Vulnerability within Maternity Care

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CONTENTS

Abstract

Name of author: Lesley Briscoe

Degree: In partial fulfilment of the requirements for the award of a Doctorate of Philosophy.

Title of the thesis: Vulnerability within Maternity Care

Key words: Vulnerability; Resilience; Biopsychosocial; Maternal; Midwife; Professional; Choice; Control; Complexity; Warmth.

Background: Vulnerability is universally present but experienced biopsychosocially on an individual level. Stigma develops when populations are labelled vulnerable. Individual vulnerability can be lessened by resources accessed to assist in developing resilience. A deeper analysis of vulnerability and resilience is required to inform policy, ethics, law and social life.

Design: Qualitative, quantitative and mixed method approaches were used.

Sample: Five papers represented the perspectives of 102 women, 21 clinicians and 13 student midwives. A further paper presented a concept analysis which included the perspectives of 10,067 women and 325 clinicians (total sample size women n=10,169; clinicians n=346; student midwives n=13).

Methods: Gadamer's ontological perspective of time, place and culture and was seen through Engel's biopsychosocial lens. Epistemologically, truth originated from multiple realities. Methodologically, women's experiences were captured via mixed methods.

Analysis: Thematic analysis and descriptive statistics were synthesised via framework analysis.

Findings: A coherent theme of vulnerability in maternity care was apparent. Women's concerns were trivialised. The professional's style of communication determined the women's experience of maternity care. Clinician control of care provision undermined women's ability to choose. Women developed resilience in adverse circumstances via: accessing other supportive members of society, identifying their need for information, talking to others and developing accommodative coping strategies.

Conclusion: The new conceptual model, in this thesis, should be evaluated via mixed methods. A biopsychosocial approach should underpin informed choice. Clinicians need raised awareness about how interaction can lower women's self-esteem and build resilience in others. Higher education needs to challenge preconceived biases in safe environments via reflective processes. Research should explore women's influential circle in decision making during maternity care. Women should be involved in the design of research to inform how best to capture their complex lived experience. Funders of research and ethics committees should request information about how implementation of evidence may be influenced by the current clinical environment. Impact should be measured post implementation. Social policy should be informed by a deeper, conceptual analysis of vulnerability and resilience.

Declaration and Index of Published Research

Six published works are presented for consideration for this thesis. The researcher's (LB) role in each of the studies are described in Table 1.

Table 1: Declaration of role related to published works. (see Appendix 5: Affidavits)

Published works	My role
1. BRISCOE, L., LAVENDER, T. and ALFIREVIC Z., 2002. Supporting women after obstetric complications. *British Journal of Midwifery*. 10 (10), pp. 620-625. https://info.britishjournalofmidwifery.com/	My idea originated from working with women in the clinical setting. I was supported by my co-authors to develop the methodology as I was a novice researcher. I applied for and presented at the ethics committee. I collected and input data. I was supported in the analysis and writing up for publication.
2. BRISCOE, L., and STREET, C., 2003. "Vanished Twin"- An Exploration of Women's Experiences. *BIRTH.* 30 (1), pp. 47-53. http://onlinelibrary.wiley.com/doi/10.1046/j.1523-536X.2003.00216.x/abstract;jsessionid=79CFCC57E022CC5EA5148EBEB61B0846.f03t03	The research question was generated by me from working with women in the clinical setting. I was successful in an application for funding to support the research process. I developed the methodology as part of an MSc programme of study. I applied for and presented to the ethics committee. I collected data. I transcribed the data. I analysed the data and then co-authored with my supervisor.
3. BRISCOE, L. and LAVENDER, T., 2009. Exploring Maternity Care for Asylum Seekers and Refugees*. British Journal of Midwifery*. 17 (1), pp. 17-23. https://info.britishjournalofmidwifery.com/	The paper was based around my MPhil research where I was supported by my supervisor (TL). I applied for funding and was successful. I applied for and presented to the ethics committee. I ran the study under the guidance of my supervisor. I transcribed and analysed the data. I wrote up the MPhil and passed the VIVA examination. I later co-authored with my supervisor.
4. BRISCOE, L., 2013. Becoming culturally sensitive: A painful process? *Midwifery.* 29 (6), pp. 559-565. http://dx.doi.org.edgehill.idm.oclc.org/10.1016/j.midw.2011.08.017	I developed the idea when I facilitated midwifery students, in higher education, to take part in international placements. I created the data collection tool and questioned if ethical approval would be required. I collected and analysed the data and I decided upon an appropriate data display. I wrote up and published.

5. BRISCOE, L., LAVENDER, T., O'BRIEN, E., CAMPBELL, M. and McGOWAN, L., 2015. A mixed methods study to explore women and clinician's response to pain associated with suturing second degree perineal tears and episiotomies [PRAISE] *Midwifery*. 31 (4), pp. 464–472 http://dx.doi.org/10.1016/j.midw.2014.12.010i EHRA:https://repository.edgehill.ac.uk/6374/	My idea was generated from carrying out a clinical audit in practice prior to teaching about perineal trauma. I developed the research protocol. I approached the research team to see if they were interested in my research protocol. The research methodology was developed further in collaboration with the research team (TL; MC; LMc). I applied for funding and was successful. I and the research assistant (EO) collected data. I analysed the data and the analysis was guided by LMc; TL and MC. I wrote the paper up and the research team influenced the final version with their expertise.
6. BRISCOE, L., LAVENDER, T. and McGOWAN, L., (2016) A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing.* 72 (10), pp. 2330-2345. Doi:http://onlinelibrary.wiley.com/doi/10.1111/jan.13017/ EHRA:https://repository.edgehill.ac.uk/7838/	There was a need to create a sense of cohesion for the research I had previously carried out. TL suggested that I carry out a concept analysis. The findings generated the underpinning theme for this PHD application related to vulnerability. LMc guided the research process for a concept analysis. I performed a systematic literature review, I collated a comprehensive data set and I abstracted data from a relevant selected sample. The sample was reviewed by LMc for rigor. I performed the analysis and consensus for analysis was reached by LB; TL & LMc. I created the paper which was reviewed by TL & LMc. Various opinions from the team were incorporated into the final paper.

No portion of this work of this thesis has been submitted for a comparable academic award at this or any other university, or for any award by a professional body. Reference to work already submitted may be made in this thesis which covers a wider field of literature.

I confirm that this is a true statement and that and the submission is my own original work.

Signed: *LBriscoe.*

Date: January 3rd 2018

Copyright Statement

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Personal Statement

I have worked at Edge Hill University since 2004 as a Senior Lecturer in Midwifery Education. I am currently employed in the role of Senior Lecturer Postgraduate Medical Education.

Previous degrees and professional qualifications in chronological order:

1983   Registered General Nurse

1986   Registered Midwife

2001   Master of Science: Practitioner Research by Research:

            Manchester   Metropolitan University.

2006   Master of Philosophy: University of Central Lancashire.

2007   Post Graduate Certificate in Education: Edge Hill University.

2007   Fellow of the Higher Education Academy

2008   NMC Registered Lecturer of Midwives

Acknowledgments

I am deeply indebted to two very eminent researchers, Professor Dame Tina Lavender, University of Manchester and Professor Linda McGowan, University of Leeds. Dame Tina has been a role model from the beginning of my research career. Her time and commitment invested in this portfolio of research cannot be underestimated. Dame Tina has been a constant supportive influence and without her presence the development of this work would not have been possible. Linda influenced this work from a later date and made a substantial contribution to later works. Linda's constant encouragement and belief has helped me to persevere and believe in myself when doubt existed. I cannot thank Dame Tina and Linda enough and I remain grateful every day for not only knowing them and sharing a growing friendship, but also for their expert and grounded opinion about research methods, standards, rigor and ethical principles that have helped to create this body of work.

I would like to thank Professor Clare Austin who provided consistent guidance about the process for a PhD by publication. I express my appreciation for the expert guidance provided. In addition, I thank Professor Bernie Carter who formed part of my early development in research and then at a later point when our paths crossed again. Bernie has provided a supportive mentorship process where her sound and practical advice has helped me to perceive future potential in research at Edge Hill University.

I would like to thank the Pro Vice Chancellor (Faculty of Health and Social care), Seth Crofts, for supporting me with time to study and write and believing in my ability to continue with this work. His openness to believing in the professional and personal development of others lifted me to believe that it may be possible to achieve the lofty goal of a PhD.

I would like to thank my family for being patient and supporting me to achieve this application for a PhD by publication. I have needed to withdraw from family life at times in order to complete this work. In doing that I deprived myself of precious time that could have been spent with my wonderful husband Allan, my three treasured children Rachael, Jack and Sophie, their supportive and wonderful partners Daniel, Jayne and Thomas. Although I spent time away from my grandchildren Emily, Isla and Maximus, who I am completely besotted with, I remain appreciative for every moment that I was able to spend with them during the development of this work.

Lastly, I am indebted to the women and clinicians who embraced and participated in the research. Their contribution to maternity care should never be underestimated. The findings of this work realise that women should be revered for their wisdom and resilience, and placed at the very centre of the health professional's focus every day.

I dedicate this work to my family

In vulnerability there is resilience…in resilience there is strength.

Introduction to the Thesis

This thesis explains how the focus of vulnerability emerged from six empirical studies published between 2002 and 2016. The writing style of this thesis encompasses two approaches. At times the style of writing is reflective of a personal journey. On other occasions the discourse reflects an academic critical analysis and synthesis. It is hoped the movement between styles enhances understanding about the personal journey and the depth of engagement with evidence surrounding maternity care in the UK.

The journey begins with papers one and two which were undertaken whilst working within a split contract that focussed on clinical work as a midwife and on work as an active researcher. Papers three, four, five and six have been undertaken whilst at Edge Hill University, as an academic member of staff and midwifery lecturer. Two empirical studies were published in a well-respected, peer reviewed, professional journal (British Journal of Midwifery), (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Lavender, 2009), together with one paper published in BIRTH (Impact Factor 1.867) (Briscoe and Street, 2003). Two papers were published in Midwifery (Impact Factor 1.861) (Briscoe, 2013; Briscoe et al. 2015) and one paper was published in The Journal of Advanced Nursing (Impact Factor 1.917) (Briscoe, Lavender and McGowan, 2016) (see Table 1: Index of Published Works).

A historical, reflective stance taken revealed that there was a need to listen to the voices of women to try and understand more about their complex experiences of maternity care. Vulnerability was a concept generated from each peer reviewed paper within this portfolio. Depth of understanding was facilitated by

interaction, language, interpretation, observation, critical analysis and synthesis of evidence generated by the relationship between researcher and participants. Women described how a lack of acknowledgement for their concerns created a negative perception which appeared to be reflective of how clinicians perceived their extraordinary and sensitive issues as an everyday occurrence. A lack of relationship in clinical care and a lack of tailored information reduced women's sense of control, created confusion or hindered informed choice. Alongside those experiences, clinicians described good intent was hindered via miscommunication.

Thesis Outline

Chapter 1: The context of this thesis is presented in Chapter 1 and includes a critical reflection about the personal journey taken whilst developing the work. The journey is set in a particular time, place, and culture. The developmental journey draws on pivotal moments that informed the work which was created whilst working as a midwife, educationalist and researcher. The reflective journey identified that bridging time via a subsequent interpretation of this work may have a positive influence for the future.

Chapter 2: Critically analyses and synthesises central themes generated from this portfolio of research. Four subthemes related to; (1) barriers to care, (2) women's choice and control, (3) women's growth towards developing resilience and (4) complexity within women's lives was underpinned by the crosscutting theme of vulnerability. There is a discussion about how implementation science should assess the impact of evidence in practice.

Chapter 3: In Chapter 3, ontological and epistemological stances generated from this portfolio will be discussed suggesting that Gadamer's ontological perspective of time, place and culture has been complemented by reality seen through Engel's biopsychosocial lens. Multiple realities epistemologically created what was known via construction, co-construction and interpretation. Methodological corroboration was underpinned by rigor related to qualitative, quantitative and mixed methods.

Chapter 4: A critical commentary based around the principles of beneficence and non-maleficence, justice and autonomy underpin this chapter. There is a discussion about how sensitive, taboo and unusual circumstances for women during their maternity create vulnerability within research ethics. The importance of including hard to reach groups is discussed.

Chapter 5: Presents a discussion about strengths and limitations of this portfolio of research. Implications for practice, education, research and policy are presented. Concluding remarks identify the researcher's journey emerged because of time, being and temporality. There is a suggestion that it is important to use pre and post evaluation techniques to assess how evidence impacts upon women's maternity care in order that change is timely.

Chapter 1

Development of the Work: A Personal Journey

This chapter presents a personal, professional and academic journey into research and reflects a developmental process to build this portfolio of published works. Thematic concepts related to vulnerability, barriers to care, choice and control, resilience and complexity have been synthesised within a description of the journey taken. However, the concepts are critically analysed in depth in Chapter 2.

1.1 Historical Context

As a nurse in 1983, a midwife in 1986, a mother to three children and a carer for elderly dependant relatives, I was able to relate directly to women and families in my care. Looking back, as a student nurse and student midwife (1980-1986) revolutionary policy changes took place, suggesting that women should be listened to and their opinions valued. However, the clinical back drop depicted a more hierarchical clinical environment. A case to illustrate how women's opinion was perceived by the hierarchy can be related to Savage (1987). Savage was an obstetrician who acknowledged women's opinion about their desired mode of birth. However, obstetric peers differed in their opinion of that importance and conflict led to Savage's suspension from practice. It could be argued that during this time publication bias ensured research about women and birth was, 'palatable' to obstetricians (Oakley, 2016: 693). During this time period, judging the quality of research became important and the strength of evidence to support ways of practicing was based on objectivist, scientific judgement (Chalmers, Enkin and

Keirse, 1989). Quantitative approaches to research dominated and little was known about how qualitative research could contribute to care. However, the latter was more likely to capture the perceptions of women and health professional's perceptions. Therefore, there was a distinct gap in our knowledge and understanding.

A driver for revolutionary change in the UK emerged from a political rhetoric which demanded that women had more informed choice, continuity and control within maternity care (Ball, 1981; Russell, 1982; Green, Coupland and Kitzinger, 1990; DH, 1993; 1999a; 1999b; 1999c; 2000; 2004; 2010a; 2010b; 2012; NHS England, 2016). The increased focus to listen to women encouraged researchers to capture women's voices. In capturing women's voices there was an awakening about how qualitative approaches assisted inquiry (Pope and Mays, 1993; 1995; Jones 1995; Lavender, Edwards and Alfirevic, 2004). At the same time, rhetoric in policy and guidelines gave clinical midwives a confidence about their ability to make a difference in care (DH, 1999a; 2001a; 2001c; 2003a; 2004; 2005; 2006; 2008a; 2008b; 2009), and suggested their ability to listen to women was important (DH, 2001a; 2001b; 2010a; 2010b; 2010c; Dodds, Goodman and Tyler, 1996). Therefore, at that time, the revolving cycle of work and life took place in a particular setting which was created by political and professional rhetoric. A critical reflexive stance taken for this thesis led to a deeper understanding about the experiences of women and clinicians. During that period and in the clinical setting, the everydayness of lived experience, proposed by Heidegger (1977; 1978) and Gadamer (2004), became apparent for one midwife, educationalist and researcher (LB). It is hoped this synthesis holds resonance with the reader.

