

Women's stories of planned Caesarean birth in their first pregnancy



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Dedication

In loving memory of my parents, Margaret and Kenward Mason, who whispered encouragement

The image on the front cover was used on my website and information sheets. I purchased a licence to use this image from www.istockphoto.com

Abstract

Caesarean birth accounts for a quarter of all births in England and is the most commonly performed operation. Despite this, little is known of how individual women experience planned Caesarean birth. Reviews of the literature reveal that rising rates of Caesarean birth are perceived to be problematic by women, clinicians and policy makers but women's experiences are either absent from this debate or perceived as universally realised.

This qualitative study involved listening to the stories of eight women to reveal how planned Caesarean birth was experienced, understood and constructed. Women were recruited in two ways: via a public website and from midwifery services in six locations across England. Narrative analysis methodology was used to explore personal, unique and situated accounts. Data was analysed using *The Listening Guide* method of multiple interpretive readings. During the research I developed additional creative, analytic devices: *emotional resonance 'word clouds'*, *metaphor poems* and the *Writing Guide*. These techniques can be used to identify additional layers of meaning and to organise and present large amounts of data.

The women in the study had varying responses to the prospect of a planned Caesarean birth. Caesarean birth was wished for, fought for, accepted, feared and dreaded. For most of the women the decision to have a Caesarean was made late in pregnancy. All women experienced huge uncertainty as they sought and sifted large amounts of often conflicting information. There was a disparity between a woman's unique experience of the events and staff behaviours which were embedded in routine practices. A delicate balance of fatalism, fear and self-efficacy was threaded through all stories as the women attempted to negotiate towards a positive experience. Specific events, interactions or interventions often triggered a reordering of these interrelated concepts. Rather than fixed or predetermined by prior experience, self-efficacy was revealed to be evolving, inter-dependent and *relational*; embedded in relationships with others and the cultures we live in.

Most of the women spoke positively of their birth experience and would repeat or recommend a planned Caesarean birth. Sometimes this was because it was preferable to repeat a known experience. Emotional support in theatre was mainly provided by anaesthetists. Being listened to and simple acts of kindness made a difference to whether or not an experience or event was perceived as positive.

The women did not simply either reject or embrace cultural ideals of childbirth and motherhood – their experiences were unique, varied and often conflicting. Individual women accepted vaginal birth as natural and something all women should experience while others rejected this in favour of the technology of surgical birth. The stories revealed a moral framework within which pregnancy, birth and motherhood was realised and each of the women alluded to a dominant ideology of the *good mother*. The women showed an awareness of the ideologies directing pregnancy and birth policy, and, in some cases that this drove how resources were allocated.

The findings from my study show the complexity and range of women's experiences of planned Caesarean birth, and provide a contribution in three broad areas: caesarean birth experience, narratives of childbirth and motherhood and narrative methodology and methods.

The women's narratives provide evidence that the current accounts of planned Caesarean birth experience are limiting. They offer alternative perspectives and extend the limited repertoire of narratives available to mothers experiencing a planned Caesarean birth. They offer a richer and deeper knowledge base from which to prepare women for planned Caesarean birth and to design services to provide women with a positive experience.

Contents

	Dedication	2
	Abstract	3
	Contents	5
	Acknowledgements	12
	Declaration	14
1	Introduction	15
	Research context and disturbance	16
	Researcher position	18
	Conclusion	21
2	Reviewing the literature	22
	Introduction	22
	Decisions about scope	22
	Definition	23
	Search strategy	25
	Cultural and social discourse	25
	Empirical studies	26
	‘Choice’ and decision-making	27
	Expectation and satisfaction	34
	Clinical outcome comparisons	37
	Resources for women	38
	Beyond published literature	40
	Developing a conceptual framework	41
	Conclusion	44

3	Methodological approach and theoretical framework	45
	Introduction	45
	Conceptual framework	45
	Theoretical approaches in childbirth research	48
	Narrative inquiry methodology and what it offers	50
	Historical development of narrative research	53
	Developments in my approach	54
	Overview of the theoretical concepts underpinning my narrative approach	58
	Conclusion	63
4	Study design and research methods	64
	Introduction	64
	Towards a participatory approach	65
	Ethical considerations and research governance	67
	Exploratory research questions	70
	Participants	72
	Recruitment	74
	Giving consent	75
	Anonymity and confidentiality	76
	Data collection	76
	Method for eliciting stories	78
	Analytic concepts	80
	The process of data analysis	83
	Validity and trustworthiness	84
	Reflections on <i>representation</i>	86
	Conclusion	87
5	Data analysis and <i>The Listening Guide</i>	88
	Introduction	88

The <i>Listening Guide</i> and Voice-centred Relational Method (VCRM)	89
Development of the Guide	90
The process of <i>listening</i>	93
Reading one: Listening for plot and the listener's (researcher's) response to the story	94
Reading two: Listening for the first-person active voice - the voice of the 'I'	95
Reading three: Listening for relationships	98
Reading four: Listening for broader social, political, cultural and structural contexts	99
Creating case studies	100
Study group	101
Creating additional analytic devices	102
Emotional resonance 'word clouds'	103
Developing metaphor poems	104
Reading five – The <i>Writing Guide</i>	108
Addressing my research questions	110
Critique of the Listening Guide	113
Conclusion	117
6 Introducing voices – eight stories. What meaning do women give to their experiences of planned Caesarean birth?	119
Introduction	119
Meaning in narrative research	120
Participant biographies	120
Eight stories	121
Charlene's story	121
Jo's story	127
Monika's story	133
Sarah's story	138
Abby's story	143
Sally's story	146

	Kirsten's story	151
	Lisa's story	157
7	What phenomena appear in women's stories of birth by planned Caesarean?	165
	Introduction	165
	Touchpoints in planned Caesarean birth	166
	The landscape of planned Caesarean birth	168
	Being pregnant	169
	Seeking and sifting information	169
	The decision	171
	Preparing for Caesarean birth	172
	In theatre	174
	Care and recovery	177
	Being at home	181
	The future	182
	Navigating uncertainty – fatalism, fear and self-efficacy	184
	Fatalism	185
	The balance between fear and self-efficacy	187
	Own capacity to perform activities without support from others	190
	The need for others to be able to manage	190
	Capacity of the female body	191
	Fatalism	191
	Self-efficacy as a relational ontology	192
	Concepts of support in childbirth	196
	Emerging narratives of planned Caesarean birth	199
	Conclusion	200

8	How does a woman’s personal story of birth (of planned Caesarean) relate to dominant narratives and ideologies of pregnancy, birth and motherhood?	202
	Introduction	202
	Identifying dominant narratives of childbirth	203
	Dominant narratives and ideologies of pregnancy, birth and motherhood	204
	Vaginal birth	205
	Medicalisation of childbirth	206
	Choice	207
	The moral framework of motherhood and the <i>good mother</i>	209
	Charlene	211
	Jo	213
	Monika	214
	Sarah	216
	Abby	219
	Sally	221
	Kirsten	223
	Lisa	225
	Counter-narratives, stories of resistance and the reflexive self	228
	The danger of the single story	234
	Conclusion	234
9	What can we learn from women who have their first baby by a planned Caesarean?	236
	Introduction	236
	Overview of the study	236
	Context	236
	Research purpose	237
	Research boundaries	238
	Findings and contribution to knowledge	238

Caesarean birth experience	239
Narratives of childbirth and motherhood	240
Narrative methodology and methods	241
The Listening Guide	241
Research design	242
Recommendations for policy, practice and research and education	244
Policy	244
Practice	245
Research	246
Education	246
My learning and the impact of the research on me	247
Dissemination techniques – moving from personal to public narrative	248
Concluding (<i>and opening</i>) remarks	250
References	252
Appendices	272
1. Consent Form	272
2. Recruitment localities in England	273
3. Agreed amendments to the research protocol to include a partner, family member or friend at the interview	274
4. Website screen shots	275
5. Methodological dilemma – oral or written narrations? Audit trail excerpt	277
6. Methods for eliciting stories	280
7. Holistic content, holistic form and categorical form analysis – Charlene’s story: audit trail excerpt	281
8. The Listening Guide - guide to the readings	287
9. Data analysis of Monika’s story	290

10. Emotion ‘word clouds’	309
11. Metaphor poems	310
12. Emotional mapping – <i>touchpoints</i>	321
13. Summary of the landscape of planned Caesarean birth	322
14. Identified and defined childbirth self-efficacy in the context of severe fear of childbirth	325

Table of figures

1. Theoretical framework and research design	60
2. Excerpt from Jo’s and Sarah’s ‘I’ poems showing a single stanza	96
3. Monika’s emotion ‘word cloud’	103
4. Monika’s metaphor poem	107
5. Reading five – The <i>Writing Guide</i>	109
6. Magnified section of planned Caesarean journey map	167
7. <i>Touchpoints</i> in the planned Caesarean journey	167
8. The inter-related concepts of fatalism, fear and self-efficacy	185
9. Analysis of a section of Charlene’s story using categorical form analysis	284

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Declaration

I declare that the research contained in this thesis, unless formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated

1. Introduction

'Man was the storytelling animal, the only creature on earth that told itself stories to understand what kind of creature it was. The story was his birthright, and nobody could take it away.'

Salman Rushdie (2012) *Joseph Anton: a memoir*, p.19. Jonathan Cape.

This thesis describes my journey to becoming a researcher. It is both an *account of* my research and a vehicle through which I *account for* my research. As such, it is the story of my research journey – a personal account, the substance of which becomes meaningful in the telling.

In qualitative research, *how* you present that story can be an integral part of the research itself; the writing style reflects the research methodology which, in turn, enhances the meaning of that methodology (Holliday, 2002). I have used narrative analysis methodology in my research study and I have therefore chosen to present a narrative, storied account of my research journey. The chapters of this account are not necessarily ordered chronologically but are arranged to reflect movement and advancement (independent of time) just as a story may be peppered with flashbacks, which enhance our understanding of the characters or plot.

Stories contain the significant events in our lives – they are how we make sense of events and derive meaning. Described as being dialogic, every storyteller has a listener or reader who is an active participant and therefore *meaning* is co-constructed – in the telling *and* the listening or reading. This meaning is not fixed but has the potential for revision and re-narration in future stories.

Throughout this thesis I have tried to address issues of trustworthiness by being transparent about my knowledge production through my *'detailed and contextual writing and by incorporating reflexive accounts of the research process'* (Koch, 1998, p. 1189). As you read this account I invite you to use the way I have expressed this research (by showing the workings) to assess its rigour (Holloway, 1997). By keeping the story visible *in the telling* I wish to keep centre-stage my acknowledgement that this account, although intentionally rigorous, is partial, represented, interpretive and (co)constructed.

Research context and disturbance

“But they like to get on the bed, don’t they?”

The midwife did not look at me for confirmation that I agreed with her, it was a rhetorical question. She believed she was stating a fact – *women in labour like to get on the bed and lie down*. This wasn’t the first time I had heard this and I was exasperated. Yes, when we are ill or exhausted we may want to go to bed but when we are in pain we may also want to get in the bath, pace up and down, rock backwards and forward, crouch down or get on our hands and knees. This is what my personal experience and my experience as a midwife told me. My personal experience was supported by my midwifery knowledge which told me that when women are able to move freely, be upright and mobile, they are more likely to cope with labour and have a better birth experience. In this room there were no alternatives to the bed, not even a comfortable chair.

I was being shown around a standard labour room in a maternity unit. I was looking at the environment and I had been talking about the importance of creating a positive environment to facilitate birth. This maternity unit wasn’t unusual, neither was this midwife inexperienced or unthoughtful. Why, then, did I feel so frustrated? I realised that my exasperation wasn’t because the unit didn’t have a state-of-the-art, homely, welcoming birth environment or that the midwife was closing off the opportunity to use her knowledge and skills to adapt the environment to be beneficial to a birthing woman. It was the fact that the midwife had been categorical about what women wanted and that she portrayed all women as being alike and sharing the same needs and wishes. This was at odds with the stories women had told me about their birth experiences, each being unique and particular.

I have no experience of giving birth myself and I am not a mother, but I have always been eager to listen to women’s stories about their birth; how they feel about it and what it means to them. These stories are a resource for my professional knowledge. When a woman asks me *‘What’s it like?’* I am able to draw on this knowledge and talk about the range of experiences women have shared with me. It is a resource that I tap into regularly and which has been invaluable to me.

I was visiting this unit because I was working for a national improvement organisation, The NHS Institute for Innovation and Improvement, which had been tasked, by the Department of Health, to explore variation in practice across England. The focus for our small team was very specific. We

were to look at variations in practice for Caesarean birth. This was important because childbirth was the commonest reason for admission to hospital in England and Caesarean the most commonly performed major operation in England. Because of this, Caesarean operations were high consumers of healthcare resource. But there was another element to this. There was a twofold difference in the range of rates of Caesarean birth across England, independent of the clinical complexity of the mother or baby. We had been asked to explore these differences against a background of concern that the Caesarean rate had been rising.

In 1985 the World Health Organisation (WHO) organised a consensus conference to explore Caesarean section against a background of concern over rising Caesarean rates. The reason for concern was their conclusion that there were no additional health benefits associated with a Caesarean section rate above 10-15% of all births (Thomas, Paranjothy et al. 2001). In other words, we were not improving the health and wellbeing of mothers and babies by doing *more* Caesareans. In England, the national Caesarean section rate doubled from 12% in 1990 to over 24% in 2005 (NHS Institute for Innovation and Improvement October, 2006) and yet, during this time, there had been no corresponding improvement in neonatal outcomes to justify the rise (NHS Institute for Innovation and Improvement October, 2006). In fact, there was an increasing concern that there may be long term health consequences for the mother (National Collaborating Centre for Women's and Children's Health, April 2004) and increased risks for subsequent pregnancies. Many reasons were cited to explain this rise, with a growth of elective (planned) Caesareans, particularly Caesareans for *maternal request* put forward as one of the reasons (Amu, Rajendran et al, 1998; Paterson-Brown, 1998; Thomas, Paranjothy et al, 2001; Dunkley-Bent, 2005).

Here, then, was the reason for my *light bulb* moment. I realised that, despite the fact that over 167,000 Caesarean operations were being performed every year in England, which accounted for nearly a quarter of all births (Health and Social Care Information Centre, 2013), we were unable to draw on our knowledge of women's experience to know what it *means* to have a Caesarean. There was limited data on how women experience an emergency Caesarean birth, but I believed that there was almost no empirical data on women's experiences of planned Caesarean birth. A planned Caesarean in this context is one which is performed before labour, is non-urgent and which may be either at the mother's request or for clinical need (see page 23 for a full definition). There was a gap in our knowledge and I, like others, resorted to making assumptions about how a woman experienced planned Caesarean birth, about what was and wasn't important to her and how she integrated this experience into her life. Without this knowledge, I felt it was difficult to

appreciate the significance of birthing by planned Caesarean to women which, in turn, had implications for potential and future developments to maternity services and maternity care.

It was this realisation that fired my interest in exploring women's experiences of planned Caesarean birth by undertaking research in this area. The rising Caesarean rate was perceived to be problematic; women, user organizations (Smith, 14th April 2008), clinicians, the media (Womack 1st April 2008) and the Government (House of Commons Hansard written Answers, 2nd April 2008) were all speculating what this rise meant (Green 2005) and there were debates about how (and if) this should be addressed. However, women's experiential knowledge of planned Caesarean was absent from the knowledge that was being used to inform that debate. I believed that research in this area was vital to fill this gap.

Researcher position

I have been a midwife for twenty-three years and my researcher viewpoint has developed from my education and experience as a midwife. One of the reasons for my disturbance was because a lack of awareness of how women experience planned Caesarean birth challenges a key concept within midwifery that of being 'with woman' (Kirkham, 1999, p. 733; Barrett, 2006 p. 228). This concept comes from a direct translation of the word *midwife* and describes a belief in the importance of the individual relationship a midwife forms with a woman. This concept often advises that a midwife should take the role of advocate in the relationship (Nursing and Midwifery Council 2008), but predominantly it is a concept which proposes the importance of a close and potentially therapeutic relationship. Fundamental to this is the ability of each woman to communicate her beliefs, wishes and experiences and of the midwife to appreciate and respond to them in a one-to-one relationship.

When I worked as a midwife in New Zealand in 1996 and 1997, I experienced a model of midwifery practice that had taken this concept a step further in a model of *partnership*. This model was based on the constitutional values of partnership between the Maori and non-Maori peoples of New Zealand and was adopted by midwives in the *Midwifery Partnership Model* (Guilliland and Pairman, 1995). Based on the notion of *reciprocity* as shared endeavour and mutual understanding, this relationship of partnership between the woman and midwife focuses on what each partner can bring to the relationship and it recognises and values each woman's knowledge and experience. In this model, midwives work in partnership with the woman and her

family in a relationship of trust, shared decision-making and responsibility, negotiation and shared understanding. The model rejects notions of advocacy – instead, midwives are asked to acknowledge each woman’s autonomy and expertise. A midwife has a responsibility to share all available information with a woman and to respect her values and the decisions she makes for her childbirth experience. This model has had a fundamental effect on the way I practise and my belief in the need to generate new knowledge from women’s experience of birth (by whatever mode) by recognising them as experts of childbirth knowledge.

Two aspects of my midwifery practice further fuelled my interest in exploring how women experience birth and how this may inform professional knowledge and practices. From 2004 to 2007 I provided a listening and information service for women who had either experienced traumatic childbirth or who were requesting a Caesarean birth in the absence of medical indications. Providing women with an opportunity to tell their story of birth has become a common intervention in maternity care by which women ‘debrief’ and make sense of their experience (Gamble and Creedy, 2005). Research in this area is growing and will contribute to new knowledge of how women experience birth. However, this listening intervention is not usually offered to women experiencing planned Caesarean birth and is reserved for women who give birth vaginally or those who have an emergency Caesarean birth.

A second and fundamental part of my practice has been facilitating a women’s focus group. I set up this group in 2001, in my unit, to support service and practice improvements in our maternity service. In this forum women were encouraged to share their experiences and give their views on possible maternity service developments. These sessions have transformed how I practise by providing an alternative view to my own professional perspective, which has made me reflect on my assumptions and values. They have also provided insight into what some women experience and offered suggestions for how we can get our services ‘right’, leading to improvements in our unit.

As mentioned previously, from 2007 to 2012 I was engaged in a national maternity service-improvement programme which developed in response to a doubling over twenty years, of the national Caesarean section rate in England. I was employed by the NHS Institute for Innovation and Improvement and my role was as a midwife consultant within a small maternity team. Our team sought to explore with maternity service providers, how their beliefs, behaviours and actions contributed to their normal birth and Caesarean birth rates and how these affected the experiences of women using their services. At first glance, this role, which demanded a focus on optimising opportunities for normal birth, could be seen to be at odds with my desire to be ‘with

woman' and supporting each woman in her choices and decisions. However, although this role, in the first instance, was promoted as *reducing Caesarean section rates* (NHS Institute for Innovation and Improvement, 2007), its aim was not to prevent particular women from having Caesareans. Instead, the team provided maternity services with a toolkit for self-assessment and improvement premised on four pathways, three of which were clinical and one which focussed on organisational culture. All pathways described correlations between staff behaviours and the normal birth or Caesarean birth rates and gave tools for improvement and examples of maternity practices across England (NHS Institute for Innovation and Improvement, 2007). The organisational culture pathway explored the impact of good communication, respect for each other's roles, effective team work and data systems. The three clinical pathways focussed on effective *care for women in their first pregnancy and labour*, support for the provision of *Vaginal Birth after Caesarean* (VBAC) options for women who had had one Caesarean and a *planned Caesarean pathway*, which sought to optimise the availability of information and make effective use of resources and women's experience (NHS Institute for Innovation and Improvement, 2007). This toolkit was premised on the concept that the Caesarean section rate would be lower if all women were able to have the best possible care in all three clinical pathways (including the planned Caesarean care pathway). Therefore, although I am inextricably linked to a programme that, if successful, would lead to fewer Caesareans being performed, this work and the focus of my research stems from a desire to understand *more* about Caesareans and from my desire for each woman to get the best care possible. For some women this means me actively supporting their decision for a Caesarean birth.

My approach to maternity service improvement has been influenced by my experiences with change management improvement methodologies, particularly by the training I have received in *Redesign* and *Appreciative Inquiry*. These techniques have been used to explore and reform professional practice and transform healthcare services. Redesign places great value on the concept of people being fundamental in planned change (Hector-Taylor, 1997). It favours a 'bottom up' approach to managing change where the people that are affected by the change are actively involved in planning it. This goes some way to addressing the authoritative approaches that are present in conventional 'top down' which often encourage resistance and make implementation difficult (Hector-Taylor, 1997). *Appreciative inquiry* is a concept, often used in action research techniques, which moves on from the conventional problem-solving approaches to change management and service redesign and takes a positive view of change (Ludema et al, 2006). Appreciative Inquiry theory proposes that critique limits the possibilities of invention; that the critic's voice silences other voices and other realities. It fundamentally believes in the notion

of co-creating the future and creating space for new voices and new discoveries to be co-authored (Ludema et al, 2006). From this viewpoint, *improvement* is about exploring experiences *in partnership* rather than seeking the *truth* to solve problems.

In 2013 I was lucky enough to be involved in a service-improvement project using a methodology which brings these elements together. Called *experience based design* (ebd), it is a method of designing better experiences for patients, carers and staff by capturing those experiences and then working together to redesign new services through co-design (NHS Institute for Innovation and Improvement, 2009). Further detail about ebd can be found in Chapters 5 and 7. Another interest, outside my clinical role, has also had an impact on my research. In Spring/Summer 2010 and then again in spring 2013, I took part in creative writing courses at the University of Brighton. These courses have helped me to write creatively, extend my academic writing style and learn about how stories are constructed through characterisation and plot development.

I have also been a member of an NHS Research Ethics Committee for the last ten years. This has stimulated my interest in the relationship between research ethics and research design and the dissemination/implementation of findings. It has also given me a desire to move beyond achieving ethical approval for my study towards acting ethically in my research endeavours.

Conclusion

I have described here beliefs, concepts and experiences that are fundamental to how I approach my professional practice as a midwife, my role in healthcare improvement and my role as a midwife researcher. These experiences have directed the decisions I have made in my research study and my choice to use a narrative methodology. It is an approach which I believe has enhanced the quality of my research of women's experiences of planned Caesarean birth, which I explore in the chapter 3, *Methodological approach and theoretical framework*. But first I will present the findings from my search of the literature to demonstrate the lack of empirical research into women's experience of planned Caesarean birth, and to establish the research territory and the contribution this research will make to professional knowledge.

2. Reviewing the literature

'What's past is prologue.'

William Shakespeare ([1610], 1968), *The Tempest*, Act 2, Scene I, p. 92, Penguin.

Introduction

In this chapter I describe the approach I took to defining the scope of my literature search and my search strategy. I share my experience of reviewing the literature and my appraisal of the literature pertaining to women's experiences of planned Caesarean birth. I conducted this initial literature review in order to understand what was already known of women's experiences of planned Caesarean birth and where there were gaps in knowledge that would justify me carrying out research in this area. I reviewed empirical data and I also chose to explore discursive texts which provided insight into how women's experience of Caesarean birth was framed in the literature. My review of the literature and data around planned Caesarean birth also included visits to online social networking/childbirth fora, attendance at conferences and discussions with professional colleagues, my research supervisors, researchers, doctoral students and pregnant and childbearing women.

My interest in women's stories of their experience drew me to narrative inquiry methodologies. In line with this methodology, the literature review was not exhaustive at the beginning of the study and an ongoing review of the literature continued as themes developed from participant's stories (see Chapters 7 and 8).

Decisions about scope

While I was designing my research strategy I began to realise that there were a number of issues about definition and scope, within the topic of Caesarean experience, which I needed to make decisions about before proceeding with my search strategy and reading of the literature.

Ultimately, this was an important and iterative part of my understanding about what was known about planned Caesarean birth and how planned Caesarean birth experience was presented in research. Both these elements confirmed my need to focus my research in this area.

One of the factors that had energised me to undertake a research study in the first place was my impression that women having a Caesarean birth were often perceived to have a uniform experience and that individual women's experience was largely missing from research evidence that was informing clinical practice. This was a notion that I believed was limiting our understanding of how women experienced and assimilated their experience of (Caesarean) birth and how we could provide effective care. From my cursory readings prior to a systematic review I realised that this viewpoint was borne out in the literature and I found it hard to distinguish between experiences of planned/ unplanned Caesarean and primary/repeat Caesarean within the literature. Although empirical studies were available that compared, for example, planned with emergency Caesarean birth; at the point that the data was presented, individual women's experiences tended to be pooled into a collective, cohort response. I believed that, prior to making comparisons between experience of different modes of birth, we needed to know about primary experience of Caesarean birth, its meaning and how that meaning was assimilated and expressed by women experiencing it. Therefore, I felt I needed to research Caesarean birth in the context of it being a primary birth experience. This necessitated focussing on the experience of first-time mothers (nulliparous women) whose Caesarean experience was planned (no labour).

I began my search from 1985 as my desire for there to be greater knowledge about how women experience Caesarean birth was contextualised against a rising national Caesarean birth rate which was perceived as problematic. The primary text that problematised the rising Caesarean birth rate was a consensus statement published by the World Health Organisation in 1985 that stated that there was no increase in health benefits associated with Caesarean rates above 10-15% of all births (World Health Organisation, 1985; Thomas, Paranjothy et al, 2001).

Definition

Having decided that I wanted to research how women experienced planned Caesarean birth, I began to realise that definitions for types of Caesarean were not straightforward. The terms commonly used to distinguish types of Caesareans – *elective* or *emergency*, have more recently been replaced by *planned* and *unplanned*. Both these sets of terms are potentially problematic, as three concepts drive the distinctions: the reason for the procedure, the urgency of the procedure and whether or not labour had started. The complexity of terminology continues – in the *reason for the procedure* there are further distinctions between whether or not the Caesarean was

medically indicated or whether it was performed for 'maternal request.' This is problematic because clinicians are not consistent when adopting these terms. How, for instance, would you describe a Caesarean for a woman who has requested it because she has tokophobia (fear of childbirth)? Would a Caesarean in this circumstance be medically indicated or for maternal request? Similarly, the term 'elective' previously described a planned, no-labour Caesarean, but it was sometimes also used to describe a Caesarean performed in labour where there was no urgency (sometimes called *scheduled*). The use of a grading system is now recommended. This system denotes the optimum timescales within which the procedure should be performed (National Confidential Enquiry into Perioperative Deaths, 1995; National Collaborating Centre for Women's and Children's Health, 2011) in order to simplify and improve clinical communication and data collection. These grades are:

1. Immediate threat to the life of the woman or fetus
2. Maternal or fetal compromise which was not immediately life-threatening
3. No maternal or fetal compromise but needs early delivery
4. Delivery timed to suit woman or staff.

National Collaborating Centre for Women's and Children's Health (2011) *Caesarean section: NICE clinical guideline*, RCOG Press, p. 117.

In this system, the distinction between unplanned and planned falls between grades three and four but grade four no longer exclusively denotes a no-labour Caesarean. However, in the context of my research interest, planned Caesarean denotes a non-urgent, no-labour Caesarean in a first-time mother, so the experience I am exploring relates to a primary birth experience. I also opted not to have exclusion criteria relating to the reason for the Caesarean (i.e. whether wished for or medically indicated) as I believed that the distinctions are less clear cut than the terms suggest and because my primary interest was in exploring *how* women experience a planned Caesarean birth. I felt that making assumptions about a correlation between the indication for the planned Caesarean and the resulting experience at this stage might foreclose my understanding and critical thinking.

Search strategy

I searched the British Nursing Index (BNI), Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsychINFO, ASSIA, AMED, MIDIRS, PubMed and the Cochrane databases using the following keywords: 'planned/elective/scheduled Caesarean', 'maternal experience', 'birth story', 'narrative', 'maternal request', 'choice', 'expectation', 'discourse'. All variations in spelling of Caesarean (Cesarean, Caesarian) were used. Studies of birth experience that were not related to Caesarean birth were not reviewed. I also reviewed the DIPEX website (which had interviews about people's experiences of health-related conditions) and I searched for books specific to Caesarean birth.

I could find no published literature of women's accounts of their experience that *exclusively* pertained to primary, planned (no labour) Caesarean birth using interpretive methodologies. Therefore, I had to search texts that focussed on Caesarean in its broadest sense to explore whether or not the information contained in the document related to planned/unplanned Caesarean and first-time mothers. In some cases, the literature stated that women in their first pregnancy, having a planned Caesarean were included in the study but the data was often embedded within the broad discourses and not directly attributable to women who had experienced a planned Caesarean in their first pregnancy. This became a frequent frustration.

In line with developments in research practice that recommend patient and public involvement in research (National Institute of Health Research, 2010), I also reviewed the methodologies and methods of the papers to see if I could understand *how* women were involved in sharing their experience. In particular, I reviewed whether the methods reflected participatory principles – where service user's perspectives may have helped to frame the research questions or the methodological approach. This was important as I wanted to ascertain whether women were responding to direct questions that might constrain their responses or whether they were able to frame their experience, for example, through the use of semi-structured interview techniques or free-text sections within questionnaires.

