Making sense of childbirth choices; exploring the

decision to freebirth in the UK.

An interpretative phenomenological study.

By

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A thesis submitted in part fulfilment for the requirements for the degree of Masters of Science in Midwifery and Women's Health at the University of Central Lancashire, School of Community Health and Midwifery.

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.

I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work.

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Précis

List of Abbreviations

WHO	World Health Organisation
RCOG	Royal College of Obstetricians and Gynaecologists
CMACE	Centre for Maternal and Child Enquiries
NMC	Nursing and Midwifery Council
RCM	Royal College of Midwives
RCN	Royal College of Nurses
RCPCH	Royal College of Paediatrics and Child Health
NICE	National Institute for Health and Care Excellence
NCCWCH	National Collaborating Centre for Women's and Children's Health
MBRRACE	Mothers and Babies: Reducing Risk through Audit and Confidential Enquires

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Abstract

Freebirthing or unassisted birth is the active choice made by a woman to birth *without* a trained professional present, even where there is access to maternity provision. This is a radical childbirth choice, which has potential morbidity risks for mother and baby. To date there have been no UK based studies. The aim of this study was to explore the decision making experience of women who chose to freebirth in a UK context.

An interpretative phenomenological study was carried out. A purposive sampling method combined with a 'snowball' technique was used to recruit women to the study (n=10). Inclusion and exclusion criteria were applied. Data collection comprised of women completing a narrative account. This was followed up with an in-depth interview. Data analysis was carried out using interpretative methods informed by Heidegger and Gadamer's hermeneutic-phenomenological concepts.

Three main themes emerged from the data: *'contextualising herstory'; 'diverging paths of decision making'* and '*the converging path of decision making'.* With the exception of one participant, the women were making an active choice based upon their previous birth experiences. For some the decision was borne out of a negative experience which was then compounded by a further poor experience with maternity services. Namely obstructive practices by maternity professionals that limited their choice to book a homebirth. Therefore, in order to feel safe they opted to freebirth. For others this was borne out of a positive experience in which their decision evolved in trying to further improve their birthing experience, therefore a midwife became redundant.

The findings mirror that of the metasynthesis carried out by Feeley et al. (2015), but unique to this study is that it is based in a UK setting. This is an important finding as the UK has a strong midwifery culture which is philosophically embedded in woman-centred care. The findings of this study demonstrate that this is not always achieved leading some women to make extreme birthing choices. Further research is essential to determine why there is such a gap between midwifery philosophy and actual care provision.

Chapter 1 Introduction

This dissertation presents the findings of an interpretative phenomenological research study into the decision making of women who choose to freebirth in the UK. This chapter shall introduce: myself the researcher; the study design and the topic contextualised in the current framework of maternity services in the UK. In addition, it will provide a brief overview of the subsequent chapters.

1.1 Introducing myself

The starting point for most research is practice (Cluett & Bluff, 2006). However, my journey started with the birth of my son in 2006. Whilst I felt fortunate to have an overall positive and empowered experience, largely due to excellent midwifery care, I still had aspects of the birth that I was unhappy with which took time to process. The particular event that caused distress during the birth involved a transfer from my homebirth into hospital which was potentially avoidable. During the year following the birth I read as much as I could about creating the optimal environment for birth as well as the many deviations of 'normal' that can be addressed with simple supportive techniques. This led me to complete a doula course with Michel Odent, a famous obstetrician whose focus is upon 'undisturbed birth' (2003). His work, alongside others, challenges mainstream midwifery and obstetric practices which may be considered to work contrary to the physiology of labour (Odent, 2003). This new perspective caused me to question many aspects of my personal birth experience as well as viewing childbirth in a larger socio-political domain whereby the medicalisation of childbirth has caused the introduction of many practices that do not support the optimal physiology of labour. The iatrogenic effect whereby practices carried out by midwives or obstetricians may lead to medical intervention, causing a cascade effect of further intervention, is now widely documented (Kitzinger, 2005; Maternity Care Working Party, 2007; Odent, 2003). I took these new understandings forward into my midwifery training in 2008, which further reinforced my personal philosophy of childbirth: a normal event in a woman's life that needs a biopsychosocial approach to care whereby her needs and choices are at the heart of the care I provide. It also further compounded my criticism of the medicalisation of childbirth in which I often felt that we do more harm than good through our normative care practices.

During this process, I stumbled across the concept of freebirthing and felt an instant resonance with the women's stories. I felt that I understood why a woman may choose it as an option in spite of the potential risk of morbidity or mortality. With greater experience as a midwife, now four years, my philosophy of childbirth has not changed and I am increasingly aware of the negative impact the medicalisation of birth is having upon midwives knowledge and skills to facilitate an optimal physiological birth. This coupled with staffing crises, increased workloads and the devaluation of

births at home or in a birth centre, I feel many women are experiencing substandard care. This can lead to negative birth experiences which have far reaching consequences long after the birth itself (Fenech & Thomson, 2014). With this in mind, I wanted to carry out this research to give the women who freebirth a voice in a bid for maternity services to listen to why a woman would make such an extreme choice. Many of the stories had accounts of a previous birth experience in which they experienced extremely poor care by maternity services. This was either due to poor relationships with their care providers and/or their care providers using medicalised practices that did not support the optimal physiology of birth. Therefore, I felt by illuminating the decision making we as midwives may learn more about women's needs for birth making us better equipped to facilitate optimal birth in any setting where a woman feels cared for and her choices valued.

1.2 Introducing the study design

The study design is based upon constructionism which has the worldview that knowledge is not an absolute, but rather a co-construction dependent upon historical and cultural influences (van Manen, 2007). Therefore its focus is upon the subjective, context-related nature of lived experiences (Smith, Flowers, & Larkin, 2010). Using this as an epistemological basis for the study, the design lends itself to qualitative research whereby the views and experiences of those who have experienced the phenomenon of freebirthing can be explored at depth. Within qualitative research there are a wide range of theoretical perspectives which guide the subsequent methodology of conducting research and the analysis. For this study, an interpretative phenomenology perspective was adopted which is justified in Chapter 4.

1.3 Introducing the topic

In the UK over 99% of women will birth with a healthcare professional in attendance, normally a midwife or obstetrician (Office of National Statistics, 2013). However, for a small number of women they may birth prior to attendance due to a rapid birth, known as 'born before arrival (BBA) (Loughney, Collis, & Dastgir, 2006). For a small number of women they may have concealed their pregnancies and consequently did not access maternity care (Friedman, Heneghan, & Rosenthal, 2007). In addition, a small number of women actively choose not to seek attendance during the birth and this phenomenon is known as 'freebirthing' in the UK or 'unassisted childbirth' in the US (Nursing and Midwifery Council, 2013). This unique phenomenon is an important topic to explore as there are potential risks to the mother or baby which shall be explored further in the background section. Furthermore, the UK has a well established National Health Service where maternity care is free for women who have resided in the UK for 12 months or longer which encourages the question of why would women choose to opt out of free maternity care given the potential risks of birthing

alone? Therefore, the key question for this study is: *Making sense of childbirth choices; exploring the decision to freebirth in the UK.* Its aim is to explore the lived experience of making the decision to freebirth by analysing the women's motivations as well as their experiences that led them to the decision. It is anticipated that this may illuminate shortfalls in maternity care provision which may assist maternity professionals and policy makers to improve the service provision.

1.4 Overview of chapters

Chapter 2: Provides the context of UK maternity services, explaining the current system, exploring the two philosophical approaches to maternity care and the tensions between them. This provides the backdrop in which freebirthing is situated.

Chapter 3: Provides a meta-thematic synthesis of the current primary literature on the phenomenon answering the question of 'Why do some women choose to freebirth?' The findings of the synthesis provides the justification for this study.

Chapter 4: Provides the epistemological basis of the study which guides the subsequent methods. Within the chapter it explores the rationale for using interpretative phenomenology as well as presenting a detailed account of my presuppositions, the foundation of further reflexivity.

Chapter 5: Provides a detailed account of all the methods used to carry out the study including how the study addresses trustworthiness and adheres to ethical principles.

Chapter 6: Provides the findings of the study. The themes that emerged from the data are explored at depth with rich in-vivo and direct quotes from the participants.

Chapter 7: Provides the discussion in relation to the findings, drawing upon wider literature to support the findings. Furthermore, it addresses the strengths and limitations of the study as well as the implications that the study has upon practice and future research.

Chapter 8: Provides a detailed account of my reflexive processes and lessons learned.

Chapter 9: Provides the conclusion to the dissertation.

1.4 Conclusion

This chapter has introduced myself, the researcher framing my intentions for the study. It has outlined the study design and introduced the topic. It has provided an overview of the subsequent chapters within the thesis.

Chapter 2- Background

The previous chapter provided the introduction to the dissertation. This chapter provides the background to current birth statistics and the basis of maternity care provision in the UK. It also explores the two major philosophical approaches to childbirth which impacts the care provision. This will contextualise freebirthing by framing in within current maternity care provision.

2.1 Birth in the UK

In 2013, the birth rate for England and Wales was 698,512 (Office of National Statistics, 2013). Almost all (97%) births took place in hospitals or birth centres and 2.3 % at home (Office of National Statistics, 2012). Under normal circumstances, women in the UK do not birth without a qualified healthcare practitioner. The World Health Organisation (2010) strongly advocates that all women and babies need skilled care in pregnancy, childbirth and immediately after. They estimate that 10-15% of pregnancies and/or birth will have obstetric complications needing intervention for optimal outcomes (WHO, 2010). The types and prevalence of risks during labour include, obstructed labour (incidence 8%, (WHO, 2008), pre-eclampsia (incidence 2-8%, (Duley, Henderson-Smart, Walker, & Chou, 2010) post-partum haemorrhage (incidence varies dependent upon risk factors, (RCOG, 2009), shoulder dystocia (incidence 0.5%, (RCOG, 2012), neonatal encephalopy (incidence variable and the statistics are unclear, (Lee et al., 2013) and cord prolapse (incidence 0.1-0.6%, (RCOG, 2008). Often these risks stated are unforeseen and require timely intervention for good outcome (King's Fund, 2008; WHO, 2010).

The Kings' Fund (2008) carried out an independent inquiry to establish the safety of UK maternity services. The inquiry concluded that for the overwhelming majority of women in England, birth is safe. In addition, the latest statistics from MBRRACE-UK (2014) found that maternal deaths in the UK that were directly attributable to problems in pregnancy or at birth have reduced from at 11 per 100,000 to 10 per 100,000. Perinatal mortality is defined as the number of stillbirths (>22 weeks gestation) occurrence at 4.2 per 1000 (MBRRACE-UK, 2015).

2.2 Maternity care for childbearing women in the UK

In the UK, qualified midwives are the lead professional for the majority of women during pregnancy, birth and the postnatal period (Renfrew et al., 2014) which is supported by governmental policies and national guidelines (DH, 1993; DH, 2007; DH, 2010; NICE, 2012). The NMC (2014) describes the role of the midwife, which includes preventative measures, as monitoring the woman and baby's health, identifying complications (and seeking assistance as necessary), advocating normal birth, health counselling, and education. The King's Fund (2008) and the recent Midwifery Lancet Series

(Renfrew, Homer et al. 2014) identified that the role of the midwife is supported by obstetrics and paediatrics. Therefore should complications arise, timely medical referrals optimise the safety of the mother-baby dyad.

2.3 Philosophies of care

Maternity models of care can be conceptualised from the disciplines of either medicine (obstetrics and gynaecology), or midwifery; two professions with strikingly different philosophies (Walsh, 2006). The medical model is considered to be based on a risk paradigm (Symon, 2006); it focuses on pathology, and employs routine use of intrapartum interventions and technology to achieve safe birth outcomes (Symon, 2006). Conversely, the midwifery model is grounded in a holistic approach (Midwifery 2020, 2010), which ascribes equal importance to women's bio-psychosocial and physical needs (NMC, 2014). It defines normal childbirth outside of an illness model and sees its role largely as supporting and enabling the woman to utilise her own resources, and only intervening when the physiology deviates from 'normal' (Renfrew, Homer et al. 2014). Furthermore, it supports birth in non-obstetric settings i.e. birth centres and at home (Hodnett, Downe, & Walsh, 2012). However, it must be noted the divisiveness between the two models is simplistic, the two may be diametrically opposed or may converge dependent upon the individual health practitioner's attitudes and beliefs (Henley-Einion, 2003).

Considerable evidence supports the midwifery model of care. Four different Cochrane reviews, totalling 53 randomised controlled trials and over 50,000 women demonstrate key interventions such as continuity of midwifery care (Sandall, Soltani, Gates, Shennan, & Devane, 2013), continuous support during labour (results were pooled with midwives, lay supporters, and semi-professional supporters) (Hodnett, Gates et al. 2013), midwife-led care (Sandall, Soltani et al. 2013) and alternative birth settings (Hodnett, Gates et al. 2013) lead to positive outcomes. These outcomes relate to reduced obstetric intervention i.e. induction, augmentation, monitoring, analgesia, episiotomy and instrumental deliveries. Women also had an increased number of vaginal births and reported higher levels of satisfaction. Moreover, the executive summary of the Lancet's Series 'Midwifery' (Renfrew, Homer et al. 2014) categorically states; '*Midwifery is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries'* (p.1).

2.3.1. Tensions between the models of care

Whilst governmental policies that support the midwifery model of care are in place and midwifery-led care with appropriate collaboration with medics is advantageous for optimal outcomes for

women and babies, tensions between the models of care exist. The biomedical model is still dominant, despite the evidence to support the midwifery-led biopsychosocial model of care (Midwifery 2020, 2010). Figures for 2012/13 demonstrate only 44.5% of women achieved a normal birth in the UK, defined as a woman whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously (Birth Choice UK, 2013). Multiple factors are attributed to the low number of normal births in the UK: structural and organisational hierarchies (DH, 2007; Healthcare Commission, 2008; Sheridan, 2010; Walsh, 2006), limited resources and increased focus on risks and litigation (Edwards & Murphy-Lawless, 2006; Symon, 2006; Walsh, 2006), all lead to situations where these recommendations are not always followed in practice. However, as discussed below, feminist critics argue that it is the medicalisation of birth that is the cause of the failure to adopt the recommendations.

2.3.2.   Feminist critique of the medicalisation of birth

The dominance of the biomedical model of birth has had longstanding criticism by a number of feminist writers (Davis-Floyd, Barclay, Davis, & Tritten, 2009; Davis-Floyd, 2001; Hunter, 2006; Kitzinger, 2005; Odent, 2003; Symon, 2006; Walsh, 2006). These writers argue that the medical model of birth is based upon a male dominant mechanistic Cartesian philosophy, where the woman's body is attended to like a machine, where parts can be separated in order to be 'fixed'. In turn, this leads to women's experiences and the bio-psychosocial aspects of birth being marginalised over the medical care provided (Walsh 2009, Kitzinger 2005). The rise of obstetric practice was believed to reflect the industrialisation of developed countries and the growing economics of production whereby technology, medicine and subsequently hospitals were seen to provide improved efficiency as well as improved safety (Hunt and Symonds, 1995; Martin, 1987). This effectively placed the responsibility and authority of childbirth in the hands of (male) doctors, technology and patriarchal institutions (Walsh 2009, Hunter 2006, Henley-Einion 2003, Davis-Floyd, Barclay et al. 2009). This in turn marginalises other bodies of knowledge and reduces women's autonomy (Belenky, Tarule, Goldberger, & McVicker Clinchy, 1986; Edwards & Murphy-Lawless, 2006; Henley-Einion, 2003; Kitzinger, 2005). However, Beckett (2005) asserts that this explanation is inadequate, and attempts to move beyond polarised essentialist arguments by drawing upon evidence that the first wave feminists campaigned for the right to have access to pain relief in order to regain control over the birthing process. This counter argument thereby highlights how women have been active agents in the medicalisation of childbirth and how, for some women, the biomedical model of birth is valued (Haines, Rubertsson, Pallant, & Hildingsson, 2012).   However, Beckett (2005) considers that perhaps in the process of campaigning for greater access to pain relief

and medical services, women lost control over the childbirth process, as well as the support of female friends, family and midwives.

2.4 Freebirthing

Within this backdrop of maternity care in the UK, it has been identified that a minority of women choose to birth without the assistance of a midwife or doctor. Instead, they choose to either birth alone or with lay birth supporters present (NCT, 2011; Nursing and Midwifery Council, 2013). This is known as freebirthing or unassisted childbirth. This is a different phenomenon to that of a concealed pregnancy, which is often characterised by a denial of the pregnancy (Friedman et al., 2007). In the UK, the proportion of women who choose to freebirth is unknown but anecdotal evidence demonstrates its occurrence (Edwards & and Kirkham, 2013; NCT, 2011; Nolan, 2008; Nursing and Midwifery Council, 2013; Wickham, 2008). Whilst no research exists directly on the risks of freebirthing due to its covert nature, a parallel in terms of risk relates to when women give birth unintentionally without a healthcare practitioner present, known as 'born before arrival' (BBA). For example, a cohort study carried out by Loughney, Collis et al (2006) suggests this occurs in 0.14-0.44% of pregnancies. BBA's are unplanned and are associated with an increased morbidity for mother (excessive blood loss) or baby (failure to retain body temperature), although overall outcomes are normally good. Therefore, the freebirthing woman (and her baby), is at potential increased risk of morbidity or mortality.

Extreme practices such as this may reflect tensions between standard care provision and women's experiences of care. It is therefore vital for maternity services to explore this phenomenon to understand why women are potentially putting their lives and that of their babies at risk.

CHAPTER 3 Literature review

3.1 Methodology; Meta-thematic synthesis

Ring et al (2010) state that qualitative research has a variety of philosophies and stems from different disciplines, but shares common values. It tends to explore the 'hows' and 'whys' of a particular experience or phenomena, rather than exploring reductionist theories or intention to treat hypotheses. While qualitative work is now a firmly established method of research, synthesising findings across a number of studies, generally referred to as a meta-synthesis is still in its infancy, and its value is a topic of great debate (Ring, Ritchie, Mandava, & Jepson, 2010). A meta-synthesis aims to 'bring together' bodies of research that focus on the same topic (Ring et al., 2010). Thomas and Harden (2008) argue that meta-syntheses are important tools to inform policy making, evidence based practice which are the cornerstones of current health and social care.

