 10*(2), 189-203. doi:10.1080/15299730802624528

Beck, C. T. (2011). A metaethnography of traumatic childbirth and its aftermath: Amplifying causal looping. *Qualitative Health Research, 21*(3), 301-311. doi:10.1177/1049732310390698

Beck, C. T., LoGiudice, J., & Gable, R. K. (2015). A mixed-methods study of secondary traumatic stress in certified nurse-midwives: Shaken belief in the birth process. *Journal of Midwifery & Women's Health, 60*(1), 16-23. doi:10.1111/jmwh.12221

Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research, 59*(4), 241-249.

Beech, B. (2014). *Am I allowed?* AIMS.

Beech, B., & Robinson, J. (1985). Nightmares following childbirth *British Journal of Psychiatry, 147*, 586.

Begley, C. M. (2014). Personal communication with Greenfield M., *Longitudinal GTM*

Benoliel, J. Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406.

Berg, M. (2010). Midwifery relationships with childbearing women at increased risk In M. Kirkham (Ed.), *The midwfie-mother relationship* (2nd ed., pp. 174-189). Eastbourne and Chippenham: Palgrave Macmillan.

Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women's experience of the encounter with the midwife during childbirth. *Midwifery, 12*(1), 11-15.

Bernhard, C., Zielinski, R., Ackerson, K., & English, J. (2014). Home birth after hospital birth: Women's choices and reflections. *Journal of Midwifery & Women's Health, 59*(2), 160-166. doi:10.1111/jmwh.12113

Bhatia, M. S., & Jhanjee, A. (2012). *Tokophobia: A dread of pregnancy* Medknow Publications & Media Pvt. Ltd. doi:10.4103/0972-6748.119649

Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide* Sage.

Birthrights. (2013a). Human rights in maternity care. Retrieved from http://www.birthrights.org.uk/library/factsheets/Human-Rights-in-Maternity-Care.pdf

Birthrights. (2013b). Consenting to treatment. Retrieved from http://www.birthrights.org.uk/library/factsheets/Consenting-to-Treatment.pdf

Birthrights. (2013c). The home birth debate: Rights and obligations. Retrieved from http://www.birthrights.org.uk/2013/09/701/

Blanchard, D., & Bourgeois, S. (2014). Systematic review summary - support for mothers, fathers and families after perinatal death. *Singapore Nursing Journal, 41*(1), 45-46.

Bondi, L. (2009). Teaching reflexivity: Undoing or reinscribing habits of gender? *Journal of Geography in Higher Education, 33*(3), 327-337. doi:10.1080/03098260902742417

Bones, E. (2007). Choices in childbirth and the right to treatment [corrected] [published erratum appears in MIDIRS MIDWIFERY DIGEST 2007 mar;17(1):150]. *MIDIRS Midwifery Digest, 16*(3), 414-420.

Boorman, R. J., Devilly, G. J., Gamble, J., Creedy, D. K., & Fenwick, J. (2014). Childbirth and criteria for traumatic events. *Midwifery, 30*(2), 255-261. doi:10.1016/j.midw.2013.03.001

Bowers, B., & Schatzman, L.Dimensional analysis. In J. M. Morse, P. N. Stern & J. Corbin (Eds.), *Developing grounded theory: The second generation*. Walnut Creek, CA: Left Coast Press.

Brook, S. N., & Hesse-Biber, P. L. (2007). *Feminist research practice* Sage.

Brown, S. J., & Lumley, J. (1998). Communication and decision-making in labour: Do birth plans make a difference? *Health Expectations, 1*(2), 106-116.

Bryant, A. (2002). Re-grounding grounded theory. *Journal of Information Technology Theory and Application, 4*(1), 25--42.

Bryant, A. (2003). A constructive/ist response to glaser. Retrieved from www.qualitative-research.net/fqs/-texte/1-03/1-03bryant-e.htm

Bryant, A., & Charmaz, K. (2010). *The sage handbook of grounded theory* (Bryant, A.; Charmaz, K. ed.) Sage.

Burge, P., & Jamieson, M. (2009). Gaining balance: Toward a grounded theory of the decision-making processes of applicants for adoption of children with and without disabilities. *Qualitative Report, 14*(4), 566--603.

Cahill, H. (2000). Male appropriation and medicalisation of childbirth: An historical analysis. *Journal of Advanced Nursing, 33*(3)

Capitulo, K. L., Perez, P. G., & Lepsch, S. (2005). Second opinion. birth plans: Are they really necessary?...writing for the pro position... writing for the con position. *MCN: The American Journal of Maternal Child Nursing, 30*(5), 288-289.

Carter, M. A. (2009). Trust, power, and vulnerability: A discourse on helping in nursing. *Nursing Clinics of North America, 44*(4), 393-405. doi:10.1016/j.cnur.2009.07.012

Chalmers, B., Kaczorowski, J., Darling, E., Heaman, M., Fell, D. B., O'Brien, B., & Lee, L. (2010). Cesarean and vaginal birth in canadian women: A comparison of experiences. *Birth: Issues in Perinatal Care, 37*(1), 44-49. doi:10.1111/j.1523-536X.2009.00377.x

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin, & Y. Lincoln (Eds.), *Handbook of qualitative research*

Charmaz, K. (2002). Grounded theory analysis. In J. F. Gubrium, & J. A. Holstein (Eds.), *Handbook of interview research*. Thousand Oaks, CA: Sage.

Charmaz, K. (2006). In Charmaz K. (Ed.), *Constructing grounded theory. A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2008). Constructionism and the grounded theory method. In J. F. Gubrium, & J. A. Holstein (Eds.), *Handbook of constructionist research* (pp. 397-412)

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.) Sage.

Chippington Derrick, D. (2012). Consent, a commonly understood concept? *AIMS Journal, 24*(3)

Chiovitti, R.F. & Piran, N. (2003) Rigour and grounded theory research**,** *Journal of Advanced Nursing* 44(4), 427–435

Churchill, H., & Francome, C. (2009). British midwives' views on rising caesarean section rates. *British Journal of Midwifery, 17*(12), 774-778.

Clarke, A., & Friese, C. (2007). Grounded theorizing using situational analysis. In A. Bryant, & K. Charmaz (Eds.), *The sage handbook of grounded theory*

Clausewitz, C. (1832). *On war* (J. J. Graham Trans.). London: Nicholas Trubner.

CMACE. (2011). Saving mothers' lives: Reviewing maternal deaths to make motherhood safer: 2006-2008. *BJOG: An International Journal of Obstetrics & Gynaecology, 118*, 1-203. doi:10.1111/j.1471-0528.2010.02847.x

Coates, R., Ayers, S., & de Visser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy and Childbirth, 14*, 359-359. doi:10.1186/1471-2393-14-359

Coleman, J.S. (1988). Social Capital in the Creation of Human Capital *American Journal of Sociology* 94, Supplement: Organizations and Institutions: Sociological and Economic Approaches to the Analysis of Social Structure

Collins, R. (2006). What is the purpose of debriefing women in the postnatal period? *Evidence Based Midwifery, 4*(1), 4-9.

Connell, E. (2015). The importance of person-centred care in reducing birth trauma. *MIDIRS Midwifery Digest, 25*(2), 218-222.

Cooney, A. (2011) Rigour and grounded theory, *Nurse Researcher*, 18, 4, pp. 17-22

Corti, L. (1993). Using diaries in social research. *Social Research Update,* (March)

Creedy, D. K., Spochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth: Issues in Perinatal Care, 27*(2), 104-111.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., . . . Rousseau, M. C. (2014). A mixed methods appraisal tool for systematic mixed studies reviews. Retrieved from http://mixedmethodsappraisaltoolpublic.pbworks.com Archived by WebCite® at http://www.webcitation.org/5tTRTc9yJ

Cronk, M. (2010). The midwife: A professional servant? In M. Kirkham (Ed.), *The midwife-mother relationship* (2nd ed., pp. 55-65). Eastbourne and Chippenham: Palgrave Macmillan.

Crossley, M. L. (2007). Childbirth, complications and the illusion of 'choice': A case study. *Feminism & Psychology, 17*(4), 543-563. doi:10.1177/0959353507083103

Cunen, N. B., McNeill, J., & Murray, K. (2014). A systematic review of midwife-led interventions to address post partum post-traumatic stress. *Midwifery, 30*(2), 170-184. doi:10.1016/j.midw.2013.09.003

Darwin, Z., McGowan, L., & Edozien, L. C. (2015). Antenatal mental health referrals: Review of local clinical practice and pregnant women's experiences in england. *Midwifery, 31*(3), e17-22. doi:10.1016/j.midw.2014.11.004

Dauphinee, J. D. (2004). VBAC: Safety for the patient and the nurse [corrected] [published erratum appears in JOGNN 2004 nov-dec;33(6):833]. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 33*(1), 105-115.

Davidson, J. O., & Layder, D. (1994). *Methods, sex and madness*. Florence, KY, US: Taylor & Frances/Routledge. doi:10.4324/9780203423455

Davies, S., & Coldridge, L. (2015). 'No Man's land': An exploration of the traumatic experiences of student midwives in practice. *Midwifery,* doi:10.1016/j.midw.2015.05.001

Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two PhD researchers. *Qualitative Research, 14*(5), 603-616. doi:10.1177/1468794113488126

Department of Health. (2007). Maternity matters: Choice, access and continuity of care in a safe service. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf

Dietsch, E., Shackleton, P., Davies, C., McLeod, M., & Alston, M. (2010). 'You can drop dead': Midwives bullying women. *Women and Birth: Journal of the Australian College of Midwives, 23*(2), 53-59. doi:10.1016/j.wombi.2009.07.002

Doucet, A., & Mauthner, M. (2006). Feminist methodologies and epistemologies. In C. D. Bryant, & D. L. Peck (Eds.), *Handbook of 21st century sociology*

Downe, S. (2008). Metasynthesis: A guide to knitting smoke. *Evidence Based Midwifery, 6*(1), 4-8.

Downe, S., Simpson, L., & Trafford, K. (2007). Expert intrapartum maternity care: A meta-synthesis. *Journal of Advanced Nursing, 57*(2), 127-140. doi:10.1111/j.1365-2648.2006.04079.x

Drach-Zahavy, A., Buchnic, R., & Granot, M. (2016). Antecedents and consequences of emotional work in midwifery: A prospective field study. *International Journal of Nursing Studies, 60*, 168-178. doi:10.1016/j.ijnurstu.2016.04.014

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology,* 14:2

Eaton, E. (2014). What is a good birth? using Q method to explore the diversity of attitudes about good birth. *Journal of Prenatal & Perinatal Psychology & Health, 28*(3), 147-173

Economic and Social Research Council National Centre for Research Methods. (2014). *Methods for the synthesis of qualitative research: A critical review.* (Working Paper No. (01/09)).NCRM. Retrieved from http://eprints.ncrm.ac.uk/690/1/0109%2520Qualitative%2520synthesis%2520methods%2520paper%2520NCRM.pdf

Edwards, N. (2010). 'There's so much potential... and for whatever reason it's not being realised.' - women's relationships with midwives as a negotiation of ideology and practice. In M. Kirkham (Ed.), *The midwife-mother relationship* (2nd ed., pp. 91-115). Eastbourne & Chippenham: Palgrave Macmillan.

Edwards, N., & Kirkham, M. (2012). Why women might not use NHS maternity services. *Essentially MIDIRS, 3*(9), 17-21.

Eichler, M. (1988). *Non-sexist research methods: A practical guide*. London: Allen and Unwin.

Eliasson, M., Kainz, G., & von Post, I. (2008). Uncaring midwives. *Nursing Ethics, 15*(4), 500-511. doi:10.1177/0969733008090521

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing, 66*(10), 2142-2153. doi:10.1111/j.1365-2648.2010.05391.x

Elmir, R. (2013). A bystander or a father: Men's experiences of birth trauma. *Australian Nursing & Midwifery Journal, 21*(3), 50-51.

Elmir, R., & Schmied, V. (2016). A meta-ethnographic synthesis of fathers' experiences of complicated births that are potentially traumatic. *Midwifery, 32*, 66-74. doi:10.1016/j.midw.2015.09.008

Euser, A. M., Zoccali, C., Jager, K. J., & Dekker, F. W. (2009). Cohort studies: Prospective versus retrospective. *Nephron Clinical Practice, 113*(3), c214-c217. doi:10.1159/000235241

Feeley, C., & Thomson, G. (2016). Tensions and conflicts in 'choice': Womens' experiences of freebirthing in the UK. *Midwifery, 41*, 16-21. doi:10.1016/j.midw.2016.07.014

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery, 30*(2), 185-193. doi:10.1016/j.midw.2013.12.004

Fenwick, J., Gamble, J., & Mawson, J. (2003). Women's experiences of caesarean section and vaginal birth after caesarian: A birthrites initiative. *International Journal of Nursing Practice, 9*(1), 10-17.

Fernandez, C. (2012). Guest editorial, themed section. *Grounded Theory Review, 11*(1), 27-27.

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*(2), 209-230.

Ford, E., & Ayers, S. (2011). Support during birth interacts with prior trauma and birth intervention to predict postnatal post-traumatic stress symptoms. *Psychology & Health, 26*(12), 1553-1570. doi:10.1080/08870446.2010.533770

Forssén, A. S. K. (2012). Lifelong significance of disempowering experiences in prenatal and maternity care: Interviews with elderly swedish women. *Qualitative Health Research, 22*(11), 1535-1546. doi:10.1177/1049732312449212

Forster, D. A., McLachlan, H. L., Davey, M., Biro, M. A., Farrell, T., Gold, L., Waldenström, U. (2016). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: Results from the COSMOS randomised controlled trial. *BMC Pregnancy & Childbirth, 16*, 1-13. doi:10.1186/s12884-016-0798-y

Francis, R. (2013). *The mid staffordshire NHS foundation trust public inquiry.* Department of Health. . (The Francis Report)

Fullbrook, S. (2008). Professional regulation. part 4: Self-regulation and the consumer council. *British Journal of Nursing* Mark Allen Publishing, 17(14), 902-903.

Gamble, J., & Creedy, D. (2005). Psychological trauma symptoms of operative birth. *British Journal of Midwifery, 13*(4), 218-224.

Gamble, J., Creedy, D., Moyle, W., Webster, J., McAllister, M., & Dickson, P. (2005). Effectiveness of a counseling intervention after a traumatic childbirth: A randomized controlled trial. *Birth: Issues in Perinatal Care, 32*(1), 11-19.

Gamble, J. A., Health, M., & Creedy, D. K. (2001). Women's preference for a cesarean section: Incidence and associated factors. *Birth: Issues in Perinatal Care, 28*(2), 101-110 10p.

Garthus-Niegel, S., von Soest, T., Vollrath, M. E., & Eberhard-Gran, M. (2013). The impact of subjective birth experiences on post-traumatic stress symptoms: A longitudinal study. *Archives of Women's Mental Health, 16*(1), 1-10. doi:10.1007/s00737-012-0301-3

Glaser, B. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B. (2005). *The grounded theory perspective III: Theoretical coding*. Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research* Transaction publishers.

Gold, R., Kennedy, B., Connell, F., & Kawachi, I. (2002), 'Teen births, income inequality, and social capital: developing an understanding of the causal pathway', *Health & Place*, 8, 2, pp. 77-83

Gottfried, R., Lev-Wiesel, R., Hallak, M., & Lang-Franco, N. (2015). Inter-relationships between sexual abuse, female sexual function and childbirth. *Midwifery, 31*(11), 1087-1095. doi:10.1016/j.midw.2015.07.011

Gottvall, K., & Waldenström, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *BJOG: An International Journal of Obstetrics & Gynaecology, 109*(3), 254-260.

Goudge, J., & Gilson, L. (2005). How can trust be investigated? drawing lessons from past experience. *Social Science & Medicine, 61*(7), 1439-1451. doi:10.1016/j.socscimed.2004.11.071

Gould, D. (2004). Birthwrite. trust me, I am a midwife. *British Journal of Midwifery, 12*(1), 44-44.

Gray, M. A. (2014). Personal communication with Greenfield M., *Longitudinal GTM*

Gray, M. A., & Smith, L. N. (2000). The qualities of an effective mentor from the student nurse's perspective: Findings from a longitudinal qualitative study. *Journal of Advanced Nursing, 32*(6), 1542-1549.

Green, J. M., & Baston, H. A. (2003). Feeling in control during labor: Concepts, correlates, and consequences. *Birth: Issues in Perinatal Care, 30*(4), 235-247.

Greenfield, M., Jomeen, J., & Glover, L. (2016). What is traumatic birth? A concept analysis and literature review. *British Journal of Midwifery, 24*(4), 254-267. doi:10.12968/bjom.2016.24.4.254

Grekin, R., & O'Hara, M.,W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review, 34*(5), 389-401. doi:10.1016/j.cpr.2014.05.003

Gubrium, J. F., & Holstein, J. A. (2008). The constructionist mosaic. In J. F. Gubrium, & J. A. Holstein (Eds.), *Handbook of constructionist research* (pp. 3--12)

Gubrium, J. F., & Holstein, J. A. (2001). *Handbook of interview research, context and method*. London: Sage.