Cultural and social discourse

During my search I came across two discursive texts on Caesarean birth. I have included an overview of them here as they provide useful examples of some of the discourses and tensions present in the literature on Caesarean birth with which to contextualise my research.

In his book *The Caesarean* (2004), Odent reviewed the historical changes in birth and explored the rise in Caesarean births. Michel Odent is a French obstetrician who is associated with the natural childbirth movement of the 1980s and a proponent of water birth. The book traces the development of the Caesarean and Odent draws on historical, mythological and evolutionary examples to explore his arguments. Two main arguments emerge – that the development of the neocortex in the human brain, due to increasing sensory perception, conscious thought and language (functions of the neocortex in humans), has reduced the ability to behave (and birth) as effectively as other mammals; and that the increased size of the human brain is problematic for birth by dint of the relative head to pelvic size. Odent's exploration of the historical development of Caesarean is used as a vehicle for proposing his beliefs on birth and evolutionary developments, rather than reflective of women's experience of Caesarean birth. In fact, women's experience of birth, Caesarean or otherwise is missing from Odent's script.

In *Caesarean – Just another way of birth?* (2007) Mander seeks to find the meaning of Caesarean for mothers and babies and those who attend them, by reviewing Caesarean within the context of childbirth discourses. Rosemary Mander is a Professor of Midwifery, a practising midwife and midwifery researcher. She critically analyses the place of Caesarean in contemporary childbearing, questions the changes that are taking place and suggests that '*rising Caesarean rates reflect a trend away from expectations of normal or uncomplicated childbearing*' (Mander 2007, p. 80). She concludes that Caesarean may not necessarily benefit either the mother or her baby but rather it may '*benefit those professionals whose investment is in extending the range of their influence*' (p.i). Mander provides a useful critique of some of the dominant discourses surrounding Caesarean birth. However, this is achieved through academic argument and meta-analysis of the research evidence rather than through the experiences or voices of women. Mander acknowledges this and suggests that '*some, particularly woman-related areas are in need of good research*' (p. 35). This text provided a valuable resource for reviewing and locating my findings within and against Caesarean discourses (see Chapter 8).

Empirical studies

With the exception of two studies which describe and present women's experiences of Caesarean birth in detail (Clement, 1995 and Bayes et al, 2008) I could find little evidence of what women said about their experience of planned Caesarean birth, what it meant to them and how they

assimilated this experience. While reading the empirical evidence, I attempted to see if I could *build* a picture of what primary, planned Caesarean birth was like from the individual studies I was reading. It was important to me to try to ascertain how I might apply this knowledge to my clinical practice; as stated previously, one of the main drivers for me to undertake this research was to be able to deepen my knowledge in a way that would be effective in clinical practice. Having explored the data that was available to me, I questioned whether I was better equipped to have a discussion with a woman about to embark on a planned Caesarean birth about the range of experiences open to her and how she could prepare for them. I found that I was not easily able to attribute the information I was presented with directly to the women involved in the study. This meant that I could not distinguish if the experience described came from women having primary Caesarean, a repeat planned Caesarean after a previous unplanned Caesarean or an unplanned Caesarean after a previous vaginal birth. Most of the studies did not provide direct quotes of what women said but described themes or reported women's views. It is not, therefore, possible to appreciate how women framed the issues themselves.

The research activity that I could find relating to planned Caesarean fitted broadly into three areas: *choice and decision making*, experience/expectation expressed as *satisfaction*; and *clinical outcome comparison*. I have used these categories to present my appraisal of the literature.

'Choice' and decision-making

The studies in this section focussed on the need for research to explore women's requests for elective Caesarean section. There were also discursive texts and commentaries on the professional's dilemma in knowing whether or not to support such requests (Amu, Rajendran et al, 1998; Bewley and Cockburn, 2002; Burgers, 2006; Esen and Archibong, 2007) and the rights of the unborn child (Bewley and Cockburn, 2002) which I have not included here as they did not include empirical data of women's views and experience.

Mould et al's (1996) observational study of one hundred and two consecutive women undergoing a Caesarean at University College Hospital, London sought to assess the extent to which women contributed to the decision for Caesarean section and their satisfaction with the decision and procedure. Women were interviewed using a standardised proforma. The authors concluded that women undergoing Caesarean section were well informed and took a considerable part in the decision-making process. They went on to suggest that women's wishes may be playing a role in increasing Caesarean section rates. They stated that high levels of satisfaction with both the

decision and the procedure itself indicated that Caesarean section is an acceptable method of delivery, particularly when an elective procedure. This assertion seems a little bold as, although 89.2% of 'women's perceived reason for the Caesarean section agreed with the doctors' reason' (Mould et al 1996, p.1074) and 69% of women having elective procedures and 51% having emergency sections recorded medium or more contribution, two out of 29 women having elective sections, and 22 out of 73 women having emergency sections stated they had no contribution. Their data on satisfaction states that all women except one were 50% or more satisfied with the decision, women's satisfaction with the operation was high in the immediate post-operative period and remained so over the following six weeks. Forty-three women (49%) said they would prefer an elective section in the next pregnancy if given the choice.

Despite seeking to understand women's satisfaction with their decision to have a Caesarean and the procedure itself I learned little of what was or was not satisfying as this study appears to focus on *how many women* were involved in decision making about how they should birth and *how many women* had *degrees* of satisfaction. I found it interesting that satisfaction with decision-making was expressed as women agreeing with the doctor's reason for the Caesarean rather than women feeling confident that they had arrived at a decision that was right for them. The concept of what satisfaction with decision-making means is not clear and points to the need for in-depth qualitative methodologies to explore the phenomena.

York, Briscoe et al's study (2005) explored the factors influencing women who chose to have an elective Caesarean following a previous emergency Caesarean section. They studied the views of ten women using in-depth, semi-structured interviews in the antenatal phase of their subsequent pregnancy. An interpretive approach was used to search for themes and categories and women provided verification of the interpreted data. The study found that women were concerned about safety and feared vaginal birth as '*the unknown*' (p. 440). Control over childbirth was important to the women in the study and the decisions about preferred mode of birth happened shortly after their first birth or early in the subsequent pregnancy. The women relied on discussions with relatives, friends or women who had similar experience, rather than detailed information from health care professionals. The authors state that the women would have welcomed more and consistent information which may have altered their decision. This study does provide useful information about how women who have one Caesarean birth make decisions about how they will birth in their next pregnancy but it does not provide information about women's experience of primary Caesarean birth.

Pakenham et al's study (2006) looked at the opinions and choices of nulliparous and multiparous women with respect to mode of birth. One hundred and seven nulliparous women and 103 multiparous women completed a questionnaire indicating whether they believed that all women should be offered elective primary Caesarean and whether they would choose elective primary Caesarean if given the choice. Women were also asked to indicate the most and least influential factors in their decision. Women with a previous Caesarean were excluded from the study. Eighty seven per cent of nulliparous women and 95% of multiparous women surveyed would not request an elective primary Caesarean although 49% of nulliparous women and 72% of multiparous women felt that women should be given the option. The perceived risks of vaginal birth were commonly cited by both groups as the reasons for wanting a primary elective Caesarean. The risks of Caesarean section birth most commonly cited for reasons to decline in both groups. Convenience of scheduling of the Caesarean and cost to the healthcare system were not important to either group (Pakenham et al, 2006). This study reflects the complexities of the decision-making process that women are faced with when contemplating risks in relation to mode of birth for their baby. It also reflects the desire women have to be involved in decisions about their birth.

In Moffat et al's study (2007), 26 women who had previously had a Caesarean for a non-recurrent cause took part in semi-structured interviews. The study found that women were influenced by their own previous experiences and expectations and preferences about the final mode of delivery often developed during the course of the pregnancy. Despite a universal desire to be involved in the process, many women did not participate actively and were uncomfortable with having responsibility for decision-making. The authors concluded that women who have had a previous Caesarean do not usually have firm ideas about mode of delivery. The women looked for targeted information and guidance from medical personnel based on their individual circumstances and some were unhappy with the responsibility of deciding how to deliver in the current pregnancy.

Emmett et al (2006) researched women's experience of decision-making about mode of delivery after a previous Caesarean section and the role of health professionals in giving information about health risks. Twenty-one women who had recently delivered and whose previous baby was born by Caesarean took part in semi-structured interviews on the influence of uncertainty on decision making, issues concerning the information they were given and decision-making roles. Information was commonly provided by doctors (mainly consultants) and more often related to procedural issues, rather than possible health risks and benefits. Women felt they had to actively

seek information rather than it being provided routinely. Most women were able to make their own decisions about mode of birth. Health professionals generally took a supportive role whichever mode was chosen. Although many women were comfortable with this approach, some felt they would have liked more guidance (Emmett et al, 2006).

Kolip and Buchter's (2009) cross sectional survey of 2,685 women primiparae who had undergone a planned Caesarean in Germany used a self-assessment questionnaire to ask women to rank, in the level of importance, reasons leading to a Caesarean in order to test their satisfaction with information given by gynaecologists and midwives. *Recommendation by the gynaecologist* was reported as the most important reason, followed by *malpresentation* and the *fear that the child may be damaged* (p.275). *Convenience, partner's request or quick births* were not included as important reasons. Although most women were satisfied with their decision, some felt that they did not receive enough information about the consequences of a Caesarean section.

These studies begin to reflect that women want active engagement and support from clinicians to support their decision-making. They challenge notions of women wanting to have *choice* about their mode of birth. Instead, they suggest that women want their clinicians to be actively engaged in the decision-making and for decisions to be shared and jointly produced (see Chapter 9, Recommendations for policy, practice, research and education).

In 2006, Kingdon et al carried out a systematic review of nulliparous women's views of planned Caesarean birth to explore the debate about the need for a *term cephalic trial* (p. 229). A term cephalic trial would compare planned Caesarean section versus planned vaginal birth in healthy women with a singleton cephalic pregnancy at term (p. 229). Suggestion that this trial was needed had come from clinicians reporting increased incidence of women requesting planned Caesarean birth. Nine papers were included in the review, which reported rates of women expressing a preference for Caesarean birth that ranged from zero to 100% at recruitment. However, the papers raised scientific and methodological problems and the authors concluded that there was little evidence that women would support a term cephalic trial at the time of the study. They stated that qualitative research which would investigate the influence of obstetric and psychological factors on women's views of vaginal and Caesarean birth was of paramount importance.

Weaver et al (2007) presented a mixed-methods study of women's and obstetrician's views on Caesarean in the absence of clinical indications. Sixty-four pregnant women (23 multiparous and 41 primiparous) were asked to complete diaries recording events related to birth planning and

expectations. Forty four women who had considered, or been asked to consider, Caesarean section during pregnancy were interviewed postnatally. Some direct quotes from women in the study were used to support the themes described. Sixty-nine per cent of women in the prospective antenatal diary study gave the answer 'vaginal birth' to the question in the recruitment questionnaire '*At this early stage, what do you think you would like for the birth of this baby*' (p. 35), only one primiparous woman answered '*Caesarean section*' (p. 35). The authors found that no women requested Caesarean section in the absence of what she herself considered clinical or psychological indications. Fear for themselves or their baby appeared to be major factors behind women's requests for Caesarean section, coupled with the belief that Caesarean section was safest for the baby. The study supported the theory that these women comprise a small minority, with psychological issues and maternal perceptions of risk appearing to be significant factors in many maternal requests.

Gamble et al (2007) undertook a critique of the literature on women's request for Caesarean section. Seventeen papers were identified, examining women's preferred type of birth. They commented that none of the studies included in their review contained detailed, methodological, rigorous examination of the type or quality of information provided to women who indicated a preference for Caesarean. The authors concluded that maternal request is not a significant factor influencing Caesarean section rates.

These studies begin to challenge the viewpoint prevalent in discourses that large numbers of women are requesting Caesarean birth. During the last ten years discursive debates have directed the rise in Caesarean rates at women choosing to have Caesareans (Kingdon et al, 2006; Weaver et al, 2007). This argument has never been entirely convincing as a large number of Caesareans performed are during labour for women who were anticipating and hoping for a vaginal birth. These studies help to inform these debates, not by providing definitive answers but by providing additional layers of complexity.

A study in Nigeria described how some women were reluctant to have Caesarean births when clinically indicated. Although there are obvious cultural differences between Nigeria and the UK, the study demonstrates the links between mode of birth choice and perceptions of risk. Ukpong and Owolabi (2004) studied fifty five women who presented for either elective or emergency Caesarean section during a 5-month period (1 December 2003 – 30 April 2004). Recruited consecutively, they were assessed for psychiatric morbidity using the General Health Questionnaire (GHQ-30), the Beck Depression Inventory (BDI) and the State Version of the State-

Trait Anxiety Inventory (STAI). Thirty-three women (60%) were initially reluctant to give consent for the operation and they had higher mean STAI scores than those who willingly consented to the procedure. The mean anxiety score for the entire study population was 41.7, which was higher than the usually accepted threshold of 40 for clinical disorder on the scale. The BDI was able to pick 11 women with depression in the study sample. As with all the studies presented here, it is not possible to know how the relative risks of birth options were described to the women. However, it would appear that perceptions of risk and subsequent decision-making may be culturally contingent. The relative morbidity and mortality rates are likely to be a key factor too.

The largest study of women's perceptions of Caesarean birth is the National Sentinel Caesarean Section Audit (Thomas et al, 2001). This study was carried out in response to concerns over the variation in Caesarean section rates across the country and the lack of good quality national maternity data. It was undertaken by the Clinical Effectiveness Support Unit (CESU) of the Royal College of Obstetricians and Gynaecologists (RCOG), in collaboration with the Royal College of Midwives (RCM), the Royal College of Anaesthetists (RCA) and the National Childbirth Trust (NCT). The audit looked at which women were having Caesarean sections and why. It also surveyed women's and obstetricians' views towards Caesarean section. The audit had two phases. Phase One aimed to determine the frequency of Caesarean sections in all maternity units (NHS and private sector) in England, Wales and Northern Ireland, in order to evaluate demographic, clinical and organisational factors associated with variations in Caesarean section rate and, to assess the quality of clinical care against agreed standards, derived from published literature. It included information on 158,299 births, of which there were 33,492 Caesarean sections. Phase Two aimed to survey maternal views and attitudes to Caesarean section, the sources of information women use and value when they are forming their views about how they wish to have their baby; it also explored clinicians' attitudes towards, and threshold for, Caesarean sections.

Phase Two, carried out during autumn 2000, surveyed 40 randomly selected units in England, Wales and Northern Ireland. Two thousand nine hundred and forty two women responded (37% of those invited to participate in the survey of women's views of childbirth); of this group 84% completed and returned the questionnaire.

The audit found that one in five (21.5%) of births in England and Wales were by Caesarean section.

The majority (63%) of Caesarean sections carried out in England and Wales were emergency procedures, 37% were done electively (p.19). Women who had a previous Caesarean section, a breech baby or, who went into premature labour, were found to be more likely to give birth by Caesarean section. Almost 3,000 pregnant women were asked about their views on Caesarean section using a standardised questionnaire. About half of respondents felt they had sufficient information about labour and common possible interventions. Whilst 40% said they had sufficient information about the risks and benefits of Caesarean section, a significant number said they would like more information on the risks (48%) and benefits (43%) involved. Women who attended antenatal classes were more likely to report they had enough information on all topics compared to those who had not attended. More than 90% of mothers expressed a wish to have a birth that was the safest option for their baby. Their own safety, a desire for a quick recovery and a birth that would not impede breast feeding were also strong preferences. About 70% of mothers wanted a mode of birth that would reduce the chances of urinary incontinence.

The Sentinel Audit provides detailed information about women's responses to questions about their experience. Unfortunately, it is not possible to know how these questions were derived and whether the themes were proposed by pregnant women or by clinicians. A more naturalistic approach could yield different areas of focus.

The final study in this section, by Montgomery et al (2007), aimed to determine the effects of two computer-based decision aids on decisional conflict and mode of delivery among pregnant women with a previous Caesarean. A randomised trial from May 2004 to August 2006 of 742 pregnant women with one previous lower-segment Caesarean section and an expected delivery at 37 weeks or beyond was carried out in four maternity units in south-west England and Scotland. Women were randomised to one of two interventions: *Usual care* (standard care given by obstetric and midwifery staff) or *Information programme*, in which women were guided through descriptions and probabilities of clinical outcomes (for mother and baby) associated with planned vaginal birth, elective Caesarean section and emergency Caesarean section. Mode of delivery was then recommended based on utility assessments performed by the woman, combined with probabilities of clinical outcomes within a concealed decision tree. Both interventions were delivered via a laptop computer after brief instructions from a researcher. The study found that women in the, information programme and the decision analysis groups, had reduced decisional conflict compared with women in the 'usual care' group. The rate of vaginal birth was higher for women in the decision analysis group compared with the 'usual care' group

(37% v 30%). The authors cite an earlier study that found no effect on mode of birth from the use of decision aids (Shorten et al, 2005) and Montgomery et al acknowledge that their findings may not be significant. The authors concluded that decision aids can help women who have had a previous Caesarean section to decide on mode of delivery in a subsequent pregnancy.

This study provides evidence of an effective tool to aid decision making. Although having reviewed the details of the intervention (Montgomery 2004) the tool focuses on outcomes associated with (and probabilities of) vaginal birth, planned Caesarean and emergency Caesarean, rather than information about how women experience the different modes of birth. An intervention which includes outcome data *and* women's experiences would be more effective in both supporting women's decision making and preparing them for their birth experience.

Expectation and satisfaction

Some studies looked at women's experience from a perspective of satisfaction which, in turn, was linked with expectation. The studies were large and provided a lot of data. Unfortunately, as stated previously, it was hard to know how to attribute the experience and whether women had experienced a planned/unplanned Caesarean and whether or not this was their first baby.

Keogh, Hughes et al's study (2006) examined the psychosocial factors (expectations, control, beliefs, anxiety, sensitivity) in mothers and birth partners before an elective Caesarean. They focused on the impact that these variables had on maternal fear and pain during and after delivery using an expectations questionnaire (EQ), anxiety sensitivity index (ASI) and short form McGill pain questionnaire (SF- MPQ).

Sixty-five women having an elective Caesarean with a regional block were recruited to the study and data was collected at three time points for the mothers – before, during the Caesarean section and after delivery on the postnatal ward – and at two time points for the birth partners – before and during the Caesarean section. The authors found that maternal fear responses varied during the operation, in that fear was greatest at the point of administration of the nerve block. Mother's preoperative, negative expectations were related to fear experiences during delivery which, was in turn, related to their postoperative pain. Maternal anxiety sensitivity was found to mediate the relationship between negative expectations and fear, whereas birth partner's fear

mediated between maternal fear and postoperative pain. Mothers' prenatal perceptions of control over drugs predicted their postoperative pain. Keogh et al concluded that maternal fear during Caesarean section not only fluctuates, but may be influenced by psychosocial factors, including their birth partner. Psychosocial factors were also important predictors of postoperative experiences.

This study identified a relationship between psychosocial factors and experience. Further research into how women develop strategies to cope with their anxiety and how clinicians can mitigate against anxiety would be very beneficial (see Chapter 9 – Areas for future research and development).

Porter, van Teijlingen et al (2007) carried out a large postal survey of 1,661 women who had delivered their first babies by Caesarean section in Aberdeen, between 1980 and 1995, to explore the factors that women identified as 'distressing' so as to understand their responses to standard questions on satisfaction. A 75% response rate showed that 81% of women were satisfied with their experience. Nevertheless, 36% rated an aspect as 'distressing' (p. 148), and 42% provided written descriptions of one or more experiences that had distressed them.

These responses were coded, using content analysis, into five major categories: before, during, and after the birth, psychological/general, and overall. The most distressing factors were of a psychological or general nature, with 66% of distressed women mentioning poor communications, fears, missing out on the birth or the immediate postpartum period, or other emotions. Events happening before, during and after the birth caused 23, 45, and 44% of women to be distressed, respectively. Surgical complications and infections were distressing, but anaesthesia was the single factor that caused most distress, leaving 102 women (20%) with unsatisfactory memories of the birth.

This study adds more than a conventional large postal survey as women also contributed descriptions of their experiences and what distressed them. The study states that women responded to an open-ended question and it described aspects of their care that they found distressing. These themes are presented with some examples of direct quotes to illustrate the themes. This study does focus on primary experience of Caesarean birth but does not distinguish between experience of planned or unplanned Caesarean birth in its findings which could have a significant influence on the interpretation of the findings.

A study undertaken by Fawcett, Aber et al in 2011 sought to develop theory in relation to women's perceptions of, and responses to, Caesarean birth. Four hundred and eighty-eight women took part in a mixed-methods international study (United States n=253, Finland n=213, Australia n=22) to examine the relation between the type of Caesarean birth (unplanned/planned), number of Caesarean births (primary/repeat) and preparation for Caesarean in women's perceptions of, and responses to, Caesarean birth.

The researchers used two tools, the POBES form and a Caesarean Birth Experience questionnaire (CBEQ), to test modes of adaptation. The POBES form contained twenty-eight items about labour, delivery and initial contact with the infant. Items were rated on a scale of 1 to 5, ranging from 'not at all' to 'extremely'. The CBEQ, developed by Fawcett in 1981, consists of five open-ended questions asking how the mother felt physically and emotionally: when she found out she was to have a Caesarean, during the delivery, after the birth. It also sought to find out her greatest needs during the Caesarean birth experience and what could have been done, by whom, to improve that experience. The data yielded was then tested by path analysis in a conceptual model which looks at adaptive responses to contextual stimuli, called the Roy adaptation model.

They found that women who had unplanned Caesareans and those who had primary Caesareans were less likely to feel prepared than those who had a planned or repeat Caesarean. Women who felt prepared had a more positive perception of their birth experience. They also found that women showed more positive adaptive responses to their Caesarean birth, especially unplanned Caesarean, than had been found in previous studies. They suggested the rising Caesarean rates meant that Caesarean birth had become normalised. Interestingly, they found that many women felt prepared for Caesarean birth but few had attended preparation for childbirth classes. They propose further research into the sources and quality of information accessed by women.

This study provides a theoretical model and instruments with which to view perception and responses to Caesarean birth. Despite this, I found that I was still no clearer in understanding what Caesarean birth *meant* to women who experience it and how I might apply these theories to clinical practice.

Clinical outcome comparisons

The studies in this section provide information with which to correlate clinical outcomes with mode of birth but the studies were limited in the depth of information presented that describes women's experience and the integration of that experience.

Griffiths, Watermeyer et al (2006) invited women who delivered at the University Hospital of Wales and Llandough Hospital between January 1999 and January 2000 to complete and return a postal questionnaire to record the prevalence of subjective urinary and faecal incontinence, incontinence of flatus, dyspareunia, subjective depression and sexual satisfaction. This was correlated with mode of delivery. Two hundred and eight women provided responses. The authors found that, there was a significant decrease in sexual satisfaction scores in women who underwent vaginal birth in comparison with those who underwent elective Caesarean section, at two years follow-up. There was also a significant increase in the prevalence of urinary incontinence, incontinence of flatus, dyspareunia and subjective depression in women who underwent vaginal birth. The authors suggest that their findings should contribute to the overall debate on elective Caesarean section on demand. However, they also acknowledge that their study may be limited in design as they didn't test long-term outcomes and, with a 53% response rate, their respondent group may not be representative of the whole population. Women were asked to rate satisfaction but were not asked to comment as to whether or not they felt that these changes related to mode of birth or other factors such as hormonal changes, tiredness, relationship changes etc. They were also not asked how they would wish to birth in the future.

Hannah, Hannah et al's (2002) follow up study to the 'term breech trial' study compared maternal outcomes of planned Caesarean delivery and planned vaginal birth at three months post-partum. A total of 1,596 women from 110 centres worldwide who had a singleton fetus, in breech presentation at term, responded to the follow-up questionnaire. The main outcome measures were: breastfeeding; infant health; ease of caring for infant and adjusting to being a new mother; sexual relations and relationship with husband/partner; pain; urinary, flatal, and faecal incontinence; depression; and views regarding childbirth experience and study participation. Baseline information was similar for both the Caesarean and vaginal delivery groups. Women in the planned Caesarean delivery group were less likely to report urinary incontinence than those in the planned vaginal birth group (4.5% versus 7.3%). Incontinence of flatus was not different between groups but was less of a problem in the planned Caesarean delivery group when it occurred. There were no differences between groups in other outcomes. The authors concluded that planned Caesarean delivery for pregnancies with breech presentation

at term may result in a lower risk of incontinence and no increased risk of other problems for women at three months post-partum. However, they acknowledged that the effect on longer-term outcomes was uncertain.

The final study in this section (by Gamble and Creedy, 2005) tested an intervention to support women who had experienced emotional trauma as a result of their Caesarean birth experience. Unfortunately, although the intervention/no intervention cohorts were separated, the experiences of women who had planned or unplanned Caesarean are not presented separately and so it was difficult to draw conclusions about the experiences of women who had a planned Caesarean birth.

Gamble and Creedy's (2005) study was carried out in Australia. Women were interviewed about their (emotional) birth trauma symptoms at 72 hours and 4-6 weeks postpartum. Symptoms were compared between women who had undergone emergency or elective Caesareans and operative or spontaneous vaginal deliveries. Of 348 women screened for trauma symptoms, 103 met inclusion criteria and were randomized into an intervention (n = 50) or a control (n = 53) group. The intervention group received face-to-face counselling within 72 hours of birth and again, via telephone, at 4 to 6 weeks postpartum. The main outcome measures were post-traumatic stress symptoms, depression, self-blame and confidence about a future pregnancy. At three month follow-up the intervention group women reported decreased trauma symptoms, low relative risk of depression, low relative risk of stress, and low feelings of self-blame. Confidence about a future pregnancy was higher for these women than for control group women. A high prevalence of postpartum depression and trauma symptoms occurred after childbirth. Although most women improved over time, the intervention markedly affected participants' trajectory toward recovery compared with women who did not receive counselling (Gamble and Creedy, 2005).

Each of these studies alluded to the impact that time (since birth experience) can have on symptom improvement and recovery (Gamble and Creedy 2005). However, *how* women integrated their birth experience over time and what it meant to them was less clear.

Resources for women

One empirical source that I reviewed was presented as a book for women. Sarah Clement's research aimed to fill in the gaps and give a portrayal of the range and scope of women's experiences of Caesarean birth in relation to specific topics. Clement, a research psychologist and *Caesarean mother* (her term), used the experiences of 200 women in her book *The Caesarean*

Experience (Clement, 1995) to provide an insight into 'how it feels to have a baby by Caesarean' (p. xv) commenting that there is 'little antenatal preparation for Caesarean' and that the book 'is written primarily for Caesarean mothers' (p. 195). Women were recruited via *Practical Parenting* magazine, in the newsletter of the *Caesarean Support Network* and in the National Childbirth Trust magazine, *New Generation* (Clement, 1995). The reason behind having a Caesarean, coming to terms with having a Caesarean birth, the partner's perspective and mode of birth in the next pregnancy are amongst some of the themes explored. I was disappointed that the methodology and analytic approach were not described and it was not clear how these themes were chosen and whether or not women's experiences gave rise to the themes chosen or whether the themes were predetermined. There were rich, vivid excerpts from women's stories which illustrated the variety of experiences against different themes. The following two excerpts related to experiences immediately after Caesarean birth under general anaesthesia:

'All I could think about was how beautiful my baby was. I didn't care how she'd been born, or think about the cut across my tummy.' (p.49);

'I don't remember feeling happy or anything, just relieved it was over and conscious of a terrible pain at the bottom of my abdomen.' (p.51).

Unfortunately, as excerpts were not named or attributed and no background information was provided (for instance, whether or not this was a woman's first pregnancy), it was difficult to appreciate the context of each experience and not possible to link individual quotes to build a picture of one woman's whole experience. I felt that further research using a narrative inquiry approach would give additional depth to the text from exploring the flow, chronology and plot of the representation which provide the shaping and ordering (Chase, 2005), by the woman of her past experience.

Clement asserts that the book has a '*political purpose*' (p. xix) which probably refers to her final chapter '*What is to be done*' (p. 199) which gives suggestions for improvements in both preparation for Caesarean and clinical practices. This could point to Clement having a desire for women's experience of Caesarean to inform clinical practices but if this is her (political) purpose it is somewhat diluted by her acknowledgement that clinicians are not the book's intended audience. The escalation in the rate of Caesarean section rate since 1995 led me to believe that that the context in which these studies were carried out has also changed and some of the procedures that were commonplace in 1991 and 1995, for example, a general rather than regional anaesthetic, are infrequent now.

Beyond published literature

My initial literature review revealed documents that helped me to identify empirical studies and key discourses which, in turn, helped me to frame the context of Caesarean birth experience and identify where further research was required. I also became aware of important research and texts by attending conferences, performing web searches, visiting social networks and childbirth forums and through networking within my professional and research community.