Ring et al (2010) describe the variety of methods that could be used where undertaking meta-synthesis, of which an understanding of theoretical underpinnings are essential. An established method is that of meta-ethnography (Ring et al., 2010). This method was designed by Noblit and Hare (1988) in the 1980's primarily in the field of education. However, the principles of this approach have emerged as a leading qualitative synthesis method in healthcare research (Ring et al., 2010). Britten, Campbell et al. (2002) describe it is a method that involves induction and interpretation, resembling the qualitative methods of the studies it aims to synthesise. Ring et al (2010) describe the 7 steps (see Figure 1) which utilises the participant's accounts, and the author interpretations from the original text to create a 'third order' interpretation, creating new insights and conceptually rich data.

Due to the established nature and robust methodology of meta-ethnography, it is a justifiable method to use for the following meta-thematic synthesis to answer the research question;

'Why do some women choose to freebirth?'

Figure 1 Noblit and Hare (1988) 7 steps

1. Getting started (the search)

2. Confirming initial interest (literature screening)

3. Reading studies and extracting data

4. Determining how studies are related (identifying common themes and concepts)

5. Translating studies (checking first and/or second order concepts and themes against each other)

6. Synthesising translations (attempting to create new third order constructs)

7. Expressing the synthesis.

3.2 Methods

3.2.1. Data collection- literature search

In line with stage 1 and 2 of the meta-ethnography approach, a systematic search strategy was conducted in March 2013 with the keywords; 'freebirth, unassisted birth, unattended birth, unassisted homebirth, DIY birth, do it yourself birth'. These were initially applied through key health databases; CINAHL, British Nursing Index, Cochrane, Medline, and MIDIRS. Due to a limited number of findings, the search was extended to include; Sociological Abstracts, AMED, ASSIA, HMIC, Psychinfo, Web of Science, Zetoc, Open Sigle, Academic Search Complete and International Bibliography of the Social Sciences. Boolean operators and the truncation of terms was used to maximise findings. Duplication of papers provided reassurance that the search was comprehensive. Papers were hand searched for relevant studies, known as 'berry-picking' (Bates, 1989) to ensure all key papers were retrieved. All relevant papers were obtained via the databases or directly from the authors. A thorough quality appraisal was carried out, which is discussed in the results section.

3.2.2. Inclusion/Exclusion criteria

As there were few papers, the inclusion criteria were kept broad and all papers of primary qualitative research in English of women that had chosen to freebirth were included. Anecdotal and opinion pieces were excluded.

Table 1 Inclusion/Exclusion criteria

Parameter	Inclusion	Exclusion
Language	English	Non-English
Population	Any woman who had met outcome criteria	Any woman that had not met outcome criteria
Outcome	Woman that had chosen to freebirth	Woman who had not freebirthed Or not chosen to have no healthcare professional present
Study type	Primary source of data	Secondary source of data
	Data that uses qualitative methods	Data that uses quantitative methods

3.3 Results

3.3.1. Search results

Figure 2 presents the search results. In line with stage 3, Table 2 presents the included studies; their characteristics, findings and quality rating.

Figure 2 Search results

129 potentially relevant articles

129 from database search

57 excluded on basis of title and abstract

Reasons for exclusion:
Did not address freebirthing (n=57)

72 full text articles reviewed

69 excluded following full text review

Reasons for exclusion:
Grey literature (n= 63)
Duplications (n=5)

4 articles included in the review
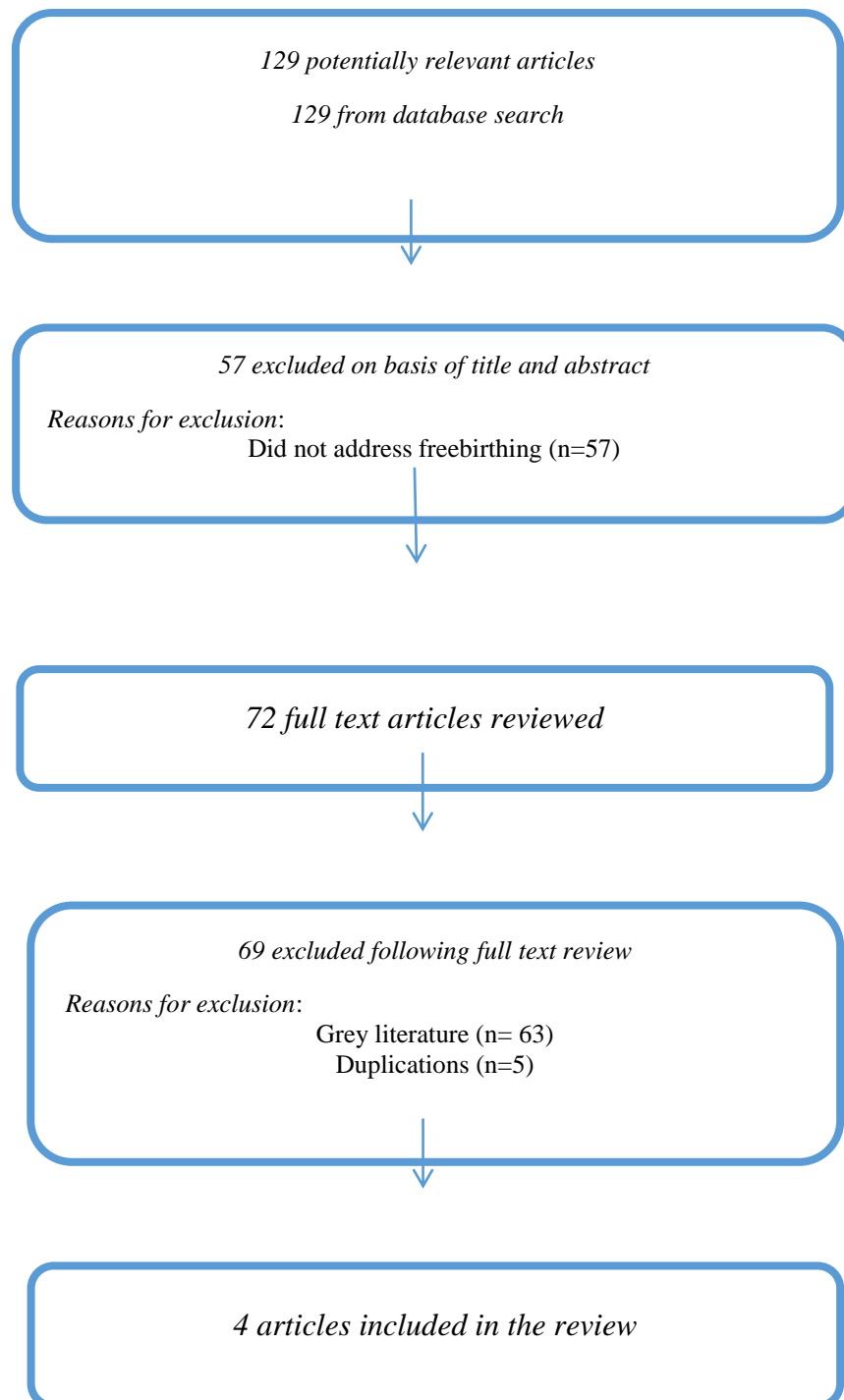
Table 2 Characteristics of studies

Author	Country	Aim	Sample	Recruitment	Theoretical framework, method and analysis	Verification of Data	Concepts	Quality Rating
Miller (2009)	USA	To explore women's narratives of why they chose to freebirth, to reveal how they process discourses in medicine and midwifery to construct their own truth	N=133; 127 online birth stories 6 interview s conducted postnatally All women had freebirthed	Online; freebirth communities Purposive-snowballing	Narrative discourse Grounded theory to analyse 127 birth stories, and 6 in-depth interviews	Triangulation	Decision making, rejection of medical and midwifery models, information sources, safety, doing it myself; control and autonomy, safety, birth experience, emotional impact, relationships with partners and God	B
Freeze (2008)	USA	To explore why women choose to freebirth, the knowledge sources they use, their concept of safety, risk and responsibility	N=84; 60 surveys, 13 telephone interviews conducted postnatally All women had freebirthed	Online freebirth communities Purposive-snowballing	Phenomenonology Web discussion, survey responses and semi-structured interviews The process of thematic analysis is described but methodology not explicit	Triangulation	Decision making, discovery, previous experience, choices, transformation, knowledge, safety, risk (reframing), responsibility, reconciling midwifery and freebirthing	C
Brown (2009)	USA	To explore women's motivations to freebirth and explore the lived experience.	N=35 26 demographic survey 9 telephone interviews conducted postnatally All women had freebirthed	Online freebirth communities Purposive-snowballing	Feminist theory Demographic survey, unstructured interviews Grounded theory analysis	None stated	Rejection of the medical and midwifery model, previous experience, search for alternatives, avoiding unnecessary intervention, personal choice, preparation, experience, practicalities, and sources of information.	B

Jackson et al (2012)	Australia	To explore how women make the choice to birth outside of the mainstream birthing system and how they perceive the risks associated with birth.	N= 20 20 semi structured interviews; either face to face or via telephone postnatally 9 women had freebirthed 11 had birthed at home against medical advice	Initial purposive recruitment at a conference followed by snowball technique	Qualitative interpretative analysis. The theoretical framework not discussed.	None stated	Birth always has element of risk, including death. The risks are greater in hospital. Rejection of the biomedical model of birth, rejection of hospitals.	B

3.3.2. Data analysis

In line with stages 4 and 5, the papers were synthesised using inductive thematic analysis (Ring et al., 2010; Thomas & Harden, 2008) founded in the framework by Noblit and Hare (1988). Each paper was individually labelled with key phrases or words. Similar phrases and words were then grouped and coded. The codes were then cross-referenced against the other papers, to identify similarities or differences between studies. These codes were repeatedly refined using an iterative process until saturation of the developed codes was reached. Once this was achieved, the codes formed the basis of sub-themes (concepts). In addition, the process of translating (Thomas & Harden, 2008) was used, as Noblit and Hare described (1988), this is where the concepts that are generated, were examined across the papers in order to move beyond simple description of the data. This then allowed for a 'third line' construct as per stage 6, in which I used my interpretation of the data to formulate the themes that are described in the results section. The process was iterative, where several attempts at developing themes were made.

3.3.3.. Quality Appraisal

A quality appraisal was carried out using the validated Critical Appraisal Skills Programme (CASP) assessment tool (Public Health Resource Unit, 2006). This tool assesses three criteria when appraising qualitative literature; rigour, credibility and relevance and ten questions are used to identify whether an appropriate research design, methodology, data collection, data analysis, reflexivity, and ethical issues have been considered. The sample size, use of triangulation and demonstration of themes arising from inclusion of primary data are hallmarks of rigorous qualitative data analysis and provide meaningful findings (Public Health Resource Unit, 2006). The studies also underwent a quality grading (Walsh & Downe, 2006) to further categorise the quality and weight of the studies. This was to support the process of using the CASP model whilst enabling a demonstrable grading of the papers that the reader may identify with.

In the case of the included studies, some methodological limitations need to be noted. Whilst Freeze (2008) and Brown (2009) were unpublished PhD dissertations, they were included due to the paucity of literature in this area. Miller (2009) and Freeze (2008) provided insufficient detail of data collection, methodology, and data analysis. Miller (2009), Brown (2009) and Jackson et al (2012) demonstrated only limited reflexivity upon their role as a researcher throughout their methodology and analysis. In addition, no researcher utilised participant validation or a second researcher to confirm the findings.

3.3.4. Participants

The four studies incorporated data collected from birth stories, surveys and interviews from 272 women. Three studies were from the USA, (n=252) and one study was from Australia, (n=20). All participants were female except one male partner who participated in a survey (Freeze, 2008). The majority of women were Caucasian, educated to high school level or above, indicating a high level of socio-economic status.

3.4 Findings

Four key themes were generated as third line constructs (Noblit and Hare, (1988) and are expressed in line with stage 7 as this synthesis of findings. The themes that emerged are: rejection of the medical and midwifery models of birth; faith in the birth process; autonomy; and agency. The themes are presented below using quotes from the participants (as pseudonyms used by the authors) interpretations of the original authors and those of my own.

3.4.1. Rejection of medical and midwifery models of birth

All studies identified that the decision to freebirth stemmed from a criticism of the medical model of birth (Freeze 2008, Miller 2009, Brown 2009, Jackson et al, 2012). Freeze (2008) and Brown (2009) found that this largely arose from a previous traumatic or disappointing experience:

> *'You know, everybody's really scared of it [birth in a hospital], it's very frightening, very traumatizing, and when you think of hospital births you think of being out of control, being in pain, being frightened of dying like that.'* (Amber – Brown, 2009 p 18)

Miller (2009) reported a minority of women gave religious beliefs as a reason, although insufficient detail about the women's belief systems was provided. Freeze (2008) and Brown (2009) found that women with prior experience of birth reported similar perceptions of hospital care. These women, described routine obstetric practices that they felt were unnecessary, harmful and did not support their personal needs for privacy, choice, or control, leaving them feeling that they had received poor treatment (Freeze 2008; Brown 2009). Jackson et al (2012) found that women framed this rejection by their perception of risks associated primarily with hospitals, procedures and routine care provision:

> *'I would also say it [freebirth] is about safety because I don't think hospitals are safe places to have babies and I don't think some midwives are safe people to have babies with.'* (Freebirth 08, Jackson et al, 2012, p564)

This led women to seek alternatives. The internet seemed to be the main source of information, in which participants 'stumbled' upon freebirthing:

> *'We discovered story after story of couples who had given birth at home, in familiar, peaceful surroundings, unmedicated, un-"managed," and un-"manipulated." The effect of this exercise—reading other couples' birth stories—was very powerful . . .* (online participant - Miller, 2008, p.63)

Freebirthing also provided women with an alternative to the midwifery model of birth. Some women believed a midwife as simply unnecessary (Miller 2009). Others had had a previous negative experience with midwifery care or viewed midwives as the first stage of intervention and therefore rejected their involvement (Freeze 2008, Brown 2009).

3.4.2. Faith in the birth process

All the four papers reported that the participants had strong faith in their ability to give birth safely. They believed that a woman who has prepared emotionally, physically and spiritually and was left to her own devices were able to access an instinctive and intuitive place within herself to birth her baby safely:

> *'What makes birth safe is for the birth process to be interfered with as little as possible, for the mother to feel safe, and for her neocortex to be unstimulated. To disturb the birth process with various kinds of rituals and practices does not in itself make birth safer; to the contrary it complicates birth and when the midwife [or doctor] "saves the day," it furthers the myth that this essentially automatic process of the body needs to be made to happen.'* (Hessel, mother of 4 (2 freebirths) – Freeze, 2008, p. 196)

This was reflected in the women's own risk assessment, from which they concluded that having a qualified birth attendant or going to hospital was riskier than freebirthing:

> *'I felt as a first timer* [primiparous woman] *that the biggest threat to my safety and my baby's safety was unnecessary intervention and you know, I was young and I knew I was healthy and I knew that if went into a hospital I was going to have to fight really hard to get my baby out safely'.* (Freebirth 08 – Jackson et al, 2012, p. 564).

Religious beliefs led some women to relinquish the birth outcome to *'God's will'* (Miller 2009). Commonly, the holistic approach was regarded as fundamental to safe outcomes for mother and baby: the majority of women took the mind-body-spirit connection seriously. Women demonstrated this by ongoing preparation throughout their pregnancies. This involved a range of self-care

methods ranging from acquiring knowledge about the birth process, incorporating good nutrition and exercise, to meditative practices in order to *'unlearn'* cultural fears of birth, as well as preparing for potential birth emergencies such as neonatal resuscitation.

3.4.3. Autonomy

All studies found that the majority of women reported a desire to freebirth in order to retain their sense of choice, control, and autonomy over their childbirth (Freeze 2008, Brown 2009, Miller 2009, Jackson et al 2012):

> *'Early on, I made a list of all the factors and elements I did or did not want to be part of this experience. My main focus was on creating an absolutely uninterrupted, undisturbed process of birthing, controlled entirely by me. I wanted no input from anyone else while giving birth. I wanted no suggestions, no instructions, no checking, measuring, or labelling. I had total confidence that I would have a safe and normal birth'* (Miller, 2009, p.64)

Miller (2009) found that the women perceived they could not retain autonomy if there was a birth attendant present because they would '*take charge'*. This finding was also reported by Freeze (2008) who found that women's prior experience of reduced control and autonomy were a catalyst for choosing to freebirth:

> *'The biggest thing is that WE the birthing moms are in control and there are NO medical trained persons there telling us what to do'.* (Suzie – Freeze, 2008, p.2)

Brown (2009) and Jackson et al (2012) reported that prior experiences of lack of control and choice were experienced as traumatising:

> *If women could be respected as intelligent beings capable of making choices and taking responsibility for them, they would probably choose to have some help, but there's no help available to them, that works for them, that treats them like human beings with a brain, capable of making their own decisions.'* (Ronii – Brown, 2009, p.19)

Brown (2009) reported how women believed that they had a *'right'* to make their own birth choices, one that was felt not to be respected by midwives or doctors, which led them to freebirth:

> *'..doctors and the medical community in general will definitely push you around for their convenience and their budget and their bottom line, and it's our right to not be at the mercy of that.'* (Suzie – Brown, 2009, p.25).

3.4.4. Agency

The decision to freebirth as a method of exerting agency over their bodies during childbirth was reported across all the studies:

> *'I have always been a woman who did what I wanted, and did it well. When people have told me over the years that I couldn't do something, I'd laugh. My response has always been, "The only thing that stops you, is you. Nothing else'* (Miller, 2008, p.64)

In a wider context, Miller (2009) proposed that the decision to freebirth reflected the rejection of the medical discourse in favour of a new holistic discourse in childbirth. Using Foucault's theory of bio-power (1973) she suggested that women are exerting agency over their bodies during birth by resisting mainstream birth practices. Brown (2009) elaborates upon Foucault's theory of bio-power, linking feminist theory with women's embodied experiences of practices of power, noting that the body is a source of control over women. She viewed freebirthing as a power force that challenged the misogynistic hegemony of current childbirth practices which assists in the process of redefining women's experience of childbirth. Freeze (2008) suggested that freebirthing illuminated the dominance of the medical model and motivated some women to exert their agency by choosing to freebirth. Jackson et al (2012) suggested that the women reject the current risk discourse of childbirth exerting agency by 'opting out of the system'.