1.2 Development of the Work

It was in 1997 that the process of research gradually became apparent to me and my journey into research began. I developed and continue to develop an understanding about differing methodological approaches whilst actively working on research. One of the first studies, Briscoe, Lavender and Alfirevic (2002) (see Table 1; Appendix 1) emerged whilst working as a data collector for a larger study (Alfirevic et al. 2001). I believe this first study provides evidence about how I struggled to understand methodological approaches to research when working in a fundamentally objectivist clinical environment and I commented that there was:

"…a growing awareness among health-care professionals that the support given to women in the postnatal period does not always meet women's needs" (Briscoe, Lavender and Alfirevic, 2002: 620),

I went on to highlight how important, 'emotional support' was for women after childbirth, pointing out that there was, 'very little scientific data' available to base care upon (Briscoe, Lavender and Alfirevic, 2002: 620). Reading this paper at a different point in history (2017) leaves me to question why I chose a survey method to capture the much needed in-depth qualitative information that was suggested within the paper. Critical reflection on this paper, synthesised with the contents of this thesis captured thematic patterns to identify that concepts related to; vulnerability, potential barriers to care, women's sense of choice and control, women's resilience and level of complexity surrounding women's lives was evident (see Appendix 2). I believe this stage in my research development, together with the cultural influence of the clinical setting, combined to create a way of thinking that was dependent upon distancing myself from the participants. However, the survey method used was the first study to include the specific inclusion criteria for

obstetric complication; severe pre-eclampsia and/or eclampsia, intrauterine growth restriction, an unexplained still birth or severe placental abruption to be explored, with intent to understand women's opinions. Reflecting on the past, I now question if I was able to represent women's opinions appropriately within the approach used.

The journey moves forward in time where assimilation of knowledge around research design helped me to consider different approaches. It was whilst working on a subsequent larger study as another data collector (Platt, Pharoah and Briscoe, 2001; Platt et al. 2001), I became aware that the women I approached to recruit were understandably distressed by losing a twin (Briscoe and Street, 2003) (see Table 1; Appendix 1). Whilst understanding how devastating the loss of any pregnancy could be and attempting to console women, I searched for information to help me understand better how women who experienced a vanished twin felt. This way of thinking led to a research question which underpinned a Master of Science degree and led to a further publication (Briscoe and Street, 2003). Here, for the first time, I used an in-depth qualitative approach to try and capture women's experiences. The research identified that women felt distressed, experienced loss, experienced a lack of emotional support and their concerns were not listened to or acknowledged (Briscoe and Street, 2003: 51). Women's vulnerability, lack of choice and control, barriers within communication, and their complex situations were apparent (see Appendix 1 and 2). However, this publication helped me to realise, gradually, the power of qualitative research, when in 2006 I received a letter from a reader in Australia relating to the published paper, explaining how the vanishing twin research had touched the family and had helped them to develop a deeper understanding about the phenomenon. I actually began to feel that it may be

possible for me to influence change through research and to potentially make a small difference.

My interest in research grew and when working clinically during 2003 I became aware that elements of maternity care created a barrier for asylum seekers and refugees. Potential inequity around women's choice and control during their maternity care became apparent (Briscoe and Lavender, 2009) (see Table 1; Appendix 1 and 2). Again, as I searched for evidence to explain how women felt I realised there was a dearth of information. Information available focussed on snap shot interviews with asylum seekers and refugees during their maternity care (Burnett and Fassil, 2002; McLeish, 2002; Sawtell, 2002). Therefore, as I entered the pathway for a Master of Philosophy, I decided that the maternity care of women who were asylum seekers and refugees should be explored further, and a longitudinal approach was adopted within a case study design (Stake, 1995). I commented that a longitudinal approach helped me to, *"…contextualise the individual experiences of women"* (Briscoe and Lavender, 2009: 17). Here was a point in my journey where I began to understand how influential the contextual setting was upon women's lives. Repetitive themes were emerging in relation to the women's vulnerability, lack of choice and control, barriers they experienced, and their need to develop and become resilient within complex situations (see Appendices 1; 2; 3; 4). I began to realise that the context involving the time and place, layered by the cultural and political environment where research was situated, had the potential to alter perception, understanding and meaning. The findings identified how there was a potential for women's voices to be silenced, not only within society, but also within the culture of the clinical setting; despite the political

drivers to create choice, continuity and control (DH, 1993). For example, in this study Meena (34 weeks gestation) explained, via an interpreter, cultural influences meant that:

> *"At home we used to speak Punjabi all the time but men who go out and about they can speak Farsi. But I wouldn't speak Farsi because I never went out … we were not allowed to go out … That's why I'm not very … I'm not used to talking to other people.'* (Briscoe and Lavender, 2009: 18).

And Grace aged 19 from Rwanda was two weeks postnatal when she highlighted how she was silenced by the glances of those in the clinical setting which resulted in Grace becoming silent and she said, *"I just kept quiet and sat down on my bed"* (Briscoe and Lavender, 2009: 22). This study revealed that women's understanding was influenced by the style of interaction and subtle display of body language. Style of interaction had the potential to render women vulnerable, silenced and influenced how women perceived 'self' (Briscoe and Lavender, 2009: 22).

1.3 Development of Methodological Approaches

My interests in the influence of the clinician, the power of perception, interpretation and meaning making developed and in 2011, when as an educationalist, my inquiry turned to an exploration of how student midwives became culturally sensitive (Briscoe, 2013: 559), (see Table 1; Appendix 1) and I commented about how, "*important it is to consider how individuals and not systems create the caring environment*". In this publication I identified how student midwives felt uncomfortable about challenging their preconceived ideas (Briscoe, 2013: 562) and that at times they found the process difficult. However, exposure to alternative cultures combined with reflexivity appeared to raise awareness and helped to make

student midwives feel more self-aware and confident (Briscoe, 2013: 561; Kingdon, 2005). Students demonstrated how clinical experience underpinned vulnerability when their insecurities were exposed. Overconfidence or arrogance had the potential to interrupt the process of deep critical reflection. Reflection facilitated a growth and helped to create resilience within the complex clinical environment (see Appendix 1).

I began to realise that I needed to understand more, and the mixed methodology used in the PRAISE study (Briscoe et al. 2015) assisted in building a deeper picture about human interaction (see Table 1; Appendix 1). This was the first of my published works where observation, interviews and questionnaires involved women and clinicians in one study. The research identified how the style of interaction had the potential to influence levels of psychological distress in women (Briscoe et al. 2015: 470) and make the overall difference to women (Briscoe et al. 2015: 471). Observations corroborated by interviews highlighted women's vulnerability. It was apparent that when women perceived a negative style of communication, women's ability to choose or be in control was lessened. However, a warm, kind sensitive approach to care facilitated partnership working and made the overall difference to women. The positive difference created by the clinician's kindness and sensitivity occurred even when women needed to be resilient by coping with pain during suturing. Key themes generated in this study reflected a complex, dynamic and intense clinical setting (see Appendix 2). Those complex experiences had the potential to influence women for the duration of their life.

I questioned what the key underlying concept to my work was and following discussion with my longstanding mentor (TL) it became apparent that vulnerability

was the coherent theme. However, the word vulnerability appeared as a vague term within literature and to understand how the term was defined, I conducted a concept analysis (Briscoe, Lavender and McGowan, 2016) (see Table 1; Appendix 1). The work permitted a structured method to explore the concept from a deeper theoretical position. The paper provided me with a sense of cohesiveness, pulling together the findings from my previous work in relation to existing theoretical and philosophical perspectives. Three main attributes to becoming vulnerable during pregnancy, birth and the postnatal period were identified; (1) the presence of a biological, psychological or sociological threat, (2) barriers experienced and (3) reparative measures engaged with (Briscoe, Lavender and McGowan, 2016: 7) (see Table 1; Appendix 1). In line with the findings of the concept analysis the term, 'vulnerable' in relation to pregnancy, birth and the postnatal period was re-defined to include:

"Women are vulnerable when they experience 'threat' from a physical, psychological or social perspective, where 'barriers' and 'reparative' conditions influence level of vulnerability" (Briscoe, Lavender and McGowan, 2016: 9).

The findings reiterated to me how important style of interaction was to women and suggested that a warm, non-judgemental, professional relationship made a difference to women physically and emotionally.

Following publication of Briscoe, Lavender and McGowan (2016) personal reflection raised questions about why it was important to ask sensitive research questions, why ask those particular groups of women and why ask at that moment in time? A deeper understanding about the purpose of this research portfolio was generated by engaging with Heidegger's theory of time and being (Hiedegger,

1977). Here, Heidegger suggested that the reason for being in the world was for individuals to be with others. Social interdependence exists and individuals thrive because 'Being-in-the-world is being-with' (In Copleston, 1972:180). The theory expands to incorporate how people are, 'thrown' into the world and to realise their individual potential they reach out to others to interpret the world through particular projects (Heidegger, in Copleston, 1972: 180-181). Heidegger (1977: viii) believed that Being exists in, 'three ecstasies of time-past, present and future'. That perspective of past and present time was said to be temporal by Gadamer (2004:295-296) who believed that understanding was a co-determined process developed by the interpreter and the historical situation of that interpreter. This was a positive perspective where:

"Time is no longer primarily a gulf to be bridged because it separates; it is actually the supportive ground of the course of events in which the present is rooted" (Gadamer, 2004: 197).

According to Gadamer (2004:469-470), 'Being' can be understood via language which provides the, "medium where I and the world meet". Therefore, this personal journey into research may have emerged from opportune moments in time where language assisted in an interpretation of how the researcher, midwife and educationalist (LB) created a thread of belonging to the women and clinicians during the continuum of maternal experiences. Maybe one of the reasons for this portfolio of research was to situate the researcher (LB) in the world, while attempting to understand and make a difference to the lives of women, clinicians and students who were part of maternity care at that time.

In summary, a personal and professional journey evolved when caring for women during their maternity care. During that journey a pathway to try and

understand more about the experiences of women and clinicians in maternity care was embarked upon by using established research approaches. Robust approaches to research underpinned a growing awareness that the time and setting of research were influenced by the social, political and professional culture where the process took place. Recurrent themes emerged related to barriers to care, women's reduced choice and control, their ability to develop resilience and how complex issues surrounded their lives. Recurrent experiences underpinned a cross cutting theme of vulnerability. Synthesised findings of the papers captured complexity apparent in women's lives and in the clinical setting. The reflective journey helped me to understand that multiple perspectives created a sense of historic perspective about what was real. Reality was understood through language and observation of human interaction. Language informed dialogue which was interpreted by individuals to create meaning. Such meaning related to 'self,' where lack of choice and lowered sense of control had the potential to reduce self-esteem and increase the level of vulnerability.

Chapter 2

Central Themes of the Thesis

Chapter two clarifies that four sub-themes were identified and were related to (1) barriers to care, (2) women's reduced choice and control, (3) resilience and (4) complexity, and all four sub-themes informed the cross cutting theme of vulnerability. The cohesive theme of vulnerability was bridged by critical reflection and synthesis of six empirical studies (see Table 1; Appendix 2). In this chapter central themes will be critically analysed to inform a comprehensive analytical commentary.

2.1 Theme Development

Themes inductively emerged from the findings of the six papers presented in this thesis by identifying rules of relation, suggested by Bolton (cited in Morse 1995, p. 35) to be linked patterns of factors, attributes, characteristics or properties. Emerging patterns were displayed in a tabular format based around Miles and Huberman's (1994) method of pattern formation. The relationship or correlation of one emerging pattern to another became evident gradually after reading and re reading each article chronologically (see Table 1; Appendix 2).

Appendix 2 highlights that patterns did not appear in the order presented in the model of vulnerability described in Briscoe, Lavender and McGowan (2016, p 2339). Order became apparent during three iterations of the table. Phase one and Phase two related to pattern formation around rules of relation and Phase three focussed on colour coding themes to clarify where the patterns existed across all publications (Appendix 2a, 2b and 2c). Pattern identification emerged in iteration

one: Phase one. For example, in Appendix 2a it can be seen that the category of, 'Help from family and friends' was visible in Briscoe, Lavender and Alfirevic (2002), Briscoe and Street (2003), Briscoe and Lavender (2009) and Briscoe et al. (2015). However that pattern was not apparent in Briscoe (2013) or Briscoe, Lavender and McGowan (2016).

Ordering into clearer patterns of correlation occurred in iterative Phase two when patterns were aligned (Appendix 2b). For example, in Briscoe, Lavender and Alfirevic (2002) women felt that staff did not listen to their concerns and a barrier was created, which led to women explaining they had unmet needs. Unmet needs emanated from not being listened to, which then led to the consequence of self-esteem for women becoming raised or lowered. However, listening to women developed the potential for reparative conditions where self-esteem developed, and the resilience of women was demonstrated. Therefore, one category came before the other category and the order became apparent gradually. Specifically, the concept of listening or not listening (the barrier) came before the consequence of self-esteem being raised or depreciated (the potential for repair or resilience). The same concept of listening became apparent in Briscoe and Street (2003), Briscoe and Lavender (2009), Briscoe et al. (2015) and Briscoe, Lavender and McGowan (2016).

Colour coding themes assisted Phase three which clarified how themes mapped across each paper. Data display across papers can be seen in Appendix 2c. Therefore, data displayed in a tabular format enabled repetitive relationships to become visible and identified the potential for order. The iterative process facilitated a deeper understanding about how one concept had the potential to lead to another,

and the table helped to make that order visible. Iterative phases reflected patterns identified in the model of vulnerability which emerged from an in depth concept analysis in Briscoe, Lavender and McGowan (2016, p 2339). The clarity from colour coding patterns led to a deeper understanding about the cross cutting theme of vulnerability within this thesis.

2.2 Sub-themes

2.21 Barriers

Several barriers where identified to care. A key barrier emerged when women felt they needed more emotional support from clinicians (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Women perceived that maternity workers disassociated their emotional responses away from women's expressed concerns, which created a lack of acknowledgement for women's open demonstration of distress (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015, Briscoe, Lavender and McGowan, 2016). Lack of acknowledgement added to women's sense of loss and lowered their ability to respond (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). In addition, women commented on how stigma was a barrier when they were categorised with the social status of asylum seeker or refugee (Briscoe and Lavender, 2009), experienced a vanished twin (Briscoe and Street, 2003) requested additional analgesia (Briscoe et al. 2015), had a same sex relationship, lived with learning needs, or lived in poverty (Briscoe, Lavender and McGowan, 2016). Women experienced miscommunication and had difficulty in

interpreting health professional's messages even though the women were English speaking. Miscommunication became less than satisfactory when women did not have English as their first language. The consequence of miscommunication was that women made assumptions about maternity events happening around them (Briscoe, and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015). In one case the woman thought the consequence of her emergency maternity care would result in death, where full explanation may have reduced her anxiety (Briscoe, 2009: 100).

At times women perceived that miscommunication with a clinician heightened a sense of fear, increased women's anxiety or silenced their voices (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015). Barriers to care emerged when maternity carers were reluctant to listen and respond appropriately which led women to increase their access to emergency care in an attempt to seek reassurance (Briscoe and Street, 2003). In Briscoe et al. (2015), women's perception about miscommunication created measurable differences in pain response and levels of anxiety.

Professional reflection on practice influences how clinicians develop and is suggested to reduce barriers to care (Schon, 1991). An exploration of how student midwives developed cultural sensitivity utilised critical reflection to underpin experience in practice (Briscoe, 2013). Overconfidence or arrogance within the process of reflection reduced depth of reflection and decreased the ability of the individual to move their thoughts positively. Results suggested that exposure to alternative cultures had the potential to reduce barriers by heightening cultural sensitivity in practice (Briscoe, 2013).