Haase, J., Kline Leidy, N., Coward, D., Britt, T., & Penn, P. E. (1993). Simultaneous concept analysis: A strategy for developing multiple interrelated concepts. In B. L. Rodgers, & K. A. Knafl (Eds.), *Concept development in nursing: Foundations, techniques, and applications* (pp. 175--192)

Hall, W., A., Tomkinson, J., & Klein, M., C. (2012). Canadian care providers' and pregnant Women's approaches to managing birth: Minimizing risk while maximizing integrity. *Qualitative Health Research, 22*(5), 575-586. doi:10.1177/1049732311424292

Hallam, J. L., Howard, C. D., Locke, A., & Thomas, M. (2016). Communicating choice: An exploration of mothers' experiences of birth. *Journal of Reproductive and Infant Psychology, 34*(2), 175-184. doi:10.1080/02646838.2015.1119260

Hanna, P. (2012). Using internet technologies (such as skype) as a research medium: A research note. *Qualitative Research, 12*(2), 239-242. doi:10.1177/1468794111426607

Harden, A., Garcia, J., Oliver, S., Rees, R., Shepherd, J., Brunton, G. & Oakley, A. (2004). Applying systematic review methods to studies of people's views: an example from public health research. *Journal of Epidemiology and Community Health* 58:794-800.

Harman, T. (2012). Agnes Gereb and the case for human rights in childbirth. *The World Post*

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. *Psychology & Health, 27*(10), 1166-1177. doi:10.1080/08870446.2011.649755

Hesse-Biber, P. L. (2007). The practice of feminist in-depth interviewing. In P. L. Hesse-Biber, & P. L. Leavy (Eds.), *Feminist research practice* Sage.

Hildingsson, I., Rådestad, I., Rubertsson, C., & Waldenström, U. (2002). Few women wish to be delivered by caesarean section. *BJOG: An International Journal of Obstetrics & Gynaecology, 109*(6), 618-623.

Hildingsson, I., Nilsson, C., Karlström, A., & Lundgren, I. (2011). A longitudinal survey of childbirth-related fear and associated factors. *Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns, 40*(5), 532-543.

Hill, M. (2014). A healthy baby is not all that matters. Retrieved from http://www.bestdaily.co.uk/your-life/news/a573059/a-healthy-baby-is-not-all-that-matters.html

Hilpern, K. (2003, 28th May). Hard labour *The Guardian, G2 Supplement*, pp. 14.

Hofberg, K., & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. A series of 26 cases. *The British Journal of Psychiatry: The Journal of Mental Science, 176*, 83-85.

Hollins Martin, C. (2007). A difficult choice *AIMS Journal, 19*(2), 3-4.

Holmberg, L. I., & Wahlberg, V. (2000). The process of decision-making on abortion: A grounded theory study of young men in sweden. *Journal of Adolescent Health, 26*(3), 230-234. doi:10.1016/S1054-139X(99)00011-7

Holmes, J. G. (1981). The exchange process in close relationships: Microbehavior and macromotives. In M. J. Lerner, & S. C. Lerner (Eds.), *The justice motive in social behavior* (pp. 261-284). New York: Plenum.

Holt, A. (2010). Using the telephone for narrative interviewing: A research note. *Qualitative Research, 10*(1), 113-121. doi:10.1177/1468794109348686

Homer, C. S. E. (2016). Models of maternity care: Evidence for midwifery continuity of care. *Medical Journal of Australia, 205*(8), 370-374. doi:10.5694/mja16.00844

Houghton, G., Bedwell, C., Forsey, M., Baker, L., & Lavender, T. (2008). Factors influencing choice in birthplace: An exploration of the views of women, their partners and professionals. *Evidence Based Midwifery, 6*(2)

Howard, L. (2016). SRIP lecture: Mental health problems in pregnancy: New evidence on detection and treatment. *SRIP Annual Conference,*

Hunter, B. (2011). The heart of the job: Emotion work in midwifery. *Essentially MIDIRS, 2*(2), 17-21.

Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery, 22*(4), 308-322.

Hunter, B., & Deery, R. (2005). Building our knowledge about emotion work in midwifery: Combining and comparing findings from two different research studies. *Evidence Based Midwifery, 3*(1), 10-15.

Hurley, K. E. (2014). To fight, or not to fight: A cancer psychotherapist with cancer confronts the battle metaphor. *Women & Therapy, 37*(3), 311-318. doi:10.1080/02703149.2014.897556

Hutchison, A. J., Johnston, L., & Breckon, J. (2011). Grounded theory-based research within exercise psychology: A critical review. *Qualitative Research in Psychology, 8*(3), 247-272. doi:10.1080/14780880903304527

Iles, J., & Pote, H. (2015). Postnatal posttraumatic stress: A grounded theory model of first-time mothers' experiences. *Journal of Reproductive & Infant Psychology, 33*(3), 238-255. doi:10.1080/02646838.2015.1030732

Iles, J., Slade, P., & Spiby, H. (2011). Posttraumatic stress symptoms and postpartum depression in couples after childbirth: The role of partner support and attachment. *Journal of Anxiety Disorders, 25*(4), 520-530. doi:10.1016/j.janxdis.2010.12.006

James, S. (2015). Women's experiences of symptoms of posttraumatic stress disorder (PTSD) after traumatic childbirth: A review and critical appraisal. *Archives of Women's Mental Health, 18*(6), 761-771. doi:10.1007/s00737-015-0560-x

Jardri, R., Maron, M., Pelta, J., Thomas, P., Codaccioni, X., Goudemand, M., & Delion, P. (2010). Impact of midwives' training on postnatal depression screening in the first week post delivery: A quality improvement report. *Midwifery, 26*(6), 622-629. doi:10.1016/j.midw.2008.12.006

Jefford, E., & Jomeen, J. (2015). "Midwifery abdication": A finding from an interpretive study. *International Journal of Childbirth, 5*(3), 116-125. doi:10.1891/2156-5287.5.3.116

Jepsen, I., Mark, E., Aagaard Nøhr, E., Foureur, M., & Elgaard Sørensen, E. (2016). A qualitative study of how caseload midwifery is constituted and experienced by danish midwives. *Midwifery, 36*, 61-69. doi:10.1016/j.midw.2016.03.002

Jomeen, J. (2010). *Choice, control and contemporary childbirth*. Oxford: Radcliffe Publishing Ltd.

Jomeen, J. (2007). Choice in childbirth: A realistic expectation? *British Journal of Midwifery, 15*(8), 485-490.

Jomeen, J. (2009). Choices for childbirth: Answer or problem? *Midwifery Matters,* (120), 15-18.

Jomeen, J. (2012). The paradox of choice in maternity care. *Journal of Neonatal Nursing, 18*(2), 60-62.

Kaufman, T. (2007). Evolution of the birth plan. *Journal of Perinatal Education, 16*(3), 47-52.

Kawachi, I., Kennedy, B.P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health* 87, 1491–1498.

Kelly, L., Burton, S., & Regan, L. (1994). Researching women's lives or studying women's oppression? reflections on what constitutes feminist research. In M. Maynard, & J. Purvis (Eds.), *Researching women's lives from a feminist perspective*

Kendall-Tackett, K. (2014). Birth trauma: The causes and consequences of childbirth-related trauma and PTSD. In D. L. Barnes, & D. L. Barnes (Ed) (Eds.), (pp. 177-191). Cham, Switzerland: Springer International Publishing. doi:10.1007/978-3-319-05116-1_10

Kenny, M., & Fourie, R. (2014). Tracing the history of grounded theory methodology: From formation to fragmentation. *The Qualitative Report, 19*(52)

Kenny, L. C., Lavender, T., McNamee, R., O'Neill, S. M., Mills, T., & Khashan, A. S. (2013). *Advanced maternal age and adverse pregnancy outcome: Evidence from a large contemporary cohort* Public Library of Science. doi:10.1371/journal.pone.0056583

Kingdon, C., Neilson, J., Singleton, V., Gyte, G., Hart, A., Gabbay, M., & Lavender, T. (2009). Choice and birth method: Mixed-method study of caesarean delivery for maternal request. *BJOG: An International Journal of Obstetrics & Gynaecology, 116*(7), 886-895. doi:10.1111/j.1471-0528.2009.02119.x

Kirkham, M. (2010). The maternity services context. In M. Kirkham (Ed.), *The midwife-mother relationship* (2nd ed., pp. 1-16). Eastbourne & Chippenham: Palgrave Macmillan.

Kirkham, M. (2004). Choice and bureaucracy. In M. Kirkham (Ed.), *Informed choice in maternity care* (pp. 265-290). Basingstoke: Palgrave Macmillan.

Kirkham, M., & Stapleton, H. (2004). The culture of maternity services in wales and england as a barrier to informed choice. In M. Kirkham (Ed.), *Informed choice in maternity care* (pp. 117-146). Basingstoke: Palgrave Macmillan.

Kitzinger, C., & Kitzinger, S. (2007). Birth trauma: Talking with women and the value of conversation analysis. *British Journal of Midwifery, 15*(5), 256-260.

Kitzinger, S. (2000). When a bad birth haunts you. Retrieved from http://www.sheilakitzinger.com/ArticlesBySheila/BadBirthHaunts.htm

Kitzinger, S. (2004). Flashbacks, nightmares and panic attacks after birth. *British Journal of Midwifery, 12*(1), 12-12.

Kitzinger, S. (2006). *Birth crisis*. New York, NY, US: Routledge/Taylor & Francis Group.

Klein, M. C., Kaczorowski, J., Hall, W. A., Fraser, W., Liston, R. M., Eftekhary, S., . . . Chamberlaine, A. (2009). The attitudes of canadian maternity care practitioners towards labour and birth: Many differences but important similarities. *Journal of Obstetrics and Gynaecology Canada: JOGC = Journal D'Obstétrique Et Gynécologie Du Canada: JOGC, 31*(9), 827-840.

Kmietowicz, Z. (2014). Named doctor will end culture of 'brief encounters' in hospitals. *BMJ: British Medical Journal, 348*(7943), 4-4.

Kottmel, A., Hoesli, I., Traub, R., Urech, C., Huang, D., Leeners, B., & Tschudin, S. (2012). Maternal request: A reason for rising rates of cesarean section? *Archives of Gynecology & Obstetrics, 286*(1), 93-98. doi:10.1007/s00404-012-2273-y

Kringeland, T., Daltveit, A. K., & Møller, A. (2009). What characterizes women in norway who wish to have a caesarean section? *Scandinavian Journal of Public Health, 37*(4), 364-371.

Kritsotakis, G., Vassilaki, M., Chatzi., L, Georgiou, V., Philalithis, A., Kogevinas, M., & Koutis, A. (2011), 'Maternal social capital and birth outcomes in the mother–child cohort in Crete, Greece (Rhea study)', *Social Science & Medicine*, 73, 11, pp. 1653-1660

Kukla, R., Kuppermann, M., Little, M., Lyerly, A., Mitchell, L. M., Armstrong, E. M., & Harris, L. (2009). Finding autonomy in birth. *Bioethics, 23*(1), 1-8. doi:10.1111/j.1467-8519.2008.00677.x

Lalor, J. G., Begley, C. M., & Galavan, E. (2008). A grounded theory study of information preference and coping styles following antenatal diagnosis of foetal abnormality. *Journal of Advanced Nursing, 64*(2), 185-194. doi:10.1111/j.1365-2648.2008.04778.x

Lane, H. P., McLachlan, S., & Philip, J. (2013). The war against dementia: Are we battle weary yet? *Age & Ageing, 42*(3), 281-283. doi:ageing/aft011

Larkin, P., Begley, C. M., & Devane, D. (2009). Women's experiences of labour and birth: An evolutionary concept analysis. *Midwifery, 25*(2), e49-e59.

Leap, N., Sandall, J., Buckland, S., & Huber, U. (2010). Journey to confidence: Women's experiences of pain in labour and relational continuity of care. *Journal of Midwifery & Women's Health, 55*(3), 234-242. doi:10.1016/j.jmwh.2010.02.001

Leeds, L., & Hargreaves, I. (2008). The psychological consequences of childbirth. *Journal of Reproductive & Infant Psychology, 26*(2), 108-122. doi:10.1080/02646830701688299

Lesanics, D. (2005). *Posttraumatic stress symptomatology following emergency cesarean delivery* . (2005-99012-136).

Levy, V. (2004). How midwives used protective steering to facilitate informed choice in pregnancy In M. Kirkham (Ed.), *Informed choice in maternity services* (pp. 57-70). Basingstoke: Palgrave Macmillan.

Lowdon, G. (2012). Who makes which decision? *AIMS Journal, 24*(3), 7-10.

Lucas, P. J., Baird, J., Arai, L., Law, C., & Roberts, H. M. (2007). Worked examples of alternative methods for the synthesis of qualitative and quantitative research in systematic reviews. *BMC Medical Research Methodology, 7*, 4-4.

Lyerly, A. D., Mitchell, L. M., Armstrong, E. M., Harris, L. H., Kukla, R., Kupperman, M., & Little, M. O. (2009). Risk and the pregnant body. *Hastings Center Report, 39*(6), 34-42.

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine, 18*(1), 41-59. doi:10.1177/1363459313476964

Mamamia. (2012). Her baby died, yet freebirthers still want you to try it. Retrieved from http://www.mamamia.com.au/freebirthing-her-baby-died-yet-freebirthers-still-want-you-to-try-it/

Mander, R. (2007). *Caesarean: Just another way of birth?*. Oxon: Routledge.

Mann, R., Adamson, J., & Gilbody, S. (2015). The acceptability of case-finding questions to identify perinatal depression. *British Journal of Midwifery, 23*(9), 630-638.

Marshall, J. E. (2005). *Informed consent during the intrapartum period: An observational study of the interactions between health professionals and women in labour involving consent to procedures* (PhD).

Martin, C. J. H., Bull, P., & Martin, C. R. (2004). The social influence scale for midwifery: Factor structure and clinical research applications. *Clinical Effectiveness in Nursing, 8*(2), 118-121.

Martin, C. M., & Kasperski, J. (2010). Developing interdisciplinary maternity services policy in canada. evaluation of a consensus workshop. *Journal of Evaluation in Clinical Practice, 16*(1), 238-245. doi:10.1111/j.1365-2753.2009.01326.x

Martin, C. H., & Fleming, V. (2011). The birth satisfaction scale. *International Journal of Health Care Quality Assurance (09526862), 24*(2), 124-135. doi:10.1108/09526861111105086

Martin, C. J. H., & Bull, P. (2010). The situational argument: Do midwives agree or acquiesce with senior staff? *Journal of Reproductive and Infant Psychology, 28*(2), 180-190. doi:10.1080/02646830903229876

Martin, C. J. H., & Martin, C. R. (2014). Development and psychometric properties of the birth satisfaction scale-revised (BSS-R). *Midwifery, 30*(6), 610-619. doi:10.1016/j.midw.2013.10.006

Mason, J. (2002). *Qualitative researching.* (2nd ed.). London, England: Sage.

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology, 37*(3), 413-431.

Maynard, M. (1994). Methods, practice and epistemology: The debate about feminism and research. In M. Maynard, & J. Purvis (Eds.), *Researching women's lives from a feminist perspective* ()

Mayor, S. (2005). Psychological therapy is better than debriefing for PTSD. *BMJ (Clinical Research Ed.), 330*(7493), 689-689.

McAra-Couper, J., Jones, M., & Smythe, L. (2012). Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology, 22*(1), 81-97. doi:10.1177/0959353511424369

McCallum, C. (2005). Explaining caesarean section in salvador da bahia, brazil. *Sociology of Health & Illness, 27*(2), 215-242. doi:10.1111/j.1467-9566.2005.00440.x

McCants, B. M., & Greiner, J. R. (2016). Prebirth education and childbirth decision making. *International Journal of Childbirth Education, 31*(1), 24-27.

McGlone, C., Hollins Martin, C. J., & Furber, C. (2016). Midwives' experiences of asking the whooley questions to assess current mental health: A qualitative interpretive study. *Journal of Reproductive & Infant Psychology, 34*(4), 383-393. doi:10.1080/02646838.2016.1188278

McGrath, P., & Ray-Barruel, G. (2009). The easy option? australian findings on mothers' perception of elective caesarean as a birth choice after a prior caesarean section. *International Journal of Nursing Practice, 15*(4), 271-279. doi:10.1111/j.1440-172X.2009.01762.x

McKenzie-McHarg, K., Scott-Heyes, G., Slade, P., Burns, J., Jones, J., McGuinness, M., & Wittkowski, A. (2016). *Perinatal service provision: The role of perinatal clinical psychology*. Leicester: The British Psychological Society.