3.4.5. Summary of key findings

Despite the methodological limitations of the studies, they generate useful insights to understanding why some women choose to freebirth. The rejection of both midwifery and medical models of birth demonstrated a mistrust that the women's needs for childbirth would not be met. They felt that the current midwifery and obstetric practices were riskier than freebirthing. Furthermore, through the process of discovering freebirth, the women demonstrated their own risk assessment and it emerged that they had a strong faith in the physiology of an undisturbed birth. There was a prevailing sense of choosing to freebirth in order to retain choice, control and autonomy over their bodies during the birth process. Furthermore, in a wider context the original authors' interpretation of women choosing to freebirth in order to exert their agency over their bodies provides a useful insight into how freebirthing is framed within the context of current maternity practices.

3.5 Gaps in the literature

The studies identified in this literature review were based in the US (n=3) and in Australia (n=1). There are notable differences between maternity provision between those two countries and the UK. First, the UK has a National Health Service, whereby maternity care is free for all pregnant women providing that they have lived in the UK for >1 year (Maternity Action 2011). Second, in the

UK, midwife led care is the default framework in which women access care. This differs from both the US and Australia and while there are distinctive differences between these two countries, the biomedical model is the dominant framework of maternity care (Childbirth Connection 2014, Donnellan-Fernandez, Newman et al. 2013) and not all women have access to midwives as default.

Consequently, the findings of the meta-synthesis cannot be transferrable to other settings, leaving a gap in terms of understanding this phenomenon and its occurrence from a UK perspective. As previously stated, there is clear anecdotal evidence demonstrating the practice occurs in the UK, but to date, there is no primary research exploring the phenomenon. Given the potential risks to mother and baby, it is an important topic to explore further and justifies primary research being undertaken in a UK setting.

3.6 Conclusion

This metasynthesis provides a unique contribution to the body of knowledge of the relatively unknown phenomena of freebirthing. It illuminates complex decision-making, and the various motivations that drive women to make this radical choice; these insights contribute to the debate and discussion about the current childbirth discourses and how this impacts women's birthing decisions. Furthermore, it has provided the platform for the current qualitative study exploring women's choice to freebirth in the UK which this study is based upon. The following chapter shall provide a detailed account of the methodology that underpins the study.

Chapter 4- Methodology

The previous chapter provided the findings of the meta-thematic synthesis highlighting the lack of literature within a UK setting. This chapter provides insights into how the research question was developed, and defines the aims of this study. A description of the variants of epistemology, ontology and their associated methodology is also provided, as well as a clear rationale for the phenomenological philosophical framework that underpins this study. In addition, it shall provide a detailed description of the theoretical underpinning of the particular phenomenological approach adopted for the study.

4.1 Research Question

Throughout the process of the meta-thematic synthesis and subsequent immersion in the principles of phenomenology (discussed in chapter 4) the research question evolved overtime through an iterative process. The key question for this study was:

Making sense of childbirth choices; exploring the decision to freebirth in the UK.

4.2 Aims

The aim of this study was to explore the lived experience of the decision making process and motivations of women who chose to freebirth. It was intended that this study would illuminate the meanings that UK women placed upon midwifery services in the UK, placing freebirthing within a wider context. This was to provide a greater understanding of women's needs for childbirth, how to meet those needs and to illuminate shortfalls in current provision.

4.4 Epistemology, ontology and methodology

When conducting research, there is a clear relationship between epistemology, ontology and subsequent methodology (Dykes, 2004).

Epistemology is the theory of knowledge i.e. a way of understanding how we know what we know, and ontology is concerned with the nature of reality (Dykes, 2004). Methodology refers to the strategies adopted to explore lines of enquiry (Dykes, 2004). The basis of one's epistemological and ontological position therefore guides the methodology required to explore a particular line of enquiry.

There are two key differing epistemologies; objectivism and constructionism (Dykes, 2004). Objectivism is grounded in a world view in which the nature of knowledge can be deduced to an 'absolute', and that within the nature of reality there is a 'truth' that can be objectively measured

(Dykes, 2004; Guba & Lincoln, 1994). When applied as a methodology, objectivism places emphasis upon testing hypotheses by deduction methods, using data which is measurable and quantifiable.

Constructionism on the other hand is grounded in a world view in which the nature of knowledge is embodied within the 'being-ness' of a human that is inextricably linked to the external world in which we live (Smith et al., 2010; van Manen, 2007). Therefore, the nature of reality from a constructionism view cannot be absolute, but is co-constructed with the world around us and is subsequently known as relativistic (Guba & Lincoln, 1994). Constructionism thereby places the emphasis upon exploring the subjective nature of lived experiences which occurs through an interaction between the investigator and what/who is being investigated (Bamberg, 2010; Guba & Lincoln, 1994; Smith et al., 2010).

A constructionist epistemological and ontological perspective was appropriate to meet the aims of the research question in terms of exploring the participants lived experience of freebirthing, with a particular focus on identifying the influences on their decision making processes.

4.5 Theoretical perspectives

Within the constructionist perspective there are a number of differing theoretical perspectives such as phenomenology, critical theory, feminist theory, narrative discourse, symbolic interactionism, ethnography, and grounded theory (Bamberg, 2010; Dykes, 2004). It is believed to be essential for researchers to make explicit which theoretical approach that adopt, as this will directly inform the methodology that is required to conduct the research (Dykes, 2004). The aforementioned approaches all vary in their philosophical underpinnings, therefore it is also argued that care needs to be taken to choose the most appropriate for any given qualitative study (Dykes, 2004). It is beyond the scope of this dissertation to describe all the different theoretical perspectives, however a hermeneutic phenomenology approach was identified as the most appropriate methodology. The next sections shall provide an introduction to phenomenology and then provide a description and rationale for lead onto a description of hermeneutic phenomenonology, the chosen theoretical approach and methodology, providing a clear rationale for its use in this study.

4.6 Phenomenology

4.6.1 Applying phenomenology

When applied to research, phenomenology seeks to reveal and share the hidden and not so hidden meanings of the subject of focus (Lester, 1999; Smith et al., 2010; van Manen, 1990). Emphasis is placed on the subjective experience of the participant and the meanings they attribute to their experience, thereby allowing the researcher to gain insights into people's motivations and actions

(Lester, 1999). It integrates the relationship between socialisation, enculturation and how we interpret our lifeworld (Bamberg, 2010). Therefore, our interpretations, or the meanings we place upon a phenomenon are constructed within a socio-cultural context (Smith et al, 2010).

However, within this broad definition of phenomenology, there are rich and complex variations of theoretical approaches that a phenomenologist may adopt, including transcendental, hermeneutical (interpretative), existential, linguistical, ethical, and the phenomenology of practice (van Manen, 2011a).

4.6.2. Historical roots

Bamberg (2010) describes phenomenonology as both a research method and philosophical way of viewing the world, which focuses upon the lived experiences and realities of human beings. The phenomenological movement was initiated by Husserl (1859-1938), who revolutionised philosophy (Kafle, 2011). Husserl's contribution is identified as Transcendental Phenomenology in which he coined the terms 'lived experience' and 'lifeworld' (Koch, 1995). His philosophy described a desire to seek out the essence of 'the thing itself', and by using a reductionist approach he attempted to uncover the essences of phenomena (Kafle, 2011). He asserted that that all actions and experiences have meanings attached to them, and he sought to uncover them within a sense of absolute 'truth' of their essence (Kafle, 2011; Smith et al., 2010). He developed the concept 'bracketing' (epoché) whereby the researcher's preconceived ideas about the phenomena in question are put aside in order to *get back to the thing itself p5* ' (Smith et al., 2010). His approach was based upon a Cartesian dualistic philosophy which aligns itself with the objectivism epistemology (Koch, 1995). However later philosophers branched away this approach criticising its alignment with a Cartesian binary perspective (Koch, 1995).

4.6.3. Hermeneutical Phenomenonology

Hermeneutic phenomenology is an approach that interprets the phenomena in question, and its basic premise is that all description is already an interpretation and that every form of human awareness is interpretive (van Manen, 2011b; van Manen, 2014). Van Manen (2011b) describes that in trying to get close to the participants account, the researcher is influenced by their own conceptions which are required to make sense of the account. Fundamental to this approach is that hermeneutical phenomenology does not seek new knowledge, rather it seeks to uncover and express an understanding of the lived experience (Koch, 1995; Smith et al., 2010). Furthermore, the hermeneutic circle offers a theory and methodology for analysis which appreciates the dynamic relationship between the part and the whole (Lester, 1999). Through an iterative process the

individual 'meaning' parts are viewed in context of the whole, and the whole is understood by the cumulative meanings of the individual parts (Smith et al., 2010).

It is imperative to understand Heidegger's influence upon the hermeneutical approach. Koch (1995) describes two of Heidegger's concepts; historicality of understanding and the hermeneutic circle and that they are inextricably intertwined. Heidegger believed that the background of a person i.e. their history, culture, socialisation etc. provides the basis through which he/she understands and interprets their lifeworld (Koch, 1995). As these pre-understandings offer the basis through which we engage with, and make sense of the world, Heidegger (1962) thereby conceived that that these are not something that can be bracketed and suspended. Furthermore, this pre-reflective understandings cannot always be made explicit, given that they are aspects of our world in which we subconsciously inherit (Koch, 1995). Heidegger (1962) recognises that by 'being-in-the-world' we are self-interpreting beings, therefore interpretation is as much a part of our life experience as the experience itself. This 'being-in-the-world' is expressed as *Daesin,* which is framed by Heidegger's ontological question; '*What does it mean to be a person*?' (Koch, 1995). Heidegger (1962) also described a threefold of interpretation in which to approach the texts being studied: fore-having which is the background of understanding; fore-sight which is entering the situation with a particular view; fore-conception which is the anticipated sense of interpretation. These three make up the hermeneutical approach to interpreting text. This approach thereby differs from Husserlian Transcendental Phenomenology in that rather than a researcher 'bracketing' their presuppositions to remove bias, their pre-understandings are laid bare and are reflected upon throughout the study to ensure that they do not mask or inhibit new insights from being unconcealed. (Laverty, 2003; Regan, 2012). The hermeneutic circle also represents and integrates this process in terms of how the researcher's pre-understandings are recognised and challenged throughout the interpretive process:

> It '*is not to get out of the circle* [of understanding] *but to come into it in the right way'* which is essential (Heidegger, 1927 p195).

Hans-Georg Gadamer (1900-2002) developed Heidegger's ideas further and sought to apply the philosophy of hermeneutic phenomenonology to practical endeavours; moving beyond abstract ideas but grounding them so that they can be displayed in the human and social sciences (Grondin, 2002). Regan (2012) reports how Gadamer identifies language as the primary medium for understanding and a means of sharing the complexities of human experience. Furthermore, the concepts of Gadamer's philosophical approach can be directly applied to qualitative research methodology (Regan, 2012). These concepts relate to the researcher's own experience of reading

and understanding to be an integral part of the interpretative process in which the relating concepts of pre-suppositions, inter-subjectivity, authenticity (trustworthiness), temporality (time affecting understanding/emotion), tradition, and history to interpreting the written word (Regan, 2012). It identifies that the relationship of the researcher to the subject is in itself interpretative, therefore by making these concepts apparent, authenticity to the subject is maintained.

Within this framework of understanding, hermeneutic phenomenology is an appropriate methodology for this study. It provided a process that explored the lived experiences of women whom chose to freebirth which integrated the relationship between socialisation, enculturation and how they interpreted their lifeworld at the time of decision making. Furthermore, I was able to situate myself, the researcher, within my lifeworld, openly and honestly, maintaining a trustworthy and authentic scope for interpretation. These aspects of hermeneutic phenomenology are not incorporated by other phenomenological approaches and I felt were essential to meet the aims of the study.

4.7 Presuppositions

Through drawing on Gadamer's work (Laverty, 2003; Regan, 2012), this section brings forward and explicitly explains my own preconceptions, my 'lifeworld' experience and knowledge of the subject in hand. An explication of my pre-understandings as potential 'biases' was to foster an open and authentic platform whereby I, the researcher could reflect upon my presuppositions and how this may affect the interpretation process. Indeed it could be said, that it was the first stage of the threefold nature of the interpretative process as described by Heidegger (1962).

From the conception of this study dating back to 2011 whilst an undergraduate student, I have kept several reflective journals, mapping my journey of my relationship to freebirthing. To bring to the fore, my own pre-understandings and biases, my supervisor, GT, and I decided that it would be of value if I were to be interviewed prior to collecting any data. This was for two reasons, first, to obtain an experience of being the interviewee, so as to allow a greater understanding and empathy for participants that I interviewed. Second, it was a further opportunity for reflexivity prior to data collection, in which I could frame my presuppositions and reflect on how these may have changed over the course of the four years I have been involved in the phenomena of freebirthing. I did not transcribe the interview, but listened to it several times.

Key aspects of the interview situates my 'being-in-the-world' in relation to freebirthing. First, reflecting upon my own personal experience of giving birth illuminated my initial distrust of the medicalisation of birth. I felt defensive during pregnancy for my birth choices, until I changed

midwives and forged a trusting bond with her. This brought to the fore the value of having a trusted midwife during pregnancy and whom was there at the birth of my son. For the full account of my birth story see Appendix 1. However, the interview also highlighted that during the postnatal period, I had to unpick and debrief aspects of my care of which I was not happy with. This led me to research 'undisturbed birth', a term coined by Michel Odent (2003) a famous obstetrician. His work challenges the everyday maternity care practices that occur daily by midwives and obstetricians. I reflected that even with my trusted midwife, I wondered if the birth would have been different (better) had I adopted his philosophy of care. This challenged me to consider the role of the midwife as it stands currently, and that of the normative practices of care that the majority of midwives provide are often at odds with true physiological birth. Therefore, my fundamental prejudices and were that the midwife is indeed the first step of intervention, and has such incredible power to alter the flow of birth.

I entered my midwifery training with two main prejudices, one against the dominance of the biomedical model of birth, I firmly believe/d that birth is a physiological and normal event. While I understood the need for appropriate intervention, throughout my training my prejudices against the biomedical model of birth strengthened. I felt that the framework in which we are trained, often does more harm than good. My other prejudice was that the maternity care system does not lend itself to the rhetoric of woman-centred care. I believe/d that women's choices are limited by risk management, hierarchal structures of the hospital institution as well as issues like staffing, morale etc. all of which are detrimental to women receiving woman-centred care.

During my training I came across freebirthing and decided to explore the topic for my undergraduate dissertation. My initial reaction was that I felt a deep resonance with the stories that I read. I felt I knew why these women wanted to do it themselves, especially for those who had received poor care during a previous birth. As a midwife, I wanted to learn from these women, what was it they knew that contradicted mainstream fear and current childbirth practices. I carried out a thematic synthesis exploring the views and experiences of women that freebirthed. This was further refined into a meta-thematic synthesis (Feeley, Burns, Adams, & Thomson, 2015), '*Why do women choose to freebirth*?' The findings are found in Chapter 2.

To demonstrate my key presuppositions about why I feel women freebirth I have included a short transcription from my pre-reflexive interview:

''GT: Why are women making this conscious choice?

CF: For some women I think they would do it anyway. It's a philosophical choice…belief that it's nature's way not to have a birth attendant. But for others, they simply don't trust us. Previous experience means that they don't trust that they will be in control of their decision making. Though I do think for a few, the decision comes from a positive experience, like a good homebirth, then they just don't feel that they need us.

GT: Do you think that this is justified-that claim they don't trust us?

CF: Yes. Yes I do. Yes from personal experience, and from my professional experience. My training was an eye opener. Which is such a shame, as I also work with excellent trustworthy midwives, who would do anything for their women. I know women could have that care. But they aren't necessarily getting that care, or getting that trusting relationship.

GT: Why is that?

CF: God that's a complicated question. Long pause…I would say being three years in now, it is largely from defensive practice, more than midwives not caring.'' (Sep 2014)

4.8 Conclusion

This chapter has defined the research question and the aims of the study. Furthermore, it has clearly demonstrated the ontological and epistemological framework that justifies the chosen methodology of hermeneutic phenomenology. The next chapter shall focus upon the methods that were used to carry out the study.

Chapter 5- Methods

The previous chapter explored the epistemological, ontological basis for the methodology that underpins this study. In this chapter explicit information about the methods used to carry out the research study are provided. Foremost it frames the methods within an ethical framework which is outlined below. Details about the sampling method, the recruitment process, data collection, analysis and how rigour was established throughout the study is also detailed.

5.1 Participants and Setting

5.1.1. Sampling method

A purposive sampling method was used. This was identified as the most appropriate method in in order to elicit the lived experiences of those women who had experienced the phenomena in question (Smith, Flowers, & Larkin, 2010). Furthermore, a snowball technique was used, whereby participants were asked to forward my information to anyone else who matched the inclusion criteria.

5.1.2. Inclusion/Exclusion criteria

As part of the recruitment process, an inclusion and exclusion criteria were applied; see table 3.

Table 3 Inclusion/Exclusion criteria

Inclusion	Exclusion
Women >18 years old	Women <18 years old
Women who had intentionally freebirthed	Women who had not intentionally freebirthed
Women who had been in the UK at the time of the freebirth	Women who were not in the UK at the time of the freebirth
Women who speak English	Women who don't speak English

5.1.3. Recruitment process

A range of websites were identified as pro-freebirthing websites, namely found via 'Google' and social media sites such as Facebook, Yahoo groups and Twitter. An initial email was sent to the website manager requesting permission to post the advertisement on their webpage (refer to Appendix 2 and 3 for copies of the email and advertisement). When consent was gained, the websites posted either my initial email which had my contact details and/or the advertisement that I had emailed them. They were also asked to disseminate the advertisement to any related websites

that they thought may be interested in the study, hence creating a snowball effect. Refer to

Appendix 4 for a clear trail of recruitment activity including where the advert snowballed.

5.1.4. Recruitment phase

There was one recruitment phase which spanned across a two week period September 2014.   The

original intention was to recruit five or six participants as deemed appropriate to a novice researcher

(Smith et al., 2010). The initial response to the recruitment was overwhelming, and within seven

days I had far exceeded the numbers I needed to undertake the study. However, when the consent

emails were issued several women did not make further contact, despite a follow up email being

issued. The recruitment phase ended when there were no more enquires from the original

purposive and subsequent snowball advertisements. 10 women were recruited into the study.

5.1.5. Participant/Researcher contact

Women who were interested in the study were invited to make initial contact to my university email

address. An email response was then issued together with an information sheet with explicit

information regarding the study aims/objectives and participatory requirements (refer to Appendix 5

for a copy of the email response, and Appendix 6 for the participant information sheet). They were

asked whether they wished to take part in the narrative, interview or both.