Additional barriers emerged when women who requested more pain relief were required to persevere with pain felt (Briscoe et al. 2015). Clinical dilemmas in intense, dynamic and complex situations led to contradiction of professional ethos and codes of practice (NMC, 2015; FIGO, 2012). Identifying barriers to care led to an understanding that complex, socially constructed layers of influence in practice created an environment where maternity care was overshadowed by pressure of time, dynamically changing circumstance, stress, or the need to refer to a doctor, which are common themes in maternity care globally (Lyndon, Zaltnik and Wachter, 2011). Experiences took place in the socially constructed environment of maternity care, where each individual brought their history, expectation and assumption to that moment in time (Berger and Luckman, 1966; Gadamer, 2004; Wachterhauser 2002; Gadamer in Dorstal, 2002: 45; Turner and Stets, 2006). Subtle messages that pervaded clinical environments created patterns of behaviour that became acceptable to all in that environment. It is apparent that the way a group thinks has the potential to permit negative styles of behaviour in an organisational environment (Akhtar et al. 2016).

In summary, barriers were associated with disassociated professionals and judgemental communication. The consequence was to make women feel stigmatised, ignored or silenced. Barriers to care negatively influenced women's sense of self-esteem and dignity. Care took place in a socially constructed clinical environment which developed an enculturation of clinician behaviour. Engagement with critical reflection raised clinician's self-awareness. The clinician's ability to respond appropriately to women's needs helped to reduce barriers.

2.22 Choice and Control

Choice and control are historical concepts recognised as pivotal to a satisfactory maternal experience (Ball, 1981; Russell, 1982; Green, Coupland and Kitzinger, 1990; DH, 1993; 1999a; 1999b; 1999c; 2000; 2001a; 2001b; 2001c; 2003a; 2003b; 2004; 2007; NHS England, 2016). When barriers in settings prevent a full range of options to choose from an illusion of control may emerge (Jomeen, 2006; 2007; 2010: 21, 2012). The concept of reduced choice was apparent in this research portfolio. For example, some women felt that information provided by health professionals did not meet their needs (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Lack of information reduced their ability to choose how they would respond in stressful situations (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015). Their responses were reliant upon health professionals who determined when it was appropriate to provide information, what information to provide and whether an interpreter was required (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015). Consequently, clinicians in this research portfolio determined the degree to which women were offered choice and if choice was made available to women, which can be associated with a medically dominated environment, lack of time and maternal compliance (Stapleton, Kirkham and Thomas, 2002).

Ogden, Daniels and Barnett (2009) suggested that having choice can be linked to positive psychological outcomes compared to having no choice. Reduced choice and loss of control has been associated with passive or active compliance (Poore and Foster, 1985). Passivity, when women permit medical staff to make

decisions, represents an external locus of control and an internal locus of control recognises a willingness to be actively part of the decision making process (Heinze and Sleigh, 2003). However, Lambert (2013) believes women make decisions differently to clinicians and agrees with Vandevusse (1999) that a decision line or continuum exists, where women move between making a decision, to relying on others to decide. Relying on others occurs especially when there is uncertainty or in fast paced environments (Lambert, 2013: 26). Ogden, Daniels and Barnett (2009) suggests that detrimental psychological outcomes become apparent when uncertainty is accompanied by no choice (Ogden, Daniels and Barnett, 2009) which were circumstances reflected in this portfolio of work (Briscoe and Lavender, 2009; Briscoe et al. 2015). Therefore, it is important to consider how choice is expressed and interpreted in maternity care. The process of decision making was not the intent of this thesis; however, it was clear that women appeared to have little or no autonomy over the process to decide.

Autonomy forms part of governmental rhetoric in current maternity care in England, suggesting that people have choice and are able to control events that affect their lives (NHS England, 2016). In the reality portrayed in this portfolio it was apparent that women experienced lack of control around biological, psychological and sociological elements of maternity care. When seen from a biological perspective, there was no control over severe complication which developed during the maternal journey (Briscoe, Lavender and Alfirevic, 2002). Psychological distress was experienced when women were not able to control pain (Briscoe, Lavender and McGowan, 2015), or when losing one twin (Briscoe and Street, 2003). Socially, women lacked control about migration, dispersal, where

they lived or how others portrayed them (Briscoe and Lavender, 2009). Interestingly, regardless of the context where lack of control was identified a warm response from the clinician made the overall difference to women.

In contrast to women's lives, clinicians' in this portfolio of research had control over how they engaged within maternity settings and their ability to adjust their style of communication to reflect a positive perception (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). One way to raise a professional's awareness about the potential for interaction to be perceived negatively would be through critical reflection. However, in this thesis, the power to reflect lay with the clinician. When the clinician engaged with the process of reflection, the process had the power to, 'move one way of thinking to another' to create a transformed perception and heightened sense of awareness (Briscoe, 2013: 563).

Unfortunately, lack of control for women during their journey to becoming a mother appears to continue throughout time, place and context, despite a considerable body of research to inform clinicians about the issue (Jomeen, 2006; McCourt, 2006). Here, McCourt (2006) provided empirical evidence ranging from 1979-2004 related to women's ability to make informed choices and suggested the main element of women's control revolved around the power of the clinician, which this thesis would agree with.

From the findings of this thesis there appears to be a cycle of perception about choice and control. To depict the cycle Figure 1 illustrates stages within a cycle that occurred when women perceived interaction to be cold and detached, as

suggested in Briscoe, Lavender and Alfirevic (2002), Briscoe and Street (2003), Briscoe and Lavender (2009), Briscoe et al. (2015) and Briscoe, Lavender and McGowan (2016). Each stage of the cycle led to another. The cycle continued and each stage increased the chance of women becoming vulnerable. Stages of the cycle included cold detached interaction (Stage 1). Stage 1 led to barriers to care being ignored by clinicians (Stage 2). When barriers were ignored women perceived a reduction in choice (Stage 3). Stage 3, where the woman experienced a decreased perception of choice appeared to reduce women's ability to control how they responded in stressful situations (Stage 4). Stage 4 relating to a decreased level of control about self-response, reflected how others treated the individual in question. Feelings associated with a negative perception about the reactions of others led to women closing down, becoming silenced and that response impacted on women's self-esteem (Stage 5). Lowered self-esteem increased women's level of vulnerability (Stage 6). Stage 6 fed back to Stage 1, when women's vulnerability caused them to perceive interactions as cold and detached.

It became clear that there was the potential for a never ending cycle to exist. In this thesis that cycle was evident over 14 years of empirical evidence within six different studies, in different settings, with different sample groups and across professional disciplines. Furthermore, evidence of the perpetuating cycle of vulnerability can be seen in health reports (Francis, 2013; Kirkup, 2015; Knight et al. 2015) which corroborates that it is crucial that this perpetuating cycle is interrupted. Interrupting the cycle with positive constructive interactions between women and their health professional would help to prevent negative outcomes for women and increase the chance of a positive experience during maternity care. It is

important to appreciate that the action of clinicians to interrupt the cycle will help women to stop feeling vulnerable during their maternity care journey.

2.23 Figure 1: Cycle of perception: choice, control and vulnerability
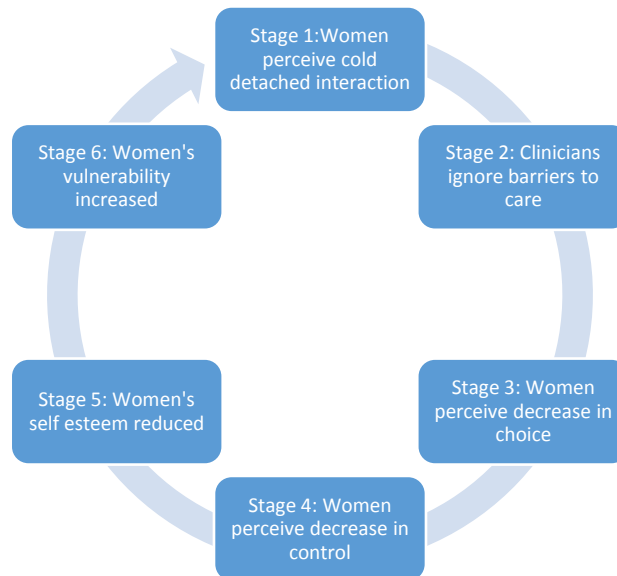
2.24 Resilience

This thesis identified that women developed resilience during their experience of maternity care (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Resilience can be perceived as a process, a trait or an outcome (Southwick et al. 2014). The concept can be present, absent or associated with a continuum (Pietrzak and Southwick, 2011). Alternative definitions include a constant element which is part of a healthy response to adversity (Bonanno, Westphal and Mancini, 2011), or a conscious effort to move forward after lessons learned from an adverse event (Yehuda et al. 2006). Southwick et al. (2014) described a paradigm shift where researchers are redefining what resilience is, how it can be fostered and how dynamic complexities

surrounding the concept can be captured. ActionAid (2016:8) later defined resilience as:

"the ability of people to recognise, challenge and transform the unjust and unequal power relations that dictate their vulnerability, to adapt positively to changing circumstances, and to mitigate, prepare for and rapidly recover from shocks and stresses such that their wellbeing and enjoyment of human rights is safeguarded".

This definition holds resonance with the findings of this thesis where unequal power occurred when women requested, but did not receive, acknowledgement of their vanished twin (Briscoe and Street, 2003), or when women were expected to persevere with pain during suturing (Briscoe, Lavender and McGowan, 2016). In another paper, resilience was apparent when asylum seekers and refugees tried to adapt to life away from their country of origin or when they found a way to cope with racism and silencing (Briscoe and Lavender, 2009). It became apparent in this thesis when power differentials existed, women demonstrated resilience through their adaptive coping strategies (Schmitz et al. 1996 cited in Briscoe et al. 2015: 470).

For some women, resilience developed through reparative processes where their self-esteem increased when they experienced warm, trusting, non-judgemental, maternity-carer/woman relationships (Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Therefore, the positive power felt within socially constructed relationships between clinicians and women assisted women to become resilient (Briscoe and Street, 2003; Briscoe et al. 2015; Briscoe, Lavender and McGowan; 2016). Rutter (2013: 482) believes that positive social relationships play a part in the development of resilience and subscribes to resilience as a

process which is not static but enables individuals to continue with their lives despite adversity. However, Starck (in Smith and Liehr, 2014: 89) adds complexity, suggesting that resilience includes three dimensions; soma (physical), psyche (mental) and noos (human spirit). Interestingly, the findings from this portfolio of work reflect Starck's perspective where resilience emerged from a complex biological, psychological and sociological perspective (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015).

2.25 Complexity

Over time it became apparent that each woman's biopsychosocial circumstances added layers of complexity to their situation (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Increasingly it became,

"clear that the body and soul are closely related to one another…we might almost say that nothing happens in the body that doesn't echo in the soul and vice versa" (Gross and Jones, 2004: 51).

There is evidence to suggest an increase in complex conditions in the general maternity population of the UK (Health Foundation 2010; NHS England, 2015). An example of that complexity in this portfolio revolved around the inseparable symbiotic relationship (Pine, 2004) of the mother-infant relationship (Briscoe and Street, 2003; Briscoe, Lavender and McGowan, 2016). Another layer of complexity could be linked to Stern's (1998 pp. 172), 'motherhood constellation', where 3 discourses around motherhood was suggested; (1) the discourse with her own mother, (2) the discourse with herself and (3) the discourse with her baby which was evident in this portfolio (Briscoe and Street, 2003; Briscoe and Lavender, 2009).   Additional layers of complexity were added via experiences

related to catastrophic life events which Baraister and Noack (2007: 175) suggest are related to war and natural disaster, socioeconomic disadvantage, parental mental illness, maltreatment, poverty, violence or illness, and were elements represented in this portfolio (Briscoe and Lavender, 2009).

In addition to layers of complexity added by catastrophe the maternity carer and woman experienced complexity when communicating between and within different languages (Briscoe and Lavender, 2009). Furthermore, complexity was apparent when student midwives strived to become culturally sensitive (Briscoe, 2013). Moreover, complexity became apparent when there was a need to take account of the woman's previous psychological experience in order to understand the woman's current psychological status (Briscoe et al. 2015) or sociologically, when the woman lived in poverty (Briscoe and Lavender 2009; Briscoe, Lavender and McGowan, 2016).

2.26 Complexity within Implementation of Evidence

Alongside of complex maternal conditions and experiences, this portfolio identified a complex historical thread when evidence was implemented. Following implementation of this portfolio and despite comprehensive rhetoric to empower women to choose and have control, little changed in practice. Moreover, there was evidence to suggest an increase in detrimental outcomes for women related to the way professionals interacted with women and their families in maternity care (Francis, 2013). The findings within this portfolio were implemented in written information locally (Briscoe, Lavender, Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009). Alongside of written information the research was

published in peer reviewed journals (see Table 1) and at other times a paper was disseminated directly into the clinical areas via newsletters (Briscoe et al. 2015) within guidelines (Briscoe and Lavender, 2009) or at local, national or international conferences (Briscoe and Street, 2002a; 2002b; Briscoe, Street and Cattrell, 2002; Briscoe, Lavender and Carter, 2003; Briscoe and Lavender, 2005; Briscoe, 2007a; 2007b; Briscoe and Lavender, 2007; Briscoe, 2011; Briscoe, Lavender and McGowan, 2014). However, at no time was there an evaluation about how that evidence impacted upon women or clinicians.

Implementing evidence presents challenges to leaders, managers, researchers and educationalists. Therefore, to support practitioners, implementation strategies were developed (Craig et al. 2006; Davidoff et al. 2008; Feldstein and Glasgow, 2008; Damschroder et al. 2009). However, Damschroder et al. (2009) identified that socially constructed concepts within individuals, teams, leaders and organisations can subtly influence how research is implemented effectively. Pre and post evaluation implementation provides one strategy that may help to inform about the impact of evidence upon women's lives (Craig et al. 2006; Damschroder et al. 2009) and it would be interesting to re-evaluate why hearing women's voices appears to be difficult in practice even today in 2017, despite the knowledge that substantial evidence is accessible. A deeper understanding may help to stop women from feeling vulnerable during their maternity care.

2.27 Vulnerability

'Vulnerability' experienced from a biopsychosocial perspective was a crosscutting theme that emerged via synthesis of findings within this portfolio of

work (Briscoe, Lavender and McGowan, 2016). Critical examination revealed that the concept can be related to a universal experience because it is 'the human condition' (Nyamathi and Koniak-Griffin, 2007: xiii). Despite a universal context the concept is separated out to those who are, and who are not vulnerable, resulting in stigmatisation of groups and populations (Fineman, 2008; Cole, 2016). However, the dilemma for theorists is that although vulnerability is universal, the concept is experienced on an individual level.

Individual vulnerability cannot be eliminated but it can be mitigated against by the resources accessed (Fineman, 2008: 10). Physical (wealth), human (education and healthcare) and social (networks of relationship) resources can be used to lessen vulnerability and develop resilience (Kirby, 2006). One social resource used in maternity care to reduce a feeling of vulnerability is to listen to women. However, despite supportive rhetoric, women in the UK continue to experience prejudice from clinicians who do not want to listen (Psarros, 2014; Kirkup, 2015).