McKenzie-McHarg, K., Ayers, S., Ford, E., Horsch, A., Jomeen, J., Sawyer, A. & Slade, P. (2015). Post-traumatic stress disorder following childbirth: An update of current issues and recommendations for future research. *Journal of Reproductive & Infant Psychology, 33*(3), 219-237. doi:10.1080/02646838.2015.1031646

McKenzie-McHarg, K., Crockett, M., Olander, E. K., & Ayers, S. (2014). Think pink! A sticker alert system for psychological distress or vulnerability during pregnancy. *British Journal of Midwifery, 22*(8), 590-595.

McKinlay, A., Grace, R. C., Horwood, L. J., Fergusson, D. M., Ridder, E. M., & MacFarlane, M. R. (2008). Prevalence of traumatic brain injury among children, adolescents and young adults: Prospective evidence from a birth cohort. *Brain Injury, 22*(2), 175-181. doi:10.1080/02699050801888824

Mey, G., & Mruck, K. (2007). Qualitative research in Germany/A short cartography. *International Sociology, 22*(2), 138-154. doi:10.1177/0268580907074539

Meyer, S. (2013). Control in childbirth: A concept analysis and synthesis. *Journal of Advanced Nursing, 69*(1), 218-228. doi:10.1111/j.1365-2648.2012.06051.x

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice, 12*(1), 8-13.

Mitchell, G., & Strain, J. (2015). The role of the named nurse in long-term settings. *Nursing Older People, 27*(3), 26-29. doi:10.7748/nop.27.3.26.e679

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Journal of Clinical Epidemiology, 62*(10), 1006-1012. doi:10.1016/j.jclinepi.2009.06.005

Morse, J. M. (2000). Exploring pragmatic utility: Concept analysis by critically appraising the literature. In B. L. Rodgers, & K. A. Knafl (Eds.), *Concept development in nursing: Foundations, techniques, and applications* (2nd ed., pp. 333--352). Philadelphia: Saunders.

Morse, J. M., Mitcham, C., Hupcey, J. E., & Tason, M. C. (1996). Criteria for concept evaluation. *Journal of Advanced Nursing, 24*(2), 385-390. doi:10.1046/j.1365-2648.1996.18022.x

Morse, J. M. (1995). *The significance of saturation*

Morse, J. M. (2000). *Determining sample size*

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery, 2*(1), 8-14 7p.

Murphy, E., & Dingwall, R. (2003). *Qualitative methods and health policy research*. Hawthorne, NY: Aldine de Gruyter.

Murphy, D. J., Pope, C., Frost, J., & Liebling, R. E. (2003). Women's views on the impact of operative delivery in the second stage of labour: Qualitative interview study. *BMJ: British Medical Journal, 327*(7424), 1132-1136.

Naples, N. (2003). *Feminism and method: Ethnography, discourse analysis, and activist research.* New York: Routledge.

NHS Choices. (2012) Consent to treatment.

NHS Choices. (2015a). Miscarriage. Retrieved from http://www.nhs.uk/Conditions/Miscarriage/Pages/Introduction.aspx

NHS Choices. (2015b). You and your baby at 37-40 weeks pregnant. Retrieved from http://www.nhs.uk/conditions/pregnancy-and-baby/pages/pregnancy-weeks-37-38-39-40.aspx

NHS England. (1993). *Changing childbirth.* London: NHS England.

NHS England. (2016). Maternity review sets bold plan for safer, more personal services. Retrieved from https://www.england.nhs.uk/2016/02/maternity-review-2/

NICE. (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care (NICE guidelines CG26).* London: National Institute for Clinical Excellence.

NICE. (2007). *Whooley questions* Antenatal care, appendix C: Women requiring additional care, (2010).

NICE. (2015) Delayed cord clamping [QS105]

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*, 491-509. doi:10.1348/135910706X120627

Nieminen, K., Stephansson, O., & Ryding, E. L. (2009). Women's fear of childbirth and preference for cesarean section - a cross-sectional study at various stages of pregnancy in sweden. *Acta Obstetricia Et Gynecologica Scandinavica, 88*(7), 807-813. doi:10.1080/00016340902998436

NMC (2016) Conduct and competence committee: Nursing and Midwifery Committee, 1-2 February.

Oakley, A. (1980). *Women confined: Towards a sociology of childbirth*. Oxford

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30--62). London: Routledge.

Oakley, A. (2005). In Oakley A. (Ed.), *The ann oakley reader: Gender, women and social science*. Bristol: Policy Press.

Oakley, A. (2016). Interviewing women again: Power, time and the gift. *Sociology, 50*(1), 195-213. doi:10.1177/0038038515580253

O'Brien, G. (2015). A cancer battle plan. *Businesswest, 32*(12), 6.

Odent, M. (1994). *Birth reborn: What childbirth should be*. London: Souvenir Press.

O'Donovan, A., Alcorn, K. L., Patrick, J. C., Creedy, D. K., Dawe, S., & Devilly, G. J. (2014). Predicting posttraumatic stress disorder after childbirth. *Midwifery, 30*(8), 935-941. doi:10.1016/j.midw.2014.03.011

O'Donovan, A., Alcorn, K., Patrick, J., Creedy, D.K., & Devilly, G.J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychology & Medicine.* Nov;40(11):1849-59

Olesen, V., Droes, N., Hatton, D., Chico, N., & Schatzman, L. (1994). Analyzing together: Recollections of a team approach. In A. Bryman, & R. Burgess (Eds.), *Analysing qualitative data* (). London, England: Routledge.

Oliver, R. (2005). Birth: Hospital or home? that is the question. *Journal of Prenatal & Perinatal Psychology & Health, 19*(4), 341-348.

Østergaard, L. R. (2015). Trust matters: A narrative literature review of the role of trust in health care systems in sub-saharan africa. *Global Public Health, 10*(9), 1046-1059. doi:10.1080/17441692.2015.1019538

Outhwaite, W., & Turner, S. (2008). *The SAGE handbook of social science methodology*. London: Sage.

Oxforddictionaries.com. (2016). Oxford dictionaries - dictionary, thesaurus, & grammar. Retrieved from http://www.oxforddictionaries.com/

Page, L. (2013). Midwifery in the UK: How do we move midwifery led care from fringe to mainstream? *Women & Birth, 26*(3), 165-166. doi:10.1016/j.wombi.2013.07.003

Pang, M. W., Leung, T. N., Lau, T. K., & Chung, T. K. H. (2008). Impact of first childbirth on changes in women's preference for mode of delivery: Follow-up of a longitudinal observational study. *Birth: Issues in Perinatal Care, 35*(2), 121-128.

Parker, J. (2004). Does traumatic birth increase the risk of postnatal depression? *British Journal of Community Nursing, 9*(2), 74-79.

Peeler, S., Chung, M. C., Stedmon, J., & Skirton, H. (2013). A review assessing the current treatment strategies for postnatal psychological morbidity with a focus on post-traumatic stress disorder. *Midwifery, 29*(4), 377-388. doi:10.1016/j.midw.2012.03.004

Penrod, J., & Hupcey, J. E. (2005). Enhancing methodological clarity: Principle-based concept analysis. *Journal of Advanced Nursing, 50*(4), 403-409. doi:10.1111/j.1365-2648.2005.03405.x

Pidgeon, H., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (). Hove, England: Psychology Press.

Pilley Edwards, N. (2004). Why can't women just say no? and does it really matter? In M. Kirkham (Ed.), *Informed choice in maternity care* (pp. 1-30). Basingstoke: Palgrave Macmillan.

Quinn, K., Spiby, H., & Slade, P. (2015). A longitudinal study exploring the role of adult attachment in relation to perceptions of pain in labour, childbirth memory and acute traumatic stress responses. *Journal of Reproductive & Infant Psychology, 33*(3), 256-267. doi:10.1080/02646838.2015.1030733

Raphael-Leff, J. (2005). *The psychological processes of childbearing* (4th ed.). London: Chapman and Hall.

Rayment, J. (2015). Emotional labour: How midwives manage emotion at work. *The Practising Midwife, 18*(3), 9-11.

RCOG. (2011). *Expert advisory group report – high quality women's health care, A proposal for change.* London: RCOG Press.

RCOG. (2006). *Law and ethics in relations to court-authorised obstetric intervention, ethics committee guideline number 1.* London: RCOG Press

Reid, M. (2011). The impact of traumatic delivery on the mother-infant relationship. *Infant Observation, 14*(2), 117-128. doi:10.1080/13698036.2011.583424

Reiger, K. (2008). Domination or mutual recognition? professional subjectivity in midwifery and obstetrics. *Social Theory & Health, 6*(2), 132-147. doi:10.1057/palgrave.sth.2007.12

Reinharz, S. (1997). Who am I? the need for a variety of selves in the field. In R. Hertz (Ed.), *Reflexivity & voice* London: Sage.

Renzetti, C. M., & Lee, R. M. (1993). *Researching sensitive topics*. Newbury Park, CA: Sage.

Rice, H., & Warland, J. (2013). Bearing witness: Midwives experiences of witnessing traumatic birth. *Midwifery, 29*(9), 1056-1063. doi:10.1016/j.midw.2012.12.003

Robert Wood Johnson Foundation. (2008). Reflexivity, qualitative research guidelines project. Retrieved from http://www.qualres.org/HomeRefl-3703.html

Roberts, N. P., Kitchiner, N. J., Kenardy, J., & Bisson, J. (2009). Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. *The Cochrane Database of Systematic Reviews,* (3), CD006869. doi:10.1002/14651858.CD006869.pub2

Robinson, J. (2002). Jean robinson's research round-up. effects of PTSD on birth. *AIMS Journal, 14*(3), 17-17.

Robinson, J. (2007). Post traumatic stress disorder. *AIMS Journal, 19*(1), 5-8.

Robson, C. (1993). *Real world research. A resource for social scientists and practitioner-researchers.* Oxford: Blackwell.

Rodgers, B. L. (1993). Concept analysis: An evolutionary view. In B. L. Rodgers, & K. A. Knafl (Eds.), Philadelphia: Saunders.

Rose, S. C., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews,* , N.PAG-N.PAG.

Rowan, C., Bick, D., & Bastos, M. H. S. (2007). Postnatal debriefing interventions to prevent maternal mental health problems after birth: Exploring the gap between the evidence and UK policy and practice. *Worldviews on Evidence-Based Nursing, 4*(2), 97-105 9p.

Rowlands, I. J., & Redshaw, M. (2012). Mode of birth and women's psychological and physical wellbeing in the postnatal period. *BMC Pregnancy and Childbirth, 12*, 138-138. doi:10.1186/1471-2393-12-138

Royal College of Midwives. (2015). Specialist maternal mental health midwife needed in every trust or health board. Retrieved from https://www.rcm.org.uk/news-views-and-analysis/news/specialist-maternal-mental-health-midwife-needed-in-every-trust-or

Ryding, E. L., Wijma, K., & Wijma, B. (1998). Experiences of emergency cesarean section: A phenomenological study of 53 women. *Birth (Berkeley, Calif.), 25*(4), 246-251.

Ryding, E. L., Wijma, K., & Wijma, B. (2000). Emergency cesarean section: 25 women's experiences. *Journal of Reproductive & Infant Psychology, 18*(1), 33-39. doi:10.1080/02646830050001663

Saisto, T., Ylikorkala, O., & Halmesmäki, E. (1999). Factors associated with fear of delivery in second pregnancies. *Obstetrics and Gynecology, 94*(5), 679-682.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2013). Midwife-led continuity models versus other models of care for childbearing women. *MIDIRS Midwifery Digest, 23*(4), 457-457. doi:14651858.CD004667.pub3/abstract

Sanders, L. B. (2006). Attitudes, perceived ability, and knowledge about depression screening: A survey of certified nurse-midwives/certified midwives. *Journal of Midwifery & Women's Health, 51*(5), 340-346. doi:10.1016/j.jmwh.2006.02.011

Schwartz-Barcott, D., & Kim, H. S. (1993). An expansion and elaboration of the hybrid model of concept development. In B. L. Rodgers, & K. A. Knafl (Eds.), *Concept development in nursing: Foundations, techniques, and applications* (pp. 107--133). Philadelpia: Saunders.

Seitz, S. (2016). Pixilated partnerships, overcoming obstacles in qualitative interviews via skype: A research note. *Qualitative Research, 16*(2), 229-235. doi:10.1177/1468794115577011

Semali, I., Leyna, G., Mmbaga, E., & Tengia-Kessy, A. (2015). 'Social Capital as a Determinant of Pregnant Mother's Place of Delivery: Experience from Kongwa District in Central Tanzania', *Plos ONE*, 10, 10, pp. 1-10

Sheen, K., & Slade, P. (2015). The efficacy of 'debriefing' after childbirth: Is there a case for targeted intervention? *Journal of Reproductive & Infant Psychology, 33*(3), 308-320 13p. doi:10.1080/02646838.2015.1009881

Shub, A., Williamson, K., Saunders, L., & McCarthy, E. A. (2012). Do primigravidae and their carers have a realistic expectation of uncomplicated labour and delivery?: A survey of primigravidae in late pregnancy, obstetric staff and medical students. *The Australian & New Zealand Journal of Obstetrics & Gynaecology, 52*(1), 73-77. doi:10.1111/j.1479-828X.2011.01396.x

Simkin, P. (2004). Doulas: Nurturing and protecting women's memories of their birth experiences. *International Journal of Childbirth Education, 19*(4), 16--19.

Simkin, P. (2006). What makes a good birth and why does it matter? *International Journal of Childbirth Education, 21*(3), 4--6.

Simpson, J. (2007). Psychological Foundations of Trust. *Current Directions in Psychological Science, 16.* 264-268.

Simpson, K. (2008). PTSD after birth. *AIMS Journal, 20*(1), 9--11.

Simpson, M., & Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review. *Women and Birth: Journal of the Australian College of Midwives, 29*(3), 203-207. doi:10.1016/j.wombi.2015.10.009

Simpson, K. R., James, D. C., & Knox, G. E. (2006). Nurse-physician communication during labor and birth: Implications for patient safety. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 35*(4), 547-556. doi:10.1111/j.1552-6909.2006.00075.x

Simpson, W., Glazer, M., Michalski, N., Steiner, M., & Frey, B. N. (2014). Comparative efficacy of the generalized anxiety disorder 7-item scale and the edinburgh postnatal depression scale as screening tools for generalized anxiety disorder in pregnancy and the postpartum period. *Canadian Journal of Psychiatry, 59*(8), 434-440.

Skeggs, B. (1994). Situating the production of feminist ethnography. In M. Maynard, & J. Purvis (Eds.), *Researching women's lives from A feminist perspective* () Taylor and Francis.

Slade, P. (2006). Towards a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics & Gynecology, 27*(2), 99-105. doi:10.1080/01674820600714582

Slade, P., & Cree, M. (2010). A psychological plan for perinatal care. *The Psychologist, 23*(3), 194-197.

Small, R., Lumley, J., & Toomey, L. (2006). Midwife-led debriefing after operative birth: Four to six year follow-up of a randomised trial [ISRCTN24648614]. *BMC Medicine, 4*, 3-4. doi:10.1186/1741-7015-4-3

Snowden, A., Martin, C., Jomeen, J., & Hollins Martin, C. (2011). Concurrent analysis of choice and control in childbirth. *BMC Pregnancy & Childbirth, 11*(1), 40-40.

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth (Berkeley, Calif.), 30*(1), 36-46.

Soet, J. E. (2002). *Prevalence and predictors of women's experience of trauma during childbirth*. (2002-95008-173).

Sorenson, D. S., & Tschetter, L. (2010). Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum women. *Perspectives in Psychiatric Care, 46*(1), 14-25. doi:10.1111/j.1744-6163.2009.00234.x

Spiteri, G., Xuereb, R. B., Carrick-Sen, D., Kaner, E., & Martin, C. R. (2014). Preparation for parenthood: A concept analysis. *Journal of Reproductive and Infant Psychology, 32*(2), 148-165. doi:10.1080/02646838.2013.869578

Stanley, L., & Wise, S. (1993). *Breaking out again: Feminist ontology & epistemology* Routledge.

Stapleton, H. (2004). Is there a difference between a free gift and a planned purchase? the use of evidence-based leaflets in maternity care. In M. Kirkham (Ed.), *Informed choice in maternity services* (pp. 87-116). Basingstoke: Palgrave Macmillan.

Steele, A. M., & Beadle, M. (2003). A survey of postnatal debriefing. *Journal of Advanced Nursing, 43*, 130--136.

Stefanacci, R. G. (2015). Hospitalists are changing care both in and outside the hospital. *Managed Care (Langhorne, Pa.), 24*(11), 31-31.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant, & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (). Los Angeles: Sage.

Stimson, L. (1995). Caseload midwifery--a cost-benefit analysis. *Modern Midwife, 5*(1), 12-14.