All interested participants were then sent out a consent form for the interview (Appendix 7), a guide

to writing the narrative (Appendix 8), a demographic questionnaire (Appendix 9) and a guide to

password protecting each document to be returned via email (Appendix 10).

It was requested that the narrative be returned within two weeks, and thus prior to the interview.

Once the narrative was received a mutually convenient time was arranged for the telephone/Skype

interview.

5.2 Data collection

The nature and purpose of hermeneutic phenomenology lends itself to interviewing as a primary

method of data collection (Laverty, 2003). Smith et al (2010) describe the interviewing process that

allows the researcher and participant to engage in a dialogue where rapport is developed and the

participant has the time to think, speak and be heard. Laverty (2003) describes how the process of

the interview must be framed with an environment of safety and trust, whereby the interaction is

based upon a 'relationship' between the researcher and participant.

Whilst interviewing is accepted to be the main source of data collection for hermeneutic

phenomenology, I would also argue for the use of personal narratives. As Bamberg (2010) discusses,

the narrative form can provide a portal into the realm of experience, as experienced by the participant. Furthermore, narrative as a method, can help participants with personal 'sense-making' of an experience, as well as bring forward the participants first stage of interpretation, which aligns itself well with hermeneutic phenomenology. Furthermore, it was felt important to enable me to engage in the first stages of the hermeneutic cycle, and one that would grow with the addition of the interview data.

There were two primary methods of data collection; narratives and interviews. The participants were invited to provide a narrative of any length prior to the interview. The aim of the narrative was for the participant to provide an account of their decision to freebirth in an unstructured way, however prompt questions were included in the narrative guide to assist the process (See Appendix 8). For some, time constraints meant that they found this difficult and needed further prompting or support i.e. a longer deadline to achieve the narrative. Nine participants provided a narrative and one participant provided a follow-up reflection following the interview (this was unprompted).

Nine out of ten interviews were carried out over telephone or Skype, but one participant preferred an online instant messaging format whereby I sought out an encrypted chat room to ensure good data protection (https://www.svyft.com/home#/room/1413310410475777223/chat).

The interviews varied in length, from 30 minutes to two hours. A semi-structured interview style was adopted in which the participants were invited to explore further the information they had provided in the narrative. A prompt sheet of questions was created should it be required (see Appendix 11). A 'conversational' manner was adopted for the interview in which I shared my personal and professional interest in the topic, with aim to provide the safe and trusting space as described by Laverty (2003) and to encourage the participants to share detailed accounts of their stories. I was mindful, that being a midwife, there was a risk that this group of women may have felt condemned for their decision making.

During the interviews, notes were made and I used opportunities to ask direct and indirect questions to help clarify the participants' views, and sense-making of their decision to freebirth. At times, this felt directive but on reflection it supports the hermeneutic approach in which it is the dynamic interplay of the interview/conversation in which interpretations are being made, and re-made (Smith et al., 2010).

5.2.1. Member checking

In order to support the data collection, a process of member checking was used whereby following the completion of the data analysis, the full findings were emailed to all participants inviting them to

provide any feedback within two weeks. Six out of 10 participants responded and no participant wanted to make any changes. Examples of the feedback included:

'I enjoyed the consolidation of a variety of viewpoints and reasoning's for choosing freebirth, it further highlighted to me how unique birth choices are. I resonated more with some themes over others. There are very nuanced differences in the decision making process and I think your overview goes some way to addressing this and highlighting, what I feel, is it's significant relevance.' (Alex, pn-8, email correspondence.)

'I am so pleased to see how superbly you managed to capture the overall drivers, practices, feelings and implications of free birthing.' (Jenny, pn-7, email correspondence).

'Thank you Claire for sending the draft. It made good reading and an emotional one too.' (Cat, pn-9, email correspondence).

5.2.2. Data transcription

Transcription is an integral part of the data analysis process, and can be described as a translation process from the recordings into text (Davidson, 2009). Davidson (2009) discusses at great length, that whilst this is an accepted part of qualitative research, it has been given little attention in the literature. There are many facets of transcription that cause debate (Oliver, Serovich, & Mason, 2005), but as Davidson (2009) describes it is essential that the researcher is transparent in their process as natural selectivity occurs depending upon the research aims, and that in itself is part of the initial data analytical period. Bailey (2008) explains that during the transcribing process that many judgements and decisions need to made i.e. the level of detail to transcribe, whether to transcribe ad verbatim opposed to correcting grammar and speech and whether to represent the non-verbal data. She states that transcription is the first stage of the interpretative process, thus the first part of data analysis.

I made several decisions with regards to the transcription process. I transcribed each interview personally, as I felt this was an important aspect of immersing myself with in the data as is true to the hermeneutical phenomenological approach. I used the f4 transcribing programme (Audiotranskription.de, 2012) which has several functions to help assist the transcribing process such as inserting time stamps where parts of the recording can be accessed readily at a later date. To manage the tension between retaining the integrity of the interview while inputting too much detail into the transcription and thus risk losing the flow, I adopted the 'simple transcript' convention (Audiotranskription.de, 2015). This was to focus upon the readability and the semantics of the interview, prioritising content over detail. I followed the simple convention that was laid out by the

f4 programme transcription guide (Audiotranskription.de, 2015), see Appendix 12 for an outline of the stated convention. The decision not to transcribe parts of the interview that went 'off topic' (i.e. not in line with the aims of the study) was made in consultation with my supervisor, GT.

5.2.3. Data storage

Data was stored in line with data protection conventions, using the password protected N drive via the University of Central Lancashire. Any files stored on my own computer, were password protected. Hard copies of data were stored in a locked cabinet, only I retained a key.

5.2.4. Data analysis

Throughout the whole process of data analysis, I have kept a reflective journal highlighting key thoughts and to provide an audit trail of any decisions I made. The first stage of data analysis occurred on receipt of the narratives whereby I read each narrative several times to glean an overview of the 'whole' as per the hermeneutic approach. I made initial notes, underlining key phrases and recording initial impressions or thoughts. During the follow up interview, I made brief notes throughout. After the interview I wrote down my reflections about it, again to glean an overview of the interview as 'whole' highlighting initial thoughts and concepts that I deemed significant at this initial stage. I transcribed the interviews and again made notes in my data analysis reflective journal about anything I felt was particularly significant. During this tentative initial stage I did not seek to identify themes, rather I aimed to just to highlight poignant phrases or significant aspects of the women's stories that were striking.

Once each interview had been transcribed, I uploaded both the narrative and interview to MAXQDA (maxqda.com, 2015), a qualitative software data programme designed to manage large quantities of data. It is unable to analyse the data, but provides a platform in which a researcher can do their own analysis using its various tools with speed and efficiency. Using the software, for each narrative and interview I started the process of coding. Each document was read line by line and significant phrases were highlighted as part of an 'in-vivo' method whereby poignant descriptive phrases illuminated key concepts pertinent to the research question (Lewis-Beck, Bryman, & Futing Liao, 2004). I interpreted the in-vivo phrases to create a code. I carried this out for each document (narrative and interview) where the process was iterative meaning that I went backwards and forwards between the texts to create new codes. I continued this until I reached a saturation point and no new codes emerged. This process was also carried out with discussions with my supervisor GT, which enhanced the integrity of this initial coding.

Once saturation of the initial codes were completed, it was clear from the data that some codes carried more 'weight' than others wherein a code was applied to more data than others. This formed the basis of initial tentative themes and allowed disconfirming data to emerge. Furthermore, I recognised that there was a large quantity of rich data which did not necessarily answer the research question, therefore data not considered to answer the research question was discarded for the next stage of analysis.

Van Manen (2014) endorses that it is through the process of writing that the researcher is able to elucidate the phenomenon in question. He states it is an integral part of the analysis and essential to the interpretative process that the researcher can work and re-work the emerging themes. I took this approach as once I had my tentative themes and through an initial discussion with my supervisor I began to write the themes trying to get close enough to the participants' accounts whilst seeking to provide my interpretations of the data. This process was iterative, meaning I went back and forth from the original data and codes, to my writing. Through this process, sub-themes emerged in which were pertinent to the over-arching themes and these were developed further. Following the initial write up and feedback from my supervisor, the themes and sub-themes were reworked. This was to provide a greater level of interpretation and synthesis contributing to a more coherent and structured 'story' illuminating the research question. This process continued to be iterative taking several different directions until as Gadamer (Regan, 2012) refers to; a 'fusion of horizons' was achieved. See Appendix 13 the list of codes extracted from the data, Appendix 14 for an example of how the codes were used from a single data source and Appendix 15 as an example of how a theme was developed using the codes and accompanying data.

5.2.5. Addressing rigour

In order to have credibility, qualitative research needs to demonstrate the rigour that was applied to the methodological actions carried out by a researcher (Smith et al., 2010). Whilst this is open to contentious debate, many researchers agree that key aspects of qualitative research can have quality principles applied (Walsh & Downe, 2006). Lincoln and Guba (1985) are lead authors on the subject of addressing rigour in qualitative research and use the term 'trustworthiness' to denote the worth of the research. Underpinning trustworthiness are four key elements: credibility, transferability, dependability and confirmability. The following sections will describe how I have ensured trustworthiness in this research.

5.2.5.1. Credibility

Lincoln and Guba (1985) outline seven key areas that ensure credibility which is defined as 'confidence in the truth of the findings'. Whilst not all seven areas are appropriate for each research study, this section outlines how credibility was achieved in this study. 'Prolonged engagement' is where the researcher has spent enough time with the data in order to understand the scope of the phenomena in question. This was undertaken via the in-depth nature of data collection, submersion within a range of data sources and my time spent during the analysis period. 'Triangulation' involves using multiple data sources in order to understand the phenomena. This is demonstrated by use of two types of data collection: narratives and in-depth interviews. 'Peer debriefing' involves conferring with peers in order to illuminate pitfalls, areas of bias and areas that need clarification enhancing the researchers attentiveness and focus to the question. During this research, I have consulted my supervisor at various intervals throughout the analysis stage to deepen my understanding of the data and to provide a constructive critique of my analysis. This has allowed a greater depth of interpretation that is evident in the findings. 'Member-checking' involves gaining the participants views and feedback upon the researcher's findings. This was carried out by returning a copy of the findings to all participants, thereby adding credibility to the findings.

5.2.5.2. Transferability

Transferability relates to how meaningful the findings are, and the extent to which they can be applied to a wider context (Lincoln & Guba, 1985). Whilst this may be difficult in qualitative research, it is accepted to achieve this that the researcher has to provide 'thick descriptions' of the phenomenon and the methods used (Lincoln & Guba, 1985). The onus is upon the reader to make this judgement when they assess the research and try to apply it in different contexts (Krefting, 1991). Within this research thick descriptions were used to illustrate my interpretations via in-vivo and direct quotes to provide meaningful findings. The phenomena was also framed within the participants' wider socio-cultural context, and disconfirming data was incorporated in order to enrich the women's different perceptions. Explicit details about the methods used throughout the research have also been provided.

5.2.5.3. Dependability

Shenton (2004) states that in qualitative research the onus is not necessarily on the reliability of being able to replicate a study in order to obtain the same results. It is accepted a different researcher may have different findings but through a clear audit trail of methods and decisions made another researcher would be able to replicate the methodology and methods used. The in-depth nature of providing such information can also provide an assessment of whether proper research practices have been followed (Shenton, 2004). This research has clearly laid out the methodology

that guided the methods used. The detailed explanations and provision of an audit trail (refer to Appendices 2-14) a reader would be able to follow the methods discussed. I also used a reflexive and data analysis journal to record all decisions made throughout the study.

5.2.5.4. Confirmability

Lincoln and Guba (1985) describe confirmability as the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest. This research has demonstrated confirmability by several methods: providing an explicit description of my pre-suppositions; sufficient detail of methods used and decisions made; triangulation via two methods of data collection and clear reflexivity. Furthermore, I have kept a reflexive journal and made available the data analysis processes of how the themes were constructed in the Appendix 17. In addition, the findings are contextualised by the participants' quotes from their various accounts.

5.3 Ethical Considerations

Prior to the study being undertaken, an ethics approval application was made to the University of Central Lancashire. Ethical approval was gained by the STEMH Ethics Committee at the University of Central Lancashire June 2014, and an amendment was approved January 2015 (see Appendix 16 and 17 for copies of the letters).

Any research carries with a great level of responsibility towards the participants involved within that research (Canterbury Christ Church University, 2006). The Department of Health (2012) has clear guidelines for researchers in health sciences to ensure that high ethical standards are met. These include duties by the researcher to ensure honesty, integrity, objectivity, accountability and openness as well as the application of professional standards (Department of Health, 2012). Guidance is based upon the ethical principles of autonomy, free and informed consent, veracity, respect for vulnerable persons, privacy and confidentiality, justice and inclusiveness, harms and benefits (Canterbury Christ Church University, 2006; Department of Health, 2012).

5.3.1 Information how this study conforms to ethical considerations

Autonomy and informed consent; All participants were provided with a written information sheet which explicitly outlined the purposes of the research, the voluntary nature of participation and how they may withdraw from the research. At the start of the interview, a consent form was completed with the participant to ensure informed consent was obtained. Due to all interviews being undertaken remotely, a consent form was forwarded to the participant, and it was signed on their behalf at the start of the telephone/SKYPE interview. All participants were also provided with my contact details

so that they are were able to contact my directly, should they wish to withdraw their data from the study.

Respect for vulnerable persons; Specific recruitment criteria was applied in order to negate the potential effects of interviewing vulnerable people; i.e. women over 18 years of age.

Privacy and confidentiality; although confidentiality can only be assured in terms of data protection i.e. details of the participants were not be shared with outside parties, the participants were made aware of assured anonymity. Participants were consented for anonymised direct quotes to be used within the dissertation, any journal papers and presentations made about this study. They were informed that all personal data would be removed from the transcripts. Only the research team had access to the raw data, all of which was sent via encrypted emails.

Harms and Benefits; whilst there may not have been any personal benefits to the participants taking part, their involvement has contributed to wider childbirth knowledge, which may have provided satisfaction to some participants. Some participants may have benefitted from '*telling their story*' and feeling heard. Furthermore, some reported looking forward to reading the findings. In consideration of potential issues that could come up during the interviews, I created a table of potential issues outlining how the matters would be dealt with e.g. complaints against the local trust, safeguarding, emotional distress etc. See Appendix 18 for the full breakdown.

5.4 Conclusion

This chapter has provided explicit detail about the methods I adopted in carrying out the study from recruitment to the data collection methods. Ethical considerations are explicit and have been applied during the research. Furthermore, the data analysis has been clearly described in order for the reader to follow the methods used and understand the decisions made which provided the findings in Chapter 5. Attention to rigour has been explained.

The next chapter provides the findings of study including demographic information about the participants.

Chapter 6- Findings

The previous chapter described the methods used in collecting and analysing the data. In this chapter, the participants are introduced, providing information on the participants' demographics to contextualise the findings. The key themes that emerged from the data: '*contextualising herstory*'; '*diverging paths of decision making*' and '*the converging path of decision making*' are then described and discussed. These themes describe what and how underlying factors and previous life experiences influenced different women's decision-making for a freebirth; as well as highlighting diverging and converging influences on how and why these decisions were made. A pseudonym for the participants has been used to ensure anonymity, together with the data source i.e. narrative or interview and associated line numbers from the transcripts.

6.1 Participants

The demographics of the participants are presented in table 4. Given that of the 33 births, 11 took place in hospital, one in a birth centre, six were homebirths and 15 were freebirths, it can be said that these women have had a wide range of birth experiences.

The demographic information provided by the participants indicates that they were mature, well-educated which suggests a high level of socioeconomic status.

Table 4 Demographic Data

Participant	Age	Area lived at time of freebirth	Type of birth				Place of birth				Ethnicity	Marital status	Highest educational level	Employment status
			Total number of births	Vaginal	Assisted	Caesarean	Hospital	Birth centre	Homebirth	Total freebirth				
1. Kate	37	York	3	3			1		1	1	White British	Divorced/ New Partner	Degree	Self employed
2. Julie	38	Huddersfield	2	2			1			1	White British	Married	HND	Part time employed
3. Claire	31	Manchester	1	1						1	White British	Separated/ New Partner	Degree	SAHM*/ voluntary work
4. Jane	33	Somerset	4	3	1		1	1		2	White British	Married	Higher education cert	SAHM/studying
5. Holly	32	Coventry	8	8			4		2	2	White American	Divorced/ New Partner	Degree x2	SAHM/part time employed
6. June	37	North Lanarkshire	5	5			2		1	2	White British	Married	Scottish Highers	Student
7. Jenny	41	Yorkshire	2	2					1	1	White European	Married	Degree	Full time employed
8. Alex	29	Nottingham	2	2			1			1	White British	Married	Degree	SAHM
9. Cat	45	Durham	2	1	1		1			1	Mixed Maya/Mediterranean	Married	PGCE	Part time employed
10. Nicky	37	Camberley	4	4					1	3	White European	Married	Higher education cert	Home educating SAHM
			33	**31**	**2**		**11**	**1**	**6**	**15**				

*NB SAHM= Stay at home mother

6.2 Contextualising 'herstory'

This first theme explores the different contexts of the participants 'herstories' – a feminist reclamation of history, from the female perspective (Dictionary.com/Unabridged, 2015) – which they felt framed their decision to freebirth. The sub-themes of '*personal herstories*', '*inherited birth beliefs*' and '*embodied birth experiences*' explore different aspects of their stories. Whilst generalisations cannot be made about *how* underlying factors and life experiences shaped the participants world view for its impact is felt in a unique way for each woman, these insights framed how their decisions about their body during childbirth were formed.   These self-reflections provided a sense of understanding of the individual nature of each participant's life at the point prior to their decision to freebirth: unique and different but all with a sense that where they began was relevant to their subsequent journey.

      6.2.1. *Personal herstories*

Within each narrative the participants' disclosures about their lives prior to freebirthing provided a rich contextual backdrop which framed their stories and that of their decision to freebirth. Three of the women reported enduring abusive relationships prior to their experience of pregnancy and birth which left them recovering from a range of mental health disorders: '*PTSD*'; '*anxiety*' and '*situational autism*'. One participant described how her abusive childhood had impacted on her world view:

> '*I absolutely hate to feel helpless, lied to or pushed around by people who think they are smarter/better than me, because of this.*' (Holly pn-5, nar, In: 4-4).