Dipex is a charity that has produced an award-winning website aimed at patients, family and friends, doctors, nurses and other healthcare professionals. The website contains interviews about people's experiences of health-related conditions. Once a study topic is identified, social scientists select participants using purposive sampling and carry out semi-structured interviews in the participants' own homes. The interviews are transcribed and returned to the respondents for review. Sections of the interview may be left out if requested by the participant. The researchers then carry out categorical analysis on the transcript. Interviews continue until the researchers are convinced that they have representations of the main themes. The following topics were reflected in interviews: *deciding how to give birth after Caesarean*, *planned Caesarean after previous Caesarean* and *vaginal birth after Caesarean*. This website reflects how personal narratives can provide a rich and valuable resource for women and clinicians. However, all 27 of the transcripts in the module relate to looking forward to decisions about another birth rather than experience of the primary Caesarean.

In this final section I present a piece of research from Western Australia of women's experiences of planned Caesarean birth for medical reasons, undertaken by Sarah Bayes. I did not find this study through my formal literature search but by attending an international conference in Glasgow in 2008. This increased my belief in the importance of not only attending to published empirical studies but in becoming immersed in the community of clinicians and researchers with a special interest in Caesarean birth. Bayes' study has had the most relevance and resonance with my study and I have been very lucky to meet with the researcher, Sara Bayes.

At the conference, Sara Bayes and Jennifer Fenwick presented the emerging findings from their study of Western Australian women's experience of Caesarean section scheduled during pregnancy for health reasons (Bayes et al 2008). A grounded theory approach was used to collect and analyse interview data from twenty-eight Australian Women who had an elective Caesarean for medical reasons. Fourteen of the women were also observed during their Caesarean operation and these observations were used to contextualise the women's experiences (Bayes et

al 2012a). This study explored how women responded to and integrated the need for Caesarean, and of the strategies they constructed to cope with the procedure (Bayes et al 2008).

When I met with Sara, she described how, on finding out that they would be birthing by Caesarean, that the women faced a core problem of *being made redundant*, the key aspect of which included them becoming un-needed and invisible, disappearing 'behind' the Caesarean and being *written off* as not *real* women or *real* mothers by midwives, doctors, theatre staff, partners, friends, family, acquaintances and themselves (Sara Bayes, personal correspondence July 2008). Interwoven with these elements was the grief they experienced, which they largely had to deal with alone because the message they got from all sides was that there was nothing to be upset about, '*what's the big deal?*' (Sara Bayes, personal correspondence July 2008).

When Sara Bayes' research was completed, seven major categories had emerged under the category of 'becoming redundant' with four sub-categories – *feeling robbed, trying to make it feel real, becoming persona non grata, travelling a new path blindly* – describing how the need for and decision to schedule an elective Caesarean affected the women and how they dealt with it. The remaining three sub-categories described the factors which influenced the woman's response to needing a Caesarean – *expecting birth would be natural, Caesarean section is hospital not women's business, hurtling towards d-day* (Bayes et al 2012b). This study provides a rich resource for comparison with the findings from my study.

Developing a conceptual framework

Having reviewed the literature available to me, I began to hone my research interests and questions. Many of the studies I reviewed compared women's experience of Caesarean birth with vaginal birth but women having a Caesarean birth were perceived to be one homogenous group rather than being distinguished by whether their Caesarean was planned or unplanned (Mould, Chong et al, 1996; Montgomery, 2004; Porter, van Teijlingen et al, 2007). In other cases, it was not easy to separate out planned primary Caesarean experience from a planned repeat Caesareans. Some studies did make distinctions between classifications of Caesarean but individual women's experiences were not included. The focus was on what information should be provided to women, rather than an extrapolation of the information women could provide – the source of the expertise, therefore, was professional knowledge not women's experience.

In studies that did concentrate on women's experience, the focus of that experience was often an *endpoint*, measured by clinical outcomes for mother and baby, for example, breastfeeding success (Karlstrom, Engstrom-Olofsson et al, 2007), genital tract morbidity and sexual function in the mother (Griffiths, Watermeyer et al, 2006; Handa, 2006) and sexual satisfaction for the partner (Gungor, Baser et al, 2008)), rather than maternal experience and *meaning*.

Some studies in the UK (Montgomery, 2004; Emmett, Shaw et al, 2006; Moffat, Bell et al, 2007) and abroad (Ukpong and Owolabi, 2004), Cheung, Mander et al, 2006) described women's involvement in the decision to birth by Caesarean. Other themes included perceptions of fear of childbirth and interventions to tackle these fears (Bewley and Cockburn, 2002); obstetricians' motivations for supporting maternal request for Caesarean and female obstetrician's preference and birth choices (Thomas, Paranjothy et al, 2001). One study reported women's refusal to have a Caesarean (Ukpong and Owolabi, 2004). But, as stated previously, women's accounts of their experience of Caesarean birth were missing from these studies and the 'choice' and 'decision making' often related to the professional's choice and decision-making, not the woman's, for example, mode of birth with a breech presentation (Hannah, Hannah et al, 2002).

Where women's views were surveyed, such as in the Sentinel audit, (Thomas, Paranjothy et al, 2001), women were given structured statements with which to agree or disagree. There was no information as to whether this framework for understanding women's perceptions was themed from knowledge of women's experience or suggested by clinicians.

Sara Bayes' study provided the richest resource for decisions that I made about the direction for my study. Meeting Sara and hearing her talk about the approach and scope of her research when I was in the early stages of exploring the design and methodology for my proposed research made me question what my research could add. Before I met Sara I had already considered my research topic and focus. I had decided to explore women's stories of planned Caesarean birth in their first pregnancy using a narrative analysis approach. My aim was to understand what this experience was, what it meant to women and how they integrated this experience into their lives. I reflected on the scope and focus of Sara's research to see what further research (by me) might add:

Sara's research provided new knowledge about how women experience and respond to an unwanted and unforeseen change in their childbearing journey (Bayes, 2010) and therefore excluded women who chose to have a Caesarean birth. I had already decided not to separate the experience of women who *chose* a Caesarean over women who *needed* a Caesarean. I believed

that our knowledge of *how* Caesarean is experienced and integrated as a life event was so limited that I might be foreclosing the potential knowledge I could gain on *what* the experience of planned Caesarean is, if I made assumptions about the significance of *why* women have a Caesarean to how they experience it.

Of the women interviewed in Sara's study, eight were having their first baby while the remaining 20 had between one and four children already (Bayes et al, 2012b). Although Sara found the responses of women in her study to be similar, regardless of parity, I believed that my research would, by focussing on planned Caesarean as a primary experience, add depth by asking: *what meaning do women give to their experience of a planned Caesarean and of becoming a mother through Caesarean birth?*

Because the women in Sara's study lived in Western Australia it is likely that the social construction of birth may be different to those described by women in England. The question I asked myself, therefore, was: *What can narrative approaches, which focus on storytelling to bring to light impressions of self-concept and social construction, reveal of how women who have planned Caesarean become mothers; and how does this relate to current childbirth beliefs and practices in England?*

Sara used grounded theory methodology to explain 'what is going on' from the participant's perspective and used this to generate theory that conceptualised the meaning, experience and behaviour of women having medically initiated planned Caesarean (Bayes et al, 2012a). Women were asked open questions as part of a semi-structured interview and Sara used short passages of women's own words to illustrate how categories were derived and theory generated.

In my research I wanted to try to understand how individual women understood and constructed their experience of planned Caesarean birth in their first pregnancy. Specifically, I wanted to understand:

What meaning do women give to their experiences of planned Caesarean birth?

What phenomena appear in women's stories of birth by planned Caesarean?

How does a woman's personal experience of birth (by planned Caesarean) relate to dominant discourses of childbirth and the social construction of birth?

Although it may be possible to extract an impression of an individual woman's experience of a primary planned Caesarean birth through extrapolation of the key findings from all the studies in my review presented here, I felt this would be an approximation of a total, lived experience.

Instead, I wanted to take an approach to gaining knowledge about planned Caesarean that would be inductive; that is, proposed, constructed and contextualised by the participants rather than the researcher. I felt that I needed to focus on women's personal narratives of their experience and take a narrative inquiry approach.

Narrative research examines the ways research participants order the flow of experience to make sense of events and actions in their life (Riessman, 1993; Holloway and Freshwater, 2007). This approach analyses how the story it is put together and the cultural resources it draws on (Riessman, 1993). A full explanation of my narrative approach is contained in Chapter 3.

Conclusion

This review of the literature helped me to begin to develop research questions and a conceptual framework for my study. I could find no published empirical studies of women's accounts of their experience that exclusively pertained to primary, planned (no labour) Caesarean birth using interpretive methodologies. There were studies which provided detailed outcome measures, emotional responses to the need for Caesarean birth and the complexities of decision making about mode of birth using women's views. There were also texts that challenged the increase in Caesarean births and debated why this might be. In most cases, individual women's voices were not used to present or frame the data of their experience and their experience was not contextualised into a coherent story of planned Caesarean birth. The exception to this was an Australian study of women's experiences of unwanted scheduled Caesarean. This study included women who were first-time mothers and women who had previously had children.

From my review of the literature, I felt that my research needed to focus on the experience of Caesarean and how this experience may inform professional knowledge and practices. I believed that what was still unknown was the whole *story* of planned Caesarean birth; the lived experience of birth and what lies beyond the Caesarean itself and how women integrate this experience into their lives. My intention, therefore, was to examine, in detail, women's lived experiences of birth by planned Caesarean in their first pregnancy by exploring their personal narratives.

In the next chapter, I continue to build on my conceptual framework by describing my methodological and theoretical approaches to my research study and how these underpin my research questions.

3. Methodological approach and theoretical framework

'Just as music is noise that makes sense, a painting is colour that makes sense, so a story is life that makes sense.'

Yann Martel (2010) *Beatrice and Virgil*, p. 15, Canongate.

Introduction

In this chapter I describe the conceptual and theoretical frameworks that have informed my choice to use narrative inquiry methodology to research women's experiences of planned Caesarean birth. I outline common opposing research paradigms and present my viewpoint in the context of the research paradigms most commonly represented in childbirth research. I explore how this has shaped my choices for research questions, research methodology and research design. I present the theoretical perspectives of narrative research techniques and the reasons why I have taken this approach. This narrative inquiry approach has influenced my choices for research design, which is discussed in Chapter 4.

Conceptual framework

In common with other researchers, I believe that producing high-quality research necessitates choosing the most appropriate methodology to answer the research questions together with a systematic, transparent and rigorous approach (Bryman, 2004; Holloway, 1997; Silverman, 2000).

It was important to me that my approach to my role as a researcher harmonised with my identity as a midwife (Carolan, 2003) and reflected my beliefs about the nature of reality (ontology) and what can be known (epistemology). These philosophical positions influenced my decisions about research design (see Chapter 4) and determined which methodology I felt would best suit my research questions (Koch and Harrington, 1998; Denzin and Lincoln, 1998; Morgan, 1998). I therefore looked at the context in which I practise as a midwife.

In the research context two primary scientific paradigms provide the backdrop against which other paradigms and perspectives operate (Denzin and Lincoln, 2000). These are commonly referred to as positivist and naturalist/interpretivist paradigms. With a positivist approach, the researcher's task is to make accurate observations about objective reality, ensuring that error and

bias are eliminated in order to identify cause-effect relationships to reveal scientific 'truths' (Marks, 2002). In naturalist/interpretivist approaches, the researcher attempts to understand the different meanings of different situations and events for people and the social processes whereby these meanings are created. Multiple realities are viewed as contingent on social relations and concepts. In this paradigm, researchers investigate how context and interpretation, including those of the researcher, influence our experience and understanding of the world (Marks, 2002).

These two primary research paradigms are also reflected in maternity care and childbirth practices where biomedical and social/holistic paradigms are described as being synonymous with positivist and naturalist methodologies respectively. It has been argued that the biomedical model provides the dominant culture and that research within this medical paradigm is mainly positivist in philosophy (Crossan 2003; Davis-Floyd, 2003). Both positivism and medicine were aligned to Cartesian dualism, which imagined a separation of mind and body (Robinson, 1998; Crotty, 2005). This conceptual distinction brings about a subject-object split '*which suggests that we can engage in scientific study of the universe utterly divorced from any consideration of the mind (or subject)*' (Crotty, 2005 p. 217).

From this perspective, knowledge, derived from logic and reason, is seen as being separate from belief (Hope and Waterman, 2003) where ideas of 'truth' and 'evidence' are allied to research methodologies that are quantitative in their data collection and analysis. These methods favour looking at objective data rather than the subjective experience of individuals. Most commonly, studies involving meta-analysis and randomised controlled trials being held as the 'best' form of evidence on which to base care decisions (National Institute for Clinical Excellence, 2001).

Feminist researchers over the last 30 years have contributed to debates on childbirth practices and developed a strong critique of the biomedical model, claiming that, in this model, childbirth is viewed as being problematic, potentially pathological and only physiological in retrospect (Hewison, 1993; Davis-Floyd, 2003; Crossley, 2007). This perspective is further criticised for being interventionist and reductionist: interventionist because birth is perceived to be mechanistic and women are fragmented into body parts and bodily functions (or dysfunctions) (Hewison, 1993; Davis-Floyd, 2003) to be controlled and monitored (Oakley, 1980; Davis-Floyd, 2003); and reductionist by limiting the possibilities of meaning and embodiment.

The midwifery profession is attributed with having a holistic approach to childbirth. From this perspective, a woman's life experiences and her individual social, economic, political and cultural contexts are acknowledged as being pivotal to her lived experience of health (and illness).

Research in midwifery has been mainly interpretivist in nature, aiming to describe and explore, in-depth, phenomena from a qualitative perspective (Crossan, 2003) focusing on the individual and their lived experiences. Historically, these competing paradigms have produced tension and conflict within maternity care and within the acknowledgement of the research that informs this care (Davis Floyd 2001). Although there is some headway in the two paradigms coming closer together, this caricature of the biomedical and holistic paradigms still exists however; these viewpoints are not exclusively held by one profession or the other.

Maternity services are credited with having a longstanding history of valuing women's views, choices and experience of birth to inform practices and policies (NHS Institute for Innovation and Improvement, 2006). Despite this, my review of the literature revealed, with few exceptions (Clement, 1995; Bayes et al, 2008), that there was very little research into planned Caesarean birth that related to the epistemological stance of childbirth within the interpretivist paradigms. The experiences of women having a Caesarean, particularly a planned Caesarean, were often absent or grouped, suggesting that women's individual experiences were not important or that they could be aggregated because they are all the same.

What was still unknown was women's lived experience of birth by planned Caesarean beyond the operation itself; what this experience meant to women and how they integrated their birth experience into their lives. I believed that my research needed to focus on the experience of Caesarean and how this experience may inform professional knowledge and practices. I therefore drew on the interpretative paradigm of qualitative methodologies to design my study as they attempt to make visible, and make sense of, the lived experiences of planned Caesarean birth.

Qualitative researchers use a wide range of interconnected interpretive practices which make the world visible in different ways (Denzin and Lincoln, 1998). Researchers are always hoping to get a better understanding of the topic under investigation (Denzin and Lincoln, 2005) by employing an appropriate strategy of inquiry. Bold (2012) argues that there needs to be a balance struck between starting from, on the one hand, an experiential framework and on the other, a theoretical framework. She argues that a theoretical approach tends to lead researchers towards positivist frameworks for exploring experience. Clandinin and Connelly (2000), however, state that starting from experience can lead you to a lack of criticality in the research. I tried to reconcile these viewpoints by returning to my review of the literature on planned Caesarean experience, my exploratory research questions and my ontological and epistemological positions to help me select the methodology that best suited my research aims. Fundamentally, it was the stories that I had heard from women as they told of their experience that have profoundly

affected the way I practise and my wish to research this topic. I wanted to listen to women and learn from them and I believed a narrative research approach would enable me to do this. I chose to study personal narratives using narrative research methods as storytelling is a common and naturalistic form of capturing the experience of events, particularly life events such as childbirth. Most children, as they begin to try to make sense of who they are, have asked their mothers to describe how they were born, by questioning how they came into *'being'*. A narrative approach appeared to offer me a way to explore how women made sense of their experience as, through storytelling, past events become integrated into a whole, meaningful experience as happenings are organised and connected (Riessman, 2008).

Theoretical approaches in childbirth research

Midwifery research of childbirth experience is inherently phenomenological in its philosophical perspective as it seeks to explore a woman's embodied, experiential meanings – that is, to offer insights into how a woman makes sense of her experience of birth. For this reason, my initial starting point had been to approach my research design within a phenomenological framework. However, as my readings of philosophical literature deepened, my theoretical underpinning shifted towards a narrative inquiry methodology. The following section and a graphic representation (see Figure 1) traces my philosophical and theoretical journey to deciding on a narrative inquiry methodology as the best framework with which to explore my research topic and answer my research questions.

Midwifery education draws on a body of knowledge (epistemology) that presents childbirth as a major life experience that is holistic, individual and subjective. Phenomenology focuses on human activity and experience to explore meaning through exploration of that individual lived experience. This complex understanding of experience *'invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world'* (Smith et al, 2011, p. 21).

To varying degrees, phenomenological research in childbirth sees women as individual and particular and/or social and situated. This mirrors the different emphasis and interests amongst phenomenologists, from Husserl finding a means by which someone might come to accurately know their own experience of a given phenomenon to identify the essential qualities of that experience (which then might illuminate a given experience for others too) to Heidegger's

concept of a situated being, whose perceptions, awareness and consciousness of being caught up in the world reveal that world and its meaning (Heidegger,[1927], 1978; Smith et al, 2011). This makes the phenomenological study of experience both a singular and also a pluralist endeavour – on the one hand, experience is uniquely embodied, situated and *perspectival*, on the other hand it is a worldly and relational phenomenon (Smith et al, 2011). Building on the work of Merleau-Ponty (1962), who conceived of a body not as an object in the world but as our means of communicating with it (Merleau-Ponty, [1962] 2013; Morris, 2012), Smith et al, 2011) describe how the singular and pluralist approaches can meld: *‘concerns with subjectivity and embodiment come together when we think about how we see another: my perception of ‘other’ always develops from my own embodied perspective* (Smith et al, 2011, p. 19).

In the case of explorations of experience through storied texts, the phenomenological approach is interpretive (Hermeneutic). Moving from the works of Husserl to Heidegger and Gadamer, Hermeneutic theory adds another layer of complexity to phenomenological approaches by focussing on the act of interpreting experience. Hermeneutic approaches focus on the relation between the context of the text production and the context of a text’s interpretation. It reflects an awareness that the reader, listener or researcher brings with them prior experiences, assumptions and preconceptions and they cannot help but perceive in the light of their own prior experience.

Where Husserl advocated attempts to ‘bracket’ the taken-for-granted world to focus on perception of that world, Heidegger proposed that interpretation was founded upon preconception (*fore-conception*) and that fore-conception should be systematically worked through during encounters with the text. Gadamer argued that, rather than putting one’s preconceptions upfront before doing the interpretation, one may only really get to know what the preconceptions are once the interpretation is underway: *‘the important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings.’* (Gadamer [1960] 2012 p. 271).

A key concept within Hermeneutic theory is the Hermeneutic circle. This circle describes how the analysis and interpretation of texts is revealed through a dynamic relationship between the part and the whole. Through this analysis, meaning of the word becomes clear when seen in the context of a sentence. At the same time, the meaning of the sentence depends upon the cumulative meanings of the individual words (Smith et al, 2011). This requires close interpretive engagement on the part of the listener or reader who is required to reflect on their preconceptions as part of this cycle, too (Smith et al, 2011).

Gadamer also emphasised the culturally and historically situated nature of experience (Gadamer, [1960], 2012; Langdrige, 2007), believing that we are *meaning makers* thrown into a world of experienced interpretations communicated through language. This language is infused with the culture into which it was thrown and so it '*brings humanity into existence*' (Langdrige, 2007 p. 43) by containing notions of self and culture beyond simply telling us what people think or feel (Gadamer [1960], 2012; Langdrige, 2007). This focus on understanding meaning (hermeneutic empathy) through a fusion of reader and text is a foundation concept of phenomenological psychology (Langdrige, 2007).

Ricoeur ([1984] 1990), also combined phenomenology description with Hermeneutic interpretation in the traditions of Heidegger and Gadamer but moved beyond understanding meaning as a purely demythologizing and empathic pursuit (Langdrige, 2007). Instead he described an approach which seeks to also demystify text through interpretation. This Hermeneutic *suspicion* involves an attempt to '*dig beneath the surface for hidden meaning*' much like psychoanalysis (Langdrige, 2007, p. 53). In later life, Ricoeur shifted his attention from phenomenological hermeneutics to narrative; from understanding meanings communicated through language to spoken speech as discourse, where function and tone of the narrative is analysed in addition to thematic content. This shift recognises that language takes on a symbolic function as discourse and that behind every discourse there is a person speaking whose narrative is a propositional (purposeful) act containing an ascribed meaning (Ricoeur, 1990).

Narrative inquiry methodology and what it offers

Narrative research (referred to interchangeably as, narrative analysis, and, narrative inquiry) is a popular research method in nursing and midwifery, which examines the ways research participants '*construct their world*' (Holloway and Freshwater 2007, p. 15). The study of narrative does not fit neatly into one academic field (Riessman, 1993) and covers psychology, psychotherapy, education, sociology and history (Lieblich et al, 1998), literature (Culler, 2000), sociolinguistics and pragmatics (Yule, 2003). Narrative research methods can be defined as '*a family of approaches to diverse kinds of texts, which have in common a storied form*' (Riessman, 2006, p. 186). Narrative inquiry is concerned with the systematic analysis of personal stories (Riessman, 2008), most commonly from spoken words, although written texts (Holloway and Freshwater, 2007) and even visual data are possible (Riessman, 2008).

The central premise of narrative inquiry is that narratives connect events in a meaningful way for a specific audience, offering insights about the world and or experiences of it (Hinchman and Hinchman, 1997). This fitted with my desire to be able to draw on 'whole' stories as a resource for my professional knowledge. Whole stories are important as they contain *emplotment* (Ricoeur, [1984] 1990), a process which '*configures temporal elements into a whole by 'grasping them together' and directing them towards a conclusion or end*' (Polkinghorne, 1991, p. 141.) Telling stories (narrativity) is a cognitive process, so studying narratives which have been ordered into a '*meaningful whole*' (Polkinghorne 1991, p. 135) enables a deeper understanding of the purpose and meaning of the story, as events are studied in relation to the plot.

I believed that my exploratory research question: *What can we learn from women's stories of planned Caesarean birth?* could be answered using narrative methodology by examining the meaning women give to their experiences of planned Caesarean birth. Narrative research examines the story itself and how the storyteller orders the flow of experience to make sense of events and actions in their life (Polkinghorne, 1988). Stories imitate life and present an inner reality to the outside world (Lieblich et al, 1998). Stories are representations of experience and contain judgements, assumptions and reasons. Therefore, narrative approaches analyse how the story it is put together and the linguistic and cultural resources it draws on (Riessman, 1993). Because of this, analysis in narrative studies is able to explore forms of telling about experience, not just the language used but also studying *why was the story told this way?* I felt that this characteristic would help me to explore not only the phenomena that appear in women's stories of birth by planned Caesarean, but also how each woman integrated this experience into her life.

Narrative inquiry also provides a method for exploring self-concept and identity against social constructions because people wish to make sense of their experience by telling a coherent, *contextualised* story. Therefore, it is necessary to capture lived experience and explore the cultural contexts and social structures in which the stories are told (Riessman, 1993). This reinforced my desire to explore both the individual, unique and personal accounts of experience by women having a planned Caesarean and how they were told within the context of dominant narratives of childbirth.

However, it is important to recognise that stories are (social) constructions. As such, they are not factual accounts, but subjective realities: meaningful constructions of past events and future possibilities. As such, they contain narrative truth: '*the story is one's identity, a story created, told, revised and retold throughout life*' (Lieblich et al, 1998, p. 7).

Narrative inquiry has its own set of theoretical concepts upon which epistemological perspectives can be applied to signpost congruent and divergent assumptions. Described as inherently interdisciplinary, narrative inquiry does not fit neatly within the boundaries of one philosophical framework but has developed alongside interpretive disciplines (Riessman, 1993).

Epistemological considerations, therefore, need to enhance the methodology by bringing with them reference points of meaning and should link the topic under investigation and with the skills and world view of the researcher. However, before finalising my approach I briefly considered other methodological approaches common in midwifery research; ethnography and grounded theory.

Ethnography is a qualitative research method which reflects the knowledge and system of meanings which guide the life of a cultural group; the aim being to learn and understand cultural phenomena (Tedlock, 2005; Reeves, 2008). Data collection is often performed through participant observation, interviews and questionnaires (Tedlock, 2003). In the case of my research topic this would inevitably involve observation of the Caesarean operation itself. My desire to be inclusive in my recruitment of participants to my study meant that I wished to recruit women from across England. Pragmatically, it would have been difficult to obtain the ethical permissions and access to NHS Institutions necessary to be able to be present in theatre during the operations, which would have compromised my intentions for broad geographical recruitment. I also felt that observing what happened in the operating theatre might stifle or direct women's stories of their experience. I had learnt previously from my professional experience of providing listening services to women, that sessions where the woman's formal record of events (medical case notes) were put to one side, for the woman to tell the story of her experience, were far more beneficial than sessions where the case notes were used to frame that experience. In my research, I was looking for representations of meaning, not seeking to validate women's experience with my observation or realistic descriptions. My research study was not attempting to explore *what happened?* so much as *what meaning did someone make of what happened?* I wished to understand phenomena through the meanings that people assign to them.

With Grounded Theory, the goal is to develop theory from systematically reviewed data obtained from real-life settings of which little is known (Benton, 1996). The question the researcher repeatedly asks in grounded theory is *What's going on here?* This discovery and proposal of theory is achieved through the analysis of data using systematic and successive levels of data analysis (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Charmaz, 2005; Bayes, 2010). While there are similarities in the techniques of data analysis between grounded theory and narrative

analysis, particularly with regard to the categorical content analysis approach described by Lieblich et al (1998) (see p. 82, in analytic concepts), greater attention may be paid to holistic concepts of meaning (through analysis of holistic content or holistic form) which keep the story whole and dialogic. With this holistic approach to analysis of narratives it is possible to reveal what Bruner describes as *illocutionary intentions* (Bruner, 1990), that is, the narrator's desire to communicate the meaning of their story. This narrative approach captures the emotion of the moment described, rendering the event active rather than passive, infused with the latent meaning being communicated by the teller. In this way, narrators *tell* to create meaning in the listener. In narrative research what is *not* said is also significant — whereas, in grounded theory, the words used become the primary focus of analysis, in narrative research, analysis of the text also involves letting the story 'speak to you' and 'hearing' what was not said (Lieblich et al, 1998). This acknowledges that how the narrator decides what (and what not) to tell is part of the making sense of the experience and deriving meaning.

Historical development of narrative research

Contemporary narrative social research has developed through two parallel (academic) paths; the post-war rise of humanist approaches in sociology and psychology and developments in narrative analysis in humanities (Squire et al, 2008). The first approach posed holistic, person-centred approaches (case studies, biographies and life histories) as a challenge to positivist empiricism (Polkinghorne, 1988; Bruner, 1990; Squire et al; 2008) ; the second reflected the development in narrative, from Russian structuralism through French post structuralist, postmodernist, psychoanalytic and deconstructionist approaches (Squire et al, 2008). Both strands were interested in the content and form of the story but, unlike the humanist approaches, the humanities were concerned with narrative fluidity and contradiction, with unconscious as well as conscious meanings (Squire et al, 2008). Rather than singular, unified and empowered storytellers, this approach assumes that multiple subjectivities (teller, hearer, writer and reader) are involved in the production and understanding of narratives. This stance is preoccupied with the social formations shaping language and subjectivity: '*In this tradition the story teller does not tell the story so much as she/he is told by it*' (Squire et al, 2008, p. 3).

These distinctions in the historical development of narrative research initially seemed problematic to me when I was trying to identify my (researcher) position. As a midwife, I work in a profession which advocates holistic approaches to woman-centred care and a need to

understand and respond to individual experience. I had turned to narrative inquiry as a method which assumes that narrative exists as an external expression of individual, internal representations of phenomena, thoughts and feelings. This seemed to fit with humanist narrative and phenomenological approaches. However, some midwifery researchers, particularly feminist researchers, are more challenging of traditional approaches to and representations of women's experience and focus on power discourses. My study related to women having a planned Caesarean birth in their first pregnancy. These women represent a minority within childbirth experience and discourses. These factors fitted with developments in narrative research in the humanities. Remembering the moves within phenomenology and hermeneutics, previously described, and returning to Riessman's assertion that narrative research is inherently interdisciplinary (Riessman, 1993), I resolved my dilemma by realising that I did not need to prematurely fix the theoretical assumptions in my narrative approach prior to consideration of the narratives presented to me, and my analysis of the phenomena and social constructs described and presented within them.

Developments in my approach

As my readings of narrative theory and my experience of narrative methodology developed, I found that my approach began to be more heavily influenced by moves that were more aligned to disciplines within the humanities and feminist approaches. In particular, I was influenced by the work and writings of Bakhtin, Barthes, Somers and Gilligan and I found an affinity with the positions taken by contemporary narrative researchers – Catherine Kohler Riessman, Molly Andrews, and Natasha Mauthner and Andrea Doucet – who all take a pluralist approach to subjectivities and a multi-level and dialogic/relational approach to narrative potential. These shifts have, in particular, influenced my approach to data analysis, the write up of my research, my research claims and issues of validity within my research (see Chapter 9).