Størksen, H. T., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M. (2013). The impact of previous birth experiences on maternal fear of childbirth. *Acta Obstetricia Et Gynecologica Scandinavica, 92*(3), 318-324. doi:10.1111/aogs.12072

Stramrood, C. A. I., Huis in 'T Veld, Elisabeth M. J., Van Pampus, M. G., Berger, L. W. A. R., Vingerhoets, A. J. J. M., Schultz, W. C. M. W., . . . Paarlberg, K. M. (2010). Measuring posttraumatic stress following childbirth: A critical evaluation of instruments. *Journal of Psychosomatic Obstetrics & Gynecology, 31*(1), 40-49. doi:10.3109/01674820903573946

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA, US: Sage Publications, Inc.

Symon, A. (2006). Midwives must not allow publicity to push them into defensive practice. *British Journal of Midwifery, 14*(9), 542-543.

Talbot, D. (2014). Exploring the 'good' birth: What is it and why does it matter? *British Journal of Midwifery, 22*(12), 854-860.

Tew, M. (2013). *Safer childbirth?: A critical history of maternity care* Springer.

Tew, M. (1995). *Safer childbirth?* (2nd ed.). London: Chapman & Hall.

Thomas, P. (2002). The midwife you have called knows you are waiting. In M. Mauthner, & V. Fleming (Eds.), *Failure to progress: The contraction of the midwifery profession*

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*, 45-45. doi:10.1186/1471-2288-8-45

Thomson, R., Kehily, M. J., Hadfield, L., & Sharpe, S. (2009). The making of modern motherhoods: Storying an emergent identity. In M. Wetherell (Ed.), *Identity in the 21st century*

Thomson, G. M., & Downe, S. (2010). Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive & Infant Psychology, 28*(1), 102-112. doi:10.1080/02646830903295000

Thomson, G., & Downe, S. (2013). A hero's tale of childbirth. *Midwifery, 29*(7), 765-771. doi:10.1016/j.midw.2012.07.008

Thomson, G., & Downe, S. (2016). Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in north-west england. *Midwifery, 40*, 32-39. doi:10.1016/j.midw.2016.06.010

Thompson, A. (2013). Midwives' experiences of caring for women whose requests are not within clinical policies and guidelines. *British Journal of Midwifery, 21*(8), 564-570.

Tracy, S. K., Hartz, D. L., Tracy, M. B., Allen, J., Forti, A., Hall, B., Kildea, S. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *Lancet, 382 North American Edition* (9906), 1723-1732. doi:10.1016/S0140-6736(13)61406-3

Tschudin, S., Alder, J., Hendriksen, S., Bitzer, J., Popp, K. A., Zanetti, R., Geissbühler, V. (2009). Previous birth experience and birth anxiety: Predictors of caesarean section on demand? *Journal of Psychosomatic Obstetrics & Gynecology, 30*(3), 175-180.

van Reenen, S., & van Rensburg, E. (2015). South african mothers' coping with an unplanned caesarean section. *Health Care for Women International, 36*(6), 663-683. doi:10.1080/07399332.2013.863893

Wald, H. S., Dube, C. E., & Anthony, D. C. (2007). Untangling the web-the impact of internet use on health care and the physician-patient relationship. *Patient Education & Counseling, 68*(3), 218-224.

Walker, L., & Avant, K. (2011). *Strategies for theory construction in nursing* (5th ed.) Pearson.

Walsh, D. (2008). 'Free-birthing' and the midwifery services. *British Journal of Midwifery, 16*(11), 702-702.

Warren, C. (2003). Exploring the value of midwifery continuity of carer. *British Journal of Midwifery, 11*(10), S34.

Weston, R. (2011). Midwifery students' significant birth stories: Telling the drama, part 1. *British Journal of Midwifery, 19*(12), 786-793.

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive & Infant Psychology, 24*(2), 107-120. doi:10.1080/02646830600643874

Wise, S., & Stanley, L. (2008). Feminist methodology matters! In D. Richardson, & V. Robinson (Eds.), *Introducing gender and women's studies* (3rd ed.). Basingstoke: Palgrave MacMillan.

Wright, L. (2003). Asking about domestic violence. *British Journal of Midwifery, 11*(4), 199-202.

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research, 5*(1), 125-137. doi:10.1177/104973239500500109

Yildiz, P. D., Ayers, S., & Phillips, L. (2017). The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *Journal of Affective Disorders, 208*, 634-645. doi:10.1016/j.jad.2016.10.009

Appendix 1 - Critical review matrix for literature search

Question	Answer	Score 0-5, 5 being best
NATURE OF STUDY: 5 – systematic review 3-4 – large scale or well designed study 2-3 – small study with more obvious flaws 1-2 – opinion piece or commentary		
STUDY PURPOSE: Was the purpose and/or research question stated clearly?		
LITERATURE: Was relevant background literature reviewed?		
APPLICABILITY: How does the study apply to your practice and/or to your research question? Is it worth continuing this review?		
STUDY DESIGN What was the design? # randomized (RCT) # cohort # single case design # before and after # case-control # cross-sectional # case study OR { phenomenology { ethnography { grounded theory { participatory action research { other _____ Marks for appropriateness of design		
METHOD(S) USED:		

Describe the method(s) used to answer the research question. Are the methods congruent with the philosophical underpinnings and purpose? # satisfaction survey # postal or face to face questionnaire # structured interviews OR { participant observation { interviews { document review { focus groups { other		
DATA COLLECTION AND ANALYSIS: Descriptive Clarity Clear & complete description of site: { yes { no participants: { yes { no Role of researcher & relationship with participants: { yes { no Identification of assumptions and biases of researcher: { yes { no Analysis method appropriate? { yes { no Results were reported in terms of statistical significance? { yes { no Drop-outs reported { yes { no		
CONCLUSIONS: Conclusions were appropriate given study methods and results { yes { no		

Total: **/40**

Appendix 2 – Participant information sheet

UNIVERSITY OF Hull

Title of Project: Choices women make in pregnancy when they have previously experienced a traumatic birth. A qualitative study.

I would like to invite you to take part in a research study. Before you decide on whether you would like to participate, I would like you to understand why the research is being done and what it would involve for you. **Please read the information below. If you have any questions please ring the number at the end of this form.**

Background

There is very little known about what choices pregnant women make, when they have previously experienced a traumatic birth. Because little is known, the support offered to women in making choices may not be best suited to their needs.

My name is Mari Greenfield, and I am a PhD student at the University of Hull. I am interested in finding out what choices women make during pregnancy and birth, when they have previously experienced a traumatic birth. I am interested in the choices themselves, and the reasons women make those choices.

What is the purpose of the study?

This study aims to find out what choices pregnant women make, when they have previously had a traumatic birth. It aims to find out the reasons for these choices, and whether women feel the choices they made helped them achieve what they wanted.

Why have I been invited?

You have been invited to take part because either you contacted me after seeing an advertisement for the study, or because someone involved in your care thought you might be interested in taking part and gave you these sheets. You have been invited because you have previously experienced a traumatic birth, and are pregnant again.

Do I have to take part?

No, it is up to you to decide whether or not you want to take part. This information will tell you what is involved in the study and then whether or not you take part is up to you. If your details were passed to me by someone involved in your care, they will not be told whether you have decided to take part or not.

What will happen if I decide to take part?

If you decide to take part I will first make sure that I can include you in the study. I need to check if you meet the inclusion criteria so I will talk to you on the phone about your current pregnancy, and whichever previous birth was traumatic. If you are eligible, I will invite you to an initial short interview (by phone or face to face), where I will also explain a bit more about the study. This should take

around 30 minutes to an hour. At the end of this, if you wish to take part, I will ask you to sign a consent form.

If you can be included, I will invite you to three longer interviews (around an hour each). They will take place at approximately the middle point of you pregnancy, just before you give birth, and a few weeks after the birth. In these interviews you will be asked about your current pregnancy, and choices you are making or have made about it. You will not have to talk about your previous births (unless you want to).

Other women will be involved in the study, but all the interviews will be one-to-one. Older children cannot be present during the interview, but the researcher is very flexible about the times that interviews can take place.

You will also be asked to keep a weekly diary about choices you are making during your pregnancy. Further information about the diary will be given in the first meeting, but it shouldn't take longer to complete than 5 minutes a week (unless you want to write more). You will be able to fill the diary in electronically or by hand.

To be involved you will need to be willing to both be interviewed and keep a diary as well.

What are the possible disadvantages and risks of taking part?

Talking about pregnancy and choice can be difficult or upsetting when you have previously had a traumatic birth. If you wish to take part, but find that participating upsets you, you do not have to continue.

What are the possible benefits of taking part?

It is hoped that by understanding what choices women make in pregnancy, after a previous traumatic birth, better information can be provided for the future to help those who work with pregnant women.

Although absolutely no advice will be given by me about your pregnancy or the choices you are making, you may find it helpful to have a time to reflect on this yourself.

What will happen if I decide I no longer wish to take part?

If after reading this information sheet you decide not to take part, you do not need to do anything. I will contact you to check whether or not you want to take part but if you do not want to, just tell me and you won't be contacted again.

If after the initial meeting you decide you no longer wish to take part, you can contact me and I will arrange for your data to be destroyed. If you decide to take part and then change your mind, even if you have started the interviews, you simply need to say, and you can just stop the interviews and, if you want me to, I will destroy your data. (Destroying the data will only be possible up to the end of the last interview.)

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me, and I will do my best to answer your questions, or you can speak to my supervisors. If you remain unhappy and wish to complain formally, you can do this through the Associate Dean for Research in the Faculty of Health and Social Care, University of Hull.

Will my taking part in this study be kept confidential?

All data will be handled according to ethical and legal practice. All information which is collected about you during the course of the research will be made anonymous.

When you take part in an interview I will record the interview but I will destroy the recording as soon as I have typed up the interview. I will make sure that the typed up interviews are anonymous.

I will give you a code number at the start of the study and all your information will have this code number on it rather than your name. I will keep the list of code numbers separate from the typed up interviews and diaries to ensure the anonymity of your results.

All the coded data I collect during the study will be stored securely on University Departmental premises for ten years after completion of the study.

If you were referred to me by someone else, they will not be told about whether you took part or not.

What will happen to the results of the study?

The results will be written up as part of my PhD. They may also be submitted for publication in scientific and health journals. Direct quotes from your interview may be used in the publication of the results of the study, but I will make sure that any quotes I use would not identify you so no-one would know they came from you. I can also send you the overall results of the study if you would like.

Who is organising and funding the research?

This research is being undertaken at the University of Hull, and is funded by them.

Who has reviewed the study?

All research is looked at by independent group of people, called an ethics committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed by the Faculty of Health and Social Care's ethics committee.

Further information and contact details

If you have any further questions or queries, please contact me, **Mari Greenfield,** the researcher on this project.

My number is: 0798 0280 153 or you can email me a.greenfield@2013.hull.ac.uk

Appendix 3 – Interview schedule

<u>Research questions</u>

5. What choices are women aware that they have?
6. What choices are they making?
7. What is their thinking about these choices?
8. How do they feel about the choices they are making or have made?

<u>Awareness</u>

How many weeks pregnant are you now/How old is your baby now?

How are you feeling about being pregnant/being a mum again?

What things are you thinking about your pregnancy/having a new baby?

<u>Choices</u>

What sort of choices are on your mind at the moment? (prompt areas below if necessary/appropriate)

- Tests
- Scans
- Seeing professionals
- Diet
- Exercise
- Pregnancy groups
- Birth choices
- Postnatal choices

(Interviews two and three)

Last time you talked about x. Have you thought any more about that?

<u>Reasons</u>

What made you choose to do/not do that?

<u>Satisfaction with choices</u>

When you had chosen to do x, how did it work out for you?

How do you feel about that?

Appendix 4 – Diary format

Title of Project: Choices women make in pregnancy when they have previously experienced a traumatic birth. A qualitative study.
Diary of:

Identity number ....

Weeks pregnant...

Date..

What are your thoughts about your pregnancy, birth, or baby this week?

Have you thought about or made any decisions related to your pregnancy, birth or baby this week?

Appendix 5 – Literature informing Concept analysis

1. [No author listed] (2012) Coventry professor champions parents with birth trauma Pract Midwife **15**(5): 9
2. Alder J, Stadlmayr W, Tschudin S, Bitzer J (2006) Post-traumatic symptoms after childbirth: what should we offer? J Psychosom Obstet Gynaecol **27**(2): 107–12
3. Allen S (1998) A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. J Reprod Infant Psychol **16**(2–3): 107–31. doi: 10.1080/02646839808404563
4. Anderson C, Logan D (2010) Impact of traumatic birth experience on Latina adolescent mothers. Issues Ment Health Nurs **31**(11): 700–7. doi: 10.3109/01612840.2010.518784
5. Anderson C, McGuinness TM (2008) Do teenage mothers experience childbirth as traumatic? J Psychosoc Nurs Ment Health Serv **46**(4): 21–4
6. Ayers S (2003) Commentary on 'Post-traumatic stress following childbirth: A review of the emerging literature and directions
7. for research and practice'. Psychol Health Med **8**(2): 169–71. doi: 0.1080/1354850031000087546
8. Ayers S (2007) Thoughts and emotions during traumatic birth: a qualitative study. Birth **34**(3): 253–63
9. Ayers S, Pickering AD (2001) Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. Birth **28**(2): 111–8
10. Ayers S, Claypool J, Eagle A (2006) What happens after a difficult birth? Postnatal debriefing services. British Journal of Midwifery **14**(3): 157–61. doi: 10.12968/bjom.2006.14.3.20577
11. Bailey M, Price S (2008) Exploring women's experiences of a Birth Afterthoughts Service. Evidence Based Midwifery **6**(2): 52–8
12. Bailham D, Joseph S (2003) Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. Psychol Health Med **8**(2): 159–68. doi: 10.1080/1354850031000087537
13. Beck CT (2004) Birth trauma: in the eye of the beholder. Nurs Res **53**(1): 28–35
14. Beck CT (2004) Post-traumatic stress disorder due to childbirth: the aftermath. Nurs Res **53**(4): 216–24
15. Beck CT (2006) The anniversary of birth trauma: failure to rescue. Nurs Res **55**(6): 381–90
16. Beck CT (2006) Pentadic cartography: mapping birth trauma narratives. Qual Health Res **16**(4): 453–66
17. Beck CT (2009) Birth trauma and its sequelae. J Trauma Dissociation **10**(2): 189–203. doi: 10.1080/15299730802624528
18. Beck CT (2011) A metaethnography of traumatic childbirth and its aftermath: amplifying causal looping. Qual Health Res **21**(3): 301–11. doi: 10.1177/1049732310390698
19. Beck CT, Barnes DL (2006) Post-traumatic stress disorder in pregnancy. Annals of the American Psychotherapy Association **9**(2): 5–9
20. Beck CT, Watson S (2010) Subsequent childbirth after a previous traumatic birth. Nurs Res **59**(4): 241–9. doi: 10.1097/NNR.0b013e3181e501fd
21. Beech BL (2007) Recovering from a traumatic birth. AIMS Journal **19**(1): 25
22. Bick D, Rowan C (2007) Postnatal maternal mental health: an update on depression and post-traumatic stress disorder following birth. Journal of the Association of Chartered Physiotherapists in Women's Health 100: 4–13
23. Boorman RJ, Devilly GJ, Gamble J, Creedy DK, Fenwick J (2014) Childbirth and criteria for traumatic events. Midwifery **30**(2): 255–61. doi: 10.1016/j.midw.2013.03.001

24. Boyce P, Condon J (2000) Traumatic childbirth and the role of debriefing. In: Raphael B, Wilson J, eds. Psychological Debriefing: Theory, Practice and Evidence. Cambridge University Press, New York, NY: 272–80

25. Byrom S, Fardella J, Sandford J, Martindale L, Bardon L, Theophilou G (2010) Collaborating to push boundaries to promote positive birth: an inspirational reflection. MIDIRS Midwifery Digest **20**(2): 199–204

26. Cohen MM, Ansara D, Schei B, Stuckless N, Stewart DE (2004) Posttraumatic stress disorder after pregnancy, labor, and delivery. J Womens Health (Larchmt) **13**(3): 315–24

27. Creedy DK, Shochet IM, Horsfall J (2000) Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Birth **27**(2): 104–11

28. Denis A, Parant O, Callahan S (2011) Post-traumatic stress disorder related to birth: a prospective longitudinal study in a French population. J Reprod Infant Psychol **29**(2): 125–35. doi: 10.1080/02646838.2010.513048

29. Edworthy Z, Chasey R, Williams H (2008) The role of schema and appraisals in the development of post-traumatic stress symptoms following birth. J Reprod Infant Psychol **26**(2): 123–38. doi: 10.1080/02646830801918422**search (continued)**

30. Elmir R, Schmied V, Wilkes L, Jackson D (2010) Women's perceptions and experiences of a traumatic birth: a metaethnography. J Adv Nurs **66**(10): 2142–53. doi: 10.1111/j.1365-2648.2010.05391.x

31. Fenech G, Thomson G (2014) Tormented by ghosts from their past': a meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. Midwifery **30**(2): 185-93. doi: 10.1016/j.midw.2013.12.004