To understand more about the concept of vulnerability existing models were explored (Berkman et al. 2000; Wilton and Kaufman, 2001; Paradice, 2002: Maslow, 1968; Maslow, cited in Gross, 2010: 141; Raynor and England, 2010). However, existing models did not capture or explain the dynamic and complex interface related to vulnerability and application was vague. Vague application of the term 'vulnerability' is apparent in maternity care, and this thesis agrees with Fineman's (2008:9) premise that the concept of vulnerability is 'grossly under theorised and ambiguous'. Fineman (2008:21) calls for a paradigm shift to centre the enduring vulnerable human condition at, 'the heart' of social and state

responsibility to influence politics, ethics and law; suggesting that there would be a more realistic representation of an actual, complex lived experience (Fineman, 2008). Vagueness of the concept in this thesis can be related to how previous models refrained from suggesting what a clinician or woman should consider next. However, the interface of vulnerability, in this thesis, emerged from patterns of experience where a constant flux of changing circumstances existed for women, and those patterns supported the development of additional guidance generated by new knowledge in Briscoe, Lavender and McGowan (2016: 2339).

This guidance from the new model of vulnerability, replicated on page 43 of this Thesis in Figure 2, acknowledged that supportive measures should be developed to assist women to move from threat worsening or threat in equipoise, through to the best anticipated outcome of threat removed.

Figure 2: Conceptual model of vulnerability during the childbirth continuum
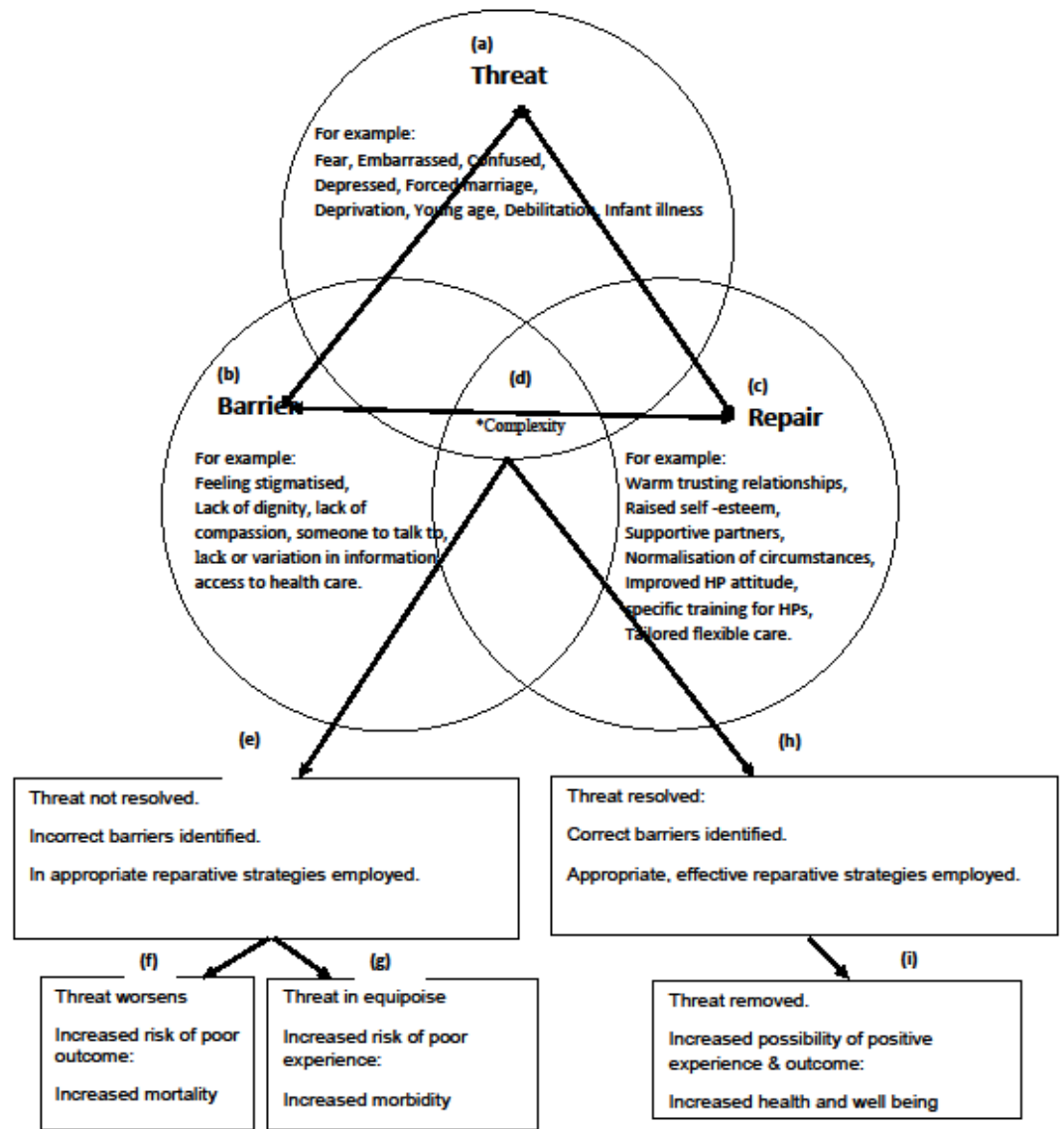
Figure 2: Conceptual model of vulnerability during the childbirth continuum. (a) Examples of Threat experienced; (b) Examples of barriers identified; (c) Examples of potential reparative strategies; (d) When all attributes merge to create complexity. *Complex issues are at times inseparable, for example, attachment, fluctuation of mood, free will or change of mind; (e) Example of potential pathway when Threat is not resolved; (f) Threat may worsen which increases the risk of poor outcome and increased mortality; (g) Threat remains the same which increases the potential for poor experience and morbidity; (h) Example of potential pathway when Threat is resolved; (i) Threat removed increases the possibility of positive experience and outcome leading to an increase in wellbeing.

(Briscoe, Lavender and McGowan, 2016: 2339)

Following publication of paper 6 (1 and 5) the Royal College of Midwives model guided midwives to support women with complex needs with positive public health messages (Gomez and November, 2016). However, women's opinions were not part of that model development. Even so, a key element of that model directed midwives to support women and their partners to design a personal journey plan for motherhood, which is a similar suggestion to the journey planner identified in early 2016 (Briscoe, Lavender and McGowan, 2016) (see Appendix 4).

A potential limiting factor to journey planning is associated with an expression that midwives find communicating sensitive information to be a challenge (McLachlan et al. 2011; Gomez and November, 2016). Here, it is important to consider that a challenge may not simply be a lack of midwifery confidence to broach a sensitive topic, but also a loss of hope of midwives who believe that there is no point in identifying underlying psychosocial problems because they are unable to create a direct change in women's lives (McLachlan et al. 2011: 726). Therefore, facilitating sensitive discussion with women who are vulnerable to biopsychosocial aspects deserves further investigation through research and evaluation in practice, to identify how midwives can facilitate; an appropriate discussion, what kind of discussion women appreciate, what strategies would make a difference to them and the optimum time for that discussion to take place.

In summary of chapter two, sub themes informed a cross cutting theme related to vulnerability. Sub themes were identified as; barriers to maternity care, women's reduced sense of choice and control, the development of resilience and

how complex issues surrounded women's lives. In addition, clinicians experienced being vulnerable when their lack of knowledge was demonstrated and their perceptions were challenged. It was apparent that complexity was experienced when implementing evidence during that period in history. Those combined elements meant there was little positive difference made upon women's lives or their experience of maternity care, at that time. A move forward for future research is to establish pre and post evaluation strategies when implementing evidence to assess impact.

Chapter 3
Philosophical Stance

The current body of work was informed by Gadamer's philosophy (2004: 119; Gadamer in Dorstal, 2002: 45 and 64-65) of how time influences setting and culture. Engel's (1977) biopsychosocial theory complements Gadamer's perspective suggesting that ontologically, knowledge was constructed and reconstructed through language via dialogue within the client/ clinician and researcher relationship. Therefore, there is a belief that multiple realities underpinned the epistemological stance which determined that truth was seen from and interpreted by individual perspectives. It will become clear that multiple perspectives influenced everything about this body of work. Ultimately, the process involved in synthesising findings from six empirical works led to questions about 'how we come to know what we know' or more importantly, 'how what we know is maintained' (Potter, 1996: 54).

3.1 Ontological Perspective

Attempts to understand what is known, knowing and knowledge form the basis of reality (Denzin and Lincoln, 2000). The stance taken to consider what reality is, may alter perception and it is thought that the paradigmatic approach to understand the nature of reality will generate different kinds of knowledge which are incompatible (Kuhn, 1962; LeCompte, 1990). That theory may help to clarify why reality in this thesis identified that women perceived a concern in one way (via their subjective experiences through a biopsychosocial lens) and clinicians saw their concerns in a completely different way (via measurable clinical observations, statistical evidence and emotional distancing). At times realities appeared to be

incompatible. It may be feasible to suggest that the medically dominated clinical environment at that time saw their knowledge as superior, and ways of demonstrating that knowledge led to a detached way of communicating with women who approached them for their maternity care.

According to Gadamer (2004: 309; Gadamer In Dorstal, 2002: 65) argumentative rhetoric associated with incompatibility of knowledge (ontology) is unfounded. Gadamer's stance is that all traditional ways of knowing occupy the same normative ground, but occupy different perspectives at different points in time, and that there is always some common ground. This belief accommodates the use of multiple methods which was evident in this portfolio of work (see Table 1; Appendix 1; 2; 3; 4). The common ground within this portfolio was linked with how knowledge was biopsychosocially constructed through interaction, dialogue and interpretation. Knowledge was not simply generated by scientific measurable facts but was influenced by; the time in history, the researcher, the cultural and clinical environment, the experiences of women and their families and how maternity care is perceived and responded to the world in which they worked.

Further questioning of the origin of knowledge led to a recurrent theme about everyday life for those who participated in maternity care in the UK during that time. Contextually, everyday life consisted of extreme circumstances experienced by women (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe, 2009). One could say that in that reality at that time, the extreme appeared to become the ordinary. Women's shared experiences highlighted their perception about participation in routine procedures (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe et al. 2015). The situatedness of

the research highlighted the everyday search of clinicians to understand what it meant to appreciate the needs of others in their care (Briscoe, 2009; Briscoe, Lavender and McGowan, 2016). Gadamer (2004: 128) suggests the spectators of tragedy can develop, 'tragic pensiveness', where familiar encounters create a belief that, 'this is how it is', in their own personal stories. Berger and Luckmann (1966: 33) agree with the concept of everyday life becoming a personal story when they suggested that:

"Everyday life presents itself as a reality interpreted by men and is subjectively meaningful to them as a coherent world…a world that originates in their thoughts and actions..."

Therefore, the distancing of clinicians may be a subconscious response to ordinary life in a maternity unit. Charmaz (2000: 523) goes further and believes that human realities and real worlds are not one dimensional because humans act within and upon their realities and their worlds help to develop a dialogue about, 'what we do, think and feel'. Feeling is related, fundamentally, to the process of knowing and Heller (2009:109) believes there is no knowledge, action, perception or recollection without feeling. Heidegger (1977; 1978) and Gadamer (2004) propose that being, doing and feeling (*their word use of feeling was related to judgement*) are chronologically placed in the past, present and the future. They go on to suggest that knowledge generated from a time based perspective occurs because individuals are thrown into situations. That stance is reflective of the findings within this thesis where; women were thrown into maternity care by virtue of pregnancy, by clinicians who were thrown into unpredictable clinical experiences and by the researcher who happened to be in that place at that time.

3.2 Ontological Biopsychosocial Perspective

Engel (1977) suggested that reality is informed by biological, psychological and sociological elements which combine to define an individual's response to health or illness. This model of health assisted in moving rhetoric from a mind / body dichotomy towards a broader understanding (Goodie, Andrasik and Peterson, 2015). A premise within the biopsychosocial model is that the clinician develops a therapeutic relationship (Morgan and Engel, 1969) to be able to understand the, 'complex reality' surrounding the patient (Ghaemi, 2009: 4). For this reason, the biopsychosocial model is associated with how relationships influence health (Adler, 2009). The term, relationship, within the model can be connected to the individual's relationship to their motives, needs or metabolic conditions (Adler, 2009: 609). Here, the process of construction and reconstruction of subjective experience reflect reality through dialogue, interconnectedness and interpretation.

The client / patient relationship depends on interpretation of client need by the clinician and is linked to holism and patient centeredness. In this case, it is suggested that relationship is important and is able to influence outcome (Mead and Bower, 2000). Within this portfolio of research women's reality lacked emotional connectedness and clinicians missed the cues of women who; required acknowledgement for their loss of a baby (Briscoe and Street, 2003), when they required explanation about their care in a non-English language (Briscoe and Lavender, 2009) or when they were in pain (Briscoe, Lavender and McGowan, 2016).

It is apparent within society that the relationship of the clinician to the patient can have a detrimental outcome in maternity care where maternal and neonatal death or morbidity are consequences (Francis, 2013; Kirkup, 2015; Knight et al. 2015). Unfortunately, those events recognise Engel's theory of dehumanization (1977) and were represented in this portfolio of research when women in their reality were met with judgmental or hostile communication (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). For this reason, Adler (2009: 610) recommends that the model is important to remind clinicians that it is possible to develop a detached approach and become, 'unaware of human suffering'. Crucial to the model is the ability of the clinician to develop self-awareness in order that the clinician understands how professionals, patients and their families influence each other, in each other's reality (Epstein, 2014). The ability to be self-aware assists the clinician to develop resilience in practice (Epstein, 2014) and to provide, 'autonomy in relation' (Borrell-Carrio, Suchman and Epstein, 2004: 579). Autonomy in relation provides a framework where informed choice is facilitated via a caring relationship, which this portfolio of work advocates.

3.3 Epistemological Perspective

Guba (1990: 18) suggests that epistemology considers the relationship of the knower (which in this thesis relates to the researcher LB) to the known (the woman or the clinician). In this thesis the relationship generated meaning through interpretation of language via dialogue or observation. Therefore, this thesis acknowledges that the findings have been influenced by the perspectives of multiple realities.

3.4 The Influence of the Epistemological Relationship upon Interpretation

Interpretation of language and observation was generated from multiple perspectives and framed understanding (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe, 2013; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). However, interpretation added a layer of understanding that demanded a self-conscious approach about how, when and why that representation appeared to be real (Charmaz, 2000: 523). Reflexivity was required to understand how the co-construction of knowledge was represented or misrepresented (Kingdon, 2005; Burns et al. 2012). The tension to accurately represent how the knower (researcher) influenced what was known (clinician or woman) was evident when interpretation was verified by women who experienced a vanished twin (Briscoe and Street, 2003) and when a woman suggested the researcher misinterpreted meaning (Briscoe and Lavender, 2009). In other papers, accuracy was established via consensus within the research team (Briscoe, Lavender and Alfirevic, 2002; Briscoe et al. 2015, Briscoe, Lavender and McGowan, 2016). However, questions remain for the researcher (LB) related to whether truth was complete or if truth captured, changed over time and it is hoped that this thesis provides a deeper analysis.

Deeper analysis suggests that the researcher's presence in qualitative research is an important part of the research process (Lincoln, cited in Guba, 1990: 67). In this portfolio the researcher (LB) generated the epistemological relationship between the respondents (Denzin and Lincoln, 2000). For example, the researcher made an a priori decision that women's voices should

be captured and designed questions to capture that reality. The researcher interpreted the woman's words and portrayed a filtered meaning (Briscoe and Street, 2003; Briscoe, 2009; Briscoe, Lavender and McGowan, 2016). However, the researcher (LB) was situated in a different social world to the participants, and there needs to be an acknowledgement that previous experiences of an individual has the potential to contaminate the research process (Hammersley and Atkinson, 1995).