Other women described certain aspects of their lives which they felt were pertinent to provide the context of their freebirthing decision. These included a diagnosis of Asperger's Syndrome, a difficult childhood marked by a father leaving the family home which left the participant with a real sense of ensuring that she was able to look after herself and not depend on others, a stream of life events that left one participant describing her '*low self esteem*' and another reporting that she did not have any support around her prior to pregnancy and childbirth.

      6.2.2. *Inherited birth beliefs*

In contrast to the difficulties that many of the participants experienced during their lives, four women described how their family herstory of homebirth created a sense that birth was a '*normal part of life*', yet '*special*'. These participants had been born at home and described it as '*idealised*', and informed a part of their herstories in which they enjoyed their mother's recounting their birth stories:

'I myself was born at home, with a midwife and to me that was idealised, a homebirth was something that has pleasant memories for me well pleasant nostalgia because my mum said 'oh you were born at home', you know, 'I was walking around hanging out the laundry the day before and the next day, I couldn't believe it I had a baby that night!' That birth story, wasn't so much that it was great, it was just normal.' (Cat, pn-9, int In: 23-23).

This positive inherited social enculturation as well as the subconscious memory of being birthed at home contributed to how the women framed birth and freebirth within their world view:

'Yea, I remember the way she spoke, you know the way with body language and things, the way she spoke about her homebirths, yes there were a few stressful things, but there was humour and she was relaxed and things, but the way she spoke about it was very much like the freebirthing women spoke about their births.' (June, pn-6, int, In: 9-9).

6.2.3. Embodied birth experiences

All of the participants, with the exception of one, had at least one previous experience of birth prior to their decision to freebirth. They reported a diverse spectrum of positive and negative experiences, all of which were intertwined with their experience with maternity professionals. Notably, all of the participants reported negative experiences of their maternity care in some capacity. These ranged from simply being *'irritated'* by the presence of midwives whereby they felt that the midwives hindered their birthing experience, to feeling their expectations were not met. These latter occasions were when the midwives assumed more of a '*medical role'* as opposed to a '*mothering role'* expectation:

'The only thing was that I'd had to work quite hard to feel undisturbed by the midwives and the busy, bossy vibe they had added to our birthing environment. X (husband) had to remind them several times that I wanted complete silence, as they would chat about holidays just outside the door.'
(Jenny, pn-7, int, In: 4-4).

Six of the women provided self-reports of a *'traumatic birth'*:

'I felt violated and humiliated. It ended up with the Dr telling me my baby was stuck and she would try to pull my baby out, in theatre, with an epidural, surrounded by strangers, in case it didn't work in which case they would perform an emergency c-section. It was the most awful experience of my life.'
*(*Jane, pn-4, nar, In:2-2).

The trauma they described encompassed a range of traumatic births which for some were fused by traumatic life experiences such as being in an *'abusive relationship'*, and *'being raped'*. There was

recognition among the women that the birth experience is an extremely important process which is a '*deeply intimate act*' which can '*play on past trauma*'. In all occasions, birth trauma occurred during a hospital birth. Repeated incidents of women '*being ignored*', '*left alone*' or conversely '*harassed*' by hospital midwives and doctors left the women feeling '*abandoned*', '*disempowered*', '*out of control*' and '*frightened*'. Non-consensual acts were carried out by maternity staff including vaginal examinations and inserting IV lines where the women reported being 'done to', rather being a part of an informed process. Furthermore, the experiences evoked a deep level of '*shame*' wherein the women seemed to internalise the actions of the maternity staff and blamed themselves for not stopping them:

'I felt ashamed, the only other thing I have ever felt ashamed of uh through the whole process, I was ashamed that I sounded like a pig that's being slaughtered.' (Cat pn-9, int, In: 25-25).

'And looking back I was like why did I consent to having syntocinon with a baby that could potentially could have been distressed? It didn't make sense.' (Kate, pn-1, int, In: 23-23).

In contrast, seven of the participants described positive experiences of birth and their interactions with the midwives. It is of note, that all of them took place in non-obstetric settings i.e. two of the women gave birth at a birth centre, and five had planned homebirths with midwives present. The participants reported positive feelings and the adjectives used to describe the birthing experience included: '*wonderful*', '*calm*', '*perfect*', '*easy*' and '*beautiful*'. Of interest, was the participant's relationship to their midwives, whereby they largely valued the '*quiet presence*' and whereby the midwives seemed to be not '*doing much*'. Others reported feeling supported by their midwives, which in turn helped to facilitate a positive birth experience. These narratives provided a stark contrast to the other women's negative experiences as they were able to reap the benefits of a calm atmosphere and supportive but quiet midwives who simply '*let them get on with it*'.

6.3 Diverging paths of decision making

The first theme contextualised the participants' lives, offering insights to their unique life stories which framed their path of decision making. This theme explores the different paths the women took in deciding to freebirth. Of the 10 women, one made the decision instinctively, three were motivated to freebirth because of a previous positive birth experience and six were motivated to freebirth because of a previous traumatic experience. All of the women who had a previous traumatic experience (n=6) booked a homebirth for their next pregnancy. However, as three of them experienced conflict with their community midwives they changed their decision to freebirth during their pregnancy. The remaining three women went onto have a successful homebirth before opting

for a freebirth in their third pregnancy. The subthemes of *'instinctive'*; *'compounding trauma'* *'seeking solace in homebirth'*; and *'improving and enhancing the birth experience'* explore these different paths in more depth.

6.3.1. Instinctive

For one participant, the path to freebirthing was entirely instinctual. Claire (pn-3) had no prior experience of birth but had made the decision to freebirth during her first trimester in pregnancy. Claire had been proactive from the start of her pregnancy in seeking out her birth options as she knew immediately that she would not birth in hospital. It was during her research into birth options that she came across the concept of freebirthing and instantly knew it was the right decision for her:

'I hadn't really explicitly thought about where/how to give birth before then, but if I had, I would have identified immediately that it wouldn't be in hospital, and I didn't want anyone else around. So as soon as I came across the concept, it made complete sense to me.' (int, In: 4-4).

This belief in part stemmed from her self-awareness of her personal needs in which she identified as *'not naturally sociable'* and an inner knowingness that having midwives around would cause her *'stress'* which she believed *'would make things more likely to go wrong, not less.'* For Claire, there was no distinction between midwifery or medical care, and she rejected both models of care. It would seem that freebirthing was the only option that she deemed suitable for her needs. Thus, her decision to freebirth was a remarkably straightforward one.

6.3.2 Compounding trauma

As referred to earlier, six of the participants reported that a previous traumatic birth was instrumental in their later birthing decisions and they all booked a homebirth. However, for three of these women their prior negative birth experience was compounded by extremely negative interactions with their community midwives. These women felt that again they *'weren't being listened to'* and that they were being *'manipulated'* and being *'bullied'* for making informed decisions to book their homebirth*:*

'To be honest I would liken some of the manipulation and a technique used by midwives as abusive.' (June, pn-6, nar, In :3-3).

They likened these negative interactions as *'going into battle'* at routine antenatal appointments which they found *'stressful'*. These women felt immense pressure to comply with local policies and guidelines and were referred to Consultant Obstetricians when they did not comply. They perceived that their care did not consider their individualised needs, knowledge or preferences for birth:

'I felt no faith whatsoever in my local maternity service in 2006. No trust. No support. Nothing but revulsion for their attitudes and revolving door policies, and for the lies and pressure they put me under without understanding I am a smart and educated girl.' (Holly, pn-5, nar, In: 5-5).

These women reported that their community midwives seemed to be *'fearful of birth',* which in turn eroded their confidence in being attended by them during their home birth. Furthermore, an awareness that it was a *'lottery'* as to who attended their homebirth, meant that for some women they did not want to take the risk of having a fearful or unsupportive midwife look after them in labour:

'The obstructive behaviour by the community midwives, the lottery of who would turn up at the birth. If their behaviour was indicative of many of the midwives in the Trust then I could not trust that they were supportive of home births. I actually became fearful that they would turn up in time for the birth as they seemed more scared of attending a home birth than I felt about having a home birth.'
(Cat,pn-9, nar, In: 8-8).

For Cat, this experience with the midwives coupled with an increasing sense that midwives would *'block her birth',* at 30 weeks gestation she made a decision to freebirth. Julie also booked a homebirth, but during her labour she decided she did not want midwives there as she felt they would interrupt and intrude upon the *'safe haven'* of her birthing space. For these women, safety did not mean midwifery attendance, rather they felt that midwives would have hindered the birth process through jeopardising their feelings of safety and security. Lack of trust in the service provision was a prevailing feeling. In this respect, the unsupportive and at times obstructive behaviour of the NHS midwives facilitated the decision to freebirth.

6.3.3. Seeking solace in homebirth

Three of the women who had a traumatic birth went onto have at least one successful homebirth with community midwives in attendance before they carried out a freebirth. For these women, they knew that they wanted to freebirth but lacked *'faith'* in themselves. Within their homebirth accounts, there was a sense that the women sought the support of midwives in order to *'prove'* that their bodies could birth safely, a confidence that had been eroded by their traumatic experience:

'I think in hindsight I probably needed to prove to myself I was capable of doing it before contemplating doing it alone.' (June, pn-6, nar, In: 8-8).

By seeking solace in homebirth these women described a great sense of *'empowerment'* and indicated that it was an affirmation of womanhood. Their accounts of their interactions with midwives were in stark contrast to those reported previously. They reported that the community

midwives were very supportive of their decision to homebirth and even in two cases, implied support for a freebirth. These women valued the community midwives support, feeling that they were *'listened to'* and thus consequently that their individual needs for birth were valued. In particular, a midwife who came across as *'hands off'* and who was an advocate for the woman was appreciated:

'…my second a beautiful homebirth, luckily supported by a case loading team in X (Trust). The NHS care I received from midwives was outstanding and I wrote a letter of commendation.' (Kate, pn-1, nar, In: 4-4).

6.3.4. *Improving and enhancing the birth experience*

Three of the 10 participants were unique, wherein their embodied experiences of childbirth (two had homebirths, one had a hospital birth) were positive and these women had no self reports of childbirth trauma. This developed a belief in their bodies to birth safely without midwifery attendance. These women differed to the others as they only had positive birth experiences to frame their reference for childbirth. They did not need to 'seek solace' in homebirth, nor did they have anything to prove to themselves, but rather they desired to improve and enhance their birth experience which became the catalyst for choosing to freebirth. For all of these three women, it was reported that the learning curve through their prior experience of birth was *'pivotal'*, and was a *'crucial part of future decision making processes'.* Their former positive experiences created a huge high after the birth where the women felt empowered and ready to start their journey of parenting:

'Not only did we suddenly have a baby, but I had birthed him in the most empowered way I knew, and yea it really set the scene for parenting. You know, for my confidence in my parenting, knowing the things that I had put in place for his birth were right and therefore, I would probably think what I am doing with the parenting and feeding probably are right because tuning into your instincts must be the thing to do laughs' (Jenny, pn-7, int: In 7-7).

During the post-partum period and when considering a future pregnancy, the women evaluated their previous experiences. They had a firm sense that their body *'could do it'*, that brought about a strong sense of *'trust'* not only of their bodies but their ability to tune into their *'instincts'* during birth. The concept of having the space to tune in to their instincts was important to the women. As they reflected upon their previous birth, it emerged that they felt a midwife's presence detracted from their ability to fully *'tune in'* and unfortunately *'disturbed'* their birth space:

'Well the fascinating thing is that because the midwife was talking to me regularly during contractions, I was very irritated by her presence (laughs).' (Nicky, pn-10, int, In: 11-11).

The concept of freebirthing evolved during their considerations for their needs during another birth. Primarily they wanted to recreate their previous experience and aimed for an even better birth by *'searching for greater depth to the experience'.* This involved a rejection of medical involvement wherein their trust in their healthy pregnancies and ability to give birth meant that they deemed *'monitoring, checks, questions, and procedures'* as unnecessary. It also involved a deep consideration for the role of the midwife and how they may contribute or potentially detract from their birthing experience. Knowledge of midwifery obligations and professional accountability also factored into the women's decision making:

'So for the second birth, we explored ways of avoiding the disturbance, while having the safety net of a midwife present. I imagined we might ask her to stay downstairs unless I asked for her. We worried about whether this would be respected, since midwives have a job to do. We then defined for ourselves what we wanted a midwife's role to be at this birth – it would be worst case scenario: to help identify a problem, and call for a transfer.' (Jenny, pn-7, nar, In: 5-5).

They were keen to stress the emergence of this decision as *'a well thought out process'*, one that took time and deep consideration:

'I do not believe that freebirth is a choice for everyone and it is something that I worked towards, rather than made hard, fast decisions about but I think it is crucial to stress that my choices were born out of positivity, a deep understanding of myself and intelligent reasoning.' (Alex, pn-8, nar, In: 11-11).

6.4 The converging path of decision making

The last theme described the diverging paths to decision making. This theme explores how these paths converge as the women validated their decision to freebirth: *'understanding the physiology'*; *'wider and trusted support'* and *'conceptualising risk'*.

    6.4.1. Understanding the physiology

Throughout all of the participant's journey of decision making, they all reported extensive research into birthing options and birth physiology, which they used to validate their choice to freebirth. This denotes the level of education that collectively the women had, as they were able to access information, make sense of it and apply it to their personal situation. Underpinning this search for knowledge was a drive to make sense of their birth experiences; positive or negative, demonstrating that birth was hugely *'significant'* and created a lasting impact upon their lives. During their research all of the participants referred to mammalian biology, in which they regarded birthing alone to be a normal and largely safe event:

'Being an avid observer of natural history all my life, I accepted that like any other mammal, I can give birth so the implicit trust I have in my biology played a fundamental role in this acceptance of birthing alone.' (Cat, pn-9, nar, In: 9-9).

The women referred to the physiology of birth, whereby the complex hormonal interplay works best when the mother is *'undisturbed'* and *'feels safe',* which in part supported their perspective that having a midwife in attendance would not be conducive to a safe birth. Midwifery care was used synonymously with medical care and it was reported *'is just no reason to medicalise birth to me'*. This rejection of midwifery attendance also derived from the women's perspective that the checks a midwife carries out during labour were *'interfering'* and would detract them from their labour. The process of validating their decision to freebirth by avid research reinforced their decision making but it could be said that for some women the decision was already made:

'I talked with other doula colleagues and my IM [independent midwife]. But my decision was solid from word go.' (Kate, pn-1, nar, In: 15-15)

6.4.2. Wider and trusted support

All of the participants sought wider support in some capacity, which further affirmed their decision making. The majority of the women had supportive partners at the time of their freebirth whom they relied upon to be their birth partners. They looked to their husbands to provide a *'protective'* and *'safe space'* for them to birth safely and trusted that they would action any emergency should it arise:

'Having gone through the wonderful homebirth together I knew that I could give birth normally and that I could trust my husband to protect and support us through the labour. He was also comfortable with things, now knowing what he needed to do and what would happen. I opted with this pregnancy to use maternity care at a minimum.' (June, pn-9, nar, In: 9-9).

Not knowing the midwife played a pivotal role and reinforced their perspective that having a stranger at their birth would impede the birth process by increasing stress hormones and reducing the hormones needed for a safe birth. They also did not want midwifery practices imposed upon them especially from someone that they *'didn't know'*:

'I wondered if the midwives were contacted, but kind of knew they weren't. I really didn't want to change the safe haven bubble and trusted people surrounding me. I also did not want to be interfered with, examined or questioned by people I did not know.' (Julie, pn-2, nar, In: 49-49).

Therefore, it can be said that the women valued knowing who was entering their birth space which elicited an important sense of trust.

All of the participants used the internet for support, whereby they accessed freebirthing websites and forums. This provided a network of support enabling the women to seek advice from other women online. Furthermore, they found the forums to be a '*safe place*' to explore their decision making remarking that it is an '*ideal group',* which was '*non-judgemental*' and '*women supporting women'* was greatly valued. This contributed to the validation process where women didn't feel like '*freaks'* for considering freebirth as an option.

Five of the participants had accessed support from a doula as opposed to a midwife. They turned to their doulas to either '*help them process their feelings'* about their decision or as a source of information which contributed to the process of validating their decision making. Three of the women had undertaken a doula preparation course which increased their knowledge and/or lived experience of observing births. For them, it also created a '*wider community for support'* for alternative birth choices which may go against local policies and guidelines.

Three of the women also employed independent midwives, which again were utilised for '*support'*, '*individualised care'* and a source of information which also contributed to the validation process. The women felt able to discuss their plans to freebirth with these professionals. Although the independent midwives may not have advocated freebirthing, their commitment to autonomous decision making meant that the women felt that their plans were respected:

'…um she works on a relationship with me and offered me information regardless of whatever policies. Because she didn't have any policies, she was employed by me and providing a service to me. So the information was a lot easier to get hold of and she was a lot easier to talk to. But yea, we were able to talk to her no problem about freebirth.' (Kate, pn-1, int, ln:63-63).

6.4.3. Conceptualising Risk

All of the participants reported upon how their conceptualisation of risk contributed to their decision making. Although for some the word risk was not explicit, it was evident throughout their narratives and interviews. Nine of the participants underwent a personal risk assessment whereby they weighed up their own risk factors for complications during labour. Overwhelmingly, the women reported that their low risk pregnancy meant that they were at a low risk of birth complications. This caused them to question the role of a midwife attending their birth as they felt '*midwives couldn't do anything to make it a better birth'*; rather they were there to '*spot signs of morbidity'.* This was felt by all of the women, a task that they were capable of doing themselves. In

addition, the women rejected midwifery care based up their understanding of iatrogenic injuries wherein, poor outcomes can be attributed to the birth practices of the medical professionals and/or the systems within maternity services. They did not want to be looked after by professionals whose concept of risk did not support optimal birth physiology or be practicing with up-to-date knowledge and skills indicating the women lacked trust in their care providers, policies and procedures:

'But the more I thought about it, the more um the more I started reading into the iatrogenic injuries that happen because you know there's this practice if baby need resuscitation, the guidelines that you cut and clamp immediately. And I really began to be quite concerned about that, everything I could get my hands on in terms of papers, on this, the evidence was saying you need to resuscitate with the cord intact.' (Jenny, pn-7, int, In: 27-27).

'I found a lot of the methods used in hospitals so out of touch with natural birth it really angered me.' (Julie, pn-2, nar, In: 42-42).