32. Ford E, Ayers S (2011) Support during birth interacts with prior trauma and birth intervention to predict postnatal posttraumatic stress symptoms. Psychol Health **26**(12): 1553–70. doi: 10.1080/08870446.2010.533770

33. Forssen AS (2012) Lifelong significance of disempowering experiences in prenatal and maternity care: interviews with elderly Swedish women. Qual Health Res **22**(11): 1535–46. doi: 10.1177/1049732312449212

34. Gamble J, Creedy D (2004) Content and processes of postpartum counseling after a distressing birth experience: a review. Birth **31**(3): 213–8

35. Gamble J, Creedy D (2004) Counselling processes to address psychological distress following childbirth: perceptions of midwives. Women Birth **17**(3): 16–19. doi: 10.1016/S1448-8272(04)80013-0

36. Gamble J, Creedy D (2005) Psychological trauma symptoms of operative birth. British Journal of Midwifery **13**(4): 218–24. doi: 10.12968/bjom.2005.13.4.17981

37. Garthus-Niegel S, von Soest T, Vollrath ME, Eberhard-Gran M (2013) The impact of subjective birth experiences on posttraumatic stress symptoms: a longitudinal study. Arch Womens Ment Health **16**(1): 1–10. doi: 10.1007/s00737-012-0301-3

38. Harris R, Ayers S (2012) What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. Psychol Health **27**(10): 1166–77. doi: 10.1080/08870446.2011.649755

39. Hofberg K, Brockington I (2000) Tokophobia: an unreasoning dread of childbirth. A series of 26 cases. Br J Psychiatry **176**: 83–5

40. Jack S (2005) Mothers with post-traumatic stress disorder after traumatic childbirth struggled to survive and experienced nightmares, flashbacks, anger, anxiety, depression, and isolation. Evid Based Nurs **8**(2): 59

41. Kahl T (2012) My birth trauma story. Midwifery Today Int Midwife (104): 43–5

42. Kitzinger S (2004) Flashbacks, nightmares and panic attacks after birth. British Journal of Midwifery **12**(1): 12. doi: 10.12968/bjom.2004.12.1.11964

43. Kitzinger S (2006) Birth as rape: There must be an end to 'just in case' obstetrics. British Journal of Midwifery **14**(9): 544–5. doi: 10.12968/bjom.2006.14.9.21799

44. Kitzinger C, Kitzinger S (2007) Birth trauma: talking with women and the value of conversation analysis. British Journal of Midwifery **15**(5): 256–64. doi: 10.12968/bjom.2007.15.5.23397
45. Lapp LK, Agbokou C, Peretti CS, Ferreri F (2010) Management of post traumatic stress disorder after childbirth: a review.
46. J Psychosom Obstet Gynaecol **31**(3): 113–22. doi: 10.3109/0167482X.2010.503330
47. Lear T (2006) Women's perceptions of the birthing experience: An ever-changing phenomenon. J Prenat Perinat Psychol Health **21**(2): 203–10
48. Lee B (2003) Caring for the emotions in pregnancy, birth and beyond. RCM Midwives **6**(11): 472–5
49. Leeds L, Hargreaves I (2008) The psychological consequences of childbirth. J Reprod Infant Psychol **26**(2): 108–22. doi: 10.1080/02646830701688299
50. Lesanics D (2005) Posttraumatic stress symptomatology following emergency Cesarean delivery. John's University, New York
51. Malik R (2008) Traumatic birth leads to creation of birth networks in India. Midwifery Today Int Midwife (87): 56–8, 69
52. Mangaoang M (2009) Childbirth-related post-traumatic stress disorder and its treatment. Ir J Psychol Med **26**(2): 76–81
53. Marjorie V (2004) Traumatic birth. RCM Midwives **7**(8): 356
54. McKenzie-McHarg K (2004) Traumatic birth: understanding predictors, triggers, and counseling process is essential to treatment. Birth **31**(3): 219–21
55. McKinlay A, Grace RC, Horwood LJ, Fergusson DM, Ridder EM, MacFarlane MR (2008) Prevalence of traumatic brain injury among children, adolescents and young adults: prospective evidence from a birth cohort. Brain Inj **22**(2): 175–81. doi:10.1080/02699050801888824
56. Meades R, Pond C, Ayers S, Warren F (2011) Postnatal debriefing: have we thrown the baby out with the bath water? Behav Res Ther **49**(5): 367–72. doi:10.1016/j.brat.2011.03.002
57. Moyzakitis W (2004) Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. Evidence Based Midwifery **2**(1): 8–14**arch**
58. Olde E, van der Hart O, Kleber R, van Son M (2006) Posttraumatic stress following childbirth: a review. Clin Psychol Rev **26**(1): 1–16
59. Oliver R (2005) Birth: hospital or home? That is the question. J Prenat Perinat Psychol Health **19**(4): 341–8
60. Parker J (2004) Does traumatic birth increase the risk of postnatal depression? British Journal of Community Nursing **9**(2):74–9. doi: 10.12968/bjcn.2004.9.2.12422
61. Patrick JC, Devilly GJ, O'Donovan A, Acorn KL, Creedy, D (2011) PTSD due to childbirth stands at between 3.1% (adjusted) and 5.8% (unadjusted). Psychol Med **41**(12): 2683–6. doi: 10.1017/S0033291711001930
62. Pizur-Barnekow K, Doering JJ, Willett M, Ruminski C, Spring M (2014) Birth-related posttraumatic stress disorder: Implications for early intervention services. Zero to Three **34**(3): 41–5
63. Polachek IS, Harari LH, Baum M, Strous RD (2012) Postpartum post-traumatic stress disorder symptoms: the uninvited birth companion. Isr Med Assoc J **14**(6): 347–53
64. Reed M, Fenwick J, Hauck Y, Gamble J, Creedy DK (2014) Australian midwives' experience of delivering a counselling intervention for women reporting a traumatic birth. Midwifery **30**(2): 269–75. doi: 10.1016/j.midw.2013.07.009
65. Reid M (2011) The impact of traumatic delivery on the mother–infant relationship. Infant Observation **14**(2): 117–28. doi: 10.1080/13698036.2011.583424

66. Rice H, Warland J (2013) Bearing witness: midwives experiences of witnessing traumatic birth. Midwifery **29**(9): 1056–63. doi: 10.1016/j.midw.2012.12.003
67. Robinson J (2002) Research roundup: Effects of PTSD on birth. AIMS Journal **14**(3): 17
68. Rowlands IJ, Redshaw M (2012) Mode of birth and women's psychological and physical wellbeing in the postnatal period. BMC Pregnancy Childbirth **12**: 138. doi: 10.1186/1471-2393-12-138
69. Ryding EL, Wijma K, Wijma B (1998) Experiences of emergency cesarean section: A phenomenological study of 53 women. Birth **25**(4): 246–51
70. Ryding EL, Wijma K, Wijma B (2000) Emergency cesarean section: 25 women's experiences. J Reprod Infant Psychol **18**(1): 33–9. doi: 10.1080/02646830050001663
71. Salter K (2009) Beating the trauma of a bad birth experience. Ment Health Today Sep: 14–15.
72. Sawyer A, Ayers S (2009) Post-traumatic growth in women after childbirth. Psychol Health **24**(4): 457–71. doi: 10.1080/08870440701864520.
73. Simkin P (2004) Doulas: nurturing and protecting women's memories of their birth experiences. International Journal of Childbirth Education **19**(4): 16–19
74. Simkin P (2006) What makes a good birth and why does it matter? International Journal of Childbirth Education **21**(3): 4–6
75. Simkin P (2011) Pain, suffering, and trauma in labor and prevention of subsequent posttraumatic stress disorder. J Perinat Educ **20**(3): 166–76. doi: 10.1891/1058-1243.20.3.166
76. Simpson K (2008) PTSD after birth. AIMS Journal **20**(1): 9–11
77. Skibniewski-Woods D (2011) A review of postnatal debriefing of mothers following traumatic delivery. Community Pract **84**(12): 29–32
78. Soderquist J, Wijma B, Wijma K (2006) The longitudinal course of post-traumatic stress after childbirth. J Psychosom Obstet Gynaecol **27**(2): 113–9
79. Soet JE, Brack GA, DiIorio C (2003) Prevalence and predictors of women's experience of psychological trauma during childbirth. Birth **30**(1): 36–46
80. Soet JE (2002) Prevalence and predictors of women's experience of trauma during childbirth. ProQuest Information & Learning.
81. Somera MJ, Feeley N, Ciofani L (2010) Women's experience of an emergency caesarean birth. J Clin Nurs **19**(19-20): 2824–31. doi: 10.1111/j.1365-2702.2010.03230.x
82. Sorenson DS, Tschetter L (2010) Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum women. Perspect Psychiatr Care **46**(1): 14–25. doi: 10.1111/j.1744-6163.2009.00234.x
83. Stramrood CA, Huis In 't Veld EM, Van Pampus MG, Berger LW, Vingerhoets AJ, Schultz WC, Van den Berg PP, Van Sonderen EL, Paarlberg KM (2010) Measuring posttraumatic stress following childbirth: a critical evaluation of instruments. J Psychosom Obstet Gynaecol **31**(1): 40–9. doi: 10.3109/01674820903573946
84. Thomson GM, Downe S (2010) Changing the future to change the past: women's experiences of a positive birth following a traumatic birth experience. J Reprod Infant Psychol **28**(1): 102–112. doi:10.1080/02646830903295000
85. Thomson G, Downe S (2013) A hero's tale of childbirth. Midwifery **29**(7): 765–71. doi:10.1016/j.midw.2012.07.008
86. Vincent M (2004) Traumatic birth... Traumatic childbirth: what we know and what we can do. RCM Midwives **7**(8): 356
87. Vythilingum B (2010) Should childbirth be considered a stressor sufficient to meet the criteria for PTSD? Arch Womens Mental Health **13**(1): 49–50. doi: 10.1007/s00737-009-0118-x

88. Wenzel A (2011) Childbirth-related fear and trauma. American Psychological Association, Washington, DC: 103–25

89. Weston R (2011) Midwifery students' significant birth stories: Telling the drama, Part 1. British Journal of Midwifery **19**(12):786–93. doi: 10.12968/bjom.2011.19.12.786

90. White T, Matthey S, Boyd K, Barnett B (2006) Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. J Reprod Infant Psychol **24**(2): 107–20. doi: 10.1080/02646830600643874

91. Zambaldi CF, Cantilino A, Farias JA, Moraes GP, Sougey EB (2011) Dissociative experience during childbirth. J Psychosom Obstet Gynaecol **32**(4): 204–9. doi: 10.3109/0167482X.2011.626092

92. Zimmerman GH (2013) Birth trauma: posttraumatic stress disorder after childbirth. International Journal of Childbirth Education **28**(3): 61–6

Appendix 6 – Consent Form

Title of Project: Choices women make in pregnancy when they have previously experienced a traumatic birth. A qualitative study.

Please initial boxes

1. I confirm that I have read and understand the information sheets for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I agree to take part in the interview part of the study and understand that my interview will be audio taped. ☐

4. I confirm that direct quotes from the interview may be used in future publications and understand that they will be anonymised. ☐

5. I agree to take part in the diary writing part of the study, and understand that direct quotes from the diary may be used in future publications and understand that they will be anonymised. ☐

Name of participant	Date	Signature
_____	_____	_____

Name of researcher	Date	Signature
_____	_____	_____

Appendix 7 – Ethics Committee approval letter

UNIVERSITY OF Hull

Mari Greenfield
Faculty of Health and Social Care

FACULTY OF HEALTH AND SOCIAL CARE

T: 01482 464680

E: j.dyson@hull.ac.uk

OUR REF: 162

16 March 2015
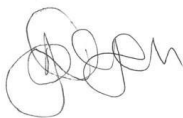
Dear Mari

Re: Amendment to project: Choices women make in pregnancy when they have previously experienced a traumatic birth.

Thank you for your letter regarding the amendment to the above project. Given the information you have provided, I am satisfied that this is only a minor amendment and therefore I am able to give Chair's approval.

I wish you every success with your study.

Yours sincerely

Dr Judith Dyson, Chair, Research Ethics Committee

cc: file/AH

Appendix 8 – Example of code development

Bold typeface indicates that these categories are new additions from most recent interview

MG	That sounds great. And, you'd mentioned when we were just doing the enrolment bit, and I'd said tell me about it later, that you were, erm, you were, doing some things about the HG.		
02	Yes. Yes, erm, I'm having acupuncture, erm, which, is great.	Alternative treatment to mainstream medicine Positive about treatments for physical symptoms	Doing non-medical things for pregnancy/birth/baby
MG	Yep		
02	Erm, I don't know, I don't know if it's working, but I know that I'm not, I don't feel quite as unwell as I did.	Unsure of effectiveness Reporting possible positive effect	**Scepticism/uncertainty about usefulness of non-medical interventions**
MG	Yep.		
02	But I don't know if that's time as well	Aware of other reasons for feeling better Acknowledging lack of knowledge	**Scepticism/uncertainty about usefulness of non-medical interventions**
MG	Mmm.		
02	I'm taking domperidone for sickness	Using alternative and mainstream medicine together	Using alternative and mainstream medicine together
MG	Mmm		
02	Also, erm, B6 and magnesium.	Using vitamin supplements as well as alternative and mainstream medicine	Using alternative and mainstream medicine together
MG	Right.		
02	Spray. The magnesium oil spray. It's not, erm, an oral dose. It's, it's to spray on my legs and arms.	Vitamins used in an alternative way	
MG	Oh right. Right okay. And, at this stage of your pregnancy, what are you thinking about your pregnancy?		
02	Erm, is it ok to feel a bit defiant?	Are her feelings allowed? 'Defiant'	Emotions about pregnancy **Seeking affirmation that feelings/emotions/choices are 'allowed'**
MG	Mmm.		**Feeling defiant**
02	Erm, I, I feel like I was incredibly bullied with [second baby]. When I was pregnant with [second baby].	Relating current feelings to experience of previous pregnancy 'Bullied'	Remembering previous experience Control Bullying

MG	Yeah		
02	And I'm, and whilst I talk the talk of you're not going to do that to me, I'm not going to be treated like that, while I was pregnant with her, I was so afraid that she would die too, that, I did as I was told in the end. Because I was so afraid, that she would die too. But this time, I have, I have (pause) a different mindset. I'm not in a negative place any more, and I feel incredibly hopeful	Telling the story of what happened last time. Relating poor treatment Fearful of death last time Persona she presented last time did not match actions This time – positive mindset 'Hopeful'	Control Saying what she could have done differently Remembering the story Telling the 'story' **Fear of death/catastrophe** This time will be different
MG	Mmm		
02	and positive, and more confident in my choices, that it won't happen again. And that actually I'll come out of it with another live baby.	This time more confident This time not fearful of death of baby	Different choices this time Changing views about birth
MG	Yeah. Yeah (pause). So at 16 weeks, you will, have come across some choices that will have been offered to you already, and you'll have some additional ones because of, because of the HG		
02	Yep		
MG	Can you tell me about what kind of tests and scans and things you've been offered, what choices you're aware of		
02	Yep		
MG	and erm, what you are thinking about them?		
02	Ok. So, I was offered an early reassurance scan at 7, between 7 and 9 weeks, which I declined.	Has declined some scans	**Declining routine/offered care**
MG	Mmm.		
02	Erm, erm, I just, my instinct tells me more than any test could. I had all those tests with [first baby], and he didn't live, and they told me he was absolutely fine, but I knew, my instinct told me that he wasn't, long before he became sick.	Trusting herself more than tests Had tests with first baby, felt something was wrong, but tests said ok First baby died Lost trust in tests?	Sources of information **Trusting/not trusting instincts**
MG	Mmm.		
02	Erm, and (pause) so I decided not to have that.	Made decision this time based on first pregnancy (this is third)	Different choices this time
MG	Mmm.		