According to Lambert, Jomeen and McSherry's critical review (2010: 323), there is a potential for all empirical study to be a subjective representation of a researcher's perception, values and experiences. Hammersley and Atkinson (1995) agree, expressing it is futile to look for any uncontaminated data, as the researcher's presence is in all research, regardless of the approach taken. However, there is a potential to 'legitimise' the participant/ researcher relationship and findings through a reflexive process, where it may be possible for the researcher to change their opinion as they learn more about themselves (Lambert, Jomeen and McSherry, 2010). Difficulty presents when researchers are not aware of their potential biases (Parahoo, 2014).

It is recognised that a dynamic, internally constructed process of mutual influence (Charon, 1979; Epstein, 2014) took place where, *'the knower and the known interact and shape on each other'* (Denzin and Lincoln, 2000:21). Interpretation of interaction suggested that women struggled to communicate their needs when they were distressed following loss of a twin and when they responded to pain. Their experience suggested that they received, no, limited or inappropriate responses from those who cared for them (Briscoe and Street, 2003; Briscoe and

Lavender, 2009; Briscoe et al. 2015). Some women had positive experiences, whilst others experienced a power differential during their maternity care (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe, 2013; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). According to Homans (1958), an individual's response to interaction with another results in value being attributed at a cost, meaning interaction that pleases another is rewarded. Mead's theory (cited in Morris, 1967: 67) complements Homan's ideas when he suggests that interaction results in a symbolic '*call out*', which influences the behaviour in the other person, and is a view underpinned by theory associated with symbolic interactionism (Denzin, 1992; Turner and Stets, 2006). In this thesis the epistemological relationship suggested that women looked upon themselves as a reflection of how others saw them, treated them, valued them or responded to them (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe, 2009; Briscoe, 2013; Briscoe, Lavender and McGowan, 2015; Briscoe, Lavender and McGowan, 2016). Therefore, the epistemological relationship of the knower (researcher) and the known (woman or clinician) was fundamental to generate a depth of understanding that assisted in forming a bridge between what happened in practice, how the women felt because of what happened and the stance taken to capture research findings.

3.5 Methodological Perspective

A consideration of methodological approach is more than a description of the technique employed to collect data and includes an, 'aspect of epistemological concern' (Jary and Jary, 1995: 410). However, there is a tension for practitioners when they are trying to understand how individuals interpret their complex lives.

Oulis (2013: 113) determines that both natural science and human science approaches should be integrated in order to bridge an abstract methodological gap. Bridging the methodological gap is not straight forward and Oakley (2016: 699) comments that real life methodology is represented by, 'ideological frameworks' sitting, 'neatly around untidy convention-challenging ideas'. The convention challenging ideas in this portfolio became apparent during the research process, when there was an attempt to capture women and clinicians experiences of messy and complex phenomenon (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe, 2013; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). According to Gadamer (2004: 343) truth can be derived from experience and he claims that a one sided opinion can be avoided by a methodical process where:

'*This true method is characterized by the fact the mind is not left to its own devices; it cannot soar as it would like. Rather, it has to climb gradatim (step by step) from the particular to the universal in order to achieve an ordered experience that avoids all hasty conclusion'*

Therefore, it is acknowledged that the search for *'truth'* (Williams and May, 1978: 36) is influenced by the parameters of a chosen paradigm, the phenomena that the researcher believes is worthy of attention, and how the strategic framework to establish truth may alter findings (Guba, 1990; Denzin and Lincoln, 2000). However, truth can be misrepresented by the standpoint taken (Dilthey, Makkreel and Frithjof cited in Dilthey, Makkreel and Frithjof 2002: 228) and when methodologies are combined (Sale et al. 2002). In this portfolio it was important that all methodological approaches considered rigor associated with multiple perspectives.

3.6 Methods

To capture multiple perspectives qualitative, quantitative and mixed methods were used in an attempt to bridge gaps in understanding (Cresswell and Plano-Clark, 2007; Johnson, Onwuegbuzie and Turner, 2007). Methods utilised quantitative survey (Briscoe, Lavender and Alfirevic, 2002), qualitative exploration (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe, Lavender and McGowan, 2016) and mixed methods (Briscoe, 2013; Briscoe et al. 2015). The movement between paradigmatic approaches was reflective of the journey through time that this researcher embarked upon (LB).

Early in this journey, as a novice researcher, methodological decisions were heavily influenced by the pervading organisational culture which valued reducing bias by distancing the researcher. That reductionist approach suggests that truth lies independently of feelings and emotion and therefore findings generated will be statistically generalisable to others (Crotty, 2003). This worldview is associated with a belief that testing theory by rejecting hypothesise forms the basis of knowledge (Phillips and Burbules, 2000). However the methodological decision around the survey approach in Briscoe, Lavender and Alfirevic (2002) did not originate, at the time (1997-1999) from an informed position.

As the personal methodological journey progressed there was a conscious decision to engage in higher education about research, which began in 1997. Growing knowledge about methodological approaches broadened an understanding that there was an invisible continuum around knowledge which included a movement between positivistic, post-positivistic, constructivist,

transformative and pragmatic beliefs (Cresswell, 2014 p3-23). New knowledge underpinned a realisation that there was a need to apply research design appropriately to specific research questions to enable the best possible investigation (Crotty, 2003; Denzin and Lincoln, 2000). A deeper understanding about philosophical beliefs led to a decision to use qualitative approaches in exploring how women who experienced a vanishing twin felt about their experiences. The approach acknowledged that experiences are socially constructed (Berger and Luckmann, 1966) and humans construct meanings via interpretation, the process is inductive and the researcher generates meaning from the activity of data collection (Crotty, 2003).

Later, during 2003-2006, the educational journey associated with undertaking a Master of Philosophy developed. During this time there was an acknowledgment that the chosen paradigm bounded how the world may be viewed (Kuhn, 1962). Consideration about which paradigm to use when exploring the perspective of asylum seekers' and refugees' experience of maternity care involved understanding, rejecting and defending methodological decisions (Briscoe, 2006). The process grew a deeper appreciation about why to reject approaches that captured lived experience (Bruyn, 1966), emancipated participants (Kincheloe and McLaren cited in Denzin and Lincoln, 2000 p279) or focussed around feminism (Oakley, 2000) was important for that study (Briscoe, 2006 p 38-44). The movement of thought engaged with during this time period reflected a wider societal awakening where researchers were discovering appropriate ways to collect data about human experience. Growing awareness began to realise that a pragmatic approach using a mixture of qualitative and

quantitative approaches appeared to be the 'most effective' to understand about real life problems (Oakley 2016: 698). A pragmatic approach recognises that real life problems arise out of situations, actions and consequences, and that solutions to problems should be found via the methodological approach that works best (Patton, 1990). Within this paradigm using all approaches available to understand the research problem is acceptable (Cresswell, 2014). A methodological decision to use mixed methods during the research journey took place (Briscoe, 2013; Briscoe et al. 2015) and the decision was pivotal to a deeper understanding about pragmatism (Cresswell and Plano-Clark, 2007; Johnson, Onwuegbuzie and Turner, 2007). The process of synthesis taken within this portfolio of research suggests that the cumulative findings are greater than each individual paper to agree with O'Cathain, Murphy and Nicholl's (2010) perspective where the sum is greater than the parts.

In summary, reality in this thesis was biopsychosocially constructed which underpinned an ontological perspective. The time and cultural environment where experiences occurred was important and dynamically influenced meanings women and their clinicians attributed to their experiences of maternity care. Multiple realties underpinned an epistemological stance where interpretation of dialogue represented subtleties within the everyday life of women and clinicians in maternity care in the UK during 2002-2016. Rigor and accuracy attached to the research process was important and was underpinned by verification and researcher consensus. In an attempt to bridge gaps in understanding multiple methods were used. However, it was important to recognise that the influence of

the researcher was pivotal to the findings and it is hoped that quality assured

processes present the most accurate interpretation of findings possible.

Chapter 4

Ethical considerations

Concepts related to beneficence and non-maleficence, autonomy and justice underpinned the research process within this portfolio from design through to publication (Hendrick, 2000; ESRC, 2016). Four of the six empirical works presented required ethical approval from local and national ethics committees. Ethical approval was required because the research involved women participants who had experienced unusual (Briscoe and Street, 2003), sensitive (Briscoe, Lavender and Alfirevic, 2002), racially motivated (Briscoe and Lavender, 2013) or traumatic events (Briscoe et al. 2015) and women had been cared for in an NHS setting in England (Health Research Authority, 2017). One study involved findings generated from student midwife evaluation where ethics approval was questioned by the researcher, but the committee suggested approval was not necessary, as the study used evaluation methods and did not involve clients in the practice area (Briscoe, 2013). Despite that, students' were informed about the plan to publish and were happy for their experiences to underpin a publication. The final study was a concept analysis of published works, where included papers had ethical approval prior to their publication (Briscoe, Lavender and McGowan, 2016).

4.1 Beneficence and Non-maleficence

The ethical principles of beneficence state that research should be beneficial to society and that researchers do no harm (Nuremberg Code, 1947/49). It was explained to participants within this research portfolio that the findings may

not benefit them directly but may help to improve care for other women in the future. However, it was apparent from the outset that the sensitive nature of the topics explored, left women open to vulnerability around their emotional responses to; severe obstetric complication and potential poor outcome (Briscoe, Lavender and Alfirevic, 2002), the experience of grief and loss (Briscoe and Street, 2003), issues related to race and stigma (Briscoe and Lavender, 2009) or intimacy (Briscoe, et al. 2015). Therefore, as Renzetti and Lee (1993: 6) highlighted it was crucial that the researcher (LB) was acutely aware of how, 'emotionally charged' the topic in focus was to prevent or anticipate potential harm or benefit. A critical reflection of field notes kept in relation to Briscoe, Lavender and Alfirevic (2002) highlighted the importance of anticipation of ethical responsiveness in research when there was a need to support a participant who was extremely distressed and who contemplated suicide during a follow up phone call with the researcher (LB). Subsequent care for that woman involved the multidisciplinary team where additional support was sought in relation to her mental health and wellbeing.

Recognition of the depth of distress women felt when engaged in sensitive research built upon clear referral patterns within ethical applications (Briscoe and Street, 2003; Briscoe and Lavender, 2009). In 2015, in discussion with the supervisors, a distress policy was developed to form a key ethical approach to the research process (Briscoe et al. 2015). Despite the presence of a supportive ethical approach I questioned why I felt it was important to continue to explore sensitive topics with women, where their participation had the potential to cause emotional distress to them and to the researcher. I believe that desire was related to how women's voices appeared to be unheard at that time and place in history. However,

not listening to women remains a current issue in maternity care despite evidence that it is important to listen, hear and act upon women's concerns (NHS England, 2016).

4.2 Autonomy

The principle of autonomy in research means that the individual has a right to information about the impact of participation (Smith-Iltis and Rasmussen, 2005). In this portfolio five of the six published papers provided participants with written information (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe, 2013; Briscoe et al. 2015). English speaking participants were able to read, digest, question and understand in an uninterrupted process. However, there was an ethical dilemma presented when language translation was required (Briscoe and Lavender, 2009). From a moral standpoint it was crucial to the researcher (LB) that all women were provided with the autonomy to decline participation. Therefore, the process of back translation was used. In this process written information was interpreted by an independent translator, following translation, the researcher (LB), with permission, asked the participant questions about the research process. Back translation, via the interpreter, helped to identify if women understood what would happen if they decided to take part in the research (Edwards, 1998; Temple and Young, 2004). However, there was always a question about words that could not be translated directly into another language, where the precise meaning may have been lost in translation (McNaughton, 1988).

4.3 Justice

Justice, within research ethics stipulates that participants should be free from discrimination based on gender, race, religion, creed, and ethnic origin (UDHR, 1948). To avoid overburdening vulnerable groups in society, it is important to establish if research can be carried out without involving those who may be deemed vulnerable (Beyer and Kass, 2002). In this research portfolio, purposive sampling ensured those who experienced the phenomena of interest were provided with an opportunity to be included. It became apparent during the research process that taking part provided women with a cathartic forum where it was possible to be heard, where it was evident that interaction in clinical practice had created a barrier (Briscoe and Street, 2003; Briscoe and Lavender, 2009; Briscoe et al. 2015). At times participants who could be considered 'hard to reach' were approached (Briscoe and Street, 2003; Briscoe and Lavender, 2009), which is an important consideration in research and provides previously hidden voices with a vehicle to inform others about their unknown worlds (Bonevski et al. 2014). Therefore, the findings of this portfolio of research have potentially raised the awareness of professionals in relation to unknown, unusual, sensitive and taboo topics and embraced Stanley and Wise's (2002: 90) theory where it was important that women's experiences were not objectified and treated, 'merely as research fodder'.

In summary, ethical considerations for this portfolio of work were guided by established ethical principles and the process was underpinned by rigor associated with protecting participants via a distress policy. Beneficence and non-maleficence, autonomy and justice were considered in all aspects of this portfolio of research. Protecting vulnerable women who experienced extreme circumstance or were hard

to reach was pivotal. However, questions remain about potential words that may be

lost in translation when information was provided.

Chapter 5

Strengths, Limitations and Implications

This chapter explores the strengths and limitations of this research portfolio where information has been complemented by precis and critique in Appendix 1; 2 and 3 due to word count limitation. Critical appraisal and synthesis have informed recommendations for implications in practice, education, research and policy. A concluding summary will identify that the cross cutting theme of vulnerability was underpinned by findings generated from sub themes associated with this work.

5.1 Strengths

This research portfolio was generated at a crucial point where a consumer revolution in the NHS took place (DH, 2001b; 2001c; 2003a; 2008a; 2010a). Published papers spanned over a decade of exploration and enabled the views of women and clinicians' in maternity care in England to be captured. A picture emerged of historical and political change within The NHS. Findings highlight how the clinician's frame of reference about what was important differed to women's perspectives. The impact of this research led to changes within local guidelines that highlighted women should be central to decisions made about their care (Briscoe and Lavender, 2009). For example, following publication of Briscoe, Lavender and Alfirevic (2002) an improved referral point in the existing system was developed for women who experienced a severe complication. This clinic was facilitated by a consultant midwife who had time allocated to listen to women's

needs. Another example occurred when an information sheet was developed based upon the findings Briscoe and Street (2003) along with information from the epidemiological paper (Platt et al. 2001). The new information assisted women and clinicians to understand more about the consequences for women who experienced a vanished twin. In addition, dissemination of all 6 papers within curriculum raised awareness of women's experiences and contributed to creating a deeper understanding about care, empathy and compassion (Briscoe, Lavender and Alfirevic, 2002; Briscoe and Street, 2003; Briscoe, 2013; Briscoe et al. 2015; Briscoe, Lavender and McGowan, 2016). Therefore, the power within this research portfolio may lie within the, 'slow tidal wave' of evidence that has, and is still helping, to change attitude (Oakley, 2016: 698), where a good enough representation of the truth as judged by accepted standards of research practice was presented (Marshall in Guba, 1990: 192) (see Appendix 1, 2 and 3) for an additional critique of individual papers).