Theoretical divisions within narrative research largely revolve around concepts of subjectivity, social influences and the narrative itself (Squire et al, 2008). Here I outline the particular theories described by Bakhtin, Barthes, Somers and Gilligan et al, that pertain to these elements and then I describe how they have influenced my narrative approach.

Mikhail Bakhtin (1895-1975) was a Russian philosopher and literary critic and theorist (Frank, 2005), whose diverse work examined the way language registered the conflict between social

groups (Brandist, 2002) and later, the dialogical possibilities of the novel (Bakhtin, 1984). The concept of *dialogism* dominates Bakhtin's work and theories (Bakhtin 1981). Bakhtin used the terms *polyphony* (many-voiced) and *heteroglossia* (an other's speech) to describe how speech is a complex cultural discourse (Bakhtin, 1981; Irvine, 2012), where the speaker's multiple and often contradictory *selves*, are infused with the voices of others. For Bakhtin, utterances were always already embedded in the social and historical expressions of others in a living context of exchange (Irvine 2012). They also contain what Bakhtin referred to as *addressivity* and *answerability* (Bakhtin, 1993) in that the words were always dialogic (by being always addressed to someone) and anticipating a response (Irvine 2012). Another key concept for Bakhtin was *unfinalisability* (Bakhtin, 1984, [1986] 2013). This concept was derived from his insight into a character in a Dostoevsky novel named Devushkin. Devushkin exemplified a new kind of literary character that was formed in dialogue with other characters but who, in apparent dialogue with the author, was able to express his dissatisfaction at being '*hopelessly predetermined and finished off*' (Bakhtin, 1984, p. 58) thus freeing himself from authorial omniscience (Frank, 2005). This concept has two implications; firstly, that subjectivities should not be *finalised* by means of producing a (historically contingent) narrative account and secondly, that the interpretation of narratives is open to being perpetually retold and regenerated:

'Dialogic expression is unfinalisable, always incomplete, and productive of further chains or responses: meaning is never closed and always orientated towards the future' (Irving, 2012).

Additional detail on how Bakhtin's theories have shaped my research design and methods can be found in Chapter 4.

Roland Barthes (1915–1980) was a French literary critic whose essay, '*The Death of the Author*' (Barthes [1967], 1977), argued against the move in literary criticism in which the author was central to literary studies and critical thinking (Culler, 2002). He challenged the assumption that the '*meaning of a work is the product of a self-determining author in control of his meanings who fulfils his intentions and only his intentions*' (Lye, 2000, p5). Barthes saw this privileging of the author as a positivist move -an attempt to obtain an authentic reading of the text, which he found limiting: '*To give a text an author is to impose a limit on that text, to furnish it with a final significance, to close the writing*' (Barthes, 1977).

Instead, Barthes proposed his *reader-response* theory, which acknowledged the active, creative role of the reader in interpreting the text (Culler, 2002). He advocated a focus on the text which he saw as *a multidimensional space in which a variety of writings, none of them original, blend*

and clash (Barthes, 1977, p. 146; Culler, 2002). Barthes believed that texts were socially and culturally constituted - *a tissue of quotations drawn from the innumerable centres of culture* (Barthes, 1977, p. 146) whose readers were also socially and culturally located. For Barthes, this meant that the meaning of the text was open to multiple interpretation, fixed only by the action of the reader on the text, thus the reader was not perceived to be a consumer of the text but a producer of the text (Culler, 2002). Despite the startling title of Barthes' *'The Death of the Author'* essay, he did not believe that the author was unimportant, rather he believed that the text *existed as meaning- potential, the potential to be actualised within the meaning-realm of the reader* (Lye, 2000, p. 4).

My interest in the work of Margaret Somers and Carol Gilligan came from my desire to research women's lives, which inevitably led me to explore the ways in which feminist theories and perspectives could contribute to my research.

Subjects and subjectivities are keen concerns for feminist researchers. Somers' writings on narrative identity criticised the tendency for identity to be perceived as fixed, essentialist, singular and categorical (e.g. racial, gendered). Somers saw that *identity* was often theorised from essential (fixed) categories constructed from given attributes, such as race or gender (Somers, 1994). She argued that, if identities were fixed, there was no room to accommodate power relations or history itself. Instead, Somers proposed the concept of *narrative identity* and fused it with a relational and historical approach which avoided categorical constraints by *'emphasising the embeddedness of identity in the overlapping network of relations that shift over time and space'* (Somers, 1994, p.607). Somers' rejection of categorical forms of identity particularly interested me and influenced my decision to replace participant biographies with (individual) story synopses (see Chapter 6). Her work marked a shift towards feminisms that value difference as much as equality.

Social location is at the core of narrative identity as stories locate people to others (Grant et al, 2012). Somers' theories on the narrative constitution of identity led to developments in subjectivity and narrative identity in the concept of a *narrated subject*, who is active and constantly changing (Doucet and Mauthner, 2008) but who, through narrativity, constitutes her social identity. Thus self and identity are not seen as essential (or authentic) properties of the person but are contextually shaped and constituted in talk and social practice (Bamberg et al, 2007) although this does not preclude the possibility of a knowing, experiencing subject outside their narrative (Doucet and Mauthner, 2008).

This concept of a relational identity continued to be developed by feminist narrative researchers (Gilligan et al, 2003, Mauthner and Doucet, 1998). Gilligan challenged notions of universal and discrete agency and proposed comparative research into female behaviour *on its own terms*, viewing female 'otherness' as variation and difference, where difference was no longer devalued (Brown and Gilligan, 1992; Mauthner and Doucet, 1998). This shift to perceiving subjectivities in their (inter-) relatedness spawned a narrative analytic methodology called the Voice-centred Relational Method (or Listening Guide). This approach to analysis of narrative data requires the active participation of the researcher to listen to the many (and relationally constituted) voices in the narrative, including those of the researcher. These concerns with the subjectivities of the researcher, enact Barthes reader-response theory by requiring the researcher to actively incorporate their own responses to the narrative at the time of data analysis (Doucet and Mauthner, 2008). An in-depth exploration of the Listening Guide analytic method and how I operationalised it in my research can be found in Chapter 5.

In terms of the narrative itself, issues of authenticity of experience are of less concern than the meaning created in the telling (and listening): *'personal narratives are (amongst other things) meaning making units of discourse. They are useful for research precisely because narrators interpret the past stories rather than produce it as it was. The truth of narrative accounts are not in their faithful representations of a past world but in the shifting connections they forge among past, present and future.'* (Riessman, 2004, p. 35).

The extent to which a subject can be known and therefore the possibilities of narrative research into *experience*, continue to exercise and energise narrative researchers. Since the 1990s, narrative researchers have viewed social life itself as being storied, and that *'narrative is an ontological condition of social life'* (Somers, 1994, p.614). From this perspective, 'experience' is constituted through narratives by individuals who construct their identities by locating themselves within a repertoire of emplotted stories and cultural narratives (Somers, 1994).

Recent moves in narrative theory, described by Molly Andrews, offer new perspectives on narrative identity, particularly in the complexity of the construction of 'the other' (Andrews, 2014). Andrews explores the relationship between narrative and imagination in everyday life. By conceiving that imagination plays a role in the ordering of events and the creation and recreating of meaning, she offers narrativity as a way of playing out possible, imagined or alternative *selves* (Andrews, 2014). The origins of narratives have been traced back to the writings of Aristotle's *Poetics*, in which narratives were premised as having sequence: *'a beginning, a middle and an end'* (Shankar et al, 2001, p.433). In the perspective offered by Riessman's quote (above) and

Andrews work on imagination, I believe that narratives may now be released from the Aristotelian constraint of having a *beginning, middle and end* and recognised as being a vehicle for imagining a *future* (Andrews, 2014).

Feminist researchers have also been interested, in not only how stories are structured and the ways in which they work but in social structures at play – *who produces the narrative and by what means; the mechanisms by which they are consumed and how narratives are silenced, resisted or accepted* (Squire et al, 2008, p. 2). Research endeavours attempt to challenge dominant cultural narratives by extending the range of possible narratives available, drawing on the personal narratives of those who are perceived as marginalised or underrepresented. Recent research on motherhood (Mauthner, 2002; Miller, 2005) has continued to extend feminist thinking to recognise the diversity of experience, marking a shift away from universal notions of agency to considering ways of knowing and experiencing the social world (Mauthner, 2002). These theoretical positions have influenced my methodological approach.

Overview of the theoretical concepts underpinning my narrative approach

Narrative research is described as being inherently interdisciplinary. I have found that drawing from across different disciplines and approaches has enhanced my understanding of the possibilities of narrative research. Despite developing through different moves, there are shared principles which I have employed in my approach to my research study:

- Storytelling (narrativity) is inherently dialogic/relational.
- Individual subjectivities always contain the voices of others, whether these voices are resisted or embraced (Frank, 2005).
- Identity is multi-voiced and perpetually open (Grant et al, 2012).
- *'Participants are more than the analysis of their narratives and such analysis will not exhaust possibilities for the onward development of their lives'* (Grant et al, 2012, p. 850).
- The subjectivity of the researcher (listener/reader) is inseparable from the production of narrative meaning, therefore researcher reflexivity is an integral part of data analysis.
- Personal narratives are shaped by larger social and cultural narratives.

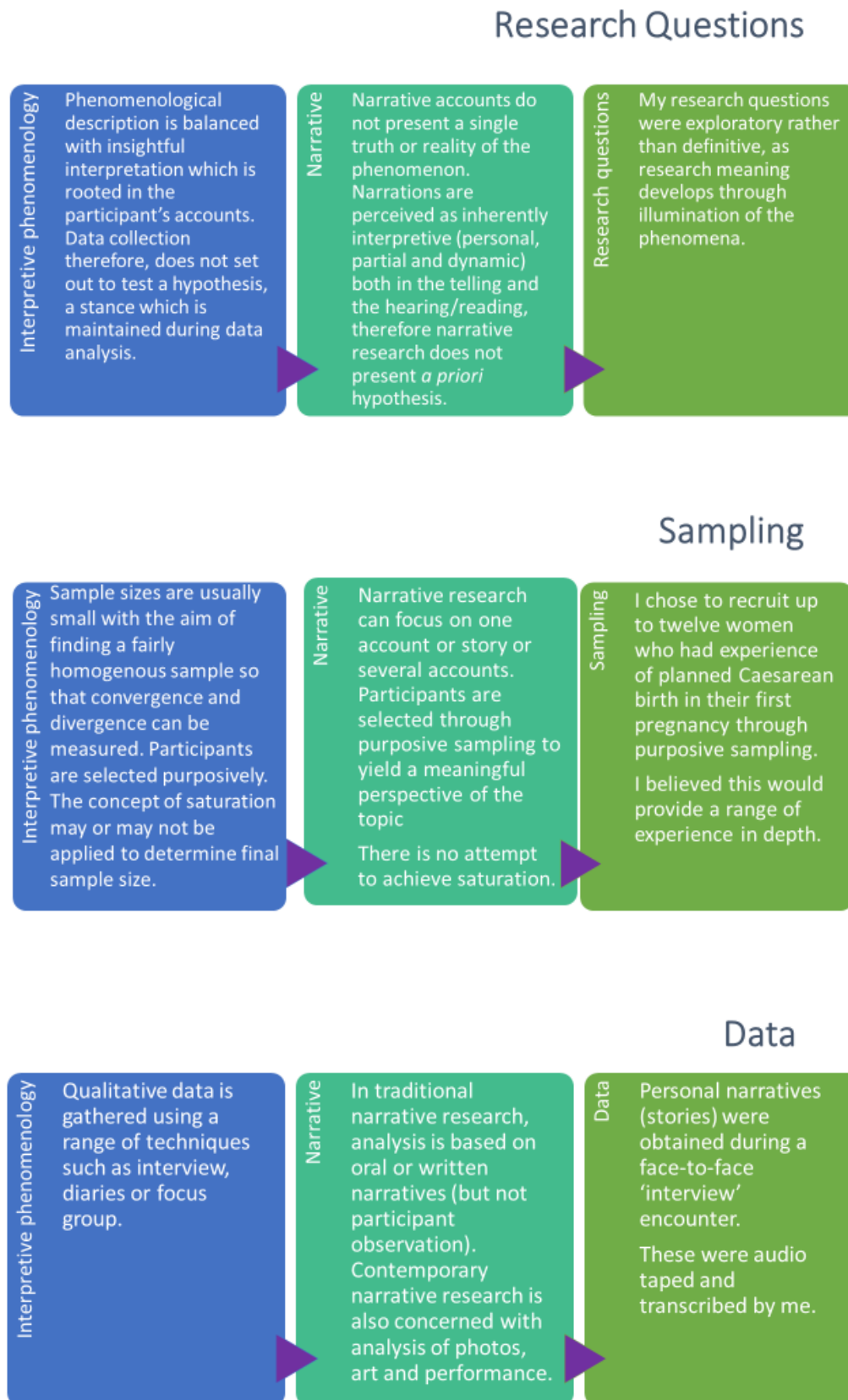
- Narratives, to varying degrees, may offer modes of resistance to existing structures of power.
- Narrative meaning resides in a relationship between the teller, the listener and the reader.
- Research claims are modest and unfinalised with the potential for revision and redistribution in the future (Frank, 2005).

These concepts serve as a framework with which to view my narrative approach. Although narrative inquiry and narrative analysis are terms that are often used interchangeably I have tried to demonstrate how taking a theoretical narrative approach (methodology) is always more than just an action on the text (method). As Baldwin (2004, p. 206) says '*narrative analysis is distinct from analysis of the narrative in that the dynamic of the narrative and the process of production of the story are facts in themselves rather than the analysis of the facts it contains*'.

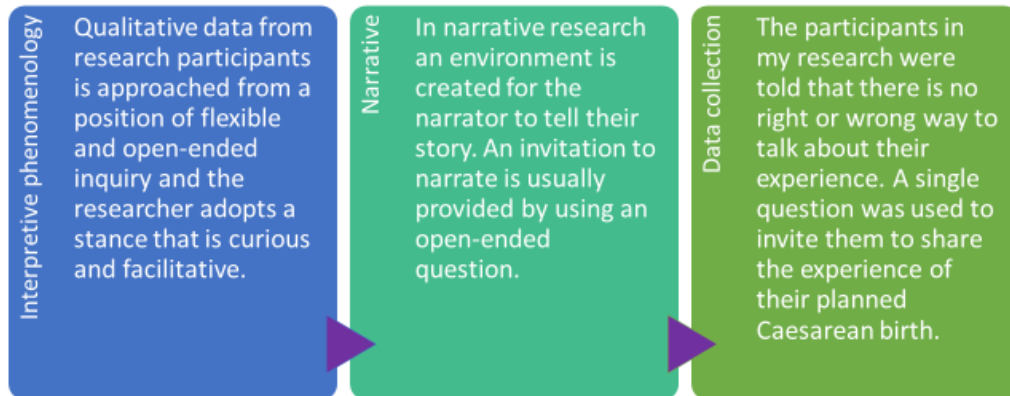
While there is no fixed way to design a narrative research project (Squire et al, 2008; Bold, 2012) researchers are encouraged to design a *fit for purpose* approach within a critical framework which can develop in parallel to the practical exploration of the topic (Bold, 2012).

In the schematic below, I have summarised the key concepts in narrative research and related them to my research design. These concepts have relational and iterative significance. I have attempted to make explicit the links and divergences between the theoretical concepts within narrative inquiry and interpretive phenomenology to reflect how my research has developed and what a narrative approach adds. Further details about the design of my study and the methods I used follows in Chapter 4.

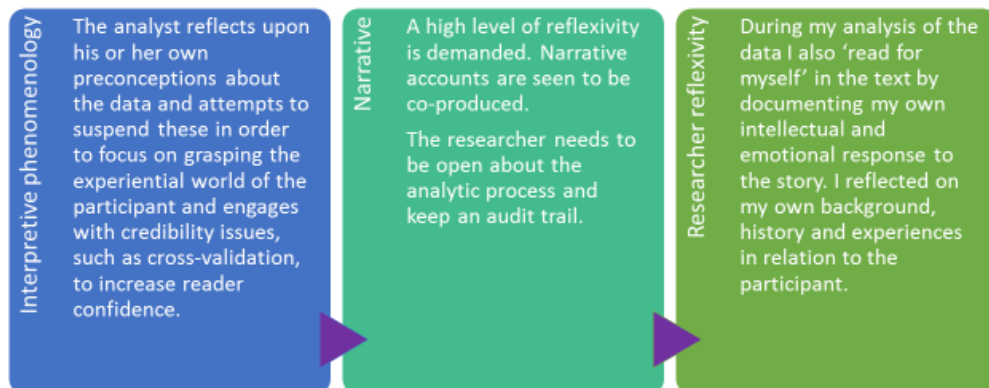
Figure 1. Theoretical framework and research design



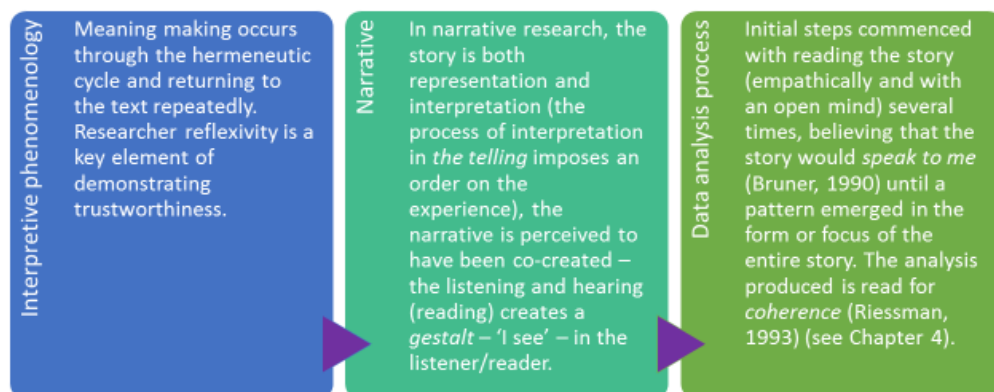
Data collection



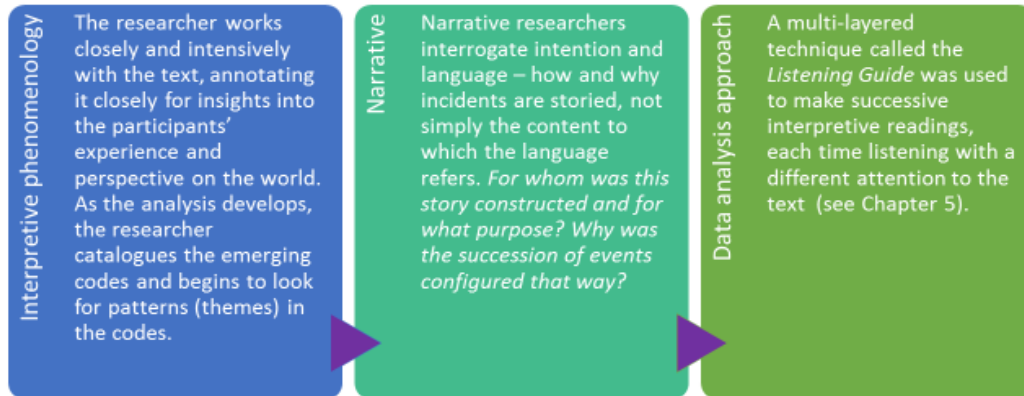
Researcher reflexivity



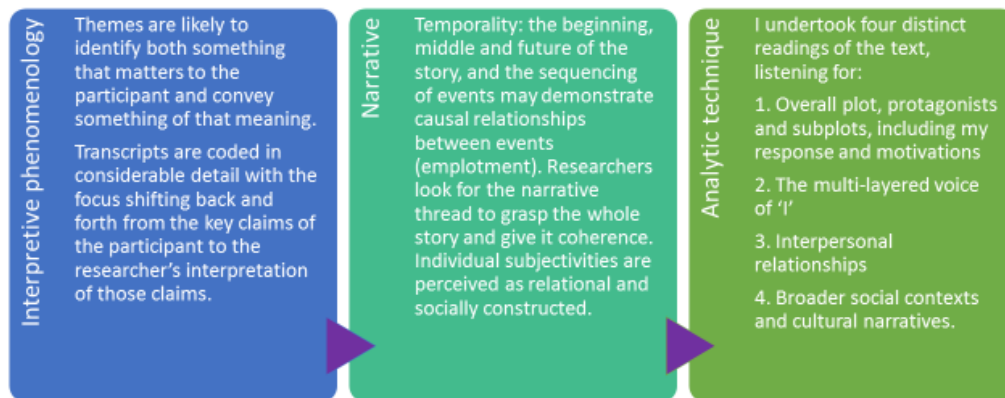
Data analysis process



Data analysis approach



Analytic technique



Data outputs



Conclusion

Taking a narrative research approach has enabled me to satisfy my research questions relating to the lived experience of planned Caesarean birth (the meaning, phenomena and discourses presented within women's stories) and, I believe, has provided me with a deeper understanding than I might have achieved through Interpretive Phenomenology. One of the most significant benefits (and challenges) with this approach has been the focus on keeping each story 'whole' in order to avoid producing an amalgam of experience or reducing someone's story to an element within it. In presenting my findings, the challenge has been to present the individual, personal narrative whilst drawing some conclusions across the narratives to provide a *metastory* that does not become a singular, authentic (grand) narrative of planned Caesarean experience. My experiences and critical evaluation of this aspect of narrative research are described in Chapters 6, 7, 8 and 9.

4. Study design and research methods

'Design is a funny word. Some people think design means how it looks. But of course, if you dig deeper, it's really how it works.'

Steve Jobs (1996) in *The next insanely great thing*, by Gary Wolf, Wired.com.

Introduction

In this chapter I present an overview of my study design and research methods, from exploratory research questions through to my rationale for analytic choices. Three women: Sharon, Sarah and Debs have had a direct impact on the approach, design and conduct of my research. These women have acted as advisors throughout the duration of my research and I describe how they have supported me and helped me to resolve key elements in the design of my research which tested my methodological assumptions.

One of the responsibilities of a researcher is to reflect their decision-making in the theoretical, methodological and analytic choices they make in their research strategy and process in order to demonstrate trustworthiness (Koch, 2004). This includes exploring research assumptions and the appropriateness of approach and design for the research topic and questions and showing how you resolved research problems (Trafford and Lesham, 2008). I present the ethical and research governance considerations which position my approach to the design before providing an account of my research journey. As a member of an NHS research ethics committee and as a midwife, I felt a responsibility for my research design to be effective and thorough in order for it to be worthwhile. My knowledge and experience of exploring research ethics has guided me to think and act ethically, both in my approach and the way I exercised that approach.

In narrative research, the narrative of the researcher is an important feature of the research strategy in order to *show the workings* of the (ultimately) produced *metastory*. In this way the reader can assess how the metastory was created and what may have been edited, reshaped or retold in turning it into a hybrid story (Riessman, 1993). The theoretical and philosophical underpinnings of narrative analysis methodology have also informed all elements of the study design. The elements I describe here have been compiled from the reflective journal I have kept throughout my research as an audit trail and I present them as signposts for the reader to show key decisions in my research and as a reflexive account of my choices and decisions.

Towards a participatory approach

My experience of listening to and working with women in my clinical practice and my belief in the principles of the partnership model (Guilliland and Pairman, 1995), which recognises women's experience and knowledge of childbirth as expertise (see Chapter 1), led me to set up a research advisory group. Members of the public bring perspectives and skills that are not always the same as those of researchers and health and social care professionals (Hanley et al, 2004; Beresford, 2007) and the main purpose of this group was to provide me with a different viewpoint to my professional, midwife perspective. I also wanted to try to ensure that the whole research process was focussed on what was important, relevant and acceptable to the users of the service (INVOLVE, 2008). As Hall (2009) reflects in her research with members of Gypsy and Traveller communities, *'How can we truly understand health care without taking a holistic approach that is shaped and guided by the experiences of the people who use it'* (p. 42).

I already knew Sharon, Sarah and Debs as they were members of a women's focus group at my local maternity service, which was designed to involve recent maternity service users in service improvement and redesign. I had facilitated this group for a number of years before going on secondment. I sought permission from the Head of Midwifery to return and attend one of the meetings to present my early research ideas and ask if there was anyone interested in providing me with support and advice during my study. I provided my contact details and invited anyone who was interested to contact me after the meeting. Sharon, Sarah and Debs responded that they would like to be involved and they have collaborated on some of the key elements of my research proposal and design. I have also had support from a friend, Imogen, who had experienced Caesarean birth and who agreed to have a pilot interview with me. She was invaluable in providing feedback on the interview question and the supporting information for potential participants.

Until recently, involvement of the public in research has been a methodological decision, rooted in participatory research approaches. These approaches are argued to not only benefit the research process, but are proposed as a political and moral imperative (Telford et al, 2002). The political imperative recognises the consumer's role in managing their own health; and the social and cultural influences through which research knowledge is appraised. Public involvement is seen as a moral endeavour by recognising the public as citizens and owners of the NHS (Telford et al, 2002). Telford et al (2002) argue that healthcare research has traditionally focused on knowledge for understanding while the public and healthcare users are more interested in knowledge for action. This shifts the focus to dissemination and

implementation of research findings. The involvement of the public in the research process leads to research that is more relevant to the public and more likely to be used. If research reflects the needs and views of the 'end user' it is more likely to produce results that can be used to improve practice in health and social care (Hanley et al, 2004; Beresford, 2007).

More recently, directives from the National Institute for Healthcare Research (NIHR) have encouraged public involvement in all research studies as an inherent part of good research practice (rather than a purely methodological one). Despite this, a study reviewing responses to the National Research Ethics Service (NRES) applications question on public involvement, showed that 43% of respondents seemed to misunderstand what the questions were asking (INVOLVE, 2011). Respondents appeared to conceive of public involvement in research as the use of people as research participants, rather than partners engaged in the choice of research topics, advising on project design or carrying out the research (INVOLVE, 2011).

I have titled this section '*towards a participatory approach*' as I don't believe that my research truly reflects all the tenets of collaboration that I believe would need to be in place to co-produce my research. As a doctoral student I did not feel that I had the scope to recruit and train women to become narrative interviewers but I feel that what I have managed to achieve is congruent with my methodological approach. I would be interested in taking a participatory approach to future research projects.

Sharon, Sarah and Debs have been invaluable in supporting me, contributing to my research design and enhancing my learning. I believe that this ultimately improves the credibility of my research. In particular, they helped me with the content and design of my website and they have been particularly helpful at key decision-making points (see section on data collection). During meetings with them, I have shared generalised interpretations and findings, discussed these with them and asked them to consider them in the light of their own experience. Drawing on their experience has helped me to further refine and inform the analytic stages of the study. They will also help me with dissemination of the findings via joint presentations and feedback to third sector maternity organisations (e.g. the NCT). These women have enabled me to feel confident about the integrity of my research and the relevance of my research to childbearing women and healthcare professionals.

Ethical considerations and research governance

During the preparation of the research design I had to consider the ethical implications of the study and ask myself: *Is this research ethical? Is the study well designed and set up to yield quality information? Does the contribution the study will have to midwifery knowledge justify and mitigate against the ethical issues?*

A number of ethical issues arose in this study and full ethical approval was sought and granted by the Faculty of Health and Social Science Research Ethics and Governance Committee (FREGC) and the NHS Research Ethics Committee (NHS REC). I made every attempt in the design of the study to limit the impact of these issues. There were no specific dis-benefits to taking part, however, women participants had recently experienced pregnancy and birth (by Caesarean operation) of their first baby. Pregnancy and birth are major life events and bring with them anxieties and expectations at a time of considerable physical and psychological changes. There are often changes to body image and self-concept and to the dynamics within close relationships. Some of these women had given birth very recently and so were adjusting to becoming a parent and the responsibility of caring for a new baby, recovering from abdominal surgery and were, most likely, sleep deprived. Detailed information about the study and what it involved was provided to any woman showing an interest in taking part, so that she had full knowledge of the level of commitment needed and she could gauge how this would impact on her individual circumstances. Information was provided to help women to assess the time commitment required before deciding to take part. The information leaflet and website stated that the 'interview' would last approximately 1 to 2 hours. I based this on my experience of listening to women's stories and on the pilot interview I conducted with my friend, Imogen.

Evidence suggests that women find sharing their birth stories helpful as part of making sense of their experience (Gamble and Creedy, 2005). For this reason, I was concerned that some women might feel that taking part in the research would benefit them and I needed to make sure that women did not take part in order to fulfil a wish to 'talk about their experience'. Although I was a practising midwife with experience in providing a listening service for women, my role during the interviews was that of researcher rather than practitioner and whilst some women may have found sharing their birth story therapeutic, this was not an objective of the interview.

Additionally, the narrative interpretive style I used relied on passive listening which, combined with the fact that I did not have access to the woman's medical notes, meant that validation of the woman's experience through listening and/or clarification of events was not possible. All women who expressed an interest in taking part in the research were made aware of local

postnatal listening services. I stressed that these services were available through self-referral and that there was no additional advantage in taking part in the research with regard to access to these services.