02	Erm, I (pause) erm, had my routine booking bloods because, I erm, have, in the past, suffered with hyperthyroidism. It was picked up after [first baby] died, and I was treated between [first baby] dying and [second baby] being born. But once [second baby] was born I was, erm, considered normal, and, medication was withdrawn. Erm, and I've been checked every month since, and I'm still within normal limits	Has medical condition which makes blood tests valuable in her opinion Has routine tests outside of being pregnant Considering value of tests offered, not just following standard advice	**Asking for more than routine/offered care** **Medical care not related directly to pregnancy** **Weighing information to make decisions**
MG	Right		
02	for, erm, throid function. So, that is another thing that had been crossed off. So I was offered those additional bloods and I just said you know what? Yeah, let's have a full blood count at the same time. I'm quite confident I know what everything is, let's just go for it. And of course everything is normal.	Using combination of medical advice and instinct to decide which tests to accept (and maybe knowledge from elsewhere?) Also requesting other tests	**Weighing information to make decisions** **Trusting/not trusting instincts** **Using medicalised language** **Asking for more than routine/offered care**
MG	Great.		
02	Erm, at the time, I was then offered a 12 week, erm, dating scan. I was confident in my dates because I, we naturally family plan, so I do my basal temperature every morning, erm, and I knew the day that I'd ovulated, so it was pretty confident of the dates.	Has used medical techniques, but self administered, to conceive Reclaiming medical terminology? Conception related to family planning	**Using medicalised language**
MG	Yeah		
02	Yeah (laughs). But I, I (pause) also have in my mind that, I, only ever saw [first baby] alive, on a scan. And so that to me, was an important part. So I really, really wanted to see that this baby was actually alive.	Scan valued for non-medical reasons Scan an opportunity to see her baby alive Scan reassuring?	**Non-medical reasons for decisions** **Fear of death/catastrophe**
MG	Mmm.		
02	Erm, and so that's what we, so I, I, I had the 12 week scan. Then, I, was obviously at the same time offered the nuchal translucency, which I declined, because we wouldn't do anything about it anyway	Had made decisions about terminating in case of abnormality before offered tests Some tests declined Had 12 week scan, but not for reasons it is routinely offered	**Declining routine/offered care** **Scepticism/uncertainty about usefulness of medical interventions/tests** **Non-medical reasons for decisions**

		Different set of values/important tests/scans – but leads to accepting some routinely offered scans/tests for her own reasons	
MG	Mmm.		
02	if the baby had Down's syndrome. I didn't have the triple test, erm blood draw. Erm, so we, we don't know. I'm quite confident that's fine. Erm, and then, I, erm. I was offered an appointment with the consultant, the obstetric consultant, which I declined, but of course they sent me a letter anyway, which I called and then cancelled. I saw my endocrinologist, who I saw all of the way through [second baby]'s pregnancy and then afterwards, for the hyperthyroidism. Erm, and (pause) she's great, very supportive of natural birth although she's not an obstetrician.	More tests declined – information they would give is not important to her Trusting instinct over tests, where not bothered about test results Repeatedly offered appointments with Consultant, which were unwanted Support of her birth choices by non-obstetric medical staff important and valued	**Declining routine/offered care** **Repeated offers of unwanted medical care** Medical staff helping **Support from others (not partner)**
MG	Right		
02	And erm, and so I feel confident that if we've got peripheral issues dealt with, I don't want to see an obstetrician. So erm, yeah, that's that's	Clear she does not want to see Obstetrician Sees importance of dealing with medical issues which are not related to pregnancy	
MG	Yeah		
02	Erm, one of the things, she did tell me, kind of (pause) well, the nurse in the clinic, kind of did a bit of a sneaky thing what, which was, I know XYZ consultant has said to you that we would like to do, erm, er, and HBA1C	Nurse perceived as 'sneaky' Nurse and Consultant working together Nurse relaying what Consultant wants	**Weighing information to make decisions** Betrayal of trust Medical staff homogenised **Being tricked into decisions** Power dynamic in choice What choice means Control
MG	Mmm.		
02	And I know you're not keen, but, can we do it anyway? And I sort of went, *sigh*, you know what? I just want to go home, just take my damn blood and do it. And of course, it all came back fine, thank god. But, I did feel pushed into that	Felt 'pushed' into medical tests she didn't want Nurse aware of her choices, but pushing her to accept unwanted tests anyway	
MG	Mmm.		

02	it was, I'd already declined and said no I don't want it, but she'd written it on the form, and I kind of felt pressured at that point, but, you know, in hindsight I'm glad she did because it's all, ammunition to say you, your glucose is fine	She had verbally made choices, they had been recorded, but was asked again for permission to do unwanted tests 'Pressured' Because results were normal, she was glad she had had tests, because it gave her 'ammunition' Might have felt differently if tests were not in normal range?	**Scepticism/uncertainty about usefulness of medical interventions/tests**
MG	Yeah		
02	So, and there is no reason now, to, to do any further testing, other than the fact that I'm, I've a raised BMI. So, erm, at that point then I was offered, erm, to meet the obstetrician. Not have an appointment, but just meet her, because she was in the next room. And I, and I was feeling very confident that yeah yeah, I'll meet her, it'll be fine, and… So I did, and she started talking about negotiating. And the, as soon as the words left her mouth, I thought there is absolutely no way I am negotiating with you. Because this is exactly what happened with [second baby], and what you just do is break me down.	Does not want further testing, because she sees no medical reason to do it Has raised BMI Had already declined appointment with Consultant verbally, then had been sent written appointment, had called and cancelled, then offered 'meeting' whilst already there, having just been 'pushed' into unwanted tests Agreed to meeting as feeling confident 'Negotiating' seen as anti-choice Sees negotiating a very strong (negative) word Relates 'negotiating' to the loss of control she experienced in last pregnancy? 'What you just do is break me down' Fearful of being pressured into agreeing to things? Avoidant behaviour with Consultant, maybe because of fear of pressure?	**Scepticism/uncertainty about usefulness of medical interventions/tests** **Bullying/pressure** **Repeated offers of unwanted medical care** **Avoidance** **Hyper sensitive to medical staff language/beliefs/intentions**
MG	Right		
02	My instinct speaks louder than anything that I've ever known about myself, and when I'm then influenced by outside, I'm pecked at and pecked at, so that stuff in my mind changes, and I think, what if? It's always the what if.	Wants to trust instinct Finds outside influence weakens her own trust in instinct Perceives how medical staff worked with her in previous pregnancy as being 'pecked at' Fearful of potential risks, trying to not allow the fear Worried about changing her mind because of outside influences, and then regretting it?	Bullying/pressure Trusting/not trusting instincts

MG			
MG	Mmm		
02	Because I know what the what if is. I've experienced it. I know what the what if is. I know that the baby could die, but, I don't need somebody to tell me, that that is an opt… that is a possibility. I, I, I just need to stay positive. And when she started to saying negotia… it's all about negotiation, and I thought no. It's not about negotiation (laugh). I didn't say anything, I just went yeah that's lovely thank you. Well go away and think about it then, and if I got to see you later in the pregnancy then I'll, I'll, of course, give you a ring. But, when I left the clinic, she sent me a letter.	Can identify clearly what she needs – positivity Has experienced the worst that can happen – her first baby died Not unaware of the risks Finds going over the risks takes away what she currently needs (positivity) Perceives negotiation as a very negative word Has taken path of least resistance to get physically away from Consultant This involved not being honest to Consultant	**Stating needs** **Fear of death/catastrophe** **Avoidance**
MG	Mmm.		
02	It was dated that day, saying it was lovely to meet you, I feel that we can work well together, erm, I've made an appointment for you for 24 weeks, and it will be lovely to see you then. Well of course I called straight away and cancelled it. Because I'm not going.	Was sent a letter same day she met with Consultant, with a pre-made appointment Cancelled it immediately Very clear she does not want to see Consultant This choice not being respected Language of letter (and meeting) sounds positive, but not perceived as such by participant	**Repeated offers of unwanted medical care** **Avoidance**
MG	Right		
02	Er, so that's something else I've declined. So I've declined the consultant care	Has declined Consultant care Decision not 'heard' by medical staff?	
MG	Yep		
02	Erm, I… have agreed to erm thyroid testing every 10 weeks	Has agreed to tests she values	**Medical care not related directly to pregnancy**
MG	Yes		
02	Which for me is, is important. That for me is something I don't want to not do	Some tests perceived as important and what she wants to do	**Medical tests being valued**
MG	Mmm		
02	Erm, because that's an all over health thing. That's not something that will exclude me from a home birth, that will not exclude me from, you know, any of the things I want to do	Perceived as important because related to her outside her pregnancy Fearful of being 'excluded' from homebirth Fearful of being 'excluded' from choices	**Fear of 'not being allowed'**

Theoretical codes	Grouping
1. Emotions about pregnancy	This pregnancy
2. Physical symptoms	This pregnancy
3. Physical symptoms linked to feelings about pregnancy	This pregnancy
4. Remembering previous experience	Story forming
5. Impact of new baby on family unit	Postnatal/parenting
6. Telling the 'story'	Story forming
7. Impact of traumatic birth on early parenting	Postnatal/parenting
8. This time will be different	Different this time
9. Cascade of interventions	Story forming
10. Breastfeeding	Postnatal/parenting
11. Previous lack of knowledge	Knowledge/information
12. Impact of traumatic birth on partner	Partner
13. Sources of information	Knowledge/information
14. More informed this time	Knowledge/information
15. Power dynamic in choice	Power and choice
16. What choice means	Power and choice
17. Homebirth	Making plans
18. Changing views about birth	Knowledge/information
19. Hospital birth	Making plans
20. Control	Power and choice
21. Different choices this time	Making plans
22. Distance	This pregnancy? Bump?
23. Betrayal of trust	Support
24. Medical staff as other	Support
25. Medical staff homogenised	Support
26. Identifying similar features in pregnancies	Story forming
27. Feeling unwell in this pregnancy	This pregnancy
28. Practicalities of getting information	Knowledge/information
29. Early planning ahead	Making plans
30. Her 'performance' in pregnancy/labour	Story forming
31. Decisions made by others	Power and choice
32. Support from partner	Support
33. Birth plans	Making plans
34. Vulnerability in labour	Story forming
35. Medical staff helping	Support
36. Exercising choice and being pushy	Power and choice
37. Asking for help	Making plans
38. Fatalism	Story forming
39. Breastfeeding	Postnatal/parenting
40. Doing non-medical things for pregnancy/birth/baby	This pregnancy
41. Combining work and motherhood and pregnancy	This pregnancy
42. Nutrition	This pregnancy
43. Exercise	This pregnancy
44. Maternity leave	Postnatal/parenting
45. Attending birth groups	Knowledge/information
46. Practicalities of getting information	Knowledge/information
47. Not being able to get information	Knowledge/information
48. Doing what is 'normal'	
49. Her 'performance' in postnatal care	Story forming
50. Medical staff not helping	Support
51. Saying what she could have done differently	Story forming
52. Low expectations	Making plans

53. Reading birth notes	Story forming
54. Not being given information	Knowledge/information
55. Scepticism/uncertainty about usefulness of non-medical interventions	Making plans Knowledge/information
56. Scepticism/uncertainty about usefulness of medical interventions/tests	Making plans Knowledge/information
57. Using alternative and mainstream medicine together	Making plans
58. Seeking affirmation that feelings/emotions/choices are 'allowed'	Support
59. Feeling defiant	Power and choice
60. Bullying/pressure	Power and choice
61. Fear of death/catastrophe	**Emotions about this pregnancy**
62. Declining routine/offered care	Making plans Power and choice
63. Trusting/not trusting instincts	**Emotions about this pregnancy**
64. Medical care not related directly to pregnancy	Support
65. Asking for more than routine/offered care	Power and choices
66. Weighing information to make decisions	Knowledge/information
67. Using medicalised language	Power and choice Knowledge/information
68. Non-medical reasons for decisions	Power and choice
69. Repeated offers of unwanted medical care	Support
70. Support from others (not partner)	Support
71. Being tricked into decisions	Power and choice
72. Avoidance	Power and choice
73. Stating needs	Support
74. Hyper sensitive to medical staff language/beliefs/intentions	Support Power and choice
75. Medical tests being valued	Power and choice Support
76. Fear of 'not being allowed'	Power and choice
77. Practicalities of arranging desired care	Support
78. What makes a birth traumatic	
79. Uncertain about plans	Making plans
80. Openness to change	Making plans
81. Battle	Making plans
82. Independent midwife	Making plans

Appendix 9 – Extract from Reflexive Journal

9th April 2015
Have conducted 3 first interviews, transcribed 2, begun third

- Women who want Consultant-led care see midwives as the gatekeepers to that. What they want is a referral, and not a lot else. Concerns from them about being 'pushed' by midwives to a less medical choice, ie, not an elective c-section, or using a birth centre instead of hospital labour ward.

- Women who don't want Consultant-led care feel they have to fight the midwives/be firm with the midwives to avoid a referral. They have concerns about midwives 'pushing' them down a more medical route – so far into a hospital birth rather than a homebirth, or into an attended birth rather than a freebirth.

- What is the role of the Community Midwives in a birth after a previous traumatic birth? What is the role of the Community Midwives during that pregnancy? Can they successfully engage with women to provide anything other than routine tests? If not, why not? Is it a desirable role?

- Community midwives quite peripheral in all interviews so far. Women's feelings towards them don't seem bad – more irrelevant really? Knowledge not sought from them at all so far. In pilot, interviewee says she said to her work colleagues she was going to see 'the chocolate teapots' every time she had a midwife appointment, reflecting how useless she felt they were.

11th April 2015
Following interview with participant 05

- Reflecting on the interview. This was the first interview in which a participant had become distinctly upset. In previous interviews some hard topics had been discussed, some of which were upsetting, but this was the first participant who had cried (openly and lots) during the interview. I checked in gently during the interview, and explicitly at the end that she was okay, she was very clear that she cries easily and that she was fine. Check with Julie/Lesley whether/how to follow this up.

- Interestingly this is her second birth, but her partner's first. I wonder whether that makes a difference both in terms of outcomes, and support. And also what difference it makes to the relationship between them down the line if this birth is good/okay/traumatic?

- Interested in the internalisation of 'setting myself up to fail' by expecting a good birth. Where does that belief come from, and what impact will it have on her forthcoming birth.

15th April 2015
Following interview with participant 04

- Reflecting on interview. I think a good interpersonal connection was established. She was disarming frankly, 'I don't have any choices really' – she is the first participant to have expressed this view. Interesting that she has two previous traumatic births, all previous participants have only had one traumatic birth (one also has a positive previous birth). From brief things she has said, it may be that she felt differently about choices in her second birth (which would be where most other participant's births are). Very aware of differences in language used between her and I in relation to agency. Sense of disembodiment 'when it will happen' (planned caesarean birth). Didn't pick up any sense of her owning the birth, but conversely language about pregnancy complications made her self rather than her body

responsible 'see what I do… see if I behave myself'. Interesting that she has removed all expectations of anything good happening – live mum and live baby are her hopes 'anything else positive is a bonus'. Think this is a real lowering of expectations in order to not be disappointed, this seems like a self-protecting mechanism to prevent trauma (check with Lesley if this is a recognised thing in psychology). Think this is not only deliberate, but may be done with some self awareness that that is what she is doing and why.

- A few times I was aware of wanting to slip into doula mode and give advice, when she said Consultant had told her delayed cord clamping isn't possible in a caesarean birth. (Fully aware this is not my role in this instance and did not do anything about it).

- Again the internalisation of her expectations being to blame for the emotional trauma of previous births? Or is this simply a defence mechanism and not an internalisation of responsibility? If it is a defence mechanism, does it work? Is it a good/bad/neutral thing?

- Slight concern she may see interviews as mildly therapeutic – she mentioned that it might help her to see that she does have some choices – check with Lesley and Julie if this is a problem and if so how to handle. Not overly worried though, as think it was more a reflection on her part that just came from having space to talk to someone outside, and maybe from talking to someone who was listening rather than telling.

18th April 2015
Have conducted 5 first interviews, transcribed 4
- Where do women get their information from? For some it is obvious because they have mentioned books, internet, groups. For participant 04, how did she know to ask the Consultant for delayed cord clamping (which was refused), when she is clear she doesn't use the internet? An intense 'search for information' seems a prevalent thing across all women. What happens when they can't find it, as with participant 01 and questions not answered at homebirth group?

- Locus of expertise – women opting for Consultant care see the expertise as being held by the medical establishment. Women keen to avoid it see themselves as the expert in what is right for them. Some evidence emerging that Consultants are not always up to date (delayed cord clamping and NICE guidelines). Seems quite all or nothing – women who see medical staff as experts not valuing their own views, or not able to argue what they want, or something like that? Women who see themselves as experts not trusting medical staff to have correct information even – not surprising they are mistrustful – examples of incorrect information being given to 04 and 06 already (04 unaware, 06 aware). Midwives, GPs, Health Visitors figure nowhere in the stories of who holds expertise.

- Fear is a big driving force. Fear of being pressured, bullied, experiencing poor care. Maybe that is determining birth choices?

- Not all women hold high expectations of birth (possibly counter to other birth trauma research?) 04 has very low expectations, possibly as a protective factor. 06 to some extent too. 01 very 'unpushy'.

- Role of partner as a support or a problem is emerging. Interesting stuff for 06 and 04, who have new partners – 04's partner has never had a baby, 06's has one baby, but 28 week baby so very different experience. The women are educating the partners – is this a thing which is likely to be successful?

- What is it about these women, as opposed to other women who have had a traumatic birth, that makes them want to have another baby/birth?

- Differences between women who have had one previous traumatic birth (01, 03, 05), and those who have had two traumatic births previously (04 and 06)? And those who have had one 'good birth' and one traumatic (02 maybe)?