Most sought assurance by their antenatal checks with a midwife, and decided that as long as the pregnancy remained *'normal'* they would *'stay home'* [freebirth]. This process of engagement and disengagement demonstrated that the women valued affirmation of clinical wellbeing during pregnancy to support their decision to freebirth for the first time. This engagement lessened with subsequent freebirths for four of the women. These women did engage with midwives during their pregnancies but on an adhoc basis, who preferred to do their own antenatal checks such as blood pressure and urinalysis. The women valued this self-generated information, and again supported their process of decision making to freebirth:

'You could say I was slightly organised, educated and focused.' (Julie, pn-2, nar, In: 40-40).

The women indicated a high level of motivation to educate themselves of potential emergency scenarios. They affirmed this during their research of birth physiology and risk factors for individual emergency scenarios including: shoulder dystocia, haemorrhage, cord prolapse and the baby needing resuscitation:

'In the end, it was a risk assessment. We weighed up the likelihood of all the risks that mattered to us, and made a decision based on our level of comfort with each of those risks.' (Jenny, pn-9, nar, 8-8).

The participants made evident a pro-active approach which shifted the responsibility of birthing their babies safely from maternity professionals and back to themselves. The women were insistent that they would access emergency services should they assess the need for it which highlights that they valued safety, if somewhat unconventionally. So whilst their concept of risk challenges current

midwifery and obstetric practices, these women demonstrated a profound quality by taking ownership of their births:

'Which is usually people's first reactions, to tell you that it is very dangerous. When actually you are the one who has got the most interest in the baby being ok. So I find it quite, quite uh, ironic, how medical staff or relatives or friends telling women who plan to freebirth that they shouldn't, that it is something that shouldn't be doing, when who has got the most interest in the baby being ok? It's the mother and then the father.' (Jenny, pn-7, int, In: 68-68).

6.5 Conclusion

The findings demonstrated that the women's prior life experiences had some impact upon their decision making, but it is evident that for the majority of participants, their decision making was directly influenced by their embodied experiences of childbirth. Moreover, the women's interactions with midwives and doctors seemed to be a crucial factor in their decision making. Those who had negative experiences lost trust in their care providers and sought alternatives. This either compounded feelings of distrust if future interactions were viewed as negative or it gave women a faith and confidence within their bodies if future interactions were viewed positively. For the women who had a further negative experience with maternity services, it perhaps left them with a sense that they had no choice but to freebirth in order to retain power and control over their experience. For women whom had a positive experience of maternity services, it would seem that freebirthing was an active choice borne from a fine tuning process in which midwives became redundant as the women further keyed into their instincts.

Overall, the women valued their own instincts during childbirth over an expert presence whom they felt would potentially detract from the birth experience and indeed they felt it would make it less safe. The findings have suggested that all of the women placed a significant meaning upon the act of childbirth itself. This is demonstrable through the complex process of self reflection whereby they 'unpacked' their previous experiences and sought a deeper understanding. The complexities of this process is highlighted by the diverging paths to freebirthing, whereby even within only 10 participants their paths differ. However, their paths converged as their individual processes propelled their commitment to researching the childbirth process and various childbirth choices.   In this sense, they became their own expert not simply relying on instinctual mammalian physiology but through seeking information to enhance their knowledge. This perhaps slightly contradicts their desire to follow the instinctual path that freebirthing seems to offer. However, it also signifies their conceptualisation of risk, which however unconventional, the women displayed their own continued

risk assessments indicating that they placed safety as a high priority. They in essence, shifted the responsibility of birth away from health professionals and took it for themselves.

Chapter 7 Discussion

The previous chapter described the synthesised findings from the participant's accounts drawing across several themes that explored the diverging and converging paths to freebirthing. This chapter will explore the findings in relation to the wider literature. The strengths and limitations of this study are described as well as the implications for clinical practice.

7.1 Wider discussion

This study has identified the key decision-making paths as to why women chose to freebirth in a UK setting. Fundamentally, the women decided that they wanted to birth their way, without disturbance or distraction and without any sense that they would have midwifery practice imposed upon them. With the exception of one participant, the women were making an active choice based upon their previous birth experiences. For some the decision was borne out of a negative experience which was then compounded by a further poor experience with maternity services. Namely obstructive practices by maternity professionals that limited their choice to book a homebirth. For these women, they lost faith in the maternity services to provide them with the care that was adequate for their needs. Therefore, in order to feel safe they opted to freebirth. For others this was borne out of a positive experience in which their decision evolved in trying to further improve their birthing experience, therefore a midwife became redundant. It is of note, that between the 10 participants they had had 33 births and had encountered varying experiences with maternity services which at times makes the findings seem conflicting or contradictory.

The desire to have power and control over one's birth experience supports the metasynthesis findings of freebirthing women in other contexts i.e. the US and Australia (Feeley et al., 2015). Furthermore, there were similarities in terms of the motivating drivers to make the decision such as: the rejection of both the midwifery and medical model of care; previous traumatic experience; and retaining normality marked by their faith in the birthing process. These were surprising findings given that the framework of maternity service provision in the UK is markedly different to other countries in that it has such a strong midwifery voice i.e. all women have access to a midwife throughout their pregnancy and the majority are looked after by a midwife during labour (Renfrew et al., 2014). Another surprising finding was how the women in this study did not seem to differentiate between midwifery and medical care, and was often used synonymously. There have been long standing debates about the differences between these two models of care, and that the midwifery model seeks to adopt a holistic approach whereby the biopsychosocial needs of women are addressed individually through creating care plans (Renfrew et al., 2014). This approach is enshrined in the Midwives Rules and Standards that all midwives have to abide by as set out by the

Nursing and Midwifery Council (2012). While a few women had positive experiences of a midwifery model of care, for many, it was likened to 'going into battle'.

This study has demonstrated the impact of self-reported poor and traumatic experiences on women's future birthing decision making. A recent metasynthesis (Fenech & Thomson, 2014) into the psychosocial impact of a traumatic birth highlights a multitude of issues including: loss of self-identity; lack of bonding with the baby; broken bonds with loved ones; and adverse effects upon mental health:

'Birth trauma changes women forever as their past, present and future selves become lost ideals'
(Fenech & Thomson, 2014, p191)

These women therefore sought alternatives in order to reduce the chance of a further traumatic birth. For some it was a direct precursor to freebirthing, as they would not allow a midwife to be present during the birth, the decision was made quickly. For others, it was only when they experienced a lack of midwifery support for a planned homebirth that led them to choose to freebirth. These insights offer support to the conclusions of Fenech & Thomson's recent meta-synthesis in that there is little research into how health professionals should identify or respond to women who have experienced traumatic birth.

A number of women felt that midwives are *'fearful of homebirths'.* This presents as a cause for concern as the safety of homebirths in appropriately selected women has long been confirmed (Brocklehurst et al., 2011). The NCT (2009) reports that homebirth service provision is variable and influenced by staffing levels and information that women receive from health care professionals. Findings from the Birthplace study (Hollowell et al., 2011; McCourt et al., 2011) agree that wide variations in service provision, staffing levels, organisational structures and midwifery retention have caused an inequity in service provision. Research by Viisainen (2000) demonstrates that women opting for community birth can face moralistic opposition, facing accusations of irresponsibility or receive conflicting advice about the safety of homebirths. A recent survey carried out by Birthplace Matters (Cleary, 2015) found that where the homebirth service was restricted by the Trust, 25% of participants said that they would consider freebirthing. This echoes the findings of this study, whereby women who do not feel supported in homebirths, will make the decision to freebirth. The RCM (2011) surveyed 553 self-selecting midwives about their attitudes to homebirth. Whilst the majority were positive about homebirth they reported that barriers such as on call demands, a lack of support and negative attitudes by the obstetric team, current staffing levels and a lack of confidence impeded the service they could offer. In addition, economic challenges (Redshaw et al., 2011) rising birth rates (Maternity Care Working Party, 2007) and increased rates of litigation

(Symon, 2006) also contribute to the pressures of, maternity services. This in turn may result in the view that community births are a luxurious extra, thereby putting the community birth services at further risk (McCourt, Rance, Rayment and Sandall, 2011). Underpinning the complexity of these issues, some feminists argue that the medicalisation of childbirth is at the crux of the problems that maternity services face and which continue to reduce equity in service provision (Benoit et al., 2005; Davis-Floyd, 1994; Deery et al., 2010; Kitzinger, 2005; Walsh, 2006).

The findings from the previous freebirthing metasynthesis (Feeley et al., 2015) indicated that some women considered a midwife to be unnecessary. In this study, further insights into this lack of faith in midwifery provision have been highlighted.   Women felt a midwife would detract them from listening and responding to their instincts during labour, which they believed was paramount for a safe birth. Midwifery practices i.e. checks and monitoring were also considered unnecessary as they believed they were able to trust their instincts in the event of something going wrong. The risk assessment made by the women in this study certainly challenges maternity concepts of risk, wherein the current risk discourse values 'doing to' over 'watchful waiting' and only acting when necessary (Symon, 2006) . These women felt it would be safer to birth alone rather than with a midwife, thereby challenging global evidence that trained midwifery birth attendance improves morbidity and mortality for mothers and babies (Renfrew et al., 2014). This perhaps reflects the increasing criticism and resistance to the over use of intervention in developed countries (Renfrew et al., 2014). These insights generated should certainly call in to debate about current normative practices during labour care, and the evidence in which they are based upon.

All of the women had an awareness about midwifery professional practice and accountability, and the conflicts that arise between the definitions of a midwife: to be with woman, supporting her choices (Nursing and Midwifery Council, 2012) and that of the reality of a midwife's working practice, one that is governed by local guidelines and policies. This caused a lack of trust between the women and their care providers. It is widely noted that there are tensions between midwifery evidence based practice and the dominance of the bio-medical model where often midwives find that their practices are constrained by organisational and structural hierarchies (DH, 2007; Healthcare Commission, 2008; Renfrew et al., 2014; Symon, 2006; Walsh, 2006). Midwives often feel disempowered by organisational constraints (Ball, Curtis, & Kirkham. M, 2003), which have adverse effects upon their own wellbeing as well as the care that they provide to women (Ball et al., 2003). In this study, the women simply chose to not engage with these political dimensions and opted out of the system by choosing to freebirth.

Unique to the findings were the reports of seeking wider and trusted support from other sources, namely doulas, independent midwives and internet forums. There has been an international increase in women seeking out the support of doulas (Steel, Frawley, Adams, & Diezel, 2015). Doula UK (2015) a leading organisation was founded in 2001 and currently has over 650 members. Steel et al (2015) define a doula as a person who offers physical, emotional and social support during the perinatal period. Whilst there is no regulation or legislation with regards to doulas, it has been noted that there has been an increasing trend towards the professionalisation of doulas as well as an increased demand for their services (Steel et al., 2015). This study echoes the findings from Dahlen, Jackson & Stevens (2011) who suggest that the rise in women accessing doula support reflects a response to the deficit in maternity services. It seems that the doula community is able to offer a continuity of care model in which is highly valued by many women. This further highlights the disparity between the available evidence that supports the midwifery continuity of care model and its implementation (Hollowell et al., 2011; McCourt et al., 2011). In addition, the women in this study reported that they sought support by doulas and independent midwives so that their decisions could be fully supported in a non-judgemental way. This need was often not met by the NHS maternity services.

7.2 Strengths of the study

This study is the first to capture primary data upon the phenomenon of freebirthing in a UK setting. The recruitment methodology was appropriate and captured a good sample size (n=10). The participants were from a range of geographical locations adding strength to the transferability i.e. they covered a range of experiences from different maternity trusts. Triangulation via three sources of data collection i.e. narratives, interviews and member checking as well as discussions and verification with my supervisor enabled credibility and more authentic interpretations to be generated.

7.3 Limitations of the study

Whilst the sample size for this study is adequate, it would also be beneficial to have a longer recruitment strategy to capture more participant's views. The participants were self-selecting due to the nature of the recruitment process, therefore, the perspectives of participants who were not active online may have been missed. Furthermore all of the participants were of similar socioeconomic class which may not be fully reflective of all women that choose to freebirth. In all research there is the potential to bias the interpretations, therefore a future study could use several independent researchers to add strength to the interpretations. The setting was via telephone/Skype and one interview was via an encrypted chat room at her request. There are

current debates over the quality of data collective via different methods i.e. face to face interviews, telephone and now the use of the internet (Opdenakker, 2006). Some researchers would argue that face to face interviews allow the researcher to pick up on social cues, but this line of argument is debatable (Opdenakker, 2006). A future study could use both face to face interviews in combination with other techniques to further strengthen the study, although this was countered through good use of triangulation.

7.4 Implications for Practice

The findings suggest that there are important gaps in maternity care in terms of meeting some women's needs. It would appear that the midwifery philosophy of woman-centred care, tailoring care to individual needs is not always carried out, leaving women to feel disillusioned with maternity services and opting out of any form of professionalised care for their births. It is imperative that women feel listened to and are active agents in the decisions surrounding their care. Notwithstanding that women's choices are respected, even if they challenge normative practices. Furthermore, it is clear that trust guidelines are conflicting with midwives autonomy to support women on an individual basis. This issue needs addressing at a policy making level nationally.

It is essential that maternity professionals carry out their practice with minimal disturbance to the labouring mother. This includes minimising the disturbance that routine observations can create, minimising the chat between themselves and fundamentally retaining a calm, quiet birthing space. All of which enhance the physiology of labour by maximising the oxytocin production of the labouring women. This helps assist a safer, optimal birth which is valued by the women in this study.

More support is required for women who have experienced a traumatic birth. Services need to be better equipped in identifying affected women, and offering adequate care and support to minimise any psychological impact. It is vital that maternity services work with the women to create future care plans that restore the relationships between the women and their care providers.

Conversely, maternity services need to recognise that for some women, the care provision that is made available during the intrapartum period, is simply not right for them and they exercise their autonomous rights to opt out of this care. These women have made an informed choice and should be supported through appropriate risk management strategies i.e. the provision of information about potential emergencies to ensure women are able to identify and act upon events that may need medical assistance. This will help to ensure a trusting relationship in which women who choose to freebirth feel able to access care should an unexpected event occur.

7.5 Implications for Research

The findings from this study indicate that many aspects of further research is warranted:

- This study focused upon the decision making of women who freebirthed in the UK, further research into the lived experience of freebirthing would be of value in order to further understand its uniqueness as a birth choice. Through this, maternity care professionals could learn about different women's needs during the intrapartum period and adapt their practice to further support women to achieve an optimal physiological birth.

- It would be advantageous to have more qualitative data into the experiences of freebirthing women and their interactions with maternity services to illuminate best and worse practices in order for maternity services to review their provision.

- More qualitative data is needed to explore all women's experiences with maternity services as they negotiate their care: in particular, it would be useful to further explore the positive aspects of maternity provision in order to disseminate across maternity services as examples of best practice.

- Qualitative data from midwives would be useful to explore the conflicts they face in trying to deliver woman-centred care whilst working within the constraints of a guideline and risk averse culture.

- Standard midwifery intrapartum practices need to be re-examined and reviewed in light of the current evidence towards the overuse of intervention.

Chapter 8 Conclusion

This study achieved its aims to explore the decision making process of women who chose to freebirth in the UK. It is unique, as to date there has been no primary literature within a UK setting. By using an interpretative phenomenological approach, rich data illuminated complex decision making factors. The women's framed their stories through the accounts of their personal circumstances and previous life experiences demonstrating that for them, these external influences were pertinent to the decision making process. This understanding is crucial to maternity professionals, because in order to provide care to women that is individualised and holistic, we need to understand that women's life 'herstories' may influence or impact their perceptions, views and beliefs. These could be in relation to their needs, childbirth choices as well as their interactions with maternity professionals. This study highlights that for these women, they valued becoming their own expert about their pregnancies and birth experience. They did not want authoritarian care approaches to be enforced upon them, rather they wanted to be treated with dignity and respect whereby they felt listened to and their choices understood. When this did not happen the women reported experiences of birth trauma, disillusionment with the maternity services which ultimately factored strongly into the decision to freebirth. For some women, it would seem they wanted to freebirth regardless of the service provision available. For these women, the decision perhaps stemmed from an ideological perspective in which they valued taking back the responsibility of their birth experience from maternity professionals, and fully embraced it for themselves. However, it is worth noting that where women felt supported by maternity professionals, they were more positive about the maternity services as a whole. So even for women who felt midwifery care is redundant during labour, it is essential that maternity professionals maintain positive, trusting relationships which keeps the service as one that is accessible and not one to be feared.

The findings mirror that of the metasynthesis carried out by Feeley et al. (2015), but unique to this study is that it is based in a UK setting. This is an important finding as the UK has a strong midwifery culture which is philosophically embedded in woman-centred care. The findings of this study demonstrate that this is not always achieved leading some women to make extreme birthing choices. Further research is essential to determine why there is such a gap between midwifery philosophy and actual care provision.

Chapter 9 Reflections

This chapter offers an overview of a reflexive account throughout my whole journey during this study. While my previously held views at the start of the study were highlighted in chapter three, this chapter explores the processes I utilised to engage with reflexivity. Finally I explore what I have learnt as a researcher and a midwife.

9.1 Reflexive processes

Throughout this study I have kept several reflexive journals: presuppositions; reflections upon interviewing; reflections upon data analysis and reflections upon literature that I have read. The journals have given me the space to write and reflect many aspects of carrying out of the study, sometimes a practical point, sometimes an emotional point. Combining my written accounts with many discussions with my supervisor, GT gave me the space to further reflect upon the issues that arose. This helped me refine my thinking, and frame any bias within context in order to move the work forward

9.2 Lessons learned

9.2.1. Personally

The narratives and the interviews touched me personally in many ways. It has been nine years since the birth of my son, and so reading/listening to the women's birth stories reminded me of the deep, sacred value that the process of birthing has upon a woman. The stories, sad or positive, reconnected me to a sense of womanhood, of shared experience and took me on an emotional journey as I connected to each individual story. Furthermore, the participants so eloquently contextualised the place that birth had in their wider world, reminding me that birth is not in isolation but has a wider impact, and that the experience itself has intrinsic value.

9.2.2. Professionally

Reflecting upon my view that the birth experience has intrinsic value, I know that this view is not shared by all women, for some women do see birth as an act that simply needs to be 'gotten through' rather than placing a value upon the experience itself. Holding the space for all the different values that women place upon birth is difficult at times, as I fully resonate with the value and sacredness of the experience of birth. However, carrying out this study has meant that I continue to reflect upon my professional practice and whether I am able to convey a sense of specialness and importance to the birth experience. I feel strongly, regardless of what value a

woman places upon her own birth experience, it is nevertheless special, and she would still want to be listened to, heard, and her wishes enabled.