All women were informed that, as I was a registered midwife, I had a professional responsibility under the professional recommendations for safeguarding children, to report disclosure of any issues relating to child safety and the steps I would take if this should occur (supportive strategies and routes for referral). For women taking part in the study, this was reiterated just before the 'interview'.

Storytelling can be a powerful force for disclosure – I was concerned that women may tell me something that they weren't planning to say, which they may not wish to share. I approached *gaining consent* as an active process rather than a single step. Women were asked to sign a consent form prior to taking part in the study, then, once they had told me their story, I asked for verbal consent to use it in my research. All women were informed that they could withdraw from the study at any point without having to give a reason.

The narrative nature of the research meant that there were a small number of participants who provided detailed narrations using direct quotes. My default position was to use pseudonyms. However, having taken advice from my advisory group, all participants had the additional option to use their own names if they wished. Telling a personal story is very powerful and some women wished to be directly connected with their story and not remain anonymous. Six out of the eight women participants chose to use their own names. All women were informed prior to consenting that detailed passages and direct quotes would be used. Both these elements were specific features of the consent form (see Appendix 1).

Some women may have been excluded from my research if they did not feel able to express themselves in English. Because a key concept in my narrative analysis approach required stories to be told *first hand* I felt that the use of an interpreter would fundamentally alter the nature and possible outputs from my research, so I chose to only include women who felt able to tell their story in English. This may have excluded some women, although English was not the first language for two of the eight women who participated.

My initial preference for recruitment of women to the study was via a public website. Website recruitment is a relatively new concept but has many positive attributes: it enables broad (potentially global) recruitment, participants are self-selecting, they can revisit the site as many times as they like before deciding whether or not to take part, they are anonymous whilst

deciding if they wish to take part and they are recruited as members of the general public rather than by nature of being patients within the NHS, which means that they are unlikely to be influenced by their clinicians. However, I realised that it was also possible that this method could exclude women who did not have access to the internet, did not visit search engines for childbirth, or whose literacy skills reduced the likelihood of reading about the research. In order to increase the diversity of potential participants I used a second recruitment strategy. This method involved having named midwives in six sites across England (see Appendix 2) who were aware of the inclusion criteria and could raise awareness of the study to women who met the criteria, by showing them the information sheet and talking it through with them. The areas were chosen to reflect geographical spread and included areas of relative social deprivation. I was not seeking to specifically direct my recruitment to women with a specific social background but I wanted to provide an opportunity for women from diverse backgrounds and experiences to take part in research. This recruitment method required the support of a caregiver (midwife) who was known to them. To minimise the risk of persuasion, the midwives were asked to raise awareness of the study by talking through the information sheet with potential participants and then putting me in contact with any women who were interested in taking part. I was responsible for the recruitment process. I gave them full information about what was involved, I emphasised that their care would not be altered whether or not they took part in the study, and that they could withdraw from the study at any time without giving a reason.

I planned to carry out the research interview in participant's homes, which potentially made me, as the researcher, vulnerable. I used the University of Brighton's Lone Worker Policy which included safeguards, such as visiting in daylight hours and carrying a personal alarm and mobile phone. 'Interview' dates and times (and in some cases the contact details of the local midwife) were logged with a member of the University staff and I 'called in' to verify that I was safe following an 'interview'.

I was aware that my research was taking place against a background of concern at rising rates of Caesarean birth. In my information leaflet and on my website I explained that it was my intention to interview both women who required a Caesarean for medical reasons and women who requested a Caesarean and I stated that no judgement would be made on women's choice to ask for a Caesarean.

Exploratory research questions

In line with narrative theories, I rejected formal *a priori* research hypothesis in favour of broad lines of curiosity. As previously stated, the narrative inquirer does not have a problem to solve or a question to answer but, instead, focuses on an experience that is of interest (Clandinin and Connelly, 2000; Bold, 2012). However, I soon realised that it is hard to be convincing about the possible worth of a research study with people whose responsibility is it to safeguard the quality of research through governance frameworks (supervisors, faculty committees and ethics committees) if the concepts were too loose. I therefore initially proposed the following exploratory questions:

What is the experience of women who have their first baby by a planned Caesarean?

- What meaning do women give to their experiences of planned Caesarean birth?
- What phenomena appear in women's stories of birth by planned Caesarean?
- How does a woman's personal experience of birth (of planned Caesarean) relate to dominant discourses of childbirth and the social construction of birth?

These initial, exploratory, research questions were rooted in the philosophical concepts within phenomenology, namely that lived experiences of Caesarean birth could be understood through explication of the meaning of phenomena. This felt comfortable because they were firmly and theoretically situated. However, when I tested them out on my advisory group, they held little meaning and the concepts felt artificial and constructed. Following discussion, the group members helped me express my research questions differently and the revised questions were co-produced with them. *Significance* replaced *meaning* and *particular occurrences* replaced *phenomena* in the original text:

What is the experience of women who have their first baby by a planned Caesarean?

- What significance do they give to their experiences of planned Caesarean birth?
- What particular occurrences appear in women's stories of birth by planned Caesarean?
- How does a woman's personal experience of birth (of planned Caesarean) relate to how birth is seen in society?

This helped me in the initial conversations and discussions I had with my advisory group and worked well as high-level concepts that I imagined could ultimately be reworked and reframed by the stories of the participants. But later, during data analysis, I found that I naturally returned to

the original wording of the questions because this wording seemed to add a level of complexity which enhanced my analysis and because the stories I was told by the research participants seemed to echo that framework. By this time, I had met with my advisory group several times and we were developing a shared meaning (and language) of what my research was about and the original language no longer seemed obscure, but integral to the research perspective.

Having undertaken my first 'interview' I also adjusted the overview question to reflect my wish to *attend to the telling* of the stories and how these women's stories are passed on into childbirth knowledge. This action was prompted by feelings that I had during that first interview, namely that the telling of the experience was particular, unique and significant, created *in the moment* and *dialogic* in the manner described by Bakhtin, where '*each voice is formed in an ongoing process of anticipation and response to other voices*' and that each voice contains the voices of others (Frank, 2005, p. 966). This requires us to hear these women's stories not as captured observations of their lives outside the interview but as acts of engagements with researchers (Mishler, 1986). I realised that I had not paid enough attention to the passing on of this woman's story and what she was telling me of her experience and recognised that this *present* story had the potential for revision and redistribution in future stories in what Bakhtin described as perpetual generation (Bakhtin, 1981; Frank, 2005). I therefore revised my overarching research question to: *What can we learn from women's stories of planned Caesarean birth?* I hope this reflects the iterative nature of research findings towards a developing epistemology, the importance of effective dissemination and my appreciation that the narrators of these stories do not have identities that are exhausted and finalised by their stories of Caesarean birth.

Developments in my understanding of narrative theory, in particular feminist narrative theory, led me to reframe my final question. Through a narrative lens, discourses are conceptualised from a perspective of dominant narratives, which serve as a moral framework. Research endeavours seek to explore subjectivities that are *emplotted* (Ricoeur, 1984; Polkinghorne, 1991), within and by cultural narratives (which may be accepted or resisted) and, in addition, extend the repertoire of available narratives for mothers to draw on.

My final research questions, therefore, represent my developed understanding of narrative theory:

- What can we learn from women who have their first baby by a planned Caesarean? (See Chapter 9).

- What meaning do women give to their experiences of planned Caesarean birth? (See Chapter 6).
- What phenomena appear in women's stories of birth by planned Caesarean? (See Chapter 7).
- How does a woman's personal story of birth (of planned Caesarean) relate to dominant narratives and ideologies of pregnancy, birth and motherhood? (See Chapter 8).

Participants

My research study was designed to explore the lived experience of birth through the stories of 12 women who had a planned Caesarean birth in their first pregnancy in England. The principle inclusion criteria were:

- First baby
- The baby was born by a planned Caesarean (also known as an elective or scheduled Caesarean)
- The mother had no experience of labour before the Caesarean
- The mother was aged between 16 and 65
- The baby was less than a year old at time of interview
- The baby was born in an English maternity service
- Both mother and baby were healthy
- The mother lived in England
- The mother was able to describe her experience in English (as a first-hand account).

The provisional sample size reflected the narrow inclusion criteria and the depth of the information that would be yielded. The size was representative of narrative research approaches which focus on the uniqueness of participants' stories and depth of the phenomena embedded in the story and was arrived at through discussion with my academic supervisors and review of narrative methodologies.

I started to analyse the participants' stories concurrently with recruitment and soon realised that the richness of data and depth of analysis required for me to make a contribution to knowledge within this field this would not be possible if I continued with a sample size of 12. This was supported by my supervisors and the transfer panel who reviewed my early data analysis as I transferred from MPhil to PhD enrolment status. I therefore reduced my sample size to eight

participants. This was both a methodological and pragmatic approach. I had undertaken sufficient analysis to appreciate the depth of findings that was being yielded and I had already interviewed four women and had another four interviews booked. Therefore, I stopped any additional recruitment and closed my website.

As identified in my search of the literature, there was very little research relating planned Caesarean in first pregnancy and I believed that the best way to explore how planned Caesarean birth was experienced and constructed, was to focus on the stories of women who had no previous birth experience. I decided to include women for whom there was a strong medical reason for their Caesarean and women who were choosing to request a Caesarean (in the absence of strong medical factors). This was because, as discussed in Chapter 2, I did not want to make assumptions and connections between the perceived *reason* for a Caesarean and the experience of it and I believed that the significance (or not) of the events and experiences leading to the decision for a planned Caesarean and variety of experiences would be yielded through the personal narratives.

As I was keen to be as inclusive as possible I had not set an upper age limit for childbearing women in my initial proposal but this was queried by a reviewer in the faculty ethics and governance process (FREGC). The British Human Fertilization and Embryology Authority (HFEA), which regulates fertility treatment, has no legal age limit for treatment, which is 'left to the clinical judgment of doctors', so I drew on my personal experience to decide on an upper limit. In 2006, a woman in East Sussex gave birth at the age of 63, so I nominally decided upon age 65 as my upper limit for inclusion in my study.

I did not collect demographic data on the participants and I opted not to include biographies of each of the women who took part in the research as I felt uneasy about limiting and finalising the identities of each participant. However I was aware that it is difficult for the reader to connect with and hold onto 'whole' stories when presented with large amounts of data. Instead, I chose to provide short story synopses with which to summarise the narrative thread and (multiple) subjectivities (see Chapter 6).

During my first research interview, the participant, Charlene, requested that her partner be present during the interview. This posed a number of methodological and ethical problems. Firstly, narrative methodologies favour the first-hand accounts of respondents' experiences. My research was focussed on the particular, unique experience of women having a planned

Caesarean birth in their first pregnancy and not seeking to understand the experiences of partners, family members or friends. Secondly, narrative inquiry methodology proposes that the context in which people tell their stories causes them to make linguistic choices about what they say and how they say it. In particular, it is proposed that the speech which comes out of an interview is jointly constructed between the interviewer and the respondent and that *meaning* therefore emerges from a reciprocal reformulating of questions and answers during the interview (Mishler, 1986). Narrative researchers are therefore charged with a responsibility to be explicit about the research context and analyse all data pertaining to that context. This concept usually applies to analysing the impact of the researcher's contribution to the story but would also apply to anyone else that is present during the interview.

As an initial response to the research participant, I welcomed and agreed to her husband being present but explained that he would not technically be a research participant as my topic of investigation was women's experiences and that I would not therefore seek consent from him. They were both happy with this. However, after I transcribed the interview I felt that there were some occasions where Charlene's partner's input was intrinsic to the story and, in some cases, caused her to reformulate what she was saying even if he did not influence or change the intent. I therefore wanted to be able to include this text in the data analysis. In order to do this, I sought an amendment to my protocol, from faculty and ethical governance structures, and developed additional guidance (see Appendix 3).

Recruitment

Participants were recruited by two methods:

- a) website

I designed a website providing information about the research, including an online consent process. The members of my research advisory group helped me with the content and design. This website could be accessed via standard search engines. The website went 'live' once ethical approval was granted and closed when I achieved full recruitment. Some examples of my web pages can be seen in Appendix 4.

- b) information sheet via healthcare professional/specialist midwife

I was aware that recruitment via a website might exclude some women from taking part so I designed an additional approach to recruitment. Specialist midwives (e.g. Additional support midwife) in six diverse localities in England (see Appendix 2) agreed to provide information about the study to women who met the inclusion criteria. Originally, I had decided to include eight sites across England but I found the process of getting agreement in some organisations so lengthy that I eventually went ahead with the six sites that were ready. I chose sites using the Index of Multiple Deprivation (Office for National Statistics 2007) as a means of recruiting women who are often excluded both socially and from opportunities to take part in research that presents their experience. Specialist midwives in the six recruitment sites were approached and they agreed to raise awareness of the research to women who were having a planned Caesarean in their first pregnancy and to provide an information sheet to any woman who was interested. The sheet provided details of how to contact me (phone or email). I then recruited women who wished to take part. Consent forms were included with the information sheet (with a stamped addressed envelope) or women could submit a consent form electronically via the website. If women did not feel able to contact me themselves, the specialist midwife agreed to help with this process. I kept in close contact with these six midwives so that I could be alerted to potential participants. All interviews took place in the participant's home (in accordance with researcher safety policies). Participants were not offered any inducements or payments to take part in this study. Despite this broad recruitment strategy, the women who took part in my study predominantly came from the south east of England and the Midlands.

Giving consent

Women who expressed an interest in taking part in the study were given verbal and written information about the study and, if they wished to take part, were asked to confirm this by signing a consent form. When each woman had been 'interviewed' I asked her again if she was happy for her narration to be used in the study. By asking for consent a second time I hoped to mitigate against the power of an interview context for disclosure. Beyond this written consent, I considered consent to take part in this study to be an ongoing process rather a fixed point in time, in accordance with the narrative approach, and participants were reminded that they may withdraw from the research at any time.

Anonymity and confidentiality

Anonymity and confidentiality are key ethical issues in any research study. As stated previously, participants in my study were given the option of whether or not they wished to use their own names rather than have pseudonyms. This approach is increasingly common in participatory methodologies which recognise that participants often want to be identified in research outputs (Tilley and Woodthorpe, 2011; Wiles, 2013) so that they can retain some ownership of their stories (Grinyer, 2002). Despite assumptions that anonymity is desirable and embedded in various codes of ethical conduct (Grinyer, 2002), I had no difficulty in getting this element of my research study approved by my local research ethics committee. I do not believe that adopting this approach enabled me to 'give voice' to participants or increase the authenticity of their experience, but I did want to challenge normative assumptions that the need for anonymity stems from a perception that research participants are always in need of protection (Tilley and Woodthorpe, 2001). Six out of the eight women opted to use their own name and none of them questioned having the choice to do so.

Most researchers are bound by ethical principles to maintain participant confidentiality but there are certain circumstances when these principles can be overridden (Wiles 2013). The information sheet explained the circumstances under which I was bound, by my professional regulations, to break confidentiality (i.e. safeguarding children), which I reiterated prior to each interview encounter.

Data collection

I had planned to collect women's stories (narrations) through interviews, with these individual narrations being taped and transcribed by me. I came to challenge my assumption that it would be preferable to collect oral narrations rather than written text (or other representations of narrative) but resolved this through readings of narrative literature and theory and discussions with my advisory group.

The dilemma related to whether the primary narrations (which were to be the focus of analysis) should be oral or written (textual). A meeting with a fellow research student had made me question my primary intention to analyse oral narrations and explore whether written narrations might be better. From a theoretical perspective I had a number of questions: *Would data collection via written narrations bias the sample to women familiar with web or social*

networking? Would a narration constructed over time rather than 'live' narration impact on the ability to resolve the research questions? What impact would the researcher being absent (virtual) have on the narration? Would the narrative be purer at the point it is presented to the reader?

I met with my advisory group and we discussed the issues (a detailed entry from my audit trail containing the transcript of this discussion can be found in Appendix 5). They believed that women would find it easier to talk about their experience than to write about it. Indeed, they felt that women *liked* talking about their experience. They thought that some content might be lost in written stories – women might revise and take things out of their stories in the process of writing them. They felt that having the researcher in the room was either of no consequence to them or a bonus as they felt that women could ask the researcher questions.

Having met with my advisory group I believed that the approach already laid out in the research design – that of listening to oral narrations in a face-to-face interview would be the best approach. However, I still wanted to test theoretical assumptions with this method and explore them in the light of midwifery theories and my research questions and so I went on to review the literature regarding data collection and forms of narrative.

My reading of the theoretical concepts of narrative research proposed narrative research approaches as diverse, where narratives could be oral or written: *'a narrative may be oral or written and may be elicited during fieldwork, an interview, or a naturally occurring conversation'* (Chase, 2005, p.652). However, most of the literature described research that used oral accounts as the primary narration, whilst accepting the theoretical possibility of written text as primary narration. Literature that focussed on the analytical concepts of narrative research theory tended to discuss and provide strategies once the primary narration had become written text through transcription.

When I looked at the history and origins of narrative, I found that storytelling was proposed by narrative researchers to be a fundamental human trait, starting in childhood, which reveals itself in a basic drive to hear and tell stories (Riessman, 1993, Culler 2000; Herman and Vervaeck, 2005; Holloway and Freshwater, 2007). Midwifery, too, has an oral tradition for storytelling where *ways of knowing* developed from experience were passed down (Fleming, 1998). Riessman (1993) argues that experience is pre-linguistic, that it is sensed but not analysed and that storytelling is a methodology for illuminating experience and that this experience is made sense of in the telling. Although there has been a growth in the use of models of written reflection in midwifery practice, oral traditions persist.

Storytelling is argued to be performative, whereby meaning is acted out in the telling of the story (Bakhtin, 1993). Described as verbal action, it is ultimately creative, and denotes that something is accomplished in the telling as the story has the potential to inform, defend, confirm, etc. (Chase, 2005). Feminist researchers treat women's personal narratives as essential for primary research (Chase, 2005) – by listening to previously silenced voices, narrative can challenge dominant discourses. I felt that *listening* to women more naturally reflected my professional experience and skills of listening to women through briefing and debriefing and focus groups. However, I had misgivings and questions about what happens to the agency of speech when it becomes authored by a researcher and I was aware of the limitations of *representation* over *presentation*.

Feminist researchers also ask questions about voice, authenticity, interpretive authority and representation (Chase, 2005). With oral narrations, the narrator has the opportunity to 'monitor' the response of the listener to the story and make decisions about how they tell their story and what they include. In this way, events are re-presented and ordered for the listener (Riessman, 1993) and the narration is a situated, interactive performance in response to a particular setting and audience (Chase, 2005). By talking and listening the narrative is produced together (Mishler, 1986; Riessman, 1993).

Having explored the theoretical constructs within narrative, I believed that written narrations would not convey any additional value to my research over oral narrations. Ultimately, if the purpose and responsibility of research in healthcare is to contribute directly to the knowledge which informs clinical care and impact on how that care is provided, then I believed that there was more value in analysing oral narratives that were co-produced in a context where the *listener* was known to be a researcher *and* a midwife. For this reason, I collected women's stories (narrations) through face-to-face interviews. The interviews were carried out between June 2011 and May 2012. They lasted between 25 minutes and two hours and took place in the participant's homes. Each participant's Caesarean birth had occurred between four weeks and one year prior to her interview.

Method for eliciting stories

I used a biographic narrative interpretive technique to elicit participant's stories. This technique uses a single, initial narrative-inducing question, for example, 'Tell me the story of your baby's birth,' to elicit an extensive, uninterrupted narration (Jones, 2002). This technique provides a

minimal and passive interview technique which is maintained by a method of non-interruption except for affirming utterances, eye contact and attention to body language, etc. (Jones, 2002). Silences are maintained unless the participant asks for help, in which case interrogative phrases such as 'tell me more' are used to prompt and encourage. This technique enables the researcher to assume the role of active listener. The interview continues until the participant ends the session. Jones (2002) described how, when using biographic narrative interpretive technique in his research, each session came to a natural conclusion with the participant implying that they had finished - "*That's about it*" or "*Well, that's my story*".

I used this biographic narrative interpretive technique in my study and I drafted the following narrative-inducing question:

'Tell me in your own words a bit about yourself and the story of your Caesarean birth. I have no set questions to ask you...I just want you to tell me about your experience as if it were a story with a beginning, a middle and how things will look in the future. There is no right or wrong way to tell your story...just tell me in any way that is most comfortable for you.'

Adapted from Veroff J, Sutherland L, Chadiha L and Ortega R (1993).

However, as I came closer to undertaking my first interview, I became more paralysed by the idea that my 'single, narrative-inducing question' might induce a single, narrative-concluding answer and that would be the end of my research. I therefore prepared and practised additional 'openers', which I constructed from the feedback I received from Imogen after the pilot interview and from discussion with a fellow doctoral student, Claire, who had analysed narrative data in her research. These are included in Appendix 6.

However, when it actually came to my first interview I found that there was no awkwardness from the narrator, Charlene, and she proceeded to share her story for the next two hours, finishing by saying, *'that's pretty much covered the whole experience!'*

With the consent of each participant I digitally (audio) recorded and transcribed their narrations. The interviews were transcribed verbatim and I included notes on vocal inference (pauses, voice drops [both pitch and volume], laughter, stammers, and repetition). In some cases, I also added notes about body language and gestures. This was not in an attempt to be more rigorous in getting at an *authentic self* but in order to help me recreate and reconnect with the interview.

Analytic concepts

All the literature I reviewed when exploring narrative analysis techniques pointed to there being no one single technique for narrative analysis but described its origins in textual analysis, content analysis and discourse analysis (Holloway and Freshwater, 2007). Analytic concepts in narrative are theoretically situated, with the main distinctions between approaches that pay more or less attention to analysis of either *form* or *content* of the narrative. Common in the literature (although seldom seen in examples provided) is the concept that different approaches could be used simultaneously, complementing each other and deepening the understanding of the data (Holloway and Freshwater, 2007). Narrative analysis, therefore, is described as a loose, intuitive, artistic and poetic process and should not be viewed as formulaic, prefigured and narrow (Roberts, 2002). Lieblich et al (1998) add another level of distinction that describes the degree to which the story is reviewed as a complete text or sectioned for analysis. They provide a framework with which to view narrative analytic approaches using two main independent dimensions: a) holistic versus categorical approaches and b) content versus form. At the polar ends of each of these dimensions, clear distinctions can be made in approach but Lieblich et al also support taking a middle ground.

In my readings of the literature I looked at how the analytic techniques were theoretically situated and reviewed the relative merits and constraints of common approaches. A popular framework in the literature was that described by Labov and Walensky in 1967. This framework described six separate elements that can be found in narratives:

Abstract – summary of the subject of the narrative

Orientation – time, place, situation, participants

Complicating action – what actually happened

Evaluation – the meaning and significance of the action

Resolution – what finally happened

Coda – returns the perspective to the present

Labov and Walenzky (1967 in Elliott, 2007).

In many cases, researchers have used the whole of this framework to categorise segments of text (with varying degrees of success) but Labov and Walenzky state that the minimum elements that

need to be included are the complicating action (the temporal component) and the evaluation (to establish the meaning of the story). I appreciated that this framework could serve as a good starting point but it did not seem to present a method for including the researcher narrative (reflexivity), which challenges the notion that narratives are dialogic and co-produced. For this reason, I ultimately rejected this approach.

The most common form of narrative analysis was thematic (content) analysis, where thematic connections and patterns were analysed to generate hypothesis. The method could be applied to single narratives, although multiple narrative were more common. Like grounded theory, the concept of saturation can be used when the narratives are exhausted and no new themes are identified. The approach contains an awareness beyond the individual (sociological and cultural issues) to produce a collective story. It is often confused with grounded theory but in narrative theory the story is kept intact by theorising from the 'case' rather than component themes across cases (Roberts, 2002; Riessman, 1993, 2008). This provides its own challenges, as the researcher has to decide how to present a meta-story from individual narrations.

Structural approaches focus on how the storytelling shapes the story and the way it is conveyed. The structure and form indicate the social function of the narrative. In this approach there is a shift from the *told* to the *telling* (Labov and Waletzky, 1967; Elliott, 2007), from what is told to how it is told. Structural approaches are mindful of the contexts in which the narrative were produced (Elliott 2007) and propose narration to be *relational* (Mauthner and Doucet, 1998; Gilligan et al, 2003) or *dialogic* (Bakhtin, 1981; Frank, 2005), reflective of the fluid identities of the narrator and told in the presence of a listener and therefore co-produced (Mishler, 1986). This gives a window onto the cultural context within which the narrations are constructed and marks a departure from phenomenology by both exploring *what was not said* and by acknowledging that '*narratives are interpretive...they do not speak for themselves.*' Riessman, 1993, p.22).

Some approaches which examined the form of the narrative support the concept that the narrative has agency by being able to make something happen *in the telling*. By studying the intention or direction of the plot or the ascent or descent or stability of the characters you can ask: *What is the action of the narrative?* (Lieblich et al (1998).

Narrative techniques operate along a continuum of concepts. At one end there are approaches to research design which, at times, appear to be almost indistinguishable from some phenomenological approaches in their use of categorical, thematic content analysis of storied text. At the other end of the spectrum, the narrative is viewed in its completeness and whole

story narratives are privileged over moves to analyse portions of text (in abstraction) which reduce the meaning of the story and are perceived as reductionist. As stated earlier, authors suggest that the researcher does not need to stick with one approach (Lieblich et al, 1998; Holloway and Freshwater, 2007; Elliott 2007) and I was attracted to frameworks that provided combinations of techniques as they appeared to provide more scope.

Lieblich et al (1998) described spectrums of approaches and they also combined features from these spectrums. The *Holistic-content* framework uses the complete life story of the individual and focuses on the content presented by it. When using separate sections of the stories (e.g. opening or closing sentences) the researcher analyses the meaning of the part in relation to the content that emerges from the rest of the narrative, a technique which is familiar in case studies. The *Categorical-content* framework is more familiar as content analysis – categories of the studied topic are defined and separate utterances of the texts are extracted, classified and gathered into these categories. The *Holistic-form* framework looks at the plots or structure of complete life stories and explores whether the story ascends towards the present moment in the narrator's life or descends towards more positive periods and situations. It looks for turning points which shed light on the entire development. It also analyses the story structure for a typology (e.g. a tragedy or comedy). The *Categorical-form* framework focuses on discrete stylistic or linguistic characteristics of defined units of narrative e.g. what kind of metaphors are used/how frequently are utterances passive or active?

This model with four techniques felt attractive to me because the authors encouraged researchers to experiment with techniques and blur the boundaries of their *two by two* model (Lieblich et al 1998) and their model appeared to present scope for layering narrative exploration. Initially, I felt drawn to the Holistic-form model as it seemed to present a method that would reveal representations of *self-concept* and the *character* of the narrator within the story. This was important to me as I wished to understand how women assimilated their birth experiences and if and how this affected their sense of self (selves). There were clearly benefits to all of these approaches but, having reviewed my exploratory research questions, I saw my analytic methods sitting somewhere between Holistic-content and Holistic-form. Birth and becoming a mother is considered to be a life-changing event. With a primary focus on the content-orientated element of the story I felt I would get at the *meaning* of the story and explore the *phenomena* of planned Caesarean birth but, with the addition of a focus on form, I hoped to reveal deeper layers of the narrator's identity (self-image). Self-image is constructed within a cultural and social setting and

so exploration of the narrator's identity would shed light on the social context in which that identity is formed.

The process of data analysis

The first stage involved an 'incubation' period after the interview and prior to the data analysis. This initial connection with the data is claimed to be intuitive, so time is needed for the information to settle and shift in the awareness of the researcher (Braud and Anderson, 1998). I found this naturally occurred on my journey home from each interview. My journey time ranged from one and a half hours to three and a half hours and, although I was usually mentally very tired from the interview, I found I couldn't disengage from the story I had just heard. Each story affected an emotional response in me as well as a cognitive or analytic one. I found that, in these first few hours, I was immersed in the emotion of the story, feeling privileged that someone would want to share their thoughts and experiences with me and I felt connected to the person who had told it to me. I also felt an instinctive sense of what the story was about.

This was compounded by the second stage, in which, before transcribing the narrations I carried out '*close and repeated listenings*' of the recording (Riessman 1993, p.60) to perceive the illocutionary force (Bruner, 1990) or narrative intention of the speaker, to try to elicit the *gestalt* of the story. How long I spent doing this varied and sometimes my 'ah, I see' moment occurred not when I was directly listening to the recording but when I was engaged in something else, usually a repetitive activity such as driving, washing up or gardening.

Having listened to each participant tell her story, I typed up a verbatim transcript of the dialogue, denoting long pauses, laughter, upward inflections, etc. as well as my interjections and dialogue. I then made a phone call to the participant before analysing the data. Originally, when I applied for ethical approval for my study, this element was designed to be an opportunity to clarify/verify the data with participants in line with concepts of validity. However, by the time I was conducting and transcribing the interviews, my reading of narrative literature had made me question the theoretical appropriateness of this element. Narrative analysis is the investigation of the '*story itself*' (Riessman, 1993, p.1) which is an interpretive, intentional, partial, plural, narrativisation of events. Whilst I believed all narrations to be unfinalised and perpetually open, each was also situated and historically contingent. Therefore, having a phone call with a participant to verify the data seemed to be inconsistent with my approach. Instead, I used the call to thank each

participant for their time and for sharing their story, I verified that the data was audible and then gave them the opportunity to ask me questions or give me feedback on the interview encounter. I also felt that it was an opportunity to reconnect after the (interview) event and, to some extent, a resolution of that event.