5.2 Limitations

This portfolio emerged through exposure of the researcher (LB) to clinical situations where women experienced extreme or routine circumstance. In addition, the researcher's experience in education influenced the focus around the development of student midwives. At the outset there was no deliberate intention to work towards a Doctorate qualification. This limited approach had the potential to undermine the possibility that the work was relevant for a higher level of academic consideration. However, the academic development within this portfolio of research highlighted a key cross cutting theme of vulnerability which has the potential to change practice, education and policy in the future.

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Limitations arise from the generalisability of the research that involved small samples (see Appendix 1, 3). For example, the quantitative survey involved only 49 women where the sample size was determined by the amount of women who experienced very specific clinical conditions (Briscoe, Lavender and Alfirevic, 2002). Purposeful sampling determined which participants were approached in research related to; a vanishing twin (Briscoe and Street, 2003), for women who were asylum seekers or refugees (Briscoe and Lavender, 2009), when student midwives experienced an immersion model of education (Briscoe, 2013) and when women experienced perineal suturing (Briscoe et al. 2015). However, the most recent publication (Briscoe, Lavender and McGowan, 2016) crossed professional disciplines and analysed a strategic sample of works involving a broad spectrum of differing experiences, and arrived at similar conclusions to the papers represented in this portfolio of research. The amalgamated papers represented the perspectives of 102 women, 21 clinicians and 13 student midwives. A concept analysis included the perspectives of 10,067 women who experienced maternity care and 325 clinicians who provided care across seven disciplines. In total perspectives from 10,169 women, 346 clinicians and 13 student midwives identified the cross cutting theme of vulnerability and assisted in creating a cohesive thread throughout this portfolio of research to corroborate and align research set in different times, and settings (see Appendix 1, 2).

5.3 Implications for Practice, Education, Research and Policy

The findings within this portfolio of research have identified that:

5.31 In Practice:

There is a need to stop women from feeling vulnerable due to the maternity care they receive. This thesis captured the voices of 10,169 women and the findings should be used to listen to the clear messages that will help to improve the woman's journey through their maternity care. A key improvement should be based around the biopsychosocial journey planner to help depict which elements, from the woman's point of view, raise or lower her potential to become vulnerable (see Appendix 4). The journey planner should not be merely another tick list, with the potential for health professionals to skim through it. The planner should be used to organise care, placing results, findings or responses into corresponding sections related to biological and physical, emotional and psychological, and sociological aspects of the woman's wellbeing.

The format should be based around the woman's words and her level of understanding. The design would draw the health professional's attention to aspects of the woman's health and wellbeing that may be hidden. Planning women's maternity care around the journey planner will draw attention to potential human suffering which occurs at times during maternity care. Raising awareness about human suffering will reduce the chance of clinicians becoming disengaged, distanced and cold, which are characteristics that Adler (2009: 60) and Engel (1977) suggests underpins acts of dehumanization evident in health reports (Francis, 2013; Kirkup, 2015). The journey planner will go further to help to prevent the 'tranquilized everydayness' of the clinician (Heidegger, 1978: 297).

In this thesis the key to women feeling vulnerable was attributed to how they were treated by clinicians. It was apparent that the relationship between clinician

and woman influenced not only the woman's experience of maternity care, but more importantly how the woman felt about self. Therefore, clinicians need to have raised awareness about how their negative interaction may lower women's self-esteem. Raised awareness can be generated by in service training where scenarios, developed from local adverse cases are explored via reflective techniques to conclude lessons learned.

To prevent or anticipate women feeling vulnerable it is important that a biopsychosocial perspective is adopted. Therefore, care guidelines should be written around biological, psychological and social aspects of women's circumstance. In addition, the biopsychosocial framework in guidelines should be used by clinicians to facilitate informed choice and increase women's ability to feel in control of decisions made.

To enable women to emerge from a feeling of vulnerability, this thesis suggests that a professional's key aim should be to help to build resilience in their clients. Therefore, organisations need to develop a tool box of strategies to help clinicians understand how to build self-resilience and resilience in others. Information could be generated via easily accessible online packages that bridges continual professional development needs.

5.32 In Education:

The concept of vulnerability in maternity care was re-defined by this thesis (Briscoe, Lavender and McGowan, 2016). Therefore, there needs to be further exploration, debate and appraisal within education to refine the concept within

curriculum, via future publication in professional journals that hold an impact factor and during conference presentation.

Furthermore, this thesis identified that clinicians feel vulnerable when their knowledge and understanding is underdeveloped. To develop clinicians further, sessions within higher education programmes need to challenge students' preconceived biases and poor styles of interaction. It is important that such sensitive topics are facilitated by educationalists in safe environments to assist clinicians to reflect upon thought processes that underpin negative action or interaction in practice.

5.33 In Research:

Mixed methodology needs to explore and investigate how clinicians can explore women's influential circle that includes family and friends, to appreciate how social relationships influence decisions made within maternity care. Innovative methods could incorporate aspects of social media, text, online or face to face support to capture key triggers in the decision making process.

Researchers have difficulty in capturing complexity in women's lives during their maternity care. Furthermore, there is difficulty in analysing and informing others about how complexity influences maternal and neonatal outcome. Therefore, researchers should involve women more in the design of research and ask the participants how they think complex aspects of their lives could be captured. This approach lends itself towards action research methods to explore the concept more in depth.

This thesis highlighted that fourteen years of research, in addition to governmental rhetoric and multiple papers by other authors has not made a

consistent difference in practice, and women remain unheard during their maternity care. Researchers need to raise importance about lack of impact from an ethical and practical stand point. To identify difference made by research, implementation science should be utilised to guide researchers about how to make impact more visible. Therefore, all research should include a section related to the audit cycle of their research, which captures pre and post evaluation of impact. Status of impact needs to include a time defined period where change will be measured. The measurement of impact should be incorporated into subsequent guidelines related to the same topic. Furthermore, ethics committees and funding bodies should require information from researchers that identifies pre and post evaluation strategies. This information will help researchers to anticipate potential barriers and solutions to implementing evidence.

Vulnerability in pregnancy, birth and the postnatal period was redefined by this thesis. It is important to explore how the conceptual model generated from Briscoe, Lavender and McGowan (2016) could be incorporated into future research. However, it is not known if the model to identify women's journey to and from vulnerability means anything to women, their families or maternity carers. Therefore, a mixed methods approach to explore the use, meaning and potential of the model locally and nationally may generate a deeper understanding.

In addition, there is a lack of in depth research to inform about how women perceive vulnerability and how resilience is linked to that concept in maternity care locally, nationally and internationally. Researchers need to use qualitative methods within different maternity communities globally to explore patterns between

vulnerability and resilience. Depth and richness of data may help to bridge theory to develop potential hypothesis that could be used for further investigation.

5.34 In Policy:

Maternal health policy reflects expert opinion and at times lacks the authentic voice of women. To reflect the lived experience of women, each maternal health policy should declare how robust research, based on the perceptions of women and their families, has contributed to policy design. Furthermore, this section should incorporate how that specific policy is interpreted and valued by women and their families. The statement would help to strengthen information about aspects of maternal health policy that are important to women.

It was clear from this thesis that policies such as DH (1993) are cited continually, without making a measurable difference or impact in practice and the slow tide of change becomes a burden. To address this issue assessment of impact should be time defined, with clear expectations for timeliness of change identified in policy. Therefore, local and national implementation of policy needs to have an assessment of change that could be managed by a standardised data set, related to the policy and its ability to change practice. The data set could be collected by organisations electronically, and fed into a national dash board. This method would help to standardise implementation strategies. In addition, the data set should include an assessment of how policy effectively made a difference to biological, psychological and sociological aspects of maternal care. The national data set should provide an explanation of why implementation succeeded or failed. This information could be collected via audit and evaluation in practice. The implementation cycle should be continued until the desired change occurs.

Social policy should be informed by a deeper, conceptual analysis of vulnerability and resilience and this discourse has the potential to influence legal and ethical aspects of policy.

5.35 Concluding Remarks for This Thesis

This portfolio of research has presented a unique opportunity to critically reflect upon fourteen years of published works where there was a focus around sensitive issues in maternity care. Importantly, the work identified how clinicians demonstrated difficulty when listening to women who expressed their needs during their maternity care experience in the UK. It was apparent that scientific rhetoric during this time encouraged professional distancing via a hierarchy of evidence that promoted reductionism within inquiry (Burns, Rohrich and Chung, 2011). However, political rhetoric at that time provided a contradictory stance where listening to women was recommended. This portfolio of research has helped to capture how that confused rhetoric influenced the experiences of women in maternity care. This important finding has identified that national policies can be undermined by subtle individuals and cultural or societal trends in practice.

The findings identified that the differing perspectives of the clinician and the client were incompatible at times. The incompatibility of perspectives made women vulnerable. A lack of relationship meant that women created their own dialogue around their complex biopsychosocial needs. However, clinicians appeared to view women's needs in a singular, detached way, where measurable outcomes and interpretation of need was based upon emotional distancing.

The synthesis of findings from this portfolio of research were inductively generated through the positive influence of temporal distance. The process of induction assisted in a reflexive and reflective journey. The journey illuminated to the researcher (LB) that there was a subconscious desire to understand how her presence in the world could make a difference to women and clinicians in maternity care. It is hoped that the culmination of this work influences the future in a positive way with an understanding that, 'the meaning of a text goes beyond its author' (Gadamer, 2004:296).

It is crucial if maternity care is to move forward positively, from a woman's perspective, that assessment of women's vulnerability during their maternal journey includes a holistic, biopsychosocial perspective of women's complex needs to reflect their reality and their lives. Pivotal to that assessment there must be an increased understanding generated by clinicians about how their relationship to women can have a positive or detrimental impact upon the outcome.

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Appendix 1: Table 2: Precis and Critique of Published Works

Published works	Precis	Critique of strengths and limitations
1. BRISCOE, L., LAVENDER, T. and ALFIREVIC Z., 2002. Supporting women after obstetric complications. *British Journal of Midwifery*. 10 (10), pp. 620-625.	This study was carried out in 1999 and involved women who were invited back to the hospital following severe obstetric complication. Complications were specifically defined and included women who had experienced either severe preeclampsia and/or eclampsia, intrauterine growth restriction, an unexplained stillbirth, or severe placental abruption diagnosed by the presence of a retro placental clot. There was a desire to understand if women who experienced severe complication needed additional support and what characteristics of support were important. A specifically designed questionnaire was piloted and amended following feedback. The number of participants was determined by how many women attended the clinic. The survey method invited 56 women to take part and 49 women agreed. Closed and open ended questions revealed that most women obtained support from family or friends. Humanistic qualities of the professional was appreciated, however some women had experienced a negative, judgemental style of interaction. A key finding was that professionals needed to include women's	**Strengths:** • This was and remains the only survey using the distinct inclusion criteria to specifically question what support women needed. • Piloting of the bespoke questionnaire took place. • 87.5% of the potential sample size agreed to take part. • Field notes were kept. **Limitations:** • The questionnaire was not validated. • Questions were designed by the researcher (LB). • The method was a superficial attempt to explore the topic. • There was little reflexive work undertaken in depth. • The sample was skewed to white, English speaking women.

	supporter/s within consultations. In addition, listening and acknowledgement about women's everyday biopsychosocial problems during their journey within maternity care was important.	
2. BRISCOE, L., and STREET, C., 2003. "Vanished Twin"- An Exploration of Women's Experiences. *BIRTH.* 30 (1), pp. 47-53.	The vanished twin happens where a multiple pregnancy is diagnosed by scan but in a subsequent scan only one twin is seen. The missing twin is said to have vanished and theories suggest the twin is voided externally or assimilated into the placenta. In 2001 I invited women to take part in the first qualitative exploration about the experience of being diagnosed with a vanished twin. The study remains the only qualitative study known about this topic as far as the author knows. The study included 5 multiparous and 4 nulliparous women and used a focus group method informed by a feminist approach. Women explained how their experiences were minimised or ignored, and their perceptions differed from clinicians. They explained that professionals attempted to placate their distress with meaningless phrases. Women's social life was influenced by how their family and friends portrayed detached emotion. They explained their fears and isolation. Women's' experiences represented a biopsychosocial perspective were there was a desire for a humanistic,	**Strengths:** • This was and remains the only in depth exploration of women's experiences of a vanished twin. • The research provided the first forum for women to share their experiences. • The sample included a breadth of individual experiences and included; women who lost a twin, a woman who lost a twin and was herself a twin, a woman how had surviving twins and then went onto have a vanished twin in a subsequent pregnancy. • Verification by participants took place. • Field notes were kept. **Limitations:** • Sample size was very small. • A woman who experienced a vanished fetus from a triplet pregnancy declined.

	warm relationship with professionals in order to feel better supported.	• A mixture of individual and focus group research took place during data collection. • Reflexivity was superficial.
3. BRISCOE, L. and LAVENDER, T., 2009. Exploring Maternity Care for Asylum Seekers and Refugees. *British Journal of Midwifery*. 17 (1), pp. 17-23.	This longitudinal case study took place between 2002-2003 and the experiences of women who declared themselves to be an asylum seeker or refugee during maternity care was explored. The study was the first lonitudinal approach to be used with this sample of women. Fourteen women were invited, four women agreed to take part. Disposable cameras were provided to the participants as an additional means of communication. There were 5 points of contact during the study where the sharing of experience was possible. The findings suggested that women's self esteem was influenced negatively by the responses of others during their maternity care and in society. Communication was underpinned by assumption. Assumption created barriers to understanding about how the women understood what happened during their maternity care. Social policy underminned the ability of maternity workers to provide appropriate care.	**Strengths:** • This was the first longitudinal study to include asylum seekers and refugees during their maternity care. • The research included hard to reach voices. • Interpreters were used. • Back translation explored if women understood their involvement in the research. • Verification by participants took place. • Field notes helped to illuminate aspects of reflexivity in the research process. **Limitations:** • A woman was dispersed following recruitment. • Disposable cameras were not as effective as expected. • Words may have been lost in translation. • Observation of interaction may have strengthened the findings.

		• Due to word limitation in the paper reflexivity was not addressed in depth.
4. BRISCOE, L., 2013. Becoming culturally sensitive: A painful process? *Midwifery*. 29 (6), pp. 559-565. doi: 10.1016/j.midw.2011.08.01.Epub.2011 Sep 23.	Previous studies within this portfolio of research suggested that communication with professionals during maternity care was problematic for women during their maternity care experiences. Therefore, I was interested to know how cultural sensitivity was developed and how that sensitivity helped clinicians to respond to the needs of women who had diverse experiences. I involved student midwives in a novel mixed method exploration about how cultural sensitivity developed during a global midwifery module that had the potential to expose students to a variety of midwifery experiences. Seventeen third year student midwives who engaged in elective placements in the UK, America, Canada and Guatemala were involved. The ability of the students to critically reflect enhanced their understanding about how to become culturally knowledgeable and sensitive to the needs of women from different cultures. The process of reflection was difficult for some especially when pre-defined ideas had been present before engaging with others. The study highlighted how the power to critically reflect and develop lies with the individual clinician.	**Strengths:** • This was the first study that used the theory of immersion to include student midwives. • Student experiences in international settings were included. • The process of becoming culturally sensitive was explored before and after the experience. **Limitations:** • One group from one UK University were included. • Follow-up in practice after return was not possible as part of this research. • Qualitative interviews may have added depth and richness to the data. • Field notes were not taken. • Reflexivity was not part of this research.