Listening to the women's stories as a midwife at times has made me angry, despairing and frustrated with the maternity systems that I am a part of. I felt angry on the behalf of some of the women, and it was difficult to remain neutral during interviews. That said, it is of further frustration, that I know the conditions in which some midwives are working and how easy it is to be thoughtless, rushed, and through conveying busyness to not really 'listen' to a woman. My own professional philosophy which endeavours to treat women as individuals, give them the time they deserve and to create care plans that meet their needs have been at times in conflict with my workload and chronic short staffing. Listening to these stories, particularly the timing of them, made me realise how separated I had become from my intrinsic professional values simply due to the nature of my working conditions. This painful realisation fuelled me to take action with my line managers and to try and facilitate change within the community team, namely trying to increase the staffing with a number of ideas. This has unfortunately not been successful, and through a further painful process of reflection where I realised I am unable to provide the care that I feel is right for women, I have chosen to leave the trust. The following is an extract of my reflexive interviewing journal:

'Finishing up the interviews, has certainly given me a sense of satisfaction and continues to cause me to reflect upon my own inherent views of birth, and my midwifery practice. Unfortunately, these interviews and the subject matter bring back to my attention the disparity between the two given the constraining model in which that I work. I don't know how to bridge this better. Particularly in my current working role, as my caseload is so large (too big for a WTE never mind a part timer), I had already begun to feel I was just a part of the machine and feel l like I am offering less and less. My caseload have so many other needs, often medical etc. that I don't think I am incorporating much about sewing those other seeds for normal birth etc. I feel like I need to create something that feels like I am being more authentic my midwifery ideals. One that can reach and/or is obtainable to most of my women (complex demographic). I am not sure what that shall or can look like. I need to further reflect upon this.' (18th November 2014).

9.2.3. Researcher reflections

Carrying out a primary study has been a whole new experience for me and I recognised that it would involve learning a whole new set of skills. The task at first seemed daunting. I realised that my role as a midwife could have been a potential barrier to seeking out the women I needed for the study, fortunately, this was unfounded and I even received valuable feedback from the participants. During the interviews, I was transparent about my role and shared my interest in the freebirthing

phenomena. When appropriate, I shared parts of my personal and professional story. This was in part due to adopting a 'conversational' approach to interviewing in which I felt was important given the personal nature of the disclosures that the women were making. At times, I reflected concerns that I was too agreeable with the women, and not quite distanced enough from their stories given my personal feelings and views. However, once I transcribed the interviews, I realised that this did not seem to impinge upon the women's stories and for some it seemed to create a safer place to voice their views. At times, the interviewees became distressed and emotional. It was difficult to 'hold their space' and just let them be, as it comes naturally to me to want to comfort and 'make it better' which is not appropriate for an interview. I respected these moments, and did offer to finish the interviews, but all of the participants were keen to have their stories heard.

During the analysis period, I continued to reflect upon my role as a midwife researcher, and the juxtaposition that this sometimes created. Using the support of my supervisor, I feel I was able to move past my personal feelings and to create something that was representative of the women's stories. Member feedback confirmed that I was able to do this, which was a relief, as my biggest fear was that I would not do the women's stories justice.

I feel fundamentally my fascination with freebirthing and my own personal experience of birth, affected my approach to entering the profession of midwifery. In reading those countless stories, in creating my own interpretations, reflections and considerations, also did something to me. It integrated into my lifeworld as a student midwife, and subsequently my lifeworld as a midwife. Part of what these quotes sum up, is my desire to express the women's stories in the hope that they will 'affect' midwives in some way. Whether, that is for them to reflect upon their own practice, respecting the birth space better, or to learn a multitude of other things from these women stories, fundamentally I want this work to speak to my colleagues. I hope that it does.

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My birth experience

My birth story is one that had a profound effect upon the rest of my life, it was a pivotal turning point for many reasons. The following extract was something I wrote for

I enjoyed a healthy pregnancy, and was committed to finding out as much about the natural birth process as possible, I prepared by reading many books such as Janet Balaskas, Ina May Gaskin and Sheila Kitzinger- all key proponents in the natural childbirth movement. I fully ascribed to the philosophy that childbirth was a natural, normal event and one that needed support rather than management. My first interaction with midwives was neutral, which led to a situation where I was on the receiving end of over-medicalisation and fear. This was an event where I my bump was measuring slightly smaller than 'average' and where I was not unduly concerned, being militantly healthy, my midwife used quite strong scare tactics inferring that I did not care for my baby. At this point, I began to feel like I may be entering a 'battle'. Fortunately, my trip to the obstetrician was sensible and I was discharged without any further fuss.

I also moved house, thus was assigned a new midwife. By this point, I had my birth plan and was ready for 'battle'! This midwife, whom I regard as a 'real' midwife, turned things around and was as encouraging and supportive about my home waterbirth plans which helped me regain confidence in my carers. Fast forward to my experience of labour….

Going into labour was one of the most empowering experiences of my life, I had found the hormonal pregnancy changes very difficult to manage, but that point of going into labour I felt like 'me' again. I felt positive and determined. The first midwife out to me, was well known as the yoga midwife so was perfect, as hands off and non-directional as I had hoped. She even encouraged me to decline the second vaginal examination which was unusual practice. Things progressed, I was coping well. Luck would have it that my community midwife, whom I loved, came on shift and took over the care. At this point my labour started to unfold slightly differently, and I felt that something was 'wrong'. I consented to an internal and was found to be 7cm, and this is where by 'knowledge' hindered my ability to stay in the labour zone. As this was deemed as very slow progress despite contracting well etc. I 'lost it', I was so disappointed and emotionally gave up. I requested a shot of meptid, which was not what I originally wanted and whilst my midwife tried to support me without it, I insisted. The administration of the drug literally meant I lost all control, and I demanded to transfer into hospital for an epidural. (It was only later, I realise I was going through transition). Once in the ambulance, the drug was in complete effect, but I could suddenly feel my body bear down spontaneously, and I knew I was too late for the epidural. Once in hospital, my midwife stayed with

me, offering lots of support and encouragement. Only once the drug had worn off, could I regain my sense of control. My second stage was very long, and I started to lose hope that I was able to push my baby out. But all of a sudden, the head was visible, and I reached down to feel his hair. Not long later he was born and given straight to me for skin-to-skin. The elation was unbelievable. The joy, the sense of achievement was tangible. As it turned out, my baby was in the occiput posterior position, hence my feeling of something being 'wrong' and the delay in the pushing stage.

Beyond the initial stage of elation, joy and sense of achievement, and absolute love for my supportive midwife, I began to experience mixed emotions. These didn't occur until some months after the birth of my son. Through a process of unpicking the negative emotions I had felt about my birth, i.e. disappointment of transferring to hospital, not achieving the homebirth, I researched more and more once again. Through this process of research, and reading other women's stories, it became a way of being able to process the negative emotions, ones that I felt guilty for having, as overall I had had such a good empowering experience.

APPENDIX 2

Dear……

Would it be ok to post on your page to recruit potential research participants? I have attached a copy of the advert for your consideration.

I am a midwife in the UK studying for my Masters with the University of Central Lancashire. My thesis is entitled; Making sense of maternity services; The views of women who have freebirthed.

I am looking to recruit 8-10 women who have freebirthed whilst in the UK for interviews.

Thank you for your time,

Best wishes

Claire Feeley

Midwife

Msc Student

Making sense of childbirth choices; the views of women who have freebirthed

Have you freebirthed?

Are you in the UK?

Are you over 18 years old?

Would you like to take part in a research study that is exploring why you made the choice to freebirth?

This study is being undertaken by a midwife-researcher as part of a Masters in Midwifery and Women's Health at the University of Central Lancashire.

If you have experienced a freebirth whilst living in the UK, are over the age of 18 and speak English as your first language, we are very keen to hear your views. Taking part will involve writing a narrative/short story about why you chose to have a freebirth, and/or taking part in a telephone interview (which will last no more than an hour) to discuss your views in more depth.

If you would like more information about the study, please contact Claire Feeley, at clfeeley@uclan.ac.uk or 07581 295401.

If you know anyone who might be interested please feel free to pass on this information.

APPENDIX 4 Recruitment activity

Date and activity	Response	Participants	Initial email sent	Response
1st October 2014, Google search, freebirthing UK				
Emailed FB group; Unassisted/Freebirth	Will post ad up			
Emailed FB group; UK Unassisted/Freebirth Childbirth Group	Posted ad up	X6 participant interested	x 6 Sent 2.10.14	x3 wish to continue 2.10.14
Emailed website http://fukoff.org/	Email address no longer working			
Emailed Unassisted Childbirth / Freebirth – ALL are Welcome! FB page				
Emailed https://groups.yahoo.com/neo/groups/unassistedchildbirth/info				
https://groups.yahoo.com/neo/groups/freebirthuk/info				
https://groups.yahoo.com/neo/groups/E_Birth/info				
2nd October 2014, created webpage for advert				
Sent ad out to ARM yahoo group page				
Posted ad on Studentmidwivessanctuary.com for dissemination				
Sent ad out to friends on homebirth groups		Another email send from snowball S from birthmate.co.uk	Email sent 2.10.14	

80

Posted ad on homebirth UK fb page

Email from
snowball received.
HR. Email sent out
2.10.14

Email sent 2.10.14

10th October
Sent out ad on twitter, retweeted x3

Title of Project: *Making sense of childbirth choices; The views of women who have freebirthed*

Name of Researcher: Claire Feeley   **Institution:** University of Central Lancashire

Contact Details: clfeeley@uclan.ac.uk/ 07581 295401

Email confirmation

Dear   ,

Thank you for your interest in the above study. I have attached an information sheet for you to read through in order for you to make an informed decision as to whether you wish to take part in this study.

If you decide that you would like to continue, could you please reply to this email indicating whether you will like to part in a) providing a narrative, b) the interview, or c) both.

I will then send out further information that shall be password protected, with detailed instructions on how to return your information securely via password protection.

Once again, I thank you for your time and interest in this study.

Best wishes

Claire Feeley

Midwife/Student researcher

Information sheet for participants

Title of Project: *Making sense of childbirth choices; the views of women who have freebirthed*

Name of Researcher: Claire Feeley   **Institution:** University of Central Lancashire

Date: 4th June 2014

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything that is not clear or if you would like more information, please contact us on the contact details provided at the end of this form.

What is the purpose of the study? This study concerns women's views and experiences of what motivated their decision to freebirth (unassisted childbirth). Currently there is very little known about why women make this decision.   It is intended that this study will enable further understanding about the decision making process and experiences of freebirth which may help inform midwifery care provision. This study is being undertaken as part of a Masters qualification. Data collection will be begin September 2014 and the project is predicted to finish July 2015.

Why have I been chosen? You have been asked to take part as you have freebirthed, live in the UK, you are 18 years or over, and you have English as your first language.

What would happen to me if I take part? If you agree to take part you will be invited to:

a) Write an account of your experience of choosing to freebirth, which needs to be emailed back to the student researcher. The email address used is on a safe network, and your files will be encrypted (instructions on how to encrypt the file will be issued, and a password will be agreed so that only the research student and you can access the file) so that your information is kept safely and securely. A prompt sheet with ideas of what to write about will also be provided. If possible, the narrative should be provided within a period of two weeks.

b) To take part in a telephone or Skype interview which should take no more than one hour to complete. At the start of the interview, you will be asked to read and consider a consent form (which

will be provided), which will be completed on your behalf by the research student. The interview will be digitally recorded following your consent.

Please note that it is up to you as to whether you would like to take part in either or both phases (i.e. write a narrative and take part in an interview).

c) We would also like you also to complete a questionnaire requesting your demographical details such as location, age, educational background, marital status, ethnicity, employment status, parity (number of children you have) will also be sent to you. You are free to answer or decline any of the questions.

d) We would like to use recorded quotes from the interviews in presentations, this is NOT essential to taking part in the study. You can indicate your choice on the consent form.

If you agree, we would also like to send you a copy of the key findings to clarify whether the work reflects your views on the topic, and you will be asked to provide any additional comments within a two week period. Following this period, it will be assumed that the findings reflect your views.

Do I have to take part? No it is entirely up to you to decide whether to take part or not. If you do decide to take part, you are still free to withdraw at any time. You may decide that you wish to complete a narrative and then decide that you do not wish to take part in the follow-up interview. If you do agree to take part in the interview, you do not have to answer any questions, you may stop the interview at any point. You will also be able to withdraw all your data (narrative and/or interview transcript) from the study up until data analysis being undertaken, and without giving a reason.

What would I have to do? Write about your decision to freebirth, this can be as short as you want, or as long as you want and/or take part in one interview that will last approximately one hour. Complete a demographic questionnaire. Provide any comments you wish about the key findings within a 2 week period.

Are there any risks involved? Occasionally interviews can bring up emotional responses. Be assured that the researcher will be sensitive to your needs and should you wish to stop the interview, the researcher will be happy to do so. If you become distressed, the researcher will be able to signpost to outside agencies to provide further assistance. These could include a Birth Afterthoughts service at with senior midwives at your local trust, referral to your local counselling services and/or your GP. The national helpline 'Birth Crisis Network' is available to all in any location see http://www.sheilakitzinger.com/birthcrisis.htm for contact numbers.

Are there any benefits involved? Whilst there may not be any personal benefits to you for taking part, your information will contribute to wider childbirth knowledge, and help to improve maternity services. Telling your story may also be beneficial, by enabling your views and choices to be acknowledged. Furthermore, some of you may enjoy reading the findings, the integration of several participants' accounts which may offer a sense of a shared experience.

Would my taking part be kept confidential? Your contact details, narrative, and interviews will all be kept safely and securely. Once the interview has been transcribed, the digital recording will be deleted. Any correspondence via email will be transferred via encrypted/password protected files, and all information will be stored on the University's server which is password protected. All hard copies of any information (e.g. consent forms) will be kept in a locked cabinet. No one will be identifiable from the findings, and personal details will not be used in the dissertation, any subsequent publications or presentations.

What would happen to the results of the study? This study will form the basis of the student researcher's dissertation and potentially be published in multi-professional journals and/or be used on study days, conferences to help inform current maternity service provision and practice. Whilst direct quotes will be used, please be assured that these will be anonymised, and you will not be identified.

 Who has reviewed the study? This study has received ethical approval from the STEMH University of Central Lancashire's research ethics sub-committee.

What do I need to do now? If you decide to take part, please let the student researcher know via email within 1 week. At this stage, please could you advise as to whether you would be willing to write a narrative and/or take part in an interview.

If you agree, you will be asked to provide a written narrative within a two week period and a prompt sheet will be provided. Once the narrative has been received, or if you would prefer to take part in an interview only, a consent form will be issued, and further contact to organise a mutually convenient time/date to take part in an interview will be made.

Who is organising the research? The research student, Claire Feeley, qualified as a midwife in 2011 with Oxford Brookes University. She is currently working in the community in Milton Keynes, whilst studying with UCLan. She is on the Midwifery and Women's Health MSc programme. This research is part of her final dissertation with UCLan, and she is being supervised by Dr Gill Thomson, a Senior Research Fellow within the School of Health. Claire has a keen interest in women's health inequalities, namely around the issues of childbirth choice, autonomy, rights and care provision. This fuelled

interest in the topic of freebirthing, in which she wrote her undergraduate dissertation on the topic. Since then, she has presented the findings of the meta-thematic synthesis at several conferences, nationally and internationally.

Contact for further information If you need any further clarification or have any questions please contact Claire Feeley directly at clfeeley@uclan.ac.uk Tel: 07581 295401

What do I do if I have any complaints about the issues in the study?

If you have any complaints or concerns about this study, please contact the research supervisor in the first instance, Dr Gill Thomson, GThomson@uclan.ac.uk, Tel: 01772 894578. Alternatively you can contact the Dean of School, Dr Nigel Harrison, NHarrison@uclan.ac.uk, Tel: 01772 893700.

Title of Project: *Making sense of childbirth choices; The views of women who have freebirthed*

Name of Researcher: Claire Feeley   **Institution:** University of Central Lancashire

Contact Details: clfeeley@uclan.ac.uk/ 07581 295401

<div align="center">

Interview Consent Form

</div>

Verbal consent shall be gained at the start of the interview by working through this form together and the student researcher shall initial on behalf of the participant.

		Box to be initialled to indicate agreement
1	I confirm that I have read and understand the information sheet dated 4th June 2014 for the above study and have had the opportunity to ask questions.	
2	I understand that I am free to not answer any questions during the interview and may stop the interview at any point	
3	I understand that my participation is voluntary and that I am free to withdraw my data from the study *prior* to data analysis being undertaken, without giving any reason.	
4	I understand that my participation will be anonymous and any details that might identify me will not be included in reports, presentations or other publications produced from the study.	
5	I am aware that I shall be sent a copy of the key findings to clarify that they are an accurate reflection of my views, and will have 2 weeks to provide any additional comments	
6	I agree that voice recordings may be used anonymously for presentations.	
7	I agree to take part in a telephone or Skype interview.	

Name of participant...

Name of researcher……………………………….…………………………..

Date..

Guide for part*ic*ipants, narratives

I would like you write about your experience of choosing to freebirth. It may be as long or as short as you wish. If you are not sure what to write about, below has some pointers:

When you found out you were pregnant, how did you feel about the upcoming birth?

Did you have access to NHS care at the time?

At what point in your pregnancy did you decide to freebirth?

What made you decide to do this?

How did you feel when you were making this decision? Was it easy/difficult?

Did you talk to anyone about your feelings, decisions? If so, did this help you make your decision?

How do you feel about your local maternity services?

Demographic Questionnaire

Title of Project: *Making sense of childbirth choices; the views of women who have freebirthed*

Name of Researcher: Claire Feeley   **Institution:** University of Central Lancashire

Date: 5th March 2014

Name:

Date of birth:

Town:

Number of births:

Type of births (vaginal/assisted/c-section):

Place of births (hospital/home with midwife/freebirth):

Ethnicity:

Marital status:

Educational background
(the highest level qualifications that you have gained):

Employment status:

APPENDIX 10

How to protect your files with a password, information for participants.

Once you have finished your document, click on FILE.

Click on the PROTECT DOCUMENT icon.

Click on the ENCRYPT WITH PASSWORD and type in a password.

It will ask you to do this twice.

Save as normal.

Email to me as an attachment.