I initially struggled to find an analytic technique that I felt would do justice to the participants in my study and my research questions. I tried the *holistic-content* analysis, *holistic-form* and *categorical-content* techniques described by Lieblich et al (1998) on Charlene's and Jo's stories. Although each of these techniques had merit (and the benefit of being well described), none of them seemed to yield the depth of a whole story that I was looking for. I found this very frustrating and began to think that I wouldn't find an analytic technique that met my expectations. I also found it very difficult, when reviewing research using narrative techniques, to find examples that described in detail how the data analysis had been carried out. Therefore, despite ultimately not using any of these techniques, I have included an outline of the steps I took to try to operationalise the techniques using Charlene's story to *show the workings* of undertaking narrative analysis and my reflexive journey (see Appendix 7).

Eventually, and serendipitously, I found an analytic technique which, while not perfect, provided me with a way into the data that enabled me to explore the depth of the content in tandem with the development of the plot, along with my researcher response. Called the *Listening Guide*, the analytic technique involves a stepped process of multiple readings or *listenings*, each time reviewing the text in a different way (Brown, 1998; Sorsoli, 2007). How I used the Listening Guide, the adaptations and extensions I made, and my critical evaluation of this analytic technique are presented in Chapter 5.

Validity and trustworthiness

In narrative research, truths cannot be established using the methods employed in other methodologies, as narratives are not necessarily testable and verifiable facts but plausible and dramatic versions of experience (Bruner, 1986; Holloway and Freshwater, 2007). Instead, narrative research looks for the approaches towards verisimilitude (Polkinghorne, 1988; Holloway and Freshwater, 2007) where something appears to be true but cannot be proven. Riessman (1993) provides a framework with which to approach verisimilitude through which the

participant's narration of their lived experiences (Holloway and Freshwater, 2007) can be tried against concepts of persuasiveness, correspondence and coherence (Riessman, 1993).

Persuasiveness is a measure of whether or not the researcher's interpretation is reasonable and convincing. It relies on the reader's response to the text. *Is this the most persuasive interpretation of the text?* In order to satisfy this requirement, I have supported my claims with evidence from the participant's stories. I also included examples where the interpretation can't be applied and examples where I have considered alternative interpretations. Throughout my writing of this research, I have chosen to write reflexively to show how I have handled and interpreted data.

Correspondence is the practice of taking results back to the individuals who participated in the study to ask *are these reconstructions recognisable as adequate representations?* As already stated, following each interview I contacted the participants once I had transcribed their story to confirm that I was able to hear and transcribe the data. At this point I hadn't analysed the data and had only broad headline thoughts about the meaning within the story so I did not explore meaning at this stage, as it was too soon to test whether my reconstructions were recognisable. Rather than a *sense check* I used this step as a *consent check* verifying that they were still happy for me to analyse their story.

The concept of coherence focuses on how the narrator's (research participant's) overall aims and goals in the story (*global coherence*) are conveyed in the structure of the narratives (*local coherence*) and present in recurrent themes unifying the text (*thematic coherence*). I balanced these components by continuously reflecting on whether or not my initial hypotheses about the narrator's beliefs and goals (*what are they telling me*) is revealed in the structure of the narrative (plot and character developments) and themes in the text (recurrent concepts). In this way, the text acts as a check on *ad hoc* theorising. Meeting with my advisory group helped with this, too, as I was able to share and discuss generalised interpretations and findings with the group and ask them to consider them in the light of their own experience. During this session I had to pay attention to issues of confidentiality so I talked in general terms about what I thought I was hearing from the participant's stories and gave some examples and the members of the advisory group gave me feedback on whether or not those interpretations resonated with their experience. This has provided a valuable sense check and alternative perspective to my (professional and researcher) assumptions.

My research design, although produced with the support and assistance of a research advisory group, could not be claimed to be participatory. I have not gone back to the women participants

with transcripts of their stories. This could be viewed as either a weakness or a strength in the design of my research, but I believe that *'validation is less a technical problem than a deeply theoretical one'* (Sandelowski, 1993, p.2). As stated previously, all stories are contextual and situated and representations of experience. I was not looking for truths or accurate portrayals of events but the meaning individuals gave to those events. Linking back to Bakhtin's concepts of the unfinalisability principle, I believed that the story presented was not the only reading or meaning that the narrator had of the events and that they would continue to *retell* their story and derive additional meanings. Layering Bakhtin's concepts further, this concept also applies to the reader of my textual interpretations. They are part of the dialogical process, too, and will retell the story based on the meaning they have derived. Other authors also note this shift from participant verification (coherence) to reader plausibility (Czarniawaska, 2004; Bold, 2012), where the reader is invited to question: *is the analysis in the research report trustworthy? Are the findings applicable in similar contexts? Have the data been analysed from a critical standpoint?* (Bold, 2012). Ultimately, verisimilitude is judged by the reader which emerges from the response to the account (Czarniawaska, 2004). I believe that my responsibility is to produce work that is thorough and robust and which is transparent about knowledge production. Rather than make attempts to take an objective stance, I have opted to tackle the dilemma of trustworthiness in the textual representation of the research findings by keeping myself in the text by writing reflexively (Birch, 1998). Moves in the understanding of reflexivity have seen a shift from reflexivity *'as a self-centred exercise towards a consideration of 'other' critical relationships that are part of how we come to know and write about others'* (Doucet, 2008 p.73).

Reflections on representation

Tensions between presenting and *representing* experience are issues that face all qualitative researchers to varying degrees. Plummer, describes writing research as *'the dark secret of social science'* (Plummer, 2001, p. 168.) in which positivist behaviours of *presenting* rather than *writing* the findings, are perpetuated (Plummer, 2001). The responsibility of writing my findings was not lost on me and I was aware of the multiple subjectivities involved in the production of a story. In particular, I was concerned that as I *'snip away at the flow of talk to make it fit between the covers of a book'* (Riessman, 1993 p.13), I might lose something of the intentional narrator, whose story was particular, significant and created *in the moment* (Frank, 2005). I had felt the impact of this verbal action when I was listening to these women tell me their stories and I did not want this

impact to be lost in (my) translation to the reader. I therefore had misgivings when it came to presenting the data and my analysis of it particularly as, like other narrative researchers, I wished to illuminate stories that have not been told before or which have been marginalised. However, along with feminist researchers, I believe that multiple subjectivities are involved in the production and understanding of narratives, including the voice of the researcher, which is explicitly brought into the process (Gilligan et al, 2003). Our role as researchers then, is to record and interpret the voices we hear in their engagements with researchers (Mishler, 1986; Riessman, 1993).

I was energised and paralysed in equal measure and was tempted to provide the reader with the whole transcript (in one case 120 pages) and write about what I got from it and ask of the reader, *did you get that too?* But that seemed disingenuous to the women who had consented to sharing their time and stories with me for me to analyse (and certainly unscholarly). After quite a lot of thought and angst, I realised that my responsibility was to reflect the meaning that the stories created in me and to be explicit about what I could and couldn't achieve in writing my findings (see Chapter 9).

Conclusion

I have presented an overview of my research design and research methods which were derived from my readings and explorations of narrative methodology. I have also shared my reflections of undertaking this research and the decisions I have made at key stages during the research. In the next chapter, I expand on the *Listening Guide* analytic method and how it has contributed to my research design and findings.

5. Data analysis and *The Listening Guide*.

'A beautifully told story is a symphonic unity in which structure, character, genre, and idea meld seamlessly. To find their harmony, the writer must study the elements of the story as if they were instruments in an orchestra – first separately, then in concert.'

Robert Mckee (1999) *Story: substance, structure, style and the principles of screenwriting*, p. 29, Methuen.

Introduction

On 22nd June 2012, I attended a symposium on the *Opportunities and Challenges in Feminist Narrative Research* at the University of Huddersfield. This symposium was organised by the 'Listening Guide Study group', a student-led initiative developed and run by postgraduate researchers. This group evolved from a workshop facilitated by Ruth Deery and Natasha Mauthner in February 2011. They provide a forum for researchers with a specific interest in this method of data analysis to learn, share and support each other.

At the conference I was able to take part in a seminar that was led by one of the authors of the method. Afterwards, I spoke to members of the study group and accepted their invitation to join the group. By attending this symposium, I had serendipitously stumbled across a method for analysing data that seemed to encompass everything I was looking for and had not found in my search of narrative analytic methods.

In this chapter, I share my experience of and reflections about analysing my participant stories using the Listening Guide method. I describe the principles underlying the method, the process of using the method and how I came to develop additional strategies to complement those already described in the Guide. I provide a critique of the method and share my experience of taking part in a study group who are united by their use of the Listening Guide.

I have devoted a whole chapter to the data analysis techniques I have used because my experience of operationalising these narrative analytic techniques has been fundamental to my development as a researcher and critical to my understanding both of planned Caesarean birth and the possibilities of narrative research techniques.

The *Listening Guide* and the Voice-centred relational method

Having struggled to find an analytic technique that would complement my theoretical approach, I was excited to hear that the *Listening Guide* appeared to offer a way of layering multiple interpretive readings in a single analytic technique (Sorsoli, 2007). This method, known synonymously as Voice-centred Relational method (VCRM) (Brown and Gilligan, 1992; Gilligan et al, 2003; Edwards and Weller, 2012), calls for the researcher to make successive interpretive *readings* of interview transcripts, *'each time listening in a different way'* (Brown 1998, p.33) which yield a *'complex and nuanced understanding of participants' stories'* (Sorsoli and Tolman, 2010, p.495).

In particular, the Listening Guide approach challenges conventional coding methods of thematic analysis (Mauthner and Doucet, 1998, 2003) and attempts to address issues of subjectivity and researcher reflexivity (Doucet and Mauthner, 2008) by attending to the many voices embedded in a person's expressed experiences (Gilligan et al, 2003) including those of the researcher. This seemed to offer me a way to explore both the content and form of a participant's story which didn't reduce a participant's story purely to the themes contained in it *and* provided me with an approach that would recognise the dialogic nature of narrative theories by emphasising researcher reflexivity.

Central to the Listening Guide method is the principle of *relational ontology* which acknowledges that humans develop in relation to one another and that our identity is inextricable from our relationships with others and the cultures we live in (Gilligan et al 2003). From this perspective, unitary concepts of *self* are rejected in favour of multiple *selves* or voices, that contrast and conflict with one another (Balan, 2005). People are viewed as interdependent rather than dependent (Mauthner and Doucet 1998, 2003) and the stories we tell are viewed as inextricably linked to and defined by the broader social, cultural and historical relationship to others (Milligan and Jones, 2010).

The features of the Listening Guide (which will be explored later) are premised on and enhanced by this concept of relational ontology, which has developed from Somers' work and which supports the positions adopted by Bakhtin and Barthes. Bakhtin and Barthes both propose that the meaning of a text spreads beyond the narrator. In the Listening Guide method, there is also acknowledgement of the critical relationships that maybe be formed in interdisciplinary academic communities in the production of knowledge and how that knowledge may be *located, read,*

reviewed and received (Doucet 2008, p.73). The method is also premised on being *open* to adaptation (Brown & Gilligan, 1992; Gilligan et al, 2003).

Building upon my theoretical position, I felt the features of the Listening Guide would enable me to respond to my research questions and offered me an approach which provided:

- multi-layered analysis to yield deeper meaning
- listening for multiple voices (subjectivities) and relationships in the research participant
- listening for the voice of the researcher and his/her (*reader*) response
- a method that could be adapted to suit the topic of study
- support for developing a network with other researchers to provide a relational interpretive framework.

Development of the Listening Guide

The Listening Guide has psychodynamic, literary, clinical and feminist foundations (Sorsoli and Tolman, 2010) and has a wide application to epistemologies which recognise that knowledge and understanding are contextually and historically grounded as well as linguistically constituted (Mauthner and Doucet, 2003).

The Listening Guide was developed, in part, from dissatisfaction with coding schemes that were being used to analyse qualitative data (Gilligan et al, 2003) and which the authors believed had the potential to reduce, oversimplify or discount the multiple threads that can run through any individual account (Milligan and Jones, 2010). Whereas coding techniques focus on predominance and theme to provide a content analysis, the Listening Guide intentionally acknowledges the embedded context of the narrative and the alignment and dynamics of separate voices (Milligan and Jones, 2010; Sorsoli and Tolman, 2010).

The method was originally conceived during Gilligan's (1982) longitudinal psychological research project examining adolescent girls' moral development and decision-making and the extent to which they resisted or silenced their sense of self as part of dominant ideas of femininity (Gilligan et al 2003, Edwards and Weller 2012). Drawing on concepts of voice, resonance and relationships, the method acknowledges the multi-layered nature of the human psyche as expressed through a multiplicity of voices present in each person's narrative (Milligan and Jones, 2010).

In the late 1980s feminists and clinical psychologists began to discern the possibilities of narrative for exploring the dimensions of human experience (Sorsoli and Tolman, 2010). Critically, there was a shift from *reading* transcripts towards *listening* to the context in which the narratives originated and acknowledging the embodied telling of stories in a relational process, with an interviewer whose central task was to listen (Brown and Gilligan, 1992; Gilligan et al, 1990, Sorsoli and Tolman, 2010).

The terms *Listening Guide* and VCRM are often used interchangeably in the literature. Despite this, I believe there are differences that mark a shift in emphasis. In 1992, Mauthner and Doucet were part of a small interdisciplinary graduate group in Cambridge that was using VCRM under the guidance of Professor Gilligan. During this time they were developing their own version of it to reflect their specific research interests and sociological focus whilst retaining the concept of relational ontology (Mauthner and Doucet, 1998).

The shifts I perceive in the development from VCRM to the Listening Guide are:

- From psychological method to sociological method
- From a preoccupation with *voice* to a focus on narrativity (storytelling)
 - From method as a way into the psyche through voice towards using the method as a way to explore a (non-unitary) subjective, narrated 'self' (selves)
- From looking for *contrapuntal* (multiple, conflicting or complementary) voices to exploring multiple relationships
 - From an understanding of an internalised, embodied self to an understanding of fluid, *relational* selves.

The multi-layered approach is premised on the belief that, through sequential readings (each with a different focus), researchers are able to '*move closer to the participant perspective*' through the stories they tell and the reality they have constructed from their experience (Sorsoli and Tolman, 2010). However, it does not assume that participants are always able to narrate their experiences coherently (particularly trauma survivors) but works with the assumption that narratives are '*nuanced, multifaceted and densely packed with diverse meanings and cryptic messages*' (Sorsoli and Tolman, 2010, p.498). Neither does it seek to articulate a set of *truths* about the narrator, rather it seeks to explore the realities of the personal narrative (Sorsoli, 2007). Each level of analysis offers unique information and calls into question other interpretations (readings) (Sorsoli, 2007). The existence of multiple perspectives enables researchers to go beneath the *loudest stories* (Sorsoli, 2007, p. 305), allowing researchers to examine both explicit and latent content in order for the pieces of the puzzle to fall into place (Sorsoli, 2007).

Many researchers using the Listening Guide continue to use the concept of *voices*, particularly *contrapuntal* or multiple (conflicting or complimentary) voices, through which to reveal silent and invisible inner worlds (Gilligan et al, 2003; Edwards and Weller, 2012). But *voice* in this context is '*a physical embodied entity and a primary way inner thoughts and feelings can be communicated to an outside audience*', rather than a metaphor for an authentic, agentic speaker (Sorsoli and Tolman, 2010, p.497). The perception that subjects have multiple identities and selves that are articulated through their stories is common in the literature on the Listening Guide but the extent to which these selves are proposed to be authentic is less clear. Mauthner and Doucet have reflected on *how can narrated subjects be known, accessed, interpreted and written about in scholarly work?* The shifts in their position are perceptible. They move from a feminist standpoint, where subjects' utterances are seen as transparent passageways into their selves and experiences of thinking (a deep subjectivity beneath accounts), through a notion of subjectivity revealed through a research encounter, where subjects are reflexively constituted between the researcher and the researched (and always incompletely known), towards a *narrated subject*, who constitutes her social identity(ies) through narratives and narrativity (Doucet and Mathner, 2008). These developments, in the epistemological and ontological perspectives, are reflected in my research questions which seek to explore storied accounts of personal experience and what we can learn from them, (see chapter 4 p.58-59), rather than personal experience per se.

Researcher reflexivity is another key feature of the Listening Guide that has gained much attention. The Listening Guide offers a reader-response reflexive strategy, influenced by the work of Barthes (Doucet, 2008) that is operationalised *during* the data analysis (Mauthner and Doucet, 2003). During analysis, the researcher is compelled to confront their own difference from and identification with the narrator as the story is told (Byrne et al 2009) by documenting their own responses at the time of analysis. Shifts in the emphasis of how this may be achieved can be seen in the texts as the authors move from visualising the *reader response* as a way to watch how the researcher is responding '*re-engaging and separating out a sense of myself*' (Doucet, 2008 p.78), to acknowledging relations between researchers and their subjects are always in '*ontological flux and subject to endless interpretation*' (Doucet and Mauthner, 2008, p.404). These distinctions are important indicators of what can be claimed about what this reader-response strategy can bring about, in terms of knowledge claims, and they appear to be more akin to the perpetually open nature of narrative proposed by Bakhtin. I believe that, rather than endorsing claims of validity, they signal shifts in emphasis and recognise the partial, provisional and perspectival nature of any knowledge claims I can make as a researcher (see Chapter 9).

The process of *listening*

The process of *listening* using the Guide involves four distinct readings of each interview transcript, each time listening and highlighting particular aspects of the narrative (Byrne et al 2009, Sorsoli and Tolman 2010).

Reading one: *Listening for plot and the listener's (researcher's) response to the story*

Reading two: *Listening for the first-person active voice- the voice of the 'I'*

Reading three: *Listening for relationships*

Reading four: *Listening for broader social, political, cultural and structural contexts.*

These analyses are then combined with writing case studies and sharing qualitative interpretations with research peers in a study group setting (Mauthner and Doucet, 1998; Mauthner, 2002).

In the following sections I describe the analytic approach in the Listening Guide and how I used it in my research. Initially, I was unsure how to relate the individual readings (listening) to my research questions (see below) but I could see that the layered readings had the potential to yield rich, in-depth interpretations which I felt would satisfy my research questions:

- *What can we learn from women who have their first baby by a planned Caesarean?*
- *What meaning do women give to their experiences of planned Caesarean birth?*
- *What phenomena appear in women's stories of birth by planned Caesarean?*
- *How does a woman's personal story of birth (of planned Caesarean) relate to dominant narratives and ideologies of pregnancy, birth and motherhood?*

In particular, I felt that the Guide would help me in my desire to explore the narrator's (multiple) subjectivities within their emplotted and '*meaningful whole*' story (Polkinghorne, 1991, p.135).

As stated previously, I had tried several analytic techniques before arriving at this one, so I was keen (and anxious) to see if this technique could be effective for my needs. Therefore, I chose to carry out all four readings in the manner suggested in the literature before I decided how to draw on my layered interpretations to answer my individual research questions.

Reading one: Listening for plot and the listener's (researcher's) response to the story

The first reading has two elements: reading for the plot and reading for our responses to the narrative (Mauthner and Doucet, 1998).

First, the text is read for overall plot by mapping the main events, protagonists and the subplots (Mauthner and Doucet, 1998) and attending to multiple contexts in which the story is embedded (Gilligan et al 2003, Milligan and Jones 2010). The reader tracks repeated words and themes, key images and metaphors, contradictions, inconsistencies in style and moral language (Mauthner, 2002, Byrne et al 2009), to reveal *who is telling the story*, (Byrne et al, 2009), *what themes are emerging*, *how themes are related*, *whether certain themes silenced* (Milligan and Jones, 2010). This step requires you to listen beyond the language used, to get to the understory. Techniques for this include listening for long pauses, drops or raises in pitch, laughter that seems out of place, etc. (Sorsoli and Tolman, 2010).

The second element of Reading one requires the researcher to *read for herself* in the text by documenting her own emotional and intellectual and response to the story (Mauthner and Doucet, 1998; Mauthner, 2002; Edwards and Weller, 2012), placing herself and background, history and experiences in relation to the person interviewed (Mauthner, 2002). This step requires the researcher to reflect on how her understanding might be influenced by her own ontological position (Milligan and Jones, 2010). Doucet and Mauthner state that this reading '*offers a practical guide for 'doing reflexivity'*' (Doucet and Mauthner, 2008, p.405).

The Listening Guide suggests using a worksheet for this reading, with the respondent's words laid out in one column and the researcher's interpretations and reactions in the adjacent column (Brown and Gilligan, 1992; Doucet and Mauthner, 2008). The aim is to expose the researcher's response to the interviewee and how this might affect the understanding and analysis they produce (Edwards and Weller, 2012) or how she later writes about the person (Doucet and Mauthner, 2008).

My initial approach was to systematically follow the steps outlined in *A Guide to the Readings* (see Appendix 8). This stepped approach had been prepared by doctoral student members of the Listening Guide study group at the University of Huddersfield. This resource had been put together as a result of readings of the literature on VCRM and the Listening Guide and through discussion and workshops with Natasha Mauthner, a primary author of the Listening Guide, and Ruth Deery, a Reader in Midwifery at the University of Huddersfield, who had used VCRM in her

own thesis. This resource was shared with me at the first study group meeting I attended and provided the basis for my data analysis.

During Reading one of my data, I tried to get a sense of the story being told and I tabulated the main events, protagonists/actors and their relationships in the story and plots and subplots (see Appendix 9 Data analysis of Monika's story). As suggested by Doucet and Mauthner (2008) I included a column where I concurrently detailed my reflexivity, by consciously documenting my own response to what was being expressed. I tried to be very honest in my responses and not to modify what I was writing for an anticipated reader. I attempted to consider why I responded in the way I did and how my thoughts and feelings might affect my understanding of the person and my interpretation of the stories being told:

When Sarah told me her story, she told me that she had weighed the risks and benefits of vaginal or surgical birth and that she had requested a Caesarean. When she then told me that she had seen a video of a natural birth at school when she was about 14, I documented my response:

'I was interested to hear that Sarah had found the video traumatic and I wondered how much this was a factor rather than her ability to rationally weigh the risks and benefits BUT I was keen not to prejudge this and to listen to her experience and viewpoint.'

(Analysis of Sarah's story: reading one).

I didn't find that it came naturally to me to think reflexively at the time of analysis of the data but I did feel that in doing this I was reconnecting with the emotional and cognitive experiences I had at the time of the interview encounter and I felt that this positively reconnected me back to that event. I also found it helpful to try to capture my preconceptions and responses.

Reading two: Listening for the first person active voice – the voice of the 'I'

The second reading focusses on how the respondent experiences, feels and speaks about herself (Mauthner and Doucet, 1998; Edwards and Weller, 2012). The focus is on the active 'I' ('we' or 'you') (Mauthner, 2002) which is telling the story (Mauthner and Doucet, 1998). The aim of this reading is to strip away events to '*discover how she speaks of herself before we speak of her*' (Brown and Gilligan, 1992, p.27) through the creation of I-poems.

I-poems are created by highlighting or underlining each use of first person 'I' and accompanying verb or meaningful text (Edwards and Weller, 2012). The second step is to lift these statements in the exact sequence they occur, placing them on separate lines like a poem (Edwards and Weller, 2012). The run of words is intuitive, as is the choice to break the poem into stanzas (Edwards and Weller 2012). This reading is helpful in pulling out the different (contrapuntal) *voices* that articulate different viewpoints used to narrate their views and experiences (Mauthner, 2002). This reading puts the narrator at the centre and gives the researcher access to an '*emerging narrated self*' (Doucet and Mauthner, 2008, p.406). From a sociological perspective, this reading represents the actor voice or sense of agency of the narrator whilst also recognising the social location of the person who is speaking (Mauthner and Doucet, 1998).

Like other researchers, I constructed the I-poems by systematically going through the transcript, cutting and pasting each use of first-person 'I' and the accompanying verb (or seemingly important accompanying text) onto separate lines. I then broke them into stanzas, based on what I intuitively felt to be changes in topics or 'voices' (see Figure 2).

Figure 2. Excerpts from Jo's and Sarah's I-poems showing a single stanza

I've just

I've never felt so lonely really

I'd be like

I'd see the whole night stretching sort of in front of me

I couldn't get out of bed (Jo)

I wasn't going to see the consultant

I didn't need counselling

I wasn't bothered by my decision

I'd made it thank you very much

I didn't need it

I didn't have an issue

I didn't want to give birth vaginally

I don't want to climb Everest! (Sarah)

Unlike some researchers, I found that the participants in my study frequently used active 'I' statements and I did not find it necessary to include *me* or *you* statements to understand how the respondent perceived and experienced themselves. I found the repeated use of 'I' to be a particularly effective indication of where the participant may be struggling to say something:

For example, in Sarah's I-poem, the first time she repeats the 'I' statement is when she talks of her encounter with the Consultant Midwife: '*I... I... left that appointment in floods of tears*'.

Until this point, Sarah had smoothly articulated her beliefs and wishes and experiences, so this *hiccup* signalled a change in how Sarah was narrating which I believed pointed to an emotional memory of the situation and the significance it held for her.

Producing the I-poems had a profound effect on me. I felt as though the character of the speaker was lifting off the page to greet me. The effect was immediate and visceral. I tried to critically analyse my response and I questioned whether this manipulation of the text was having a heightened or skewed impact on me. I was also wary of believing that I had somehow tapped into a (singular reading of) an authentic characterisation of the person. On reflection, I believe that my response came as a reaction to a reconnection with the experience of listening to their story, and the meaning it created in me at the time, and a recognition of something intuited but not explicitly said during the interview encounter that was central to meaning.

Creating I-poems appears to be a popular element in the Listening Guide and is a feature that has been favoured above other steps by some authors. I think this element is powerful and revealing but, ultimately, I feel the strength of it is that, in tandem with the other readings, it throws up additional perspectives and alternative readings of the story told.

Reading three: Listening for relationships

Originally used to identify contrapuntal voices (Gilligan et al, 2003; Milligan and Jones, 2010), the third step is described as listening for relationships (Mauthner and Doucet, 1998). This step looks at how each person expresses their experience through a multiplicity of voices (Gilligan et al 2003, Milligan and Jones 2010) and interpersonal relationships (Mauthner, 2002) and the broader social networks within which they live (Mauthner and Doucet, 1998).

This reading concentrates on how participants talk of other relationships and what they see as the consequences of these relationships, and the multiple subjectivities involved (Edwards and Weller, 2012). It is informed by relational concepts of agency rather than singular concepts of agency, underlining an approach where narrated subjects are not constituted in language or discourse but rather in relation to other subjects (Doucet and Mauthner, 2008). This reading for co-occurring (contrapuntal) voices/multiple subjectivities accords with ontological accounts of self (selves) as embedded, interpretive and relational, may reveal individual, moral frameworks (Milligan and Jones, 2010).

To some extent I had already covered elements of this stage as part of my Reading One, as I had already tabulated a column for *relationship*. I did find it helpful to revisit the range and character of the relationships in the story, which I did by listing them in the sequence in when they appeared in the story (see Appendix 9). This was often helpful to reveal the complexity and often contradictory nature of relationships. In particular, I found that it helped me to focus on how the situation/event might impact upon personal agency.

For instance, in Sally's story, she told me how, in pregnancy, she had discussed with the midwives and doctors whether or not to have a Caesarean and she said:

'I would have gone along with whatever they wanted me to'

However, when, in theatre, during her Caesarean birth, she was told that she couldn't have skin-to-skin contact with her baby, she reveals that she is less amenable to accepting the professional's opinion:

'...she was with me still at that point but the midwife was very, oh well, you know, you've had a Caesarean and you're poorly...and it was actually, well, you didn't respect what I said to you, that I wanted skin to skin,'

I interpreted this as Sally feeling that the mode of her baby's birth was less important to her than trying to secure immediate intimacy with her baby; and that it was easier for

Sally to negotiate with her medical team about her wishes during pregnancy than whilst in theatre.

In the context of my study I also found it interesting to think about who might be missing from a story (e.g. baby, partner, midwife) and the significance this revealed. Ultimately, I found it more helpful to have already begun to explore relationships from the perspective of how protagonists/actors were introduced into the plot (as part of reading one) than if I had solely examined relationships in this third reading.

Reading four: Listening for broader social, political, cultural and structural contexts

In Reading Four, the participant's account and experiences are viewed against broader social, political cultural and structural contexts (Mauthner and Doucet, 1998) and the structured power relations and dominant ideologies that frame their narratives (Doucet, 2008) and shape the participant's sense of self (Edwards and Weller, 2012).

This reading requires the researcher to listen for places where the participant's thoughts, feelings, decisions and choices seem to be constrained by context or where cultural norms are reflected or resisted (Mauthner, 2002.)