20th April 2015
Have conducted 5 first interviews, transcribed 4, begun 5th
- Breastfeeding has been important to all participants so far. Beck found breastfeeding could add to trauma if unsuccessful, or ameliorate some effects if successful. Women who have had a traumatic birth are less likely to have further children, and likely to have longer age gaps. Maybe these women have all gone on to have further children BECAUSE breastfeeding was successful/semi-successful? Idea for further research in the future – quantitative research comparing subsequent birth rates amongst women who have had traumatic births, and breastfed, against women who have had traumatic births, and not breastfed.
- Women 'having unrealistic expectations' is sometimes said to be a contributory factor in birth trauma. That is usually taken to mean having unrealistic expectations about method of delivery. At end of interview 01 with participant 03, she is talking about her expectations. Implies that a mum needing help with breastfeeding should override shift change, tea breaks, etc. Talks about poor care. Maybe the unrealistic expectations women hold are of the care they will be provided in Maternity services, rather than of how birth will be?

26th April 2015
Have conducted 5 first interviews, mid transcribing interview 5
- Transcribing first interview with participant 04. Relating to point above, reflected that perhaps for women who have Consultant-led care rather than midwifery, or those who have midwives with little time, there may not be many opportunities to just talk about their pregnancy and/or birth, without being given advice.

28th April 2015
Have conducted 5 first interviews, mid transcribing interview 5
- Feeling quite upset transcribing this interview. The participant has had two traumatic births, medically and emotionally. On listening to her interview in detail during transcription, my surface interpretation is that she feels the only way to not have an emotionally traumatic birth this time is to suppress/abandon/put to one side all her desires. Yet when prompted even slightly in the interview, it is clear those desires are there, and are important to her. But I am interpreting her actions as being not to insist on them, or even explore them further, because if she admits to herself that she really wants anything, she will set herself up for an emotionally traumatic time. Slight concern that this emotional strategy may not work for her in retrospect. But also feeling saddened that she isn't being supported in some other way. There doesn't seem to be any emotional support from midwifery – all concerned with medical appointments and routine stuff. Even having a designated midwife (which has been arranged through HOM is about making sure she is medically monitored according to the Consultant's plan post birth. Has not discussed breastfeeding with designated midwife (something she definitely wants to do), just how often her obs will be done. And I am sad that two birth experiences should have made her feel this is the only coping strategy available to her – to bear the emotional responsibility for disappointment.

5th May 2015

Have conducted 6 first interviews, mid transcribing interview 6

- Reflecting again on power, and role of midwives. Participant 5 is under Consultant, but needs midwives to arrange hospital appointments and change things. It all seems a battle. Is the battle from the woman or the midwife? A feeling of almost a celebration of the battle/fight – I won't be defeated this time? Choice as a prize for winning the fight?

- Again interesting to look at sources of information (participant 5 is writing her degree dissertation on traumatic birth, so has different sources of information to most other participants). No-one is using antenatal classes as a source of information at all. Very little use of midwives as a source of information. Consultant used by two participants for information, notes by one, mostly not using medical sources even if under Consultant care though.

7th May 2015

Have conducted 6 first interviews, mid transcribing interview 6

- Really struck by a line in transcript that I didn't consciously hear during interview. After minor disagreement with midwife over location of an antenatal appointment 'It was like she was trying to take my child away'.

Appendix 10 – Extract from interviews

Interview 01
Participant 03

MG	Okay, that's the, the recorder switched on there. So, erm, the first questions that I wanted to ask you about, I've already just asked you as we were chatting, but it was about how many weeks pregnant you are now?
03	About 12 plus 2
MG	And how are you feeling about being pregnant again?
03	Erm, quite anxious because the sickness has got quite bad. And it was bad through my last pregnancy, erm, so it makes you quite worried that it's going to continue all the way through again
MG	Right. Did it continue all the way through last time?
03	Yeah, right through labour
MG	Oh gosh, right. That's not much fun.
03	Yeah, it was contraction, sick, contraction, sick (laughs)
MG	(laughs) Oh dear
03	All the way through
MG	Right, and so does that, is that feeling the same level of sickness as last time?
03	Erm it got, it wasn't as bad, but the past sort of 48 hours it's been really bad
MG	Right
03	So they've thankfully put me on the strongest drugs they can now, to try and avoid emission, so I'm hoping that and ice lollies will sort of get me through the day
MG	Right (laughs) Oh dear. Erm, and other than the sickness, er, how are you feeling about being pregnant again?
03	Erm, excited. I still can't really think about… erm, birth side of things yet, erm, and I've spoken to my midwife and she's, she was my midwife initially last time
MG	Right
03	And she's really good that she understands, a lot of what I went through
MG	Right
03	Erm, and, that, she's referred me to the Consultant so that I can talk to them about having an elective
MG	Right
03	Rather than a natural birth
MG	Yeah. And, and that's something that you're interested in, is it?
03	Yeah very
MG	Yeah
03	Erm, because I tore quite badly with [first baby]
MG	Right
03	Erm, and because when I went into labour I was already severely dehydrated erm, and I was meant to be induced, but I sort of started partly on my own, and then was partly induced… And I just was in no fit state to labour and I just don't want to get in that state again
MG	Yeah
03	Because then after she was born my body just shut down
MG	Right
03	And that sort of, that had a knock on effect for several months really
MG	Mmm, yeah
03	Where I just couldn't, I didn't feel I could parent her properly cos I just wasn't well enough
MG	Mmm
03	So I just think I need that control over the situation, sort of knowing when it will happen and, how it will happen and things like that

MG	Mmm. Right. And so when's your referral to the Consultant, do you know?
03	Erm, they think it'll be about 14 15 weeks so it should be quite soon
MG	Oh right, well that'll be good to be able to erm, to get some answers I guess? At that point?
03	Yeah, yeah.
MG	And how are you feeling about being a mum again?
03	Er, really excited. Erm, my little, my younger brother's got two, er, my niece who's, 9 months older than my little one, and then, my nephew's sort of just been born, so it's similar age gap
MG	Ah right, yeah
03	So it's nice to see them interacting together and to see my little one interacting with her nephew. She's fascinated. She gave him a bottle the other day and was so excited
MG	(laughs)
03	Yeah we'd thought of having two of them really
MG	Yeah, that sounds good. And erm, what things are you thinking about your pregnancy now?
03	Erm… well at the moment there's a lot of practical things that are up in the air, so that's sort of getting in the way. Er, my job's ended
MG	Right
03	So I'm trying to job hunt before anybody realises that I'm too big and pregnant. Erm, and also we don't have anywhere to live at the moment. Cos we've rented our place out and we're looking at moving
MG	Right
03	So we can't… those practical bits are sort of a bit arrgh
MG	Right
03	Cos I can't sort of nest and settle and do any of that cos I don't even know where I'm going to live (laughs)
MG	Wow, that's a lot to be
03	And there's the whole issue of if the sickness and stuff carries on being bad,
MG	Yeah
03	So I'm relying on my parents quite a lot for childcare. And if we move away I won't have any family support. So then what do I do? So it's sort of, there's a lot sort of other outside [inaudible] going on which is sort of a bit of a worry
MG	Gosh. That's an awful lot to be having going on
03	Yeah
MG	In early pregnancy
03	It wasn't great timing (laughs) but hey ho (laughs)
MG	These things happen don't they? Yeah
03	Yeah. And also my sort of, my best friend is a nurse, and she was actually my birth partner when, [first baby] was born. Erm, and she was a great support through the pregnancy last time but she's actually, she's just had a miscarriage herself
MG	Oh gosh
03	So I haven't, I can't really talk to her about the pregnancy at the moment, I've sort of, lost that support from her for a minute. So it's really difficult cos she's like why, my one sort of mummy friend who, who gets a lot of it.
MG	Yeah
03	So it's been quite hard not just sort of having her to refer, to refer to for support at the moment
MG	Yeah, I bet, yeah
03	But she's just, you know, really going through it herself, so…
MG	Yeah, I bet… And what sort of, erm, you'd said that you're having an anti-emetic from, from, is that from the doctor or from the midwife or…?
03	Erm, from, the… gynae doctor recommended that the, nurse prescribe it to me today
MG	Right
03	So they've actually given me [drug] now
MG	Right
03	Which I think's quite, the strongest they can

MG	Right
03	So, hopefully that'll work
MG	Right. And so are you seeing erm, sort of the midwives and people a little bit more because of the sickness?
03	Yeah
MG	Yeah
03	Yes. She said normally they skip the 16 week and the 20 something week one but she wants to still see m, erm, and she's talking about referring me to the peri-mental, prenatal mental health just to make sure that everything's sort of okay
MG	Mmm
03	She said then if I do see the Consultant and I do want to have, the section it'll sort of help my case if I can sort of explain it to a mental health erm, professional as well as to the midwife sort of team
MG	Right. And how do you feel about that referral?
03	Erm, yeah. Happy really I think because, I just, I feel okay at the moment but, I do feel like the slightest little thing's going to spark me off
MG	Right
03	Just because everything else is so, sort of chaotic
MG	Mmm
03	I just feel that someone's going to say something quite minor and it's going to be like the worst thing in the world
MG	Mmm
03	But I'm not finding I'm bonding that much with the pregnancy yet. Erm, like we've, we've decided we don't want to find out what we're having
MG	Right
03	Because there's pressure from family to have a boy
MG	Right
03	Erm, my husband is the only son with children
MG	Right
03	So there's sort of the pressure there…
MG	Carry on the family line
03	Yeah, and I honestly don't mind either way. But equally, I don't know. I mean even with [first child] I didn't really accept that I was having a baby until sort of 24 weeks
MG	Right
03	Just… I dunno… I've got a lot of medical professionals as friends and family, and I just, found it, easier to, deal with the pregnancy to deal with it as a pregnancy rather than a product of a baby if that makes sense? (laughs)
MG	Mmm. It makes sense
03	It was only when she was 24 weeks and I thought well if I went into labour and if something happened they would do everything for her that I could really bond. So I think it's kind of going the same way this time. I'm just thinking I'm so sick, and , I've been feeling so, rough, that it might affect the development. And if something came up at one of the scans, of course I'd be devastated… but I don't feel that I'd think I'd lost a baby, I've lost a pregnancy. Does that make sense?
MG	Right. It does, it does. Yeah
03	I think later along I'm sure I'll be wanting to buy loads, and…
MG	Yeah
03	Probably will regret not finding out, but at the moment I'm just sort of, yeah, it's a pregnancy not a baby yet.
MG	Mmm. So, how does your other half feel about not finding out?
03	Erm, he's happy to not find out.
MG	Right

03	Yeah, I think he's feeling the pressure even more so (laughs). You know, why did you not produce a boy? (laughs)
MG	(laughs) Yeah, yeah, well, it'd, it's his fault, is it?
03	But he's equally coming up with really silly names, so that's kind of his way of dealing with the pressure of it, is to come up with really humourous names.
MG	Right. And what's
03	And he's obviously quite worried about me with the sickness
MG	Yeah
03	Cos I was so poorly last time
MG	Yeah, yeah. That must be really hard to watch a partner go through
03	I think it's almost easier that he's away a lot (laughs)
MG	Right
03	Cos he works away, so I think it's almost easier that he doesn't have to see it day in…. Yeah he's quite erm, he's very hospital phobic, and quite sort of, illness phobic, so he really panicked, and I think because I was so sick, and he had to go through that and hear that, that it's actually kind of nice that he's not, not having to be around to hear that any more
MG	Right
03	Cos it's, it can't be nice (laughs)
MG	Mmm. No
03	Erm, so it's kind of almost, easier to have that, sort of, hidden from him in a way.
MG	Yeah. So, where he's working away, is that where you're thinking of moving to?
03	Yeah
MG	Yeah. Right. I see, That makes sense, then. Erm,
03	There's sort of the whole worry then… it's a whole new hospital, and is that worse than the hospital that I already know
MG	Mmm
03	Erm, but equally, if I can have an elective, then I could possibly still come and have baby down here
MG	Right
03	Which would then be a lot easier with [first baby], because then my parents could look after her, and [partner] could be with me in the hospital
MG	Right
03	Whereas up there, someone would have to come up to us
MG	Mmm. That's, that's interesting about how that would work then, in terms of who would provide your maternity care?
03	Yeah
MG	Yeah
03	Yeah, I'm not sure.
MG	No, no. That'd be interesting to, to discuss I guess at the consultation…
03	Yeah
MG	Yeah. And so, erm, what other choices are you being offered about your pregnancy at the moment?
03	Erm, I got offered the… the, is it the, the test they do at, the NT test that they do at the 12 week scan
MG	Right, yeah. And…
03	I think that's it so far
MG	Right. And you said that you, you are going to have the 12 week scan, but that's… they're a little behind in your area
03	Yep
MG	So that's, that's in a few weeks.
03	Yeah, next week
MG	Yeah. And what other kind of, thinking about choices, that you might make about things like diet and exercise and pregnancy groups, what kind of choices are you making there?

03	Erm, I'm just trying to eat anything I can possibly keep down (laughs)
MG	(laughs) Yeah
03	Today's choice is mainly going to be ice lollies, cos I had one this morning, and it's stayed down (laughs) So, yeah, I'm just trying to eat what I can little and often
MG	Yeah
03	Erm, and things like salt and vinegar crisps seem to stay down quite well
MG	Right. Right
03	And just to sort of, well, I mean I can't not keep active with a toddler.
MG	No. Yep
03	But trying to balance that with like rest so like today she's in nursery so I'm meeting a friend for lunch who's down from London
MG	Right
03	And then I'm going to spend the rest of the afternoon just sat on my bum, cos I just need that time, cos I've been up since 3 o'clock
MG	Oh gosh
03	So I can sleep between feeling sick and being I just have had hardly any sleep
MG	Right
03	So…
MG	Gosh
03	Kind of finding those little moments to just relax really
MG	Yeah. Absolutely
03	I got an app that my friend recommended called… what's it called, I'll have a look… erm, mind the bump
MG	Right
03	Erm, and it's all about like mindfulness and relaxation through pregnancy and birth
MG	Right
03	So I've started to, kind of doing that
MG	Mmm
03	Just cos I can't switch off at night because there's so much going on. I can't sleep very well
MG	Right
03	Er, so I thought if I maybe start doing that, each evening maybe that'll sort of help, the whole relaxing and the, and then later on it gets, you know, bonding with the bump and… like talking to your baby and stuff like that
MG	Right
03	So I'm hoping that'll sort of help as well
MG	Yeah. And are you finding that…
03	[At same time] And a lot of the birth was panic. I did really panic. Because I felt so… so ill.
MG	Mmm
03	And because I didn't feel… in control… and I've just… I was in no fit state to labour (laughs)
MG	Mmm
03	And even the Consultant that I have seen said they shouldn't have let me labour that long in the state I was in
MG	Mmm
03	Erm…. And that all kind of added to the anxiety
MG	Mmm
03	Whereas I've spoken to other mums who had sort of traumatic births and they said their second birth or subsequent birth has gone a lot better
MG	Mmm
03	Because they've just been more prepared and more calm
MG	Mmm
03	So, I thought, maybe that sort of stuff will help as well
MG	Yeah. Yeah. That sounds erm, that sounds good. Is it, erm, working for helping with sleep and relaxation?