5. BRISCOE, L., LAVENDER, T., O'BRIEN, E., CAMPBELL, M. and McGOWAN, L., 2015. A mixed methods study to explore women and clinician's response to pain associated with suturing second degree perineal tears and episiotomies [PRAISE] *Midwifery*. 31 (4), pp. 464–472 http://dx.doi.org/10.1016/j.midw.2014.12.010i	An audit in clinical practice identified that pain relief for perineal suturing was poorly documented. The results raised questions about how women felt about their pain relief during the procedure and led to the development of the PRAISE study. This was the first study to use observation in real time to explore the topic during the process of suturing and it was carried out in 2013. The observational method contributed to mixed approaches to data collection that included validated self-assessment measures and interviews. Forty women and 21 clinicians were involved. At times their perceptions differed. The findings highlighted that the style of communication made the overall difference to women. Women wanted a warm, sensitive and gentle interaction. However, observations corroborated a detached, abrupt and disengaged style was experienced by women at times. Mild, moderate and severe pain was reported by women. Psychological distress was also apparent in relation to future functioning. There was a wide variation in practice related to how pain relief was administered. The importance of considering previous psychological distress was highlighted. The study highlighted the need for further research to develop a broader perspective about perineal suturing from a biopsychosocial perspective that would help	**Strengths:** • This was the first time observations, face to face interviews and validated scales were used in a real life setting related to pain and perineal suturing. • Recall bias was minimised by interviews taking place as soon as possible after suturing. • The method facilitated corroboration of data. • Field notes were taken. • Reflexivity took place. **Limitations:** • This was a feasibility study to explore if the approaches were acceptable to women and clinicians. • Recruitment was dependent upon two participants (The woman and the clinician) agreeing to take part at the same time. • The inclusion criteria was narrow and excluded many women. • Women who did not speak or read English were excluded.

	to develop a decision tree related to pain relief during perineal suturing.	
6. BRISCOE, L., LAVENDER, T. and McGOWAN, L., (2016) A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing*. 72 (10), pp. 2330-2345 10.1111/jan.13017.	A critical review of this portfolio of research generated the theme of vulnerability. Upon looking closer at literature it was noted that the concept of vulnerability was vaguely applied to women's experiences during their maternal journey. This paper used concept analysis to ascertain the current status of the concept and to identify how policy, practice, research and education may benefit from redefinition. Multiple data bases where searched during 2014 and a cross discipline approach permitted a deeper understanding about how the concept was used. Morse's qualitative framework identified that three main attributes contributed to vulnerability which included the presence of threat (1), barriers (2) and reparative experiences (3). Women's perceptions differed to that of clinicians. The concept was redefined to include a biopsychosocial focus. This study clarified the importance of including of key elements (bio, psycho, social) during maternity care provision and there was a suggestion that appropriate journey planning may facilitate women's needs more appropriately.	**Strengths:** • This was the first concept analysis to consider vulnerability within maternity care. • The method used a cross discipline approach. • The approach assisted in redefinition of the concept of vulnerability. • A holistic stance about vulnerability evolved. **Limitations:** • The focus was on papers from the UK only. • A model evolved which was not tested or explored further. • The interpretation of data relied upon the opinions of three researchers.

Appendix 2: Iterative Phases related to Theme Development

Appendix 2a: Table 3: Iterative Phase 1: Rules of Relation: Pattern identification across published papers

Emerging Pattern	Article in Thesis					
	Briscoe, Lavender and Alfirevic (2002)	Briscoe and Street (2003)	Briscoe and Lavender (2009)	Briscoe (2013)	Briscoe et al (2015)	Briscoe, Lavender and McGowan (2016)
Help from family and Friends	X	x	X		X	
Poor staff attitude	X	x	X		X	X
Not listened to or heard	x	x	x		X	X
Kind staff/ good demeanour	X		X	x	X	X
No/ not enough Information for self or family	X	X	X	x	X	X
Enough information	X					
Enough information for family	X					
Insensitivity from staff	X	X	X		X	X
Staff Distanced/ lack of desire to care	x	x	x	x	X	X
Staff engaged	x	x	x	x	X	X
Lack of staff availability	X	x	X	x	X	X
Good communication	X				X	X
Poor communication	x	X	X		X	X
Insensitive family		x				
Shame/Stigma/felt bad about self	x	x	x		X	X
Confusion due to lack of information		x	X	x	X	X
Assumptions made	x	x	x	x	X	X
Language barrier : speaking or not speaking English	x	x	X	x	X	X
Culture influenced interaction	x	x	x	x	x	X
Isolation		x	X		x	X
Worry/ Anxiety	x	x	X	x	x	X
Reframing/ Repairing/ Grateful	x	x	X	x	x	X
Resilience	x	x	x	x	x	X
Oppression/ Silenced		x	x		X	X

Emerging Pattern	Article in Thesis					
	Briscoe, Lavender and Alfirevic (2002)	Briscoe and Street (2003)	Briscoe and Lavender (2009)	Briscoe (2013)	Briscoe et al (2015)	Briscoe, Lavender and McGowan (2016)
Women responsible for asking about their own needs: Information/pain/interpreter	x	x	x	x	x	X
Scared/Anxiety/ Fear/ Low mood	x	x	x	x	X	x
Poor housing			x	x		x
Young <= 19			x			X
Low level of education			x			X
Lack of control physically, psychologically, sociologically	x	x	x	x	X	X
Staff controlled depth of reflection		x	x	x		
Reflection facilitated understanding				x		
Distress	x	x	x	x	x	X
Pain	x	x	x	Painful experience	x	X
Own free will influenced choice/or action	x	x	x	x	x	X
Trauma/Violence/Domestic			x		x	x
Complex situations	x	x	x	x	x	x
Vulnerability	x	x	x	x	x	x

Appendix 2b: Table 4: Iterative Phase 2: Rules of Relation: Inductively ordered themes across published papers

Emerging Pattern	Article in Thesis					
	Briscoe, Lavender and Alfirevic (2002)	Briscoe and Street (2003)	Briscoe and Lavender (2009)	Briscoe (2013)	Briscoe et al (2015)	Briscoe, Lavender and McGowan (2016)
Vulnerability/Threat						
Lack of control physically, psychologically, sociologically	x	x	x	x	X	X
Worry/ Anxiety	x	x	X	x	x	X
Distress	x	x	x	x	x	X
Pain	x	x	x	Painful experience	x	X
Barrier						
Worry/ Anxiety	x	x	X	x	x	X
Poor staff attitude	X	x	X		X	X
Insensitivity from staff	X	X	X		X	X
Staff Distanced/ lack of desire to care	x	x	x	x	X	X
Not listened to or heard	x	x	x		X	X
Reparative experiences that helped to create resilience						
None/ not enough Information for self or family	X	X	X	x	X	X
Lack of staff availability	X	x	X	x	X	X
Poor communication	x	X	X		X	X
Insensitive family		x				
Shame/Stigma/felt bad about self	x	x	x		X	X
Confusion due to lack of information		x	X	x	X	X
Assumptions made	x	x	x	x	X	X
Language barrier : speaking or not speaking English	x	x	X	x	X	X
Culture influenced interaction	x	x	x	x	x	X
Isolation		x	X		x	X
Oppression/ Silenced		x	x		X	X

Emerging Pattern	Article in Thesis					
	Briscoe, Lavender and Alfirevic (2002)	Briscoe and Street (2003)	Briscoe and Lavender (2009)	Briscoe (2013)	Briscoe et al (2015)	Briscoe, Lavender and McGowan (2016)
Women responsible for asking about their own needs: Information/pain/interpreter	x	x	x	x	x	X
Scared/Anxiety/ Fear/ Low mood	x	x	x	x	X	x
Poor housing			x	x		x
Young <= 19			x			X
Low level of education			x			X
Staff controlled depth of reflection		x	x	x		
Enough information for family	X					
None/ not enough Information for self or family	X	X	X	x	X	X
Lack of staff availability	X	x	X	x	X	X
Women responsible for asking about their own needs: Information/pain/interpreter	x	x	x	x	x	X
Distress	x	x	x	x	x	X
Pain	x	x	x	Painful experience	x	X
Resilience						
Kind staff/ good demeanour	X		X	x	X	X
Staff engaged	x	x	x	x	X	X
Good communication	X				X	X
Reframing/ Repairing/ Grateful	x	x	X	x	x	X
Resilience	x	x	x	x	x	X
Women responsible for asking about their own needs: Information/pain/interpreter	x	x	x	x	x	X
Reflection facilitated understanding				x		
Help from family and Friends	X	x	X		X	X

Emerging Pattern	Article in Thesis					
	Briscoe, Lavender and Alfirevic (2002)	Briscoe and Street (2003)	Briscoe and Lavender (2009)	Briscoe (2013)	Briscoe et al (2015)	Briscoe, Lavender and McGowan (2016)
Complexity						
Worry/ Anxiety	x	x	X	x	x	X
Lack of control physically, psychologically, sociologically	x	x	x	x	X	X
Relationship with self, baby, her mother	x	x	x	x	x	x
Reflection facilitated understanding				x		
Own free will influenced choice/or action	x	x	x	x	x	X

Appendix 2c: Iterative Phase 3: Table 5: Empirical works mapped to colour coded central themes of this thesis

Published works	Colour coded central themes of this thesis: Vulnerability: Barrier (1) Choice and Control (2) Resilience (3) Complexity (5).
BRISCOE, L., LAVENDER, T. and ALFIREVIC Z., 2002. Supporting women after obstetric complications. *British Journal of Midwifery*, 10 (10), pp. 620-625.	Women experienced threat from biopsychosocial determinants of health related to severe preeclampsia and/or eclampsia, intrauterine growth restriction, unexplained stillbirth, or severe placental abruption. A barrier evolved around non engagement of families in this research at that time. The woman had no control over the physical condition experienced. The professional controlled information and time allocated to the consultation. Women suggested increased resilience when the professional listened, and demonstrated helpful, kind and caring characteristics. Resilience developed via emotional and practical support from family and friends. The issue of support is complex and involves biopsychosocial aspects that are not easily separated.

BRISCOE, L., and STREET, C., 2003. "Vanished Twin"- An Exploration of Women's Experiences. *BIRTH* 30 (1), pp. 47-53.	Women's vulnerability occurred when they experienced the biological threat of losing a twin. A barrier occurred when there was a lack of evidence based information. The barrier was compounded when the clinician's attitude was detached of human emotion and dehumanised the client. Women became distressed which led to feelings of fear and isolation. A feeling of loss and grief influenced women's social lives which created a barrier for them and their loved ones. A lack of evidence based information reduced the ability of the women to feel in control. Lack of control hindered the woman's ability to choose how to respond. Women's resilience developed when empathetic listen skills were demonstrated by professionals and when they were provided with evidence based information. Resilience was demonstrated by multiparas who continued to ask for information even though the professional continually dismissed their requests. The biological loss of a twin involved psychological and social aspects where the combined elements represent a complexity surrounding the phenomenon.

BRISCOE, L. and LAVENDER, T., 2009. Exploring Maternity Care for Asylum Seekers and Refugees. *British Journal of Midwifery*, 17 (1), pp. 17-23.	Women were open to the threat of poor physical, psychological and social conditions which left them vulnerable during their maternal journey. Maternity carer's attitude and style of communication had the potential to create a barrier to care. Professional communication reduced women's ability to choose or feel in control. Women's self-esteem was lowered when they experienced poor communication, loss of choice and a lowered sense of control. Resilience developed when the professional listened and responded in a non-judgemental way. Resilience was demonstrated by women who tried to adapt to the clinical or social situation they lived in. Women who are asylum seekers and refugees and experience maternity care in the UK have complex needs which are influenced by biopsychosocial elements.

BRISCOE, L., 2013. Becoming culturally sensitive: A painful process? 29 (6), pp. 559-565. doi: 10.1016/j.midw.2011.08.017. Epub 2011 Sep 23.	Student midwives are vulnerable in clinical situations when they lack knowledge about their own or other cultures, which leaves women open to insensitive practice. Potential barriers related to overconfidence or arrogance about what was known. Students were able to choose whether to engage in the model of immersion within the module and the depth to which they critically reflected. Critical reflection increased depth of knowledge and facilitated a movement of thought, assisting the student to have an increased sense of resilience. Resilience was demonstrated in clinical settings when narrowed perspectives where challenged and confidence developed. Developing cultural sensitivity in practice involves complex dynamics. There is a need to consider; how narrowed perspectives are built in an individual, where the most appropriate safe environment is to explore sensitive issues, which critically reflective process is used and how movement of thought can be best supported to enhance confidence about culturally sensitive topics. A biopsychosocial perspective is appropriate to underpin the process.

BRISCOE, L., LAVENDER, T., O'BRIEN, E., CAMPBELL, M. and McGOWAN, L., 2015. A mixed methods study to explore women and clinician's response to pain associated with suturing second degree perineal tears and episiotomies [PRAISE] *Midwifery*. <u>31 (4</u>), pp. 464–472 http://dx.doi.org/10.1016/j.midw.2014.12.010i	Women who experienced intimate perineal suturing were vulnerable. A cold, detached, unemotional style of clinician communication created a barrier to women's wellbeing during suturing. This way of communicating was perceived negatively by women. In addition, a barrier occurred when clinician's shifted the responsibility for achieving a pain free status over to women. When the shift took place women where left to continually request pain relief. Style of communication had the potential to hinder choice and create a lowered sense of control during the suturing process. Women's resilience grew when previous psychological distress related to perineal suturing was acknowledged by professionals who generated a warm, kind, sensitive style of communication. Women demonstrated resilience when accommodative coping strategies assisted to downgrade pain felt and facilitated perseverance with pain. Perineal suturing involves a complex process and the women's situation should be viewed holistically from a biopsychosocial perspective.

BRISCOE, L., LAVENDER, T. and McGOWAN, L., (2016) A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing,* 72 (10): 2330-2345 10.1111/jan.13017.	Women where vulnerable when they experienced threat was seen from a biopsychosocial perspective that crossed disciplines. As an example, threat was identified as stigma, fear, age, debility, forced marriage, deprivation, domestic violence, mental ill health or infant illness. Barriers such as loss of dignity, lack of compassion, stigma, lack of information and access to health care were experienced by women. In addition, poor style of communication with professionals or length of intervention created a barrier. Style of communication in practice influenced the women's sense of choice and control about their situation. Women's resilience developed when professionals were able to provide warm, trusting relationships, non-judgemental attitudes and tailored flexible care. Every aspect of the women's life from a biopsychosocial perspective created complexity. Increased complexity was apparent when the symbiotic mother baby bond, free will and choice were acknowledged.