During this fourth reading I focussed on looking for the structured power relations and dominant ideologies that framed the narratives before me, using the *A Guide to the Readings* (see Appendix 8) I had used for the other readings (Appendix 8). However, based on readings I had made earlier, I also asked myself questions posed by Frank (2002 in Holloway and Freshwater, 2007), which I found helpful in consolidating my response to the text:

How does the narrator mark the beginning and end of the narrative and how it is constructed?

How does the narrator seek to affect the listener in the story, what change does the narrator seek to bring about in the listener?

How does the story represent a world view that is typical of some people in particular social situations, e.g. oppressed peoples?

What larger societal narratives are embedded in the specific narratives told by the speaker?

How are the social narratives being accepted or resisted?

During this fourth reading I was torn between reading for what I perceived to be the dominant cultural scripts and ideologies and responding purely to what was appearing from the text. For instance, the cultural narrative of breastfeeding as indicative of 'good' mothering and its consequences are laid out in Kirsten's story:

'There is a lot of pushing on the breastfeeding...that I think could push a woman into some sort of depression.'

What I might have missed if I wasn't consciously thinking about my (researcher) response to what she was saying is that she obviously felt that I also supported this cultural ideology because she told me:

'I know you saw me having the bottle here but I'm pumping at the moment...he is getting breast milk.'

This also implied to me that Kirsten perceived that, while I was in her house asking her to tell the story of her baby's birth, I was also likely to be observing (and judging) her mothering style. I didn't find this level of reflexivity came easily to me. In view of this, I felt that reading four, like reading one, would also benefit from concurrent researcher reflexivity in the form of documenting reader (researcher) response.

Creating case studies

Mauthner described how, once she had completed the four readings of the Listening Guide, she developed case studies to move from a holistic understanding of individuals to tackling the data as a whole (Mauthner, 2002). Each case study contained key points in each woman's experiences and circumstances and details of their socio-demographic, educational and employment location (Mauthner, 2002). These were combined with summaries from the four readings (Mauthner, 2002). Once individual (holistic) narratives had been analysed, Mauthner found that it was possible to search for different and common themes across the interviews, tackling the data as a whole (Mauthner, 2002).

Unlike other stages in the Listening Guide, I could not find detailed guidance on how this was achieved and I struggled to comprehend how I would condense the huge amounts of data I had accumulated and pull the readings together and *write* the meaning in response to my research questions. Two elements in particular were important to me: getting to the subtext of the story – *what this story is about* (rather than purely capturing the story events) and keeping the individual unique story whole – *how this person speaks of herself* in relation to others and in relation to the topic (planned Caesarean birth). I was keen to find a method that would capture and hold the meaning and the character of the story whilst reducing it to a manageable form. To do this, I created a fifth reading, which I have called the *Writing Guide* (described later), which uses a framework for reviewing story structure and plot development (see *Creating additional analytic devices*).

Mauthner (2002) stated that, as well as producing case studies and summaries of the key points for each participant, she also reviewed data on each woman's socio-demographic, educational and employment details. I opted not to present demographic details of the participants in my study as I felt it was ultimately limiting and potentially in conflict with concepts of narrated subjectivities. This is explored in Chapter 6 (Participant biographies) and Chapter 9 (Research design).

Study group

The final process described by Mauthner and Doucet is sharing interpretations with research peers in a study group (Mauthner and Doucet, 1998; Mauthner, 2002). Mauthner and Doucet spent 17 months analysing their data, supported by a study group (Mauthner and Doucet, 1998). Within this group, they were able to get other group members perspectives on key elements of their transcripts (Mauthner and Doucet, 1998). Mauthner advocates the use of this interpretive community which she says can serve as a relational interpretive framework (Mauthner, 2002). She describes how, through working with other researchers in a study group, she was able to develop an interpretive community that came to reflect the relational nature inherent in the methodology (Mauthner, 2002). Describing how, within the group, participants read extracts from transcripts whilst other members contributed their perspectives on the interview narrative, she comments that this element is not well documented by other authors or researchers (Mauthner and Doucet, 1998). I don't find this surprising as ethical considerations around data

sharing and academic requirements for a student to claim their research as *all their own work*, often hamper this sort of innovation and relational working.

I, too, have benefited hugely from my relationship with other members of the Listening Guide study group (based at the University of Huddersfield). Undertaking a PhD can be a lonely process, exacerbated by the fact that, by definition, you are usually exploring a topic in a way that few other researchers are engaged in. I have found the opportunity to meet with other students across different disciplines to interrogate a methodology very valuable. Primarily, these interactions have provided me with a means of challenging my perspective, sense-checking my findings, helping me weigh the relative benefits of key methodological decisions, whilst I strove for a good methodological *fit*, as a note from my reflective journal shows:

'It's useful to have a time when your mind is back focussed on the specifics of analysis. You have debates – you share things. I've written down odd little things that somebody's said during the meeting and realised that I need to think about that aspect in my research.'

Ultimately, being part of a study group is also about taking the relational element inherent in the Guide and making it operational, as one group member said:

'There is something about mirroring, and walking the talk of the guide...Just to work in isolation and to claim stakes in the listening guide – it's possible, of course it is – your relationship is with your participants and all the other voices, but this is just another very practical means of adopting the relational elements of the Guide.'

(Kate – Listening Guide Study Group member).

Creating additional analytic devices

Once I had completed the four readings, I found that I wanted to return to two of the elements of Reading One that I had felt were particularly illuminating but which I felt I hadn't fully explored using the Listening Guide method. These elements were attending to *emotional resonances* and *metaphors*. Whilst constructing the I-poems I was struck by how powerful the visual representation of the text had been for me and I considered how I might use a visual medium with emotional resonances and metaphors. I came up with the idea of producing *word clouds* of

emotional resonances and *metaphor poems*. These two elements and the *Writing Guide* are my original contributions to extending the Listening Guide method.

Emotional resonance word clouds

Word clouds are a visual way of representing text data in a weighted list (Wikipedia, 2014). The clouds give greater prominence to words that appear more frequently in the source text. Data is fed into an online programme, in this case I used *Wordle* (Wordle.net), and the resulting design reflects the relative importance of each word by font. Importance is indicated by a large size font which reflects the frequency of use of the word in the data list entered.

I had not seen word clouds used before in association with the Listening Guide method or with a person's emotions but I had seen it used as a healthcare improvement technique, to grab the audience's attention and reflect back a group's shared priorities. In this scenario it had been a powerful tool for communicating complex information simply.

With this in mind, I made word cloud pictures for the emotional resonances for each of the participant's stories. As an example, Monika's emotion word cloud can be seen in figure 3.



Figure 3. Monika's emotion 'word cloud'

Like I-poems, I found these word clouds to be very powerful, particularly in reflecting the conflicted nature of the emotions in the stories. I felt a reconnection with the interview encounter and the intensity and meaning of the stories I had heard. I also found it helpful to reflect on the similarities and the differences in emotional experience between the eight stories (see Appendix 10).

However, I recognised that there were tensions between my wish to use a variety of innovative analytic devices and my theoretical challenge to coding schemes. Word clouds, like coding schemes, rely on *frequency* of the stated emotion as an indication of significance. In addition, the emotions represented are not seen in context of the events which prompted them. Despite these contradictions, I found the process of constructing and exploring emotional word clouds and juxtaposing different analytic devices helpful in giving me additional layers of interpretation.

Later, when I came to look specifically at my research question which explores the phenomena described in planned Caesarean birth, I used a technique called *experience based design* (NHS Institute for Innovation and Improvement, 2009) which identifies *touchpoints* – key moments and interactions in the pathway or journey where the emotions have been shaped (see later in this Chapter and Chapter 7) which felt more satisfying than exploring emotions out of context.

Developing metaphor poems

Whilst listening to the participant stories, I was struck by how my understanding of what I believed to be the meaning of their stories was heightened when they used a metaphor. These metaphors acted as signposts to a deeper meaning, enabling me *‘to gain a gestalt understanding of the meanings in the data’* (Carpenter, 2008, p.277). Although the Listening Guide recommends exploring metaphors as part of reading one; reading for plot, there is no information in the guide on how to select them or what to do with them in the theoretical context of the analysis using the Guide.

Metaphors are described as being a universal part of everyday language (Todd and Harrison, 2010), and are likely to be present in every narrative text. Metaphor analysis is an emerging method. With its origins in cognitive linguistics, it has been adopted by social scientists using a range of epistemological positions (Todd and Harrison, 2010).

A metaphor can be defined as:

‘A figure of speech in which a word or phrase is applied to an object or action to which it is not literally applicable — a thing regarded as representative or symbolic of something else.’

www.oxforddictionaries.com 2014

In particular, metaphors are proposed as constituting '*a displacement and an extension of the meaning of the words*' (Ricoeur 2003, p.1) with the power of the metaphor being to project and reveal a world (Ricoeur, 2003).

Metaphors have been used as a tool by researchers in two ways: for the analysis of metaphors of a respondent within a narrative, or for the description of or construction of theory, for example, Foucault's metaphor of *panopticon* (Todd and Harrison, 2010). A panopticon is an institutional building that allows a watchman to observe activity at all times. In Foucault's metaphor it is used to illustrate the observed and socially quarantined nature of modern society.

Research participants can use metaphors to describe specific events, or their experiences and emotions (Deacon, 2006). As metaphors '*allow people to describe one thing using the analogy of another*' (Deacon, 2006, p.101), metaphors may be used when someone is struggling to say something or when they wish to create a vivid picture of the experience, event or feeling. As such, metaphors are a linguistic device of heightened emphasis in the narrative and therefore signpost elements of the narrative which warrant further analysis. Within the theoretical framework of the Listening Guide, if stories are believed to reflect relational ontology then I feel it is reasonable to see the benefit of deeper study of the use of metaphors, which are *relational* linguistic devices enabling linguistic transference of one (analogous) meaning to another.

Lakoff and Johnson extended the notion of metaphors from a purely linguistic device (as a feature of language) to a cognitive device, where metaphors are a feature of thought (Lakoff and Johnson 1980). For Lakoff and Johnson, metaphors structure human thought and understanding of experiences and, as such, portray complex realities and illuminate aspects of phenomena not previously noticed (Lakoff and Johnson 1980). Metaphors can also reveal cultural context as they are '*shaped by the linguistic and cultural context within which they are found*' (Froggatt, 1998, p.333).

The use of deeper analysis of metaphors within the Listening Guide/VCRM methodology has already been described by Ruth Deery in her study of midwives experiences of engaging with clinical supervision in a community midwifery setting (Deery, 2003). Deery undertook a fifth reading to look at how emotions were expressed through the use of metaphors. She found that they seemed to provide further insight into the culture of midwifery work and the associated emotional consequences. Through this additional reading, focussed on reading for metaphor, she identified 'body as container' and 'emotions as energy' as metaphors in the midwives accounts of the culture of midwifery. This additional reading and understanding of these embodied

metaphors highlighted neglected aspects of the midwives' emotional wellbeing and the way they had been socialised to manage, experience and perform emotion (Deery, 2003).

Metaphor analysis is increasingly being seen as an opportunity to examine phenomena from a unique and creative perspective. Despite this, Carpenter (2008) advises caution when using metaphor analysis. She argues that misuse of metaphors (mixing metaphors or using metaphors that do not fit the data) can misrepresent the data and may detract from the intended research message (Carpenter, 2008).

Although there is no fixed way of undertaking metaphor analysis, Todd and Harrison (2010) suggest that the first step is to make decisions about which words or 'discourse units' may be deemed to be metaphorical. The aim is to *'go beyond revealing a structural 'systematicity'... of concepts and to examine the intentions (conscious or not) driving the use by the speaker'* (Todd and Harrison 2010 p. 482).

Like construction of I-poems, I systematically went through the transcripts of participant's stories underlining all the metaphors in the narrative and then placed them in sequence in a single continuous stanza. I opted not to separate into stanzas as I didn't want to lose the flow and thread of the text.

I have chosen to illustrate this with Monika's metaphor poem (see Figure 4) because, as it is short, it can be produced in its entirety here and because, despite English not being her first language, I believe it reflects that metaphor poems could be broadly used for any narrative study, as a way into meaning and plot. The metaphor poems for each of the study participants can be found in Appendix 11.

As mentioned earlier, I constructed the metaphor poems after I had completed the other four readings, so I had already some preliminary thoughts and findings. I had already appreciated the variety in the unique experiences (see Chapter 6), the degree of uncertainty that the women were experiencing in pregnancy played out in the stories as a delicate balancing of fatalism, fear and self-efficacy (see Chapter 7) and the range of expectations of motherhood (see Chapter 8).

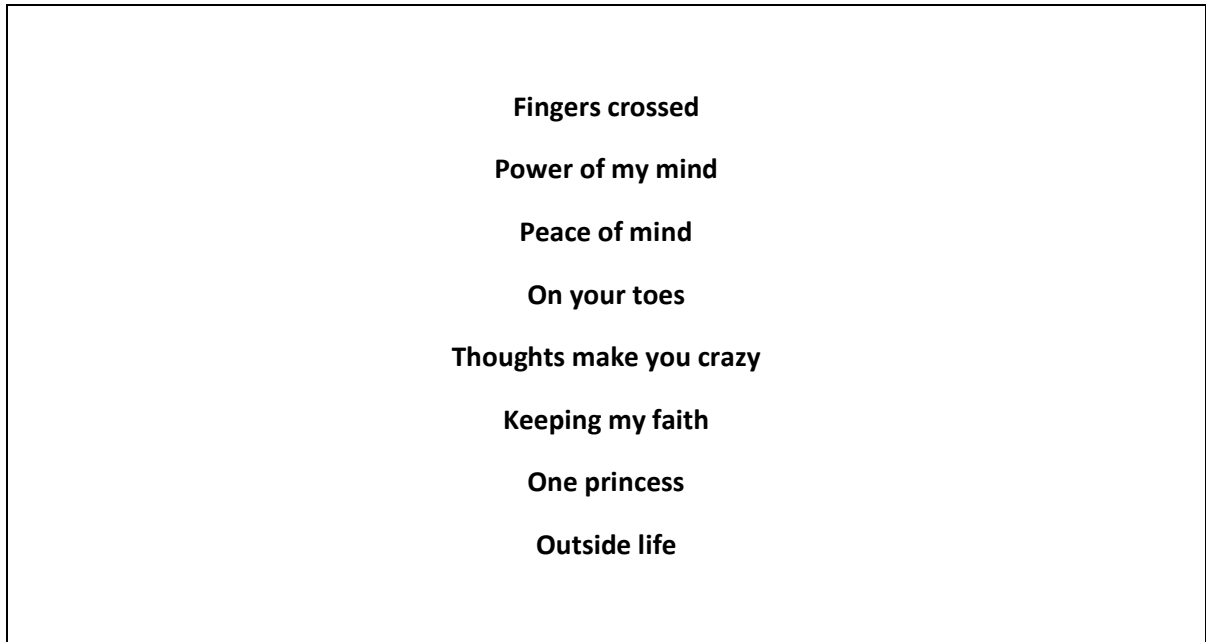


Figure 4. Monika's metaphor poem.

In Monika's metaphor poem I was struck, not only by the meaning I got from it, but also how the language used compounded that meaning. For example, the balance between bodily expressions (*fingers, toes*) and cognitive expressions (*mind, crazy*) seemed to reflect the balancing of fatalism, fear and self-efficacy I had already noted more broadly from my other readings of her narrative. The language in the poem also powerfully tells of Monika's relational ontology and what is at stake; Monika is planning to have one child only and she wants what is best for her child (*one princess*). The final line (*outside life*) also provides a glimpse into Monika's relational ontology and the context in which she experiences motherhood; that it is a very important part of her life but one which is balanced with other relationships.

I found the process of constructing metaphor poems extremely useful in providing additional and deeper layers of understanding, helping me reconnect with the meaning and experience of the interview encounter, and providing a way of distilling a manageable essence of each story. I also found it was a useful way of keeping in mind the character of each participant's whole, unique story.

As Carpenter (2008) says: *'The choice to use metaphors should not become a self-serving attempt at creativity that supersedes subject and substance. At their best metaphors illuminate meanings of experience; at their worst, metaphors distort or obscure the essences of them'* (p. 274).

I found that analysis of the metaphors contributed to my understanding of the phenomena of planned Caesarean birth, not just as an interpretive device or way into data that cannot be spoken of literally but also by providing linguistic signposts to key elements of the story. I believe that constructing metaphor poems could prove a useful adjunct to the Listening Guide for other researchers.

Reading five -The *Writing Guide*

The framework for Reading Five, my additional reading, came from course notes from a creative writing course that I had attended at the University of Brighton, led by Dr Michael Wilson. This framework, which I have called *The Writing Guide* (see Figure 5) is drawn from narrative criticism and creating writing methodology. With its roots in Aristotelian *poetics* (dramatic theory), narrative criticism focusses on characterisation, story structure and plot development. These techniques look at what is often referred to as the narrative arc of the story; the beginning, middle and end of the story and how the character(s) develops through the events of the plot. In this technique, the story structure and ordering of events serve to tell *of* the character(s) and how they are challenged/changed as a result of the events in the story.

By creating and then carrying out this fifth reading, I found that I was able to get at the subtext of the story and have a better understanding of the relationship between the construction of the story and my reader response. It made me feel more confident about which elements of the story were significant as signposts for deeper meaning. I also found it to be an effective way to manage such huge amounts of interpretive data. From this reading I was able to put together story summaries and *write* my findings of the participant's story, as proposed by Plummer (see Reflection on representation, p. 69), in a way that was manageable and which contained the meaning, characterisation and the narrative arc of the individual stories. I have used this framework to reveal the meaning of planned Caesarean birth inherent in the eight individual stories (see Chapter 6).

Figure 5. Reading five – The *Writing Guide*.

Reading five – The *Writing Guide*.

Adapted from Wilson M (2010) Introduction to narrative, *from Idea to Print*, course notes, University of Brighton.

What is the premise of the story?

Premise conveys something of the value of the story and gives an idea of where we are going with the story. It usually involves conflict or polarity.

What values or conflicts are we dealing with?

Values are usually universal and in opposition, e.g. love/hate

What is the inciting incident?

The inciting incident is an event that displaces and challenges the central character/suggests a goal/highlights a need, that is either revelation or action – engages the reader/suggests an ending

The dilemma. Is there a crisis?

What is in the balance/going to happen? How do the values develop over time?

The Climax

The most highly charged scene/deciding moment. What is being shown and why? How does the character act?

Resolution

What is the outcome and how does the character respond to it?

Characters

They should have something to lose and something to gain, what is it?

Where are the turning points and shifts?

This usually applies to value changes and can be subtle

The narrative arc

Look at the beginning and end of the story – what has changed, and why?

Addressing my research questions

Once I had carried out all five readings I returned to my research questions to see which elements of analysis would best answer my questions (below, in italics). I drew to a lighter or heavier extent on all of the discrete readings in the Listening Guide to answer my research questions. I also made decisions about the extent to which I would present the findings as individual accounts or draw from across all accounts to answer the research questions.

What meaning do women give to their experiences of planned Caesarean birth?

Narrative researchers believe that story telling is inherently meaningful as it '*is a cognitive process that gives meaning to temporal events by identifying them as parts of a plot*' (Polkinghorne, 1991, p. 136). For this question, I drew heavily on all four readings as, together, they revealed how the narrator ordered the flow of experience to make sense of events and their actions to tell a contextualised story, embedded in their feelings. Personal narratives are both intentional (saying something that the narrator believes is important) and contextualised (socially constructed). Through reading one I was able to follow the plot and unfolding events of the story and to listen to the drama (the *why*) of the narrative. Reading two enabled me to listen to how the participant was perceiving and experiencing themselves in relation to others (Reading three), within a temporally and situated narrative (Reading four). The word clouds enabled me to appreciate the depth and span of the emotional resonances. My own researcher reflexivity, carried out in Reading one, enabled me to consciously and actively focus on my emotional and intellectual response to what I was hearing and to recognise that my interpretation of the unfolding story was partial and perspectival. The metaphor poems gave me linguistic signposts to key elements in the story.

Specifically, for this question, I used my *Writing Guide* to frame and condense the whole story into what I believed to be meaningful accounts of planned Caesarean birth. To address this question, the findings are presented as individual accounts (see Chapter 6).

What phenomena appear in women's stories of birth by planned Caesarean?

In describing the phenomena of planned Caesarean birth (see Chapter 7) findings were drawn from across all accounts. The challenge in this question was deciding what to select from the individual stories to produce a metastory of planned Caesarean birth which wouldn't reduce the meaning and intention of each narrator. Unfortunately, despite being widely reported and encouraged in narrative analytic techniques (Lieblich et al 1998), I could find no guidance on how

to reconcile my aim to keep the women's individual stories whole whilst attempting to produce an interpretation of those stories in the form of a metastory. I knew that I could use the story structure to reveal significant events and phenomena: how scene, plot, character and event were used by the narrator to communicate meaning - to understand *what is the dilemma?* But I was still perplexed as to how I could draw from each story to explicate the phenomenon of planned Caesarean birth. I explored themes and the context in which those themes were expressed using Reading One. I also looked at emotional resonances and the word clouds I had constructed. But I felt that I was missing the relational significance of the context in which those phenomena were being described, both in terms of *what was happening* and *who was involved*. I realised that I could draw on expertise that I had developed in my role in service improvement by using and adapting an improvement methodology called the ebd approach: experience-based design (NHS Institute for Innovation and Improvement, 2009).

Experience based design (ebd) is a method of designing better experiences for patients, carers and staff by capturing the experiences of those involved in healthcare services (NHS Institute for Innovation and Improvement, 2009). The process involves looking at the care journey and the emotional journey people experience when they come into contact with a particular pathway or part of the service (NHS Institute for Innovation and Improvement, 2009). Staff, patients and carers then work together to understand these experiences and then to improve them (NHS Institute for Innovation and Improvement 2009). Ebd has four components: capturing experience, understanding experience, improving experience and measuring experience. The *capture* phase starts with getting patients and staff involved and helping them to tell their stories, usually through discovery interviews, in a method similar to the narrative techniques I used. The *understand* phase then involves identifying emotions, mapping 'highs' and 'lows' and finding *touchpoints*. Touchpoints are '*any moment where a user interacts in some way with the service*' (NHS Institute for Innovation and Improvement 2009, p. 28). A pathway or journey map is then created to give an understanding of the concrete steps or activities of the process. Through an emotional mapping exercise, participants have an opportunity to identify key moments and interactions in the pathway where the emotions have been shaped – the touchpoints. Touchpoints are not limited to the process steps as they are based on subjective experience of care (NHS Institute for Innovation and Improvement, 2009). By systematically identifying the touchpoints, you can map the most important elements of the service from the point of view of the people who experience it. The *improve* and *measure* phases involve turning experience into action through co-design and evaluating and sustaining the improvement respectively. These experiences are then used to understand not just the care journey but the emotional journey

people experience when they come into contact with a particular pathway or part of the healthcare service (NHS Institute for Innovation and Improvement, 2009).

Using my analysis of the themes and emotional resonances from Reading One, I identified and mapped the touchpoints in the planned Caesarean journey using *ebd* (NHS Institute for Innovation and Improvement 2009), (see Appendix 12) and then I focussed on Reading Three to explore the relational significance and interdependence of phenomena, relationships and context. My findings are presented in Chapter 7.

How does a woman's personal stories of birth (of planned Caesarean) relate to dominant narratives and ideologies of pregnancy, birth and motherhood?

For this question I relied heavily on my analysis from Reading Four, which listened for the broader social, political, cultural and structural contexts in which the stories were told. Reading Three also helped me to appreciate the social and personal networks and how they contributed to the moral frameworks which revealed ideologies of pregnancy, birth and motherhood in the stories.

As stated previously, I was torn between reading for what I perceived to be the dominant cultural scripts and responding purely to the text. This made me question the degree to which I may be explicating dominant narratives and ideologies or just recognising and responding to them. This highlighted the need for me to be critically reflexive and acknowledge that my interpretations could not be divorced from my experience of working as a midwife and being part of an academic community which explores pregnancy, birth and mothering practices.

My findings of the dominant narratives and ideologies of pregnancy, birth and motherhood are presented using individual accounts (see Chapter 8).

What can we learn from women who have their first baby by a planned Caesarean?

This question focusses on the research output and what can be known from the analysis of the eight stories in terms of my contribution to knowledge production. To answer this question, I explored the bounds of what can be known, in the context of hearing these women's stories as purposeful engagements with the researcher rather than indicative of their lives outside the interview (Mishler, 1986). I returned to theoretical perspectives in narrative research and the Listening Guide; in particular to concepts of the narrative identity (the narrated subject and

researcher reflexivity), the possibilities of personal narratives as social action and the potential for this storied account of my research journey (research product) to be disseminated - revised and redistributed in future stories in perpetual generation (Bakhtin, 1981; Frank, 2005).

Critique of the Listening Guide

One of the features of the Listening Guide method that makes it attractive is that it demystifies the process of data analysis by outlining practical steps that researchers can follow like a recipe (Doucet 2008, Edwards and Weller, 2012). This appears to have been a deliberate strategy in response to what the authors found to be a lack of clear guidance in other techniques which tend to gloss over how they were achieved or describe them in abstract terms which make them difficult to apply (Mauthner and Doucet 1998, 2003). I certainly found that the practical steps of the four readings were instantly appealing having struggled with other analytic techniques, however, despite providing a very thorough and systematic approach to the data analysis I found that there was no guidance on how to present findings or how the different readings could be used to address specific research questions. Authors that have used the Listening Guide have used different techniques for presenting their findings and some have even presented the I-poems with no researcher commentary (Koelsch and Knudson, 2009). Some authors also found that they sometimes had difficulty in interpreting data because a compelling pattern didn't emerge (Sorsoli and Tolman, 2010) or that individual readings (in this case I-poems) were contradictory to the clear intention of the whole text (Milligan and Jones 2010). I found the Listening Guide extremely useful in analysing my data but I had to develop my own technique for writing up that analysis. I also feel that some questions about the technique remain unanswered:

How are the systematic readings used to answer specific research questions?

When confronted with a large number of research participants (Mauthner, 2002), how do you select which texts to do full analysis on?

If data analysis is supported by group discussions (Mauthner, 2002, Doucet, 2008) where and how do you document their responses?

Central to the method, is the notion of *listening* in different ways to achieve optimal understanding (Sorsoli, 2007). For some authors, *listening* signifies an attempt to recreate the

listening that occurred during the interview and insert the interviewer back into the transcript (Doucet 2008, Edwards and Weller, 2012). However, Doucet (2008) indicates that some of her analysis was carried out by research assistants who had not been present at the interview so how this feature is realised was not clear to me. Listening also refers to attempts to *actively* listen to how participants *speak of themselves before we speak of them* but I question whether it is really possible to constrain *how* we listen so as privilege the participant viewpoint, particularly when the first reading focusses on plot (rather than characterisation) and then researcher reflexivity. The terms *listening* and *reading* are often used synonymously and I believe that *reading* also necessitates active participation. I find it more helpful to conceive that we listen or read *relationally* – (always) in response to and because of our multiple, situated and perspectival selves.

The Listening Guide is also critical of thematic coding methods which it is argued fail to acknowledge the embedded context of the narrative (Milligan and Jones, 2010, Sorsoli and Tolman, 2010). Authors argue that with thematic analysis, much of what was compelling in the narrative aspects of life disappears when taken out of context (Sorsoli and Tolman, 2010). Mauthner and Doucet believe that by taking time to listen through the four readings, and delaying the stage when the transcripts are cut up and grouped, the listener is brought into a relationship with the person speaking which helps to maintain individual narrative and the differences between respondents (Mauthner and Docuet, 1998). However, Edwards and Weller (2012) use both thematic analysis and I poem analysis in their longitudinal case study and to look at change and continuity in a young person's sense of self. They found that neither techniques were superior but they provided different angles of analysis (Edward and Weller, 2012).

One of the most contentious elements of the Guide revolves around concepts of voice and subjectivities (Mauthner and Doucet, 1998, Edwards and Weller, 2012). Doucet and Mauthner are critical of simplifying the process of representing voices as though these speak on their own rather than through the voice of the researcher. They have come to appreciate that the *(Omni)*presence of the researcher through all stages of the research renders it impossible to fulfil the feminist aim of listening to women 'in and on their own terms' (Doucet and Mauthner, 2008). They question the extent to which people can be known and they propose instead the concept of narrated subjectivity; a storied (constructed) self (selves) that researchers can come to know through layered reading of their narrative using the listening guide (Doucet and Mauthner, 2008). Edwards and Weller feel that this is not entirely satisfying as the concept of a narrated subject threatens the notion of an interview encounter which is co-produced and disrupts the subjectivity of the researcher (Edwards and Weller, 2012).