03	Erm, not so far but I've only been doing it a few days
MG	Right
03	So hopefully it will
MG	Right
03	Erm, and I've sort of, it's just working out the little stresses… Like we had a place, a house we applied for, which we found out yesterday we didn't get, so I've to go back to sort of square one with house hunting, but then I have got a job interview, hopefully next week, so that's sort of, it's just getting all these little things in place
MG	Mmm
03	So that I can start to relax a bit more
MG	And are you looking for jobs where you're hoping to be living?
03	Yeah
MG	Yeah. So you're having to travel to job interviews as well?
03	Yeah, yeah.
MG	That's an awful lot on
03	Yeah. At the, at the moment the travel's not too bad, but… um, I keep getting sciatica in my leg
MG	Right
03	I think, cos of, where baby's positioned, it's right on a nerve. And it just sets my leg off when I'm driving
MG	Right
03	Driving is not massively comfortable
MG	Right
03	Erm, so I'm hoping, I dunno. But now the sickness is bad I'm thinking should I even be moving, should I just, give in to the fact of staying here for another six months, but then it's us living apart, it's the impact that has on [first baby]
MG	Mmm
03	It's all a bit urgh
MG	And are you living, at the moment, in the house you're going to rent out, or are you living with your parents?
03	Er, no, I'm living with my parents
MG	Right
03	Yeah, our, our house should be rented out by Monday which will be one huge relief gone.
MG	Yeah. Yeah. It's stressful isn't it, being a landlady?
03	Yeah, people like oh what are you, there's like a list of so many stressful events, I think it's about ten, and they say if you've got any more than two, then that's sort of a high stress year, and I think we've got about five and it's like why have we done this to ourselves? (laughs)
MG	(laughs)
03	It's just how things have worked out
MG	Yeah. Absolutely
03	I couldn't help my job from ending
MG	No
03	We, we can't live in the flat, partly because… I've just got too many memories attached to it of how things were with [first baby]
MG	Mmm
03	And even during my pregnancy and before that we had problems with the neighbours, and although they're not there any more I still don't feel safe there
MG	Mmm
03	So I can't, with him away, I can't live there with [first baby]. It just, it sends anxiety through the roof. I just never feel safe there.
MG	Right, right
03	And because it's an open plan flat it's quite a difficult area to keep safe for her
MG	Right

03	Erm, so, but within all of that, it's sort of a case of right well you're going to be working away so the best thing is for me to be at my parents, but then that's kind of got the stress of we're having to share a room, she ends up in with me most nights, and it's sort of how long I can feasibly do that with, you know the bigger I get. She's a bit of a thrasher (laughs)
MG	Yeah
03	So yeah, it's all a bit up in the air (laughs)
MG	Wow. That sounds like so much going on at the same time (laughs)
03	And then, meanwhile I'll just grow another human (laughs)
MG	Yeah (laughs) yeah, grow an extra, and extra spine while you're at it (laughs)
03	Yeah (laughs)
MG	Yes. Yeah, that sounds incredibly hard work. Erm… have you thought, in, in any of this about your kind of postnatal choices? Or is that… a distant horizon?
03	Erm… I, I really really want to be able to breastfeed this time.
MG	Mmm. Did you breastfeed [first baby]?
03	Erm, partly. Erm, I used to feed her once a day and then pass out. Basically
MG	Gosh
03	I didn't have enough milk, erm, my, I had really bad gallstones
MG	Right
03	And that plus the trauma of the birth and the, I was severely anaemic, I just didn't have enough milk, but I persevered once a day up until… she was about four months, and then she got a bad cold and couldn't be bothered and that was it, within like three days my milk was gone cos I'd had so little
MG	Right
03	So this time I really really want to feed
MG	Yeah
03	Erm…
MG	And have, have you spoken to any of the, the professionals around, or your birth supporters or the people about that?
03	Erm… I've spoken to a few other expectant mums that, had problems last time and then want to do it this time and sort of, I've sort of spoken to friends about it but, er, my friends that have had more than one children, child, one gave up on breastfeeding her second really quickly cos it was too much, cos her older one, there's quite a big age gap. She just couldn't, manage all the school runs and everything else. She got really flustered with it all and gave up, and now, my brother, my brother's partner, she's just given it up, because this time she just hasn't, she hasn't got enough milk
MG	Right
03	She's just not well enough. So, I haven't really, I haven't really got anyone I can talk to who struggled the first time, who did it the second time
MG	Mmm
03	But one of my friends is a, is it BAMBI? Breast Support… it's some sort of breast support
MG	Oh right
03	But I think she's… up near Manchester
MG	Right
03	And she did, she, um, breastfed her little one who's the same age as [first baby] for like 20 months
MG	Wow
03	So she's quite a good sort of, resource of support
MG	Yeah
03	And she said oh I can teach you like how to make lactation cookies (laughs)
MG	(laughs)
03	And take fenugreek, and you know, do all these things that can help
MG	Yeah

03	Whereas I think last time because I was so poorly I didn't get the support to try and increase my milk or anything because it was taking it out of me so much to do anything
MG	Mmm
03	But I kept going that long because if didn't, poor [first baby], she couldn't, go for a poo (laughs)
MG	Right
03	Cos the formula's so thick, it just bound her up
MG	Right, yeah
03	So she was getting her feed every day and then I was going to bed. Because it would just completely wiped me out
MG	Right
03	So I just want to be able to do that really. Erm…
MG	Are those the kind of memories that you were talking about, about being associated with the flat?
03	Yeah
MG	Yeah
03	Yeah. I just sort of, those sort of struggles really.
MG	Yeah
03	Yeah. I mean [husband] he used to get home at like half six, I'd barely get his tea done, I'd feed her, and then I'd have to go to bed
MG	Right
03	And although, yes, it's his role as a dad to do that, I, I wasn't enough of a, partner
MG	Umm
03	I mean I stopped being a partner completely to be a mum, and I don't want that balance to go this time
MG	Mmm
03	And I don't want [first baby] to, feel that I'm not being her mum, because I'm doing too much for baby… with two, and especially a demanding toddler, but I just, wanna be able to find that balance, and I think, I got into a bit later with [first baby] – babywearing
MG	Right, yeah
03	And I think I really want to be able to do that because you can so easily just, pop them on the boob, strap them in, and carry on playing with the toddler
MG	Yeah
03	You know baby's happy cos they got, getting their cuddles, getting their milk, and toddler's happy cos they're getting your attention
MG	Yeah
03	And just trying really, to get that balance going
MG	Yeah, yeah. So, by babywearing you mean carrying in a sling, on you?
03	Yeah, yeah
MG	What, what kind of slings did you have?
03	Erm, I've got an Ergobaby that I still carry [first baby] in now, which I love
MG	Right
03	Erm, but it's obviously for a slightly bigger ones
MG	Yeah
03	My friend is posting me down a Close Caboo, it's a stretchy wrap
MG	Yeah, yeah
03	So I can use, I think you can use that… from about six pounds, so I can use that from newborn
MG	Yep. Yeah. Oh great
03	And I think that will help with the bonding too because I just, I couldn't, I didn't bond with [first baby] initially I just couldn't
MG	Right
03	I was too poorly
MG	Yeah. That's just, it's really hard isn't it

03	I knew, I knew I loved her to pieces, and I knew that I wanted to look after her, and protect her, but I didn't really feel like… I don't know, I didn't really feel like her mum… until, probably about the Christmas
MG	Right. And when was she
03	And that led to a lot of guilt
MG	Right… When was she born?
03	The July
MG	Right. So that's quite a long time to have felt… a sense of
03	Yeah, it was only after I'd had my gallbladder out in the November and it was only once I started recovering from that I really sort of felt like, oh I'm her mum
MG	Right
03	And she's my daughter, and that sort of, bond came. Before that I knew I had to love her, and I did love her and I, protected her
MG	Mmm
03	But that bond wasn't there until later
MG	Right.
03	And that's why now I love her company, I love spending time with her, and I just… I always… I don't know when that guilt's going to go away
MG	Mmm
03	Of shaking that sort of initial… bit that I, I just don't feel I did enough for her
MG	Right… so you're hoping for a very different experience this time?
03	Yeah
MG	Yeah. It's interesting you said you weren't, buying anything for the baby… but your friend is sending you a stretchy wrap down
03	Yeah
MG	Yeah. Does it, does it feel okay to accept… things for the baby even though you're not sure it's a baby yet?
03	Yeah, yeah cos I think I'll probably end up using it for my nephew, for now
MG	Ah right, yeah
03	Cos um, yeah, cos he's quite dinky
MG	Right
03	So, I'll probably end up using it with him, cos I've (laughs) I'd rather than do that than push these ridiculous huge, my brother's pushchair is just crazy big
MG	Right
03	Um, whereas we've still got the one we had from [first baby]'s, we're just going to use the same one
MG	Yep
03	But I think… I don't know, some of my friends who are having second or third ones, are like, you know, really excited about buying everything new, and I keep thinking, well maybe, I should be, but I'm just like, ah no, we'll use the same pushchair, and we 'll use the same this
MG	Yeah
03	And we need to get a cot, cos we sold our cot
MG	Right
03	But, I'm not really, I don't know, I'm not really… excited about buying the material things
MG	Right
03	Cos it's just stuff
MG	Yeah
03	And they don't know
MG	Yeah
03	As long as they're cuddled and fed, and got a clean bum, they don't, really mind what else they've got, so…
MG	Is there a sense of it being, nice to use the things for the new baby that you used for [first baby] as well?

03	Yeah, yeah
MG	Yeah
03	I think, and then there's, you know… there's sort of… yeah, I don't want… cos we're probably going to be in a worse financial situation than when we had [first baby] (laughs)
MG	Right
03	And I don't want… I wouldn't want her to sort of look back, and think oh well you bought a nice , you know, fancy new buggy for the new baby, and I had quite a, a cheap one
MG	Right
03	I don't want to build those sort of resentments. Cos I've seen them, with, sort of friends and their siblings
MG	Right
03	And they've felt like… you know, because they were the second baby, or the last baby, that mum went all out for them and not the first one
MG	Right
03	And equally you don't want to go too far the other way
MG	Yeah. So it sounds like, having, parity between the children is quite important to you?
03	Yeah
MG	Yeah. Mmm. Interesting. Is that another, motivation behind, wanting to breastfeed? That you did it for [first baby]?... Or not at all?
03	Yeah possibly, but then I don't feel I did enough for her
MG	Right
03	With the breastfeeding, so I… want to you know, give it a good go this time
MG	Yeah
03	But I think, I'm slowly coming to terms with the fact that that wasn't my fault, and I… should have had more support from the professionals
MG	Yeah
03	And… they should have listened, because I did tell them, several times that I was passing out after I was feeding her. Because I was just so anaemic and so weak
MG	Mmm
03	And I just got sort of told, oh just keep putting her to the breast. And I don't think she latched very well
MG	Right
03	Um, I don't think she had a tongue tie or anything, but she definitely didn't latch well
MG	Right
03	And I didn't really get any support with any of that
MG	Right
03	I remember when I just first had her in the hospital, and she was struggling to latch, and, sort of, this midwife just came along like expressed into a, got me to express into a cup and walked off, and I just remember thinking like, that's great, cos she's got milk right now, but like, I feel like you've just, you know, like milked me like a cow (laughs) and I have no idea what you just did
MG	(laughs) Wow
03	(still laughing) what am I going to do when she needs feeding again in a couple of hours? I don't know what you did
MG	That's, that's quite, that's quite invasive
03	I know! And I was sort of like that's great that she's fed, but what do I do now?
MG	Right… wow
03	And then within, cos we were in for about three or four days
MG	Yeah
03	I think within three days they were starting to top her up with formula
MG	Right
03	And I was sort of like, Oh. Oh. Okay.
MG	Wow
03	I just felt like, oh okay, I'm failing her already then.

MG	Oh gosh
O3	And they were like, no, you know, you've lost a lot of blood, your milk supply will increase, and just keep pumping and stuff
MG	Mmm
O3	But then, you'd have a change of shift and a change of midwife, and they'd be like, oh she's hungry, I'll go and get a bottle. And they'd just go and do it
MG	So a lot of inconsistent care postnatally?
O3	Yeah, and um, then I was, I was readmitted, when she was about, five six days old. She was fine, but I had an infection
MG	Right
O3	And um, and then they kept feeding her. And it got to the point where I would just let them feed her, because it was the case of every time she made the slightest noise, they would feed her. Not even a cry, just a, you know, little babies make noise. And they'd pick her up and they'd feed her, and then she'd vomit all over them. And I just thought, you know what, just let her do it because… I just got to the point where I was fed up of saying to them, no she's not hungry
MG	Right
O3	And how many ounces has she had and nerr. And they'd go off and they'd come back in scrubs, and they'd be like, well she finished it, and then she threw it all up
MG	Right
O3	And the I just thought… what else can I do? I'm too weak to argue with you
MG	Mmm
O3	So they just ended up constantly feeding her and making her sick
MG	Mmm
O3	And then once I stopped feeding her and she was exclusively on milk, she actually ended up on Neocate
MG	Right
O3	Um, because she didn't tolerate the dairy very well
MG	Right
O3	And even now, she doesn't drink any milk. She eats cheese, and she has yoghurts, but she won't touch milk. She won't eat cereal, she won't drink milk, I've tried it every which way, banana, chocolate, strawberry (laughs)
MG	(laughs) Right
O3	Ice-cream, she just doesn't like it. Unless it's a yoghurt she just won't eat it
MG	Right
O3	And I just think, I had lactose intolerance problems
MG	Right
O3	As a teenager, so maybe she's the same
MG	Right
O3	And they say that it's not natural for humans actually to have cow's milk
MG	Yeah
O3	So, and I just think, it took them too long to figure that out
MG	Yeah
O3	Cos it was nearly six months before they put her on the Neocate
MG	Right
O3	Um, and then she stopped having it at just over a year. She's not really had any milk since
MG	Right
O3	And I said this to the Health Visitor who just keeps saying, oh just keep trying her with milk
MG	Right
O3	But she won't even drink soya milk. I've tried rice milk and all sorts
MG	Right
O3	Um, but, I said she does, you know I'm not worried about her calcium, because she eats green vegetables
MG	Mmm

03	She's a really good eater. She's not fussy at all apart from the milk thing. So um, it's not that I'm worried about calcium
MG	Mmm
03	But you know, they always go on don't they about how important it is children have milk
MG	Yeah
03	And I think, but she won't drink it (laughs)
MG	(laughs)
03	So that makes me feel really worried
MG	Yeah… it sounds like, erm, postnatally when you were in the hospital, there's a lot of things of not, and, and possibly during the birth, there's a lot of things of not being listened to?... About what was going on
03	Yeah. I think… after I'd had her and they took me up to, like, the Delivery Suite room, it's a huge room
MG	Right
03	And… um, I think I lost my confidence with them then because, um, [first baby] was under a light, and so she was in a crib, quite far away from my bed. I mean if my bed was sort of here, she was at least over here if not further
MG	Right
03	I, had a catheter in and everything else I couldn't get up to her
MG	Mmm
03	She started crying, which I assumed she was hungry, having… she'd been born at like 2am, and this was probably about 7-8am in the morning
MG	Right
03	Um, and I went to press my call bell, and they hadn't given it to me
MG	Wow
03	It was still up on the wall about a metre behind me
MG	Right
03	So I ended up having to… throw a Sprite bottle that I could just about reach on the table next to me at my husband
MG	(laughs)
03	To wake him up, to get him to get the call bell. And then the midwife came in, and was like oh, is everything ok? And I said, well I had no call bell and my baby's crying and they went she's hungry and I was like yeah I know that, I've got a catheter in and I can't get up
MG	Right
03	And then they sort of just gave her to me and went yeah she needs a feed and walked out. And that's the first time I'd actually held her since she'd been born
MG	Wow
03	And I was like, I, I, I don't know what to do. I haven't got a clue. Like, this is my first baby, I want to feed her but how do I, like what do I have to do?
MG	Right
03	Like, you can read all the books, but when a baby doesn't latch easily, which she didn't
MG	Yeah
03	You know, they just say put her to the breast it's like, well, she just looks at me (laughs)
MG	(laughs)
03	She just looks at me as if to say well what do I do and I'm looking at her and going I don't know
MG	(laughs)
03	And that's sort of, from the moment I didn't have that bell, I just really lost confidence in them
MG	Mmm
03	And then to just walk out… And then she came back in, and was like, oh has she fed? And I was like, no, she won't do it, I don't know what I'm doing
MG	Right

03	And then she was like oh well I'll get someone to come back in a minute cos we're changing shifts… and luckily the woman who then came, the midwife who then came back was lovely and really helpful
MG	Right
03	But I, sort of, you know, it always seemed that like, their routine overtook
MG	Mmm
03	And obviously I understand there's lots of other mums
MG	Mmm
03	But if it was, you know sort of change over time or time for tea, that was priority
MG	Right. Yeah
03	So in that case, maybe I would be better off with a different hospital, but… two or three of the midwives I had were absolutely, fantastic. Brilliant. Couldn't do enough. But a couple, the care was just really lacking
MG	Right. Are you concerned about that, for thinking about having your baby… there again?
03	I've already spoken to them when I went in for a follow up about [first baby]'s birth
MG	Right
03	But there's two particular midwives whose names I couldn't remember, but I know what day I saw them. And I know what they've written in my notes, to say that I don't want them anywhere near my care
MG	And have they said that's okay?
03	Yeah. One of them made a complaint that I was violently aggressive to her, erm…
MG	[inaudible]
03	When I was admitted for sickness, and I was in a lot of pain, erm and I was, cos the gallbladder was causing so much pain that I, erm, I was crying for painkillers, and she… gave me pethidine and then said I had to have a band on and be admitted, and I'd already told her that I didn't want to be admitted, I wanted to go home
MG	Right
03	She shouldn't have given me the pethidine. Erm, and then she stormed off. And then… um…
MG	She shouldn't have given you the pethidine because, she couldn't let you home after?
03	Yeah
MG	Right
03	She should have explained to me that if I had it that I had to stay in
MG	Yeah
03	She didn't. Erm, so then her supervisor came over and was like what's the problem, you've been aggressive, and I was just sat there crying saying how can I be aggressive, I'm in a lot of pain. I'm clearly upset, like that's not aggressive, that's, I'm just upset. I don't understand what's going on. So she said well you've had pethidine you have to stay in now for six hours. And I said I told her that I was in a lot of pain but I didn't want to stay in. Because… I just had had enough of being admitted at that point
MG	Mmm
03	And she, and I did, I did apologise to her and she came over and she was like well you shouldn't be so damn rude. And I was just like, oh, okay. But I just, I, I, I'm really sorry, I'm just in a lot of pain, I, I didn't mean to be rude, I just, I didn't understand what you were telling me… So I've asked for her to be like absolutely nowhere near me
MG	Yeah
03	Um, and the one who just sort of shoved her on me and then wandered off cos it was her shift change and that was it. I've asked that I don't have any care from her either and they said that they should be able to do that. I think from what sort of they were saying that at least one of them doesn't work in the hospital any more