In a separate email, send me your password so I can access the document.

Any problems, ring me 07581 295401 and I can talk you through it.

Thank you!

Claire Feeley

APPENDIX 11

Interview prompt questions

Whilst I envisage that I shall be exploring the topics within the participants narrative, in the event that a participant has not completed a narrative or that the narrative does not describe the decision making process, further prompt questions may help.

Can you tell me about your decision to freebirth?

Did you have access to NHS care?

How did you feel about your past birth experience? (if applicable) or

How did you feel about the upcoming birth?

What came into your decision making? Did you discuss it with anyone?

How do you feel about the decision now?

Do you know anyone else who may be interested in this project? (Pass on researcher contact details).

24th September 2014 Revised questions

In retrospect, do you feel you would have liked to have a trusted midwife at your birth?

Why do you think other women choose to freebirth?

Could you suggest ways in which the maternity services could improve?

APPENDIX 12

A system for simple transcription (Audiotranskription.de, 2015)

The underlying transcription rules

1. Transcribe literally; do not summarize or transcribe phonetically. Dialects are to be accurately translated into standard language. If there is no suitable translation for a word or expression, the dialect is retained.

2. Informal contractions are not to be transcribed, but approximated to written standard language. E. g. "gonna" becomes "going to" in the transcript. Sentence structure is retained despite possible syntactic errors.

3. Discontinuations of words or sentences as well as stutters are omitted; word doublings are only transcribed if they are used for emphasis ("This is very, very important to me.") Half sentences are recorded and indicated by a slash /.

4. Punctuation is smoothed in favor of legibility. Thus short drops of voice or ambiguous intonations are preferably indicated by periods rather than commas. Units of meaning have to remain intact.

5. Pauses are indicated by suspension marks in parentheses (…).

6. Affirmative utterances by the interviewer, like "uh-huh, yes, right" etc. are not transcribed. EXCEPTION: monosyllabic answers are always transcribed. Add an interpretation, e.g. "Mhm (affirmative)" or "Mhm (negative)".

7. Words with a special emphasis are CAPITALIZED.

8. Every contribution by a speaker receives its own paragraph. In between speakers there is a blank line. Short interjections also get their own paragraph. At a minimum, time stamps are inserted at the end of a paragraph.

9. Emotional non-verbal utterances of all parties involved that support or elucidate statements (laughter, sighs) are transcribed in brackets.

10. Incomprehensible words are indicated as follows (inc.). For unintelligible passages indicate the reason: (inc., cell phone ringing) or (inc., microphone rustling). If you assume a certain word but are not sure, put the word in brackets with a question mark, e.g. (Xylomentazoline?). Generally, all inaudible or incomprehensible passages are marked with a time stamp if there isn't one within a minute.

11. The interviewer is marked by "I:", the interviewed person by "P:" (for participant). If there are several speakers, e.g. in group discussions, a number or a name is added to "P" (e.g. "P1:", "Peter:").

12. The transcript is saved in rich text format (.rtf file). Name the file according to the audio file name. E. g. interview_04022011.rtf or interview_smith.rtf.

Broad Codes	Sub-codes	Sub-codes	Frequency
APPENDIX 13 Code System			
These codes were generated iteratively from all narratives and interviews. The number column indicates the frequency of the code.			
These codes were the initial basis for interpretation.			
Broad Codes	**Sub-codes**	**Sub-codes**	**Frequency**
Personal experience			4
	External influencing factors		41
	Family history		13
	First birth		4
		positive experience	10
		Expectations	9
		positive experiences of care	9
		negative experiences of care	25
	Subsequent births		5
		positive experiences of care	13
		negative experiences of care	17
		emotions related to experience	15
	Engagement with maternity services		51
		disengagement with maternity services	3
		negative experience of care providers	22
		Social services involvement	24
Professional experience			4
	Doulas		1
		Accessing and experience of doulas	7
		Becoming a doula	7
		Employing a doula	11
		Experience as a doula	14
	negative experience with midwives		4
	experience of uninterrupted birth		2
Independent midwife			5
decision making			58
	critical moment		26
	emotions making decision		15
	subconscious decision		2

	Needs during birth		29
	acceptance of risk		9
		alternate view on risk	18
	knowingness		42
	unknown care provider		4
		uncertainty of care	3
		forced choices	3
Freebirth experience			1
	Finding freebirthing		31
	Wider support		22
	Planning the freebirth		15
		Planning	12
		Emergency planning	21
	Experience of the freebirth		36
		subsequent freebirths	10
		unassisted pregnancy	8
		Reflections on future births	13
		Calling the midwives	17
		Emotions during freebirth	13
Views/attitudes towards maternity services			29
	Wider narrative of life choices		13
	Relationship with care giver		9
	significance of birth		10
	Collaborative practice		3
	Support for midwives		8

Code	Segment
APPENDIX 14 An example of the code system that was extracted from the data. This is taken from one participant's narrative account.	
The first column indicates the code/sub codes that I applied, the second column is the data source.	
Code	**Segment**
personal experience\External influencing factors	As I began meeting other new mothers and hearing their birth stories I was shocked at the level of interference and intervention.
personal experience\First birth\positive experience	She was born within 6 hours of arriving, in the pool, nothing more. This experience was pivotal.
personal experience\First birth\positive experiences of care	When I had my daughter I knew nothing about birth and upon reflection feel that I was relatively fortunate in terms of the treatment and care I received from my antenatal midwife and the midwife at the hospital.
personal experience\Subsequent births\positive experiences of care	During the birth the midwives pretty much left my husband and me alone and I was pushing her out before she returned.
personal experience\engagement with maternity services	I found it difficult to establish these boundaries and felt very misunderstood by my antenatal midwife who constantly engaged in the single focus of the perceived medical risk in birth.
personal experience\engagement with maternity services	I decided to opt out of NHS care at approximately 30 weeks. Disengaging was a natural process; it was the next step of my turning inwards and preparing for a more spiritual experience of birth
personal experience\engagement with maternity services\negative experience of care providers\Social services involvement	My midwife referred me to Social Services for opting ou
professional experience	and also completed a doula preparation course which supported me in understanding the questions and answers I was in pursuit of.
professional experience\Doulas\Becoming a doula	Since my first birth I had done a great deal of reading on the subject and also completed a doula preparation course which supported me in understanding the questions and answers I was in pursuit of.
professional experience\Doulas\Employing a doula	I decided to hire a doula to support me with my thought processes and emotions
decision making	The learning curve through the experience of her birth is crucial to my future decision making processes.

decision making	It felt unnecessary to me personally, and I certainly didn't feel I would benefit from routine monitoring, checks, questions and procedures; if anything I felt it would detract and interfere with my pregnancy
decision making	I knew that with my second, I was searching for a greater depth to the experience, something more intuitive as I had come to trust myself more than I had previously, not just through experience, but through research that supported my beliefs in understanding the science behind mammalian instinct, physiological birth and the huge value of the hormonal and emotional process. I felt very early on that I wanted to birth unassisted and tentatively began exploring and understanding my feelings. It clearly veered away from the mainstream but I felt an incredible pull towards it.
decision making	I decided to opt out of NHS care at approximately 30 weeks. Disengaging was a natural process; it was the next step of my turning inwards and preparing for a more spiritual experience of birth
decision making	but I think it is crucial to stress that my choices were born out of positivity, a deep understanding of myself and intelligent reasoning.
decision making\critical moment	When I found out I was expecting my second, it felt completely natural and normal to have minimal medical involvement. It felt unnecessary to me personally, and I certainly didn't feel I would benefit from routine monitoring, checks, questions and procedures; if anything I felt it would detract and interfere with my pregnancy
decision making\emotions making decision	it was liberating and freeing to feel as though I was beginning to understand myself and my body, finding my own inner source of strength and knowledge.
decision making\emotions making decision	but I think it is crucial to stress that my choices were born out of positivity, a deep understanding of myself and intelligent reasoning.
decision making\Needs during birth	I knew that with my second, I was searching for a greater depth to the experience, something more intuitive as I had come to trust myself more than I had previously,
decision making\Needs during birth	Disengaging was a natural process; it was the next step of my turning inwards and preparing for a more spiritual experience of birth.

decision making\Needs during birth	Defining the conditions that were right for me, in my circumstances, as an individual and what I personally hoped to learn and achieve through my investment in the safety of such a holistic birth journey.
decision making\acceptance of risk	Nothing could have changed my mind about birthing unassisted except the occurrence of a genuine, serious medical issue. In this hypothetical scenario I would readdress my options and choose what was most appropriate for me and my circumstances at that time.
decision making\knowingness	When I found out I was expecting my second, it felt completely natural and normal to have minimal medical involvement
decision making\knowingness	it was liberating and freeing to feel as though I was beginning to understand myself and my body, finding my own inner source of strength and knowledge.
Freebirth experience	but I think it is crucial to stress that my choices were born out of positivity, a deep understanding of myself and intelligent reasoning.
Freebirth experience\Finding freebirthing	When I found out I was expecting my second, it felt completely natural and normal to have minimal medical involvement. It felt unnecessary to me personally, and I certainly didn't feel I would benefit from routine monitoring, checks, questions and procedures; if anything I felt it would detract and interfere with my pregnancy. Since my first birth I had done a great deal of reading on the subject and also completed a doula preparation course which supported me in understanding the questions and answers I was in pursuit of.
Freebirth experience\Finding freebirthing	, but through research that supported my beliefs in understanding the science behind mammalian instinct, physiological birth and the huge value of the hormonal and emotional process. I felt very early on that I wanted to birth unassisted and tentatively began exploring and understanding my feelings
Freebirth experience\Finding freebirthing	Throughout my preparation, I found an online Freebirth community in which I became and remain active within
Freebirth experience\Wider support	I decided to hire a doula to support me with my thought processes and emotions. My husband was also extremely understanding. We both read Laura Shanley's Unassisted Childbirth, amongst other enlightening perspectives (I also found the Midwife Thinking blog highly valuable, and of course, Michel Odent),

	which really brought into alignment often hard to find information about birth which completes the larger context of the issues women face.
Freebirth experience\Wider support	Throughout my preparation, I found an online Freebirth community in which I became and remain active within. It is a wonderfully complex and diverse population. I have found it to be a very open, supportive, nurturing community which holds space for women from all kinds of spheres and who go on to experience many different birth outcomes
Freebirth experience\Planning the freebirth	Since my first birth I had done a great deal of reading on the subject and also completed a doula preparation course which supported me in understanding the questions and answers I was in pursuit of.
Freebirth experience\Planning the freebirth	Reading was like unlearning many myths perpetuated in our culture that come to be deemed 'normal', it was liberating and freeing to feel as though I was beginning to understand myself and my body, finding my own inner source of strength and knowledge.
Freebirth experience\Planning the freebirth\Planning\Emergency planning	Nothing could have changed my mind about birthing unassisted except the occurrence of a genuine, serious medical issue. In this hypothetical scenario I would readdress my options and choose what was most appropriate for me and my circumstances at that time.
Views/attitudes towards maternity services	My midwife referred me to Social Services for opting out. This situation did not resolve itself until after the birth, where it culminated in, what I feel was a violation of my rights and privacy
Views/attitudes towards maternity services	I believe Freebirth to be a valid birth choice on a spectrum, as opposed to a decision 'outside of the system'.
Views/attitudes towards maternity services\Wider narrative of life choices	Women should be free to access this information, to make up their own minds for there needs to be more than the limitations of the NHS, and more than the limitations of a medical approach.

Appendix 15 An example of a theme development

This table demonstrates how the codes were used to develop the theme and its sub-themes, using extracts of data from their original source.

THEME: Contextualising 'herstory'

Sub-theme	Codes used: italic / Sub-codes in italic	Data extract example
Personal 'herstories'	External influencing factors	'I absolutely hate to feel helpless, lied to or pushed around by people who think they are smarter/better than me, because of this.' (Holly pn-5, nar, In: 4-4).
		my dad left me when I was very young, and my mum was left in financial direstraits, his absence meant that my mum was like get your education first because nobody can take that away from you. So I always made sure that I could look after myself and my kids. (muffles) and controlling how many kids I actually have, making sure I was happy in my marriage before I had kids (muffles) this is what I wanted control over (muffles) (Cat, in:int:27-27)
		I was recovering from PTSD either from the abusive relationship I had escaped from (June, in:nar 3-3)
Inherited birth beliefs	Family history	no none at all. I knew what I could do and um, you know one piece of that puzzle is probably because I was born at home , my parents were born at home, my father's mother was the local lay midwife who helped everybody in the village, so birth was not a scary thing to me. it was just a normal part of life. Which is not for everybody these days. anymore, there are quite some people who are terrified. (Nicky, in: Int:65-65)
		'I myself was born at home, with a midwife and to me that was idealised, a homebirth was something that has pleasant memories for me well pleasant nostalgia because my mum said 'oh you were born at home', you know, 'I was walking around hanging out the laundry the day before and the next day, I couldn't believe it I had a baby that night!' That birth story, wasn't so much that it was great, it was just normal.' (Cat, pn-9, int In: 23-23).
		Um, so I mentioned it to him, and he was fine because both of his parents were born at home (June in: int 15-15)
Embodied birth experiences	First birth	Yes I do speed births (Nicky, in:int 9-9)
		And um, so they asked for an ambulance to take me to hospital, which isn't far away, 20 minutes away. They assumed that I would have a cesarean, but then that night they told me that they wanted to start my labour with a prostin and on reflection I think they said that to make me feel better, there was no discussion, they just told me they would start me with a prostin and if that didn't work it would be a ceserean. (Cat, in:nar 9-9)

Positive experience	when I went into hospital the midwife that I had was wonderful. Really hands off, um (Alex, in: int 9-9)
	Our first born Reuben's birth was a wonderful calm home water birth (Jenny, in:nar 4-4)
	So it was all perfectly fine, a positive experience , I was very happy. I think ideally I would have gone for a homebirth but I was talked out of it by all these well meaning people saying you couldn't possibly have your first at home (Jane, in:int 7-7)
Expectations	I was quite frightened when I went into labour, I don't think I was frightened of birth so much or what was happening, it was more the unknown I suppose. That was something that was on my mind in the last few weeks of pregnancy a lot, how would I know I was in labour, what would it feel like? And I just didn't know (Alex, in int 9-9)
	We'd learned HypnoBirthing and I was relaxed and comfortable throughout. Ian (my husband) was completely supportive and turned out to have a flair for doulaing. I prepared my mind and body for optimal oxytocin and endorphin release, and trusted that all else would follow. (Jenny, in: int 4-4)
	I think I expected and thought from midwives it was more kind of a mothering role more than such a medical one. (Julie, in: int 9-9)
Positive experiences of care	And uh, um, we called the midwife after that. And they were lovely on the phone and were saying 'well try and stay at home as long as you can, you know when things get too much for you, then come in'. (Alex, in: int 13-13)
	My local midwifery team were very supportive of homebirth (Julie, in: nar 41-41).
Negative experiences of care	They did not seem to understand what kind of space I needed. (Jenny, in: nar 4-4)
	'I felt violated and humiliated. It ended up with the Dr telling me my baby was stuck and she would try to pull my baby out, in theatre, with an epidural, surrounded by strangers, in case it didn't work in which case they would perform an emergency c-section. It was the most awful experience of my life.' (Jane, pn-4, nar, In:2-2).
Subsequent births	
Positive experiences of care	my second a beautiful homebirth, luckily supported by a caseloading team in Edinburgh. The NHS care i received from midwives was outstanding and I wrote a letter of commendation. (Kate, in: nar 4-4)
	Yes they were very good. Um, so you know the homebirth itself was a very positive experience. (June, in: int 27-27).

Negative experiences of care	And uh, and that was my first homebirth with my 5th daughter and it was fine, it was quiet, it was easy. (Holly, in: int 17-17)

 I went to see the consultant, and the consultant was very umm(.) pause 1 sec rude, she pulled the dead baby card on me. I tried to ask for continuous monitoring and outright refused, and said that I absolutely had to be induced, otherwise I'd put my baby's life at risk. (Alex, in : int 7-7)

They did try to have lots of conversations over my head, as well, you know I didn't really feel like they were there in any supportive capacity really, but that was down to the one to the other (Holly, in: int 40-40) |
| Emotions related to experience | My trust of maternity services was zero. The only reason my second child was born in hospital is because my abusive husband gave me no choice but to do so. (June, in: nar 3-3)

'I felt ashamed, the only other thing I have ever felt ashamed of uh through the whole process, I was ashamed that I sounded like a pig that's being slaughtered.' (Cat pn-9, int, In: 25-25).

'And looking back I was like why did I consent to having syntocinon with a baby that could potentially could have been distressed? It didn't make sense.' (Kate, pn-1, int, In: 23-23). |

5th June 2014

Gill Thomson and Claire Feeley
School of Health
University of Central Lancashire

Dear Gill & Claire

Re: STEMH Ethics Committee Application

Unique Reference Number: STEMH 208

The STEMH ethics committee has granted approval of your proposal application 'Making sense of childbirth choices; The views of women who have free-birthed.' Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

Kevin Butt

Vice Chair

STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

7th January 2015

Gill Thomson and Claire Feeley
School of Health
University of Central Lancashire

Dear Gill & Claire,

Re: STEM Ethics Committee Application

Unique Reference Number: STEMH 208 amendment

The STEMH Ethics Committee has approved your proposed amendment to your application 'Making sense of childbirth choices; The views of women who have free-birthed'.

Yours sincerely,

Kevin Butt

Deputy Vice Chair

STEMH Ethics Committee

APPENDIX 18

Table 5- Potential ethical issues 1

Issues that may arise	Researcher response
Participants may get distressed or upset during the interview.	I would offer to end the interview immediately and offer initial support. If further action is needed, I shall signpost the participant to either Birth Crisis Helpline, or their local counselling services.
Participants may have had a prior traumatic birth experience and wishes/needs to discuss this further.	As above, I could signpost the participant to either the Birth Crisis Helpline, counselling services and/or if appropriate to their local Supervisor of Midwives or Consultant Midwives who offer a Birth Afterthoughts service. This entails talking through their medical notes whilst offering a supportive debrief of their birth.
Participants may wish to complain about their experiences of prior maternity care.	I shall signpost them to their local PALS service at the hospital in question, who deal with any complaints seriously.
Safeguarding concerns may be identified	I shall need to end the interview and inform the participant that the information that they have disclosed may be classified as a safeguarding issue. I will explain that the information would need to be passed on to a third party i.e. Social Care.