Appendix 3: Table 6: Characteristics of the Sample Population for this Thesis

Published works	Sample Size	Sample Characteristics
1. BRISCOE, L., LAVENDER, T. and ALFIREVIC Z., 2002. Supporting women after obstetric complications. British Journal of Midwifery. 10 (10), pp. 620-625.	• Women x 49.	• Mean age 28 • Primiparous x 29 • Multiparous x 20 • Ethnicity not recorded • From field notes most women where white and had English as their first language.
2. BRISCOE, L., and STREET, C., 2003. "Vanished Twin"- An Exploration of Women's Experiences. BIRTH. 30 (1), pp. 47-53.	• Women x 9.	• Aged between 25-43 • Primiparous x 4 • Multiparous x 5 • White • English speaking
3. BRISCOE, L. and LAVENDER, T., 2009. Exploring Maternity Care for Asylum Seekers and Refugees. British Journal of Midwifery. 17 (1), pp. 17-23.	• Women x 4.	• Aged between 19-36 • Non English speaking x 3 • English speaking x 1 • Women were not asked to define their ethnicity. • Country of origin: • Africa x 3 • Afghanistan x 1
4. BRISCOE, L., 2013. Becoming culturally sensitive: A painful process? *Midwifery*. 29 (6), pp. 559-565. doi: 10.1016/j.midw.2011.08.01.Epub.2011 Sep 23.	• Student midwives x 13	• Demographics of the sample not recorded.
5. BRISCOE, L., LAVENDER, T., O'BRIEN, E., CAMPBELL, M. and McGOWAN, L., 2015. A mixed methods study to explore women and clinician's response to pain associated with suturing second degree perineal tears and episiotomies [PRAISE] *Midwifery*. 31 (4), pp. 464–472 http://dx.doi.org/10.1016/j.midw.2014.12.010i	• Women x 40 • Clinicians x 21.	**Women:** • Mean age 29 • White British x 34 • Other ethnicity x 6 (Not specific) • Primiparous x 22 • Multiparous x 18 **Clinicians:** • Junior Midwives x 5 (Band 5) • Experienced Midwives x 3 (Band 6) • Midwife Managers x 2 (Band 7)

		• Junior Doctor x 1 (SPT 1-3) • Experienced Doctor x 3 (SPT 3-5)
SUB TOTAL	Women: 102 Clinicians: 21 Student Midwives: 13	
6. BRISCOE, L., LAVENDER, T. and McGOWAN, L., (2016) A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing.* 72 (10), pp. 2330-2345 10.1111/jan.13017.	Twenty Five Papers: 1. Women x 289. 2. Women x10. 3. Specialist Community Public Health Nurses x 6 teams (Unspecified amount of clinicians) provided 60 sets of data. AND Women x 8. 4. Women x 8. 5. Women x 60. 6. Women x 1474 AND Health Visitors (HV) x 80. 7. Women x 295 AND 80 HVs. 8. Women x 17 AND Health Professionals (HP) x 17. 9. Women x 12. 10. Women x 24. 11. Women x 10. 12. Women x 22. 13. Women 2064. 14. Women x 4084 AND 138 HVs. 15. Women x 623. 16. Women x 193. 17. Women x 403. 18. Women x 9 AND HPs x 10. 19. Women x 9. 20. Women x 61. 21. Women x 39. 22. Women x 27.	Twenty Five papers: 1. Age range 14-46. 2. Age range 18-36. 3. No age range provided. 4. Age range 17-37. 5. Mean age 28. 6. Mean age of women 32. No data for HVs. 7. Mean age of women 28. No data for HVs. 8. Mean age of women 36. No data for HPs. 9. Black Caribbean women x 12. Age range 18-43. 10. Age range 23-39. 11. No age range provided. 12. Age range 25-45 included Irish, African, White, and Asian women. 13. Age range stated as below 19 (6%) and above 35 (1%). Age categories: Age 20-24 (17%); 25-29 (29%); 30-34 (31%. 14. Mean age range of women 30-32. No data for HVs. 15. Mean age 28. 16. Age range not recorded. 17. Mean age take up group 27.94, self-exclusion group 24.94. 18. No Demographics recorded. 19. Age range 23-40. 20. Mean age 27.90.

	23. Women x 22. 24. Women x 254. 25. Women x 50.	21. Mean age 34. Age range 19-42. 22. Age range 18-45. 23. Age range 18-45. 24. No Age recorded. 25. All over 30 years. 45 were white.
Accumulative sample size for this thesis	Women : 10169 Clinicians: 346 Student Midwives: 13	

Appendix 4: The Journey Planner

Appendix 4a: Journey Planner using an APIEM model

(Assessment, Planning, Implementation, Evaluation and Modification) Woman's Name:

Date of Birth: **Clinic/Hospital Number:**

	Biological	Psychological	Sociological
Assessment			
Plan			
Implementation			
Evaluation			
Modification			

*Sections would be expanded at the time information is keyed into the document

Appendix 4b: Illustration of how to operationalise a biopsychosocial journey planner

To illustrate how the journey planner would be operationalised in practice a scenario is presented. The scenario emerged from the findings of this thesis and the description is based around events that actually occurred. Therefore, the events are not fictitious and the life presented is real.

This illustration can be used as a method to promote understanding about the journey planner. The prompts below provide an example and are not definitive. The journey planner provides a new framework and should be refined and tested in practice to fit around women's needs and the local maternity care service. The journey planner can be implemented by policy makers who desire constructive transformation within maternity care, change agents in practice, educationalists in higher education, researchers, students, women and lay people who are interested in maternity care.

Use Appendix 4a to document an assessment, plan and implementation strategy.

Linking with the multidisciplinary team for biological, psychological and sociological support will be essential. The process for linking with the multidisciplinary team will vary locally, nationally and internationally and pathways need to be identified, streamlined, and made accessible to support Ruth.

Ruth's Story:

The setting for Ruth's story is the UK but could be extrapolated to any country in the world:

Ruth is an asylum seeker/ refugee and was seventeen years old.

She became pregnant when she was 16 after she was raped during her journey to seek asylum.

She was homeless and had no money.

She was hungry and felt weak from her journey.

She complained to her friend that she felt constantly sick and had a horrible discharge below (per vaginum). The discharge was green.

Her friend took her to a health centre.

The centre examined Ruth and suspected her to be around 24 weeks pregnant.

They also suspected Ruth had a sexually transmitted infection.

Ruth asked about abortion and the health professional explained that it was difficult to abort a pregnancy at that gestation.

The health professional noticed bruising on Ruth's abdomen, back and arms.

Pin pricks were also noticed around Ruth's arms.

Using the journey planner

Place yourself in the role of a health professional and use the journey planner in Appendix 4a to record your biopsychosocial assessment. The planner uses a model based around Assessment, Planning, Implementation, Evaluation and Modification (APIEM) to move through the woman's maternity journey. The **APIEM** model should be circular, constantly evolving to meet the woman's needs. The Health Professional should be able to explain decisions via the model verbally and within documentation.

Based on Ruth's scenario consider:

- What are your aims here?
- What is your biopsychosocial assessment for Ruth?
- What style of communication should be considered?
- Reflect upon what style of communication have you experienced around this type of scenario previously?
- Think about the potential of control in this situation
- What strategies could be used to build Ruth's resilience?

Assessment action points:

Biological assessment:

- Routine observations
- Sexually transmitted infection screening
- Anomaly screen
- Fetal wellbeing assessment
- Nutrition
- Pads for vaginal discharge
- Disposal of Pads
- Infection control

Psychological assessment:

- Attentively listen
- Kind and compassionate demeanour
- How will Ruth be facilitated to feel a sense of control?
- What information will Ruth need to enhance her sense of choice and control?
- How will Ruth's self-esteem be supported?
- How will Ruth build her resilience?
- Consider bruising and pin pricks and question about domestic violence
- Question around self-abuse

Sociological Assessment

- Accommodation appears to be a priority for Ruth, Ask about housing/accommodation
- Ruth may lead a chaotic life style question around Ruth's circle of influential friends
- How can Ruth be assisted to feel secure and safe?
- Consider how to support Ruth with potential drug abuse

Planning action points

Consider what your aims are here:

- To identify the current status of Ruth and her baby
- To form a plan of maternity care that meets with Ruth's expectations; the service planners requirements; local maternity care policy and standards of good practice
- To provide a realistic plan forward
- To establish good partnership working via; kind, considerate, respectful, informative communication
- What conclusions and plan have you made?

Biologically:

- Ruth needs full information in relation to the results of her biological
- assessment

Psychologically:

- Consider how Ruth will feel about her assessment.
- Discuss sensitive issues using an engaged partnership style of communication.

Sociologically:

- Realistically approach future appointments with a plan to ensure maternity care is accessible.
- Gain an understanding about how Ruth will attend appointments within a defined time line
- Assess if appointments are better in clinics or at home.
- Identify how Ruth will be reminded of her antenatal care within her chaotic life style
- Identify if Ruth can move to a supportive environment

Implementation action points:

Consider what things may facilitate or create barriers for you during the implementation of your plan.

Think about solutions to help you implement the plan such as:

- Consider biopsychosocially how you will implement your plan in your practice setting. What style of communication should be considered?
- Think about the potential of control in this situation?
- What strategies could be used to build Ruth's resilience?

Evaluation action points:

Consider defined time points to evaluate. Based on Ruth's case, time points may fall outside of the routine points of contact. Evaluation should be based around Ruth's biological, psychological and sociological needs.

Modification action points:

In this scenario events around Ruth changed. Connections made via the Health Professional and the multidisciplinary team facilitated Ruth to gain access to a temporary shelter, away from negative influences associated with her influential circle.

Her one friend who helped her to go to the health centre moved in with her.

Ruth found help from her friend particularly reassuring.

Ruth's friend helped her to remember when to see a midwife.

The midwife visited Ruth in her accommodation.

Ruth survived on food handouts from her neighbour and local community centre.

Her friend helped to buy food by working in a field picking food produce every now and again.

Biological modification:

- Modification will be defined by the parameters of biological assessments that are within or outside of an acceptable range of measurements

Psychological modification:

- Modification will revolve around the need to build Ruth's self-esteem and by identifying what Ruth needs to build her resilience

Sociological modification:

- In this scenario the availability of accommodation was temporary. This was realistic at that time. However within this modification there is a need to plan for the future.

At this point the APIEM circle may revert back to the assessment stage to establish the plan to provide accommodation to a new mother and baby.

Appendix 5: Affidavits

Affidavit 1

Edge Hill University

Lesley Briscoe

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Lesley
•••

CS   Clare Street <c.street@mmu.ac.uk>
Mon 13/02/2017, 16:07

To Whom it May Concern:

I confirm the accuracy of the description given below. During the research process, I acted as Lesley's research supervisor and then co-author of the published article.

I hope this brief statement is sufficient for your needs, but do not hesitate to get back to me if you require further information.

Regards,

Clare

Clare Street
Programme Leader – BSc (Hons) Contemporary Health Practice (CHP) degree
Manchester Metropolitan University
Department of Nursing
Brooks Building Birley Campus
53 Bonsall Street
Manchester
M15 6GX
Sat Nav postcode: M15 5RN
Phone: 0161 247 2543

NEED TO SEE ME? We are situated in a large open plan office to which there is no access for students. Due to this, and my variable commitments, the best thing to do if you would like to see me is email or phone for an appointment.

For information about the new Birley Campus see http://www2.mmu.ac.uk/birley/

Edge Hill University

Lesley Briscoe

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Lesley Briscoe
Mon 13/02/2017, 15:53

Dear Clare
I hope you're well.
It was good to talk just now.
I've ccd in Professor Dame Tina Lavender, Professor Mcgowan (who are my external mentors) and the Graduate School at Edge Hill University, for information.
I would appreciate if you would respond to all copied in.

I'm in the process of submitting a PhD by publication and as part of that process it is required that co authors confirm my role in the research process.
I would be very grateful if you would confirm my role in the following study:

1.	Briscoe, L., and Street, C., 2003. "Vanished Twin"- An Exploration of Women's Experiences. *BIRTH*. 30 (1), pp. 47-53.	The research question was generated by me from working with women in the clinical setting. I was successful in an application for funding to support the research process. I developed the methodology as part of an MSc programme of study. I applied for and presented to the ethics committee. I collected data. I transcribed the data. I analysed the data and then co-authored with my supervisor.

Many thanks for responding to this request.
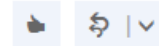Kind regards
Lesley

Affidavit 2

Tina Lavender <tina.lavender@manchester.ac.uk>
Mon 13/02/2017 15:56

Dear Lesley

I confirm your role in all of the papers below

Kind regards

Tina

Prof Dame Tina Lavender
Professor of Midwifery and Director for the Centre of Global Women's Health
Division of Nursing, Midwifery and Social Work
University of Manchester
...

GraduateSchool: Thank you for your e-mail. Please note: we aim to respond within two working days bu...

Edge Hill University

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LB Lesley Briscoe   👍   ↩ Reply all | ∨
Mon 13/02/2017 15:49
To: tina.lavender@manchester.ac.uk
Cc: Linda Mcgowan <l.mcgowan@leeds.ac.uk>; ● GraduateSchool ☆

Sent Items

Label: keep for (2 years) Expires: 13/02/2019 15:49

Dear Dame Tina
I hope you're well.
I've ccd in Professor Mcgowan and the Graduate School for information.
I would appreciate if you would respond to all copied in.
You are supporting me with a PhD by publication and as part of that process it is required that co
authors confirm my role in the research process.
I would be very grateful if you would confirm my role in the following studies:

	Published works	My role
1.	1. Briscoe, L., Lavender, T. and ALFIREVIC Z., 2002. Supporting women after obstetric complications. *British Journal of Midwifery*. 10 (10), pp. 620-625.	My idea originated from working with women in the clinical setting. I was supported by my co-authors to develop the methodology as I was a novice researcher. I applied for and presented at the ethics committee. I collected and input data. I was supported in the analysis and writing up for publication.
2.		
3.	3. Briscoe, L. and Lavender, T., 2009. Exploring Maternity Care for Asylum Seekers and Refugees. *British Journal of Midwifery*. 17 (1), pp. 17-23.	The paper was based around my MPhil research where I was supported by my supervisor (TL). I applied for funding and was successful. I applied for and presented to the ethics committee. I ran the study under the guidance of my supervisor. I transcribed and analysed the data. I wrote up the MPhil and

		presented to the ethics committee. I ran the study under the guidance of my supervisor. I transcribed and analysed the data. I wrote up the MPhil and passed the viva examination. I later co-authored with my supervisor.
4.		
5.	5. Briscoe, L., Lavender, T., O'Brien, E., Campbell, M. and McGowan, L., 2015. A mixed methods study to explore women and clinician's response to pain associated with suturing second degree perineal tears and episiotomies [PRAISE] *Midwifery*. 31 (4), pp. 464–472 http://dx.doi.org/10.1016/j.midw.2014.12.010i	My idea was generated from carrying out a clinical audit in practice prior to teaching about perineal trauma. I developed the research protocol. I approached the research team to see if they were interested in my research protocol. The research methodology was developed further in collaboration with the research team (TL; MC; LMc). I applied for funding and was successful. I and the research assistant (EO) collected data. I analysed the data and the analysis was guided by LMc; TL and MC. I wrote the paper up and the research team influenced the final version with their expertise.
6.	6. Briscoe, L., Lavender, T. and McGowan, L., (2016) A concept analysis of women's vulnerability during pregnancy, birth and the postnatal period. *Journal of Advanced Nursing*. 72 (10), pp. 2330-2345 10.1111/jan.13017.	There was a need to create a sense of cohesion for the research I had previously carried out. TL suggested that I carry out a concept analysis. The findings generated the underpinning theme for this PHD application related to vulnerability. LMc guided the research process for a concept analysis. I performed a systematic literature review, I collated a comprehensive data set and I abstracted data from a relevant selected sample. The sample was reviewed by LMc for rigor. I performed the analysis and consensus for analysis was reached by LB; TL &
		relevant selected sample. The sample was reviewed by LMc for rigor. I performed the analysis and consensus for analysis was reached by LB; TL & LMc. I created the paper which was reviewed by TL & LMc. Various opinions from the team were incorporated into the final paper.

Many thanks for your continued support with this process.

Kind regards
Lesley