Researcher subjectivity and reflexivity is another key component of the Listening Guide and needs to be similarly critiqued. The researcher is asked to document their reader response at the time of the unfolding of the story but it is important that we don't see reflexivity as an attempt for trustworthiness and we need to remember that just as participant accounts are narrative constructions so are researcher narrations/reflexive accounts (Bishop and Shepherd 2011). Mauthner and Doucet provide deeper reflections on their research studies with the benefit of 'hindsight' and detachment' from their doctoral work (Mauthner and Doucet, 2003; Bishop and Shepherd, 2011). Bishop and Shepherd are critical of this stating that '*Despite our best efforts at 'doing reflexivity', both immediately following and when reflecting back on an interview, there are influential factors that escape our gaze. Reflections of the past are particularly imperfect (p.1283) and 'distance and time have not brought me closer to the truth of exactly what happened.'*' (Bishop and Shepherd,2011, p.1288.).

Researcher reflexivity is undoubtedly a thorny issue - to ignore it is to ignore the influence of our ontology, for as Sorsoli says '*as researchers we hear stories in a chamber that holds echoes of our own stories, our research questions and the stories we have heard others tell.'*' (Sorsoli, 2007, p.320). However, we need to exercise caution when making claims about the benefits of distance from the analysis. Stories are alive with the possibilities of alternatives selves and experiences. Ultimately, I believe, we need to be explicit about what we can and can't achieve (see Chapter 9).

From my readings of Bakhtin's work, I feel that more emphasis should be placed on the historicity of the accounts so as not to fix or finalise the subjectivities of the participant and researcher but recognise them as historically contingent. I would also like to see further development around concepts of reader-response and how this relates to the multiple subjectivities of real and potential readers of the research story (thesis). The *who* that is reading the research account is largely ignored as a feature of meaning making in literature on the Listening Guide and yet concepts of relational ontology ultimately apply to narrator, listener, transcriber, analyst and reader. Being aware of an active reader and asking them to be self-reflexive by actively inviting them to hear the text whilst tuning in to their own locations of for instance gender, race, gender, sexuality etc. (see Chapter 6, Participant biographies) would further challenge and extend the possibilities of this method.

The Listening Guide method is premised on there not being only one way to carry it out (Gilligan et al, 2003; Sorsoli and Tolman, 2010). I found, like other researchers, that working systematically through all the readings takes a great deal of time (Mauthner and Doucet, 1998; Sorsoli and Tolman, 2010) and produces a wealth of data that it is often difficult to know how to manage. It is

a technique which is more suited for particular types of data such as in depth interviews, (Sorsoli and Tolman, 2010) for small case studies (Edwards and Weller, 2012) or for *tuning your ear* for a larger sample (Mauthner and Doucet, 1998).

Balan (2005) found that although time-intensive, the different stages allowed her to be sufficiently immersed in the data to facilitate being able to see emerging themes, commonalities and differences (Balan, 2005). At times, I felt that I was drowning under the wealth of data and that it was taking me further away from getting closer to the nub of what someone was telling me. I found that I needed to employ techniques which, having exploded the data enabled me to manage it and retell it in such a way that it could be meaningful to a reader(s). I resolved this through developing my own techniques (metaphor poems, touchpoints (see Chapter 7) and a narrative structure framework, the *Writing Guide* (Figure 5) which helped me to shape the data in a meaningful way.

The Listening Guide is credited with being adaptable and open to development. Sorsoli (2007) argues that the goal is to choose layers that will illuminate a particular phenomenon in different ways and that this necessitates choosing layers that are appropriate, instructive and clearly related to the researcher's questions and theoretical framework (Sorsoli, 2007).

From my reading of the literature, the listening guide has been used by a small number of researchers in different ways: in specific and longitudinal studies, small and large, involving female and male participants, in face to face interviews and in online relationships. Some of the adaptations researchers have made or suggested are listed here:

- Training and involving research participants (in this case socially excluded teenagers) in the interpretation and analysis (Byrne et al 2009)
- Instead of I poems, representing contrapuntal voices as 'dialogue' - using underlining and italics to show the different voices (Tolman, in Sorsoli and Tolman, 2010)
- Producing *me* or *you* poems to reflect idiomatic use of language (Edwards and Weller, 2012)
- Using the first reading alone for some studies which purely require accurate representation of the manifest content of the interviews (Sorsoli, 2007)
- Creating I-poems for other protagonists in the story (in this case partners, friends, school and social care) (Bekaert, 2014)
- Analysing an online (self-completion) survey and a semi-structured email interview. Participants were encouraged to use emoticons (e.g. 😊, ☹️) capital letters, coloured and

varying fonts to suggest paralanguage (e.g. changes in intonation and emphasis etc) (Golding, 2011)

- Creating a researcher I poem (Reid, 2014)
- Including contextual clarification to anchor the statements in I poems (Milligan and Jones 2010)
- Devising and providing a 'member-checking package' which included background reading on the principles, detailed analysis of first reading and researcher reader-response, full I poem, participant profile (which participants they were invited to amend) a transition metaphor (e.g. war zone casualty), interpretations of contrapuntal voices and full verbatim transcripts (Balan, 2005).

Many researchers have adapted or developed the method to tailor it to their research focus. As already stated, I used an improvement methodology called ebd and I developed word clouds of emotional resonances, metaphor poems and a Writing Guide to enhance my use of the Guide. This was because I felt that the four readings alone did not fully support my research questions or wholly help me to operationalise the technique. But, as the original authors of the guide state, the Listening Guide offers a way into a relationship with the data rather than a fixed framework for interpretation (Brown and Gilligan, 1992; Gilligan et al, 2003) or recipe (Doucet, 2008). Rather than being a flaw in the original design it is an indication of its potential and mirrors the emphasis on interdependence and relationality which lies at the heart of the Listening Guide (Byrne et al, 2009). Ultimately, how the Listening Guide is used should be determined by the best strategy for responding to your research questions.

Conclusion

In this chapter I have shown how I used the repeated and focussed readings within the Listening Guide and added an additional reading, *The Writing Guide*, to analyse the stories in my study. I have also critiqued some of the elements of the Listening Guide and described how I have adapted and extended the Listening Guide method in response to my study.

The Listening Guide method has enabled me to systematically attend to the many multiple subjectivities embedded in a participant's expressed experience; and the concepts of relational ontology have enabled me to include my researcher reflexivity at the time of the analysis. The adaptations and developments I have using the Listening Guide have not fundamentally challenged

the ontological or epistemological stance of the Listening Guide methodology, namely the concept of relational ontology and narrated subjects, rather they provide additional ways to engage with the data and to condense whole narrated stories into manageable summaries/case studies. I do however have some critique of the elements of (reader-response) researcher reflexivity which I believe can only ever be partial and constituted at the time of analysis and which warrant further development to include the reader of the research 'output'.

Ultimately, the strength of the Listening Guide method is that it offers a pathway into a relationship with the data rather than a fixed framework (Brown and Gilligan, 1992). In addition, the growing number of researchers who are prepared to share and *show the workings* of how they have operationalised this method provides a valuable resource to other researchers and seeks to unveil the mystique of *how to do* data analysis that pervades much research writing.

In the next four chapters I address each of my research questions in turn using findings derived from the multiple readings I obtained from the Listening Guide and my additional fifth reading. In the next chapter I focus specifically, on *What meaning do women give to their experiences of planned Caesarean birth?*

6. Introducing voices – eight stories. What meaning do women give to their experiences of planned Caesarean birth?

'A problem for the biographer is the omniscience. We know the narrative sequence. We record our subject's childhood and youth with wisdoms of what was to come – we have God-like advantage over the person of who we write... and in a curious way this both distances one from the subject and invites more personal feeling.'

Penelope Lively (1984) *According to Mark* p. 207, Penguin Modern Classics.

Introduction

In this chapter I introduce the voices and stories of eight women: Charlene, Jo, Monika, Sarah, Abby, Sally, Kirsten and Lisa, and the meaning these women gave to their experience of planned Caesarean birth. I define *meaning* in narrative research and I problematise issues of *representing* (writing) life stories and producing participant biographies for the reader.

I focus primarily on how the women made sense of their experience of planned Caesarean birth and therefore how their stories create meaning in how planned Caesarean birth was experienced, understood and constructed. My intention has always been to present whole stories and to go beyond a purely thematic or content analysis approach, which can fracture text into snippets and eliminate the structural features that characterise narrative accounts (Riessman, 1993). It is not possible to present a complete story from each participant, so I have had to make decisions about what to include and what to leave out.

I have used a variety of analytic devices (see Chapter 5) to explore meaning in the personal narratives. These include the four readings of the *Listening Guide*, and the techniques I have developed: *emotional resonance word clouds*, *metaphor poems* and the *Writing Guide*. This chapter draws specifically on the device I created as a fifth reading - the Writing Guide (see Figure 5, p.88). I have used this framework throughout the chapter to explore the narrative structure and to *represent* meaning and narrative identity in these eight women's stories. In Chapter 7, I address my research questions about phenomena by drawing from *across* the eight stories; then in Chapter 8, I return to a focus on the individual stories to present dominant ideologies of pregnancy, birth and motherhood. Throughout these chapters I hope that the reader will be able to keep in mind the whole, emplotted story of each participant which I have represented here.

Meaning in narrative research

Fundamental to narrative research is the concept that telling stories is meaningful: '*a primary way individuals make sense of experience is by casting it in narrative form*' (Riessman, 1993, p.4). Analysis of narrative, allows the researcher to systematically study these personal experiences and the meaning they have, by exploring how events have been constructed by the (active) storyteller (Riessman, 1993). As stated previously, crucially, stories do not mirror a world '*out there*' (Riessman, 1993, p.5) but how protagonists interpret things (Bruner 1990) and create plots from disordered experience (Riessman, 1993). These plots have characters, episodes, imagery, a setting, themes, and an evolving story of self. Thus stories can reveal personal experience through a '*perspective ridden character*' (Riessman 1993 p.5).

Storytelling is also viewed as *performance* through which an (intentional) narrator has to convince the listener that something important happened (Riessman, 1993). As well as analysing the significance of characterisation and sequencing of events, the researcher has to dig beneath the surface for hidden meaning (Langdridge, 2007) and narrative intention. Narratives, then, are both interpretive (sense-making for the story teller) and interpreted (made sense of by the researcher and then by the reader).

What I present here, although partial, are eight holistic accounts drawn from what I perceive to be the defining, critical moments and turning points inherent in each story as it was told to me. While I believe that both the participant accounts and my (researcher) reflexive account are narrative constructions, what I have written here does come from the power of an individual's story to be performative and transformative. I believe my responsibility is to show the (verbal) action of their story on me, by producing an account of what I heard and the meaning it created for me.

Participant biographies

In narrative research, the story is the primary focus of analysis and the identity and emplotment of the narrator unfolds during the telling of the story (Ricoeur [1984] 1990). For this reason I did not carry out a demographic surveys of the participants as I believed that biographical distinctions that were perceived to be important by the participant would come through their narration. I was also aware from my readings of feminist literature that there were inherent tensions in the

theorising of a biographical self, which could be researched and illuminated (see Somers, Mauthner and Doucet and Gilligan on narrative and relational identity in chapter 4).

If I were to provide biographical details for the reader, which features should I chose? Somers was critical of the tendency to slide into fixed, essentialist and singular categories of race, sexuality or gender believing that rather than contesting forms of difference (which marginalise females) they may reinforce them (Somers 1994). As she argues, there is no reason to assume that people with similar attributes will share common experiences or be moved to common meanings of social action (Somers 1994). I believe this also has relevance for the transferability of research findings and whether it is possible to conceive that findings can be plausible and applicable in contexts other than the one in which they were constructed.

While I can conceive that participant's might not mention biographical details (e.g. race, sexuality, disability, age) in their stories because they are so embedded in their identities, I felt that I was faced with having to construct biographies by trying to pick out characteristics that I thought the reader would wish to know. Like my issues with representation described earlier (see Chapter 4), I was anxious not to be reductionist or finalising of the participants' identities. I have also opted not to locate these stories within narrative typologies (e.g. trauma narratives, resistance narratives, illness narratives etc.) as I believe that this limits the reading of their content. Instead, I have chosen to provide *story synopses* to assist the reader in holding a summary of each participant's particular, narrative identity and I invite the reader to comprehend each of these stories without making assumptions about able-bodiedness, sexuality and race.

Eight Stories

Charlene's story

Synopsis

Charlene had a lot of anxieties and fears about pregnancy and never pictured herself giving birth naturally. Being listened to by a Psychiatrist was a breakthrough for Charlene and the psychiatrist supported her decision to have a Caesarean. In hospital, Charlene would have loved to have been able to be put at ease more not made to feel so young and naïve. She often felt left alone on the wards, but she felt that the theatre team were there for her and she found the atmosphere in theatre very calming. Part of her feels that she has missed out on her birth experience but she doesn't feel she could have coped with a normal

delivery. Charlene got through her experience with the support of her partner and feels the experience has brought them closer together.

Charlene's story reflects that she was dealing with a number of conflicts. These conflicts were between: empathy and indifference/judgement; fear and assurance; not having a clue and knowing what her body was capable of; loneliness and companionship.

Charlene started her story by revealing that she had a history of abuse and that this was the reason for her Caesarean. Charlene had seen her obstetrician and he had referred her to a psychiatrist for support and she also had additional support from her community midwife. Together, they had planned for Charlene to have a vaginal birth:

'I sort of thought that I could go through with the whole pregnancy and it would be okay and we had discussed sort of just having an epidural.'

The deciding moment came for Charlene thirty six weeks into her pregnancy, when she experienced a vaginal bleed and was admitted to hospital where she was given a vaginal examination:

'I had my first ever, sort of vaginal examination, and it just made me absolutely petrified at the thought of anything, of having one like that again and anything else invasive down there.'

The staff were busy and Charlene felt pressurised that she had to choose between her baby's health and her fears:

'She said if you want to find out if everything's OK we need to do it right now. So there was no time...cos I knew that it was best for her sake (looking to baby) if I had it but I desperately didn't want it ...I just felt pressured that I had to for the sake of my baby to find out that everything was OK.'

Charlene found the experience very traumatic:

'I was in a right state...I was in absolute pieces...it was awful, absolutely awful and I understand they were busy and everything...[but] to be told that you need to do this there and then otherwise you got to go...'

The next day Charlene saw a psychiatrist who supported her decision to have a planned Caesarean.

Charlene had a Caesarean and was surprised that she came out of it alive:

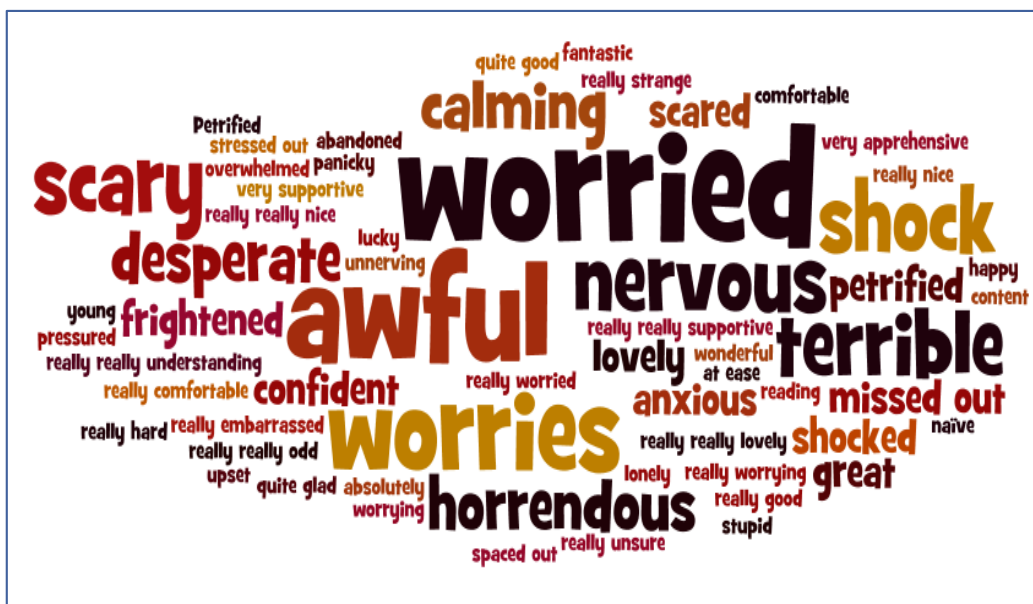
'cos I'd got myself into the point of thinking I'm going to die. I had the whole talk with Nick, which I think he found really upsetting. You know, that I wasn't going to survive (voice shaky) and you know what he would have to do to look after her the baby and so forth. That was hard. But I think that would have been the same whatever op you have, I think. Especially if it's your first operation.'

Throughout her story Charlene talks of how important her partner's support was.

'But we got through it, in the end, didn't we?'

'Actually the more things that went wrong and the more things people had to say, I think the closer it brought me and you, didn't it? So as much as people thought, you know, we were going to fall apart and we wouldn't be able to cope, I think it has been the complete opposite.'

When Charlene talks of herself she talks of someone who is worried and at times, terrified at the prospect of having her baby. The extent of Charlene's anxieties is revealed in her emotion word cloud:



Her fears related to both vaginal birth *and* having a Caesarean but when she looked back on her experience, she reflects that she felt that she couldn't have coped with a vaginal birth:

'I don't think I could have coped with a normal delivery, as much as I would have liked to and it is the most natural thing in the world, and I thought I could when I got pregnant -there is no way that I could have done (voice slightly shaky)' .

In contrast to this, she also described an innate sense that she (or her body) knew what was right for her:

'I wished that they had just sort of listened...cos you know your own body'
'...just try and listen to your own body and listen to your own instincts...'

The most significant turning point in Charlene's story is when she meets with the psychiatrist:

'And it was like finally...someone has actually listened.'

An excerpt from Charlene's metaphor poem reflects how significant this was:

Never in a million years
Vent my whole story at him
Finally – break through!

This made Charlene feel *'happy, content... 'so that made a massive difference cos he said to us there and then, I one hundred per cent support you having a section.'*

Another significant event was when Charlene made friends with someone who was in a similar situation:

'I also had a friend that...had the same sort of anxieties and fears I did...she was seeing an extra support midwife as well...our pregnancies were pretty much exactly the same and so I think we supported each other a lot... all the way through ... we've been quite closely connected... I think having someone

else's support that...actually understands that you are nervous and you're anxious and you're worried about things really helps...so I think that definitely got me through the last week.'

Other friends and family were less supportive:

'I think people...and their opinions have a lot to do with how you feel about things...to be told constantly all the way through that I'm a women, I should be able to, you know, just give birth naturally – that...caused a lot of issues in my head and a lot of upset,'

Charlene found her pre-op assessment very useful:

'She explained everything that was going to happen, I also spoke to the anaesthetist – they came round and explained. So I was much clearer.'

But there were other times when she felt she was asked to make choices without having the information:

On breastfeeding: *'and they were looking at me like I was stupid like, I should know you know what I want to do and they kept saying it's your choice at the end of the day, we're not here to push you either way.'*

This made Charlene feel *'young and naïve.'*

'I didn't know what to do - I didn't know what was best. I wanted whatever was best, and that's what I kept saying, and I felt really stupid because they, like you know, I've got to make a decision...one way or the other. And how do you make that sort of decision? I was thinking I want what's best for my baby...cos that's all any mother wants at the end of the day...but I don't know what's best,'

Lack of time was a key element for Charlene and it appeared to be linked to whether or not she felt cared for:

'I think if someone had actually sat down with me and explained everything that was going to happen - recovery period, things like that, I think I would

*have felt a lot more better ...because as soon as I had that pre-op, I felt (pause)
great.'*

Charlene's feelings often related to being physically left alone. However there were also examples where Charlene attributed her loneliness to staff attitude; either by not wishing to spend time with her, by not being empathic about how she might be feeling or by not sharing their knowledge with her:

*'I think if they had actually had the time or wanted to - cos they probably did
have the time.'*

With the new baby: *'You are just left, and you you...feel (pause) feel completely abandoned.'*
*'yeah they left me but I had just had the op – just had my daughter,' I couldn't do a lot of things
and they left me with a baby... 'you feel left alone and you don't use the buzzer...no one spent any
time to see how I was.'*

Ironically the point at which Charlene was most alone, when her partner had gone home, instead of spending time with Charlene, the staff offered to take her baby away: *'your partners gone
home. They weren't busy, and they said they weren't busy at night, cos they kept asking me if...if I
wanted them to take [the baby] for the night...so that you can get some sleep,'*

Charlene demonstrates the impact of having companionship with the staff when she describes having time with the return-to-practice midwife:

*'And she actually spent some time with me and she was quite happy to sit
there and have a little chat, and I thought that made such a difference, that
made a big, big difference to how I felt ...especially at night when you're lonely,
if someone just came and gave you a little company, and just seeing if you're
okay, and how you were with things.'*

Charlene thought that the theatre team were 'there for her':

*'They haven't got to attend you know umpteen other people - they are there
for you.'*

And she found her experience: *'very calming being in there. I never thought in a million years that
I would say that it was calming being in theatre'* She also felt able to cope with catheterisation:
'yeah I felt confident enough that her and another lady were doing it - and they were still, you

know, touching my downstairs area... so and I was alright with them doing it, which I think is a big step.'

Charlene's story starts with her reason for wanting a planned Caesarean birth. Throughout her story she voices fears and anxieties she faced when having her baby. Charlene felt very reassured by her experience in theatre and by the end of her story, Charlene is more confident about repeating her experience and having more children:

'I would definitely have another section erm which I didn't think that I would feel like erm but I do – for definite...I would just be on top of my aftercare...cos I know a bit more what to expect...the next time erm so but then it certainly hasn't put me off.'

Jo's story

Synopsis

Jo discovered that she had a low lying placenta at her twenty week scan. She had an easy pregnancy and had planned to have a natural birth. Finding out that she might need a Caesarean came as a massive shock and she was surprised by how emotional she felt about this, which she saw as a huge contrast to the staff from whom it was very routine. Jo had a prolonged stay in hospital as her baby had jaundice and needed phototherapy on the special care baby unit. Jo's Caesarean was fine but throughout her stay she felt that there was no room to explore her emotions, she felt vulnerable and lonely and increasingly as though she were failing to be a good mother. Jo now feels that she has all sorts of issues about birth and she is not sure how to unpick them.

Jo's story contains two stories in one, both of which reflect how she felt about her experience and how she felt about herself during this time. Jo tells of the events that led her to have a Caesarean birth and her experience of having her baby readmitted for treatment for jaundice on the Special Care baby Unit (SCBU). Both of these elements tell of how Jo felt that she had a very emotional response to her situation and how she felt that this was in conflict with how staff perceived the circumstances, which made her feel more vulnerable.

Jo's story tells of the following conflicts; between pregnancy and birth as a unique and emotional experience and birth as a routine event; being an active decision-maker and being passive and feeling vulnerable; feeling knowledgeable and feeling incompetent.

At her twenty week scan, Jo learned that she had a low lying placenta and that she may need to have a Caesarean birth. She was really surprised by her emotional response to this information:

'I remember it being a huge deal for me and I had a really emotional reaction to it, which I perhaps wouldn't have predicted at all. And if I'd thought about, you know, if I'd had that kind of news, how would I have reacted? And it was completely sort of irrational reaction – that perhaps I'd failed in some way already.'

One of the key features of Jo's story is her surprise at how she reacts to this information. Jo's story was the one I found the hardest to listen to, partly because I thought she was very hard on herself and what she perceived to be failings and also because her story felt unresolved and she was left with feelings of inadequacy. There may be a number of reasons for this, but my interpretation was that the conflict Jo described between how she thought she would react and how she did react, which she felt was exacerbated by the staff's lack of appreciation and understanding of how she felt, has produced a disruption in what Jo believed about herself and what she thought she was capable of. From the quote above, I feel that her feelings of inadequacy relate both to her emotional state and her physical state – that maybe she hadn't been able to grow a placenta in the right place.

Uncertainty also played a huge role as Jo was unable to make decisions for herself and plan her birth. Throughout pregnancy, right up until a few days before her baby was born, Jo did not know how her baby would be born:

'There was uncertainty right up until the very end, because they were waiting to see if the placenta would move. And it did move, but it didn't move far enough. And so I was still having scans the week before erm and then we were talking matters of centimetres – will it move another centimetre – and then you'll be giving birth naturally and so even the week before, there was a lot of uncertainty and that was quite difficult for me to to deal [with].'

Jo spent a lot of time trying to get more information so that she could process what was happening to her but being unable to find information seemed to compound Jo's feeling of inadequacy and vulnerability:

'I didn't know a lot about Caesarean birth, or erm the implications for me personally or the baby or the risks of it. And as I say I'm the kind of person who has to go and amass all that information. It's actually quite tricky to find, if you're looking for, say statistics on mortality rates! (laughing) which is the kind of thing that I was then thinking about! (smiling) as I say completely irrational over the top reaction. You're worried about the risks and you know I, I just couldn't find that information very easily.'

Having been sure at the start of pregnancy that she wanted a vaginal birth, Jo began to see that there may be some positives about having a Caesarean:

'I sort of came to terms with it quite slowly (quietly) and in the end I was kind of thinking oh I think maybe this might be better, than natural birth! (laughing). Especially when I got to the hospital and you are in the delivery ward and you can hear all the screaming and I'm thinking, right, maybe! (laughing) maybe I'm the lucky one here - I don't know. (laughing)'

Even when Jo began to get used to the idea of a Caesarean, she found that having to see different staff made her experience even more impersonal:

'They gave me another appointment in the end... a complete stranger who I didn't know, and again I'm thinking I don't think anyone's thinking about how this might feel – to me – you know someone's come over and not even introduced themselves and they're going to make a really important decision that will completely determine what my birth is like and I don't even know who they are.'

The pivotal point came when she met with an obstetrician who told her that she might need to have a classical incision for her Caesarean birth. Jo didn't know what this meant, didn't feel that she could ask what it meant and felt very scared:

I sat down with a consultant

I didn't know any of that

I'd kinda got visions of being gutted like a fish

I just felt that I was being a bit irrational

I was

I was

I need to do something with all of that

I did feel really quite scared

Compared to how Jo felt in pregnancy and after her baby was born, and her anxieties about the birth, she felt the birth was a good experience:

'The birth itself was actually quite positive (laugh) in the middle of all that, the bit I was most worried about actually was fine.'

Interestingly, when she talks of the actual birth, her language is surprising unemotional. This may reflect just how straight forward and undramatic this part of her experience was compared to other elements:

'I just lay down in a room and then they handed me a baby – it couldn't have been easier (laugh) you know.'

Initially, I was wondered if Jo might have felt little emotion at her baby's birth, but thinking critically about my interpretation of her story I think that the way she phrased this I feel that the language used is dramatically - indicating the difference between how she feels with this part of her experience and the low emotions in ante and post natal period.

In the second stem of Jo's story, Jo's baby became jaundiced and was admitted to the SCBU. Jo blamed herself for this but she also felt that the midwife was not supportive of her and that she thought it was her fault:

'I thought he'd wake me up... he was in the same room as me but um and he didn't and he'd slept for four hours ... and his bilirubin levels had crept up as a result because he hadn't had enough fluids and the midwife came round on the Sunday and took more blood and was just horrified by the colour of him and actually was again really quite mean to me I think.'

Jo was given a strict feeding schedule which involved breastfeeding her baby every two hours:

'And so they took him to put him on the billy bed and this ridiculous 2 hour feeding schedule which was the worst experience I've ever been through because he was taking about an hour to feed and then I'd have to express

between. Obviously I had nothing left and then feed him again an hour later, it was all very dark and miserable.'

The difficulties Jo felt with her postnatal experience didn't really resolve until she went home again after her son had finished his treatment for jaundice. The breakthrough for Jo came when she felt that she began to get somewhere with breastfeeding and her baby slept through the night:

'I have never had that much sleep in months

I just felt brilliant'

Throughout Jo's story she portrays herself as someone who is vulnerable and overwhelmed by the uncertainty of events. Before pregnancy, Jo felt she was someone who actively sought information, was used to challenging information and asking questions. During pregnancy Jo was surprised at how emotional she felt during her experience and how vulnerable she felt. She felt unable to get the information she wanted that would help her to make decisions and ask questions:

'I've never been scared of asking questions of people or challenging what they are saying to me but in the early days I absolutely was ... (pause) I wouldn't have said boo to a goose.'

With the continuing uncertainty of how Jo would have her baby, her inability to track down the information she wanted that would help her to make decisions and feel active in her care, and her perception that staff were unemotional and unable to appreciate why she would be emotional, it's not surprising that she found her whole experience difficult:

'It was just such a dark (pause) time...I don't know but I just felt very alone and very (pause) scared really and inadequate and all of those things and I think that started to creep in with my care before I even had, had him.'

There were some positives to Jo's experience that made a big difference to how she was feeling. Jo went to NCT classes during which she was able to role play her theatre experience:

'They knew that because I'd already said that I might be having a Caesarean at that point they did kind of throw in a bit of content for me as well. And so at the NCT sessions... we did a session where... it was like role play – who's going

to be in the room when you are in surgery? And so you get a sense of how many people are involved, you know. Cos I wouldn't have imagined that there would be so many people there. And I could imagine that that might be quite overwhelming if you weren't sort of prepared for that and that kind of thing was very helpful.'

Having some input into personalising her birth was also really important, which Jo found she was able to achieve through writing a birth plan:

'I'd sort of gone from being you know really upset and distraught and feeling like a failure - had spent you know a number of weeks coming to terms with it and thinking you know actually this could be quite positive and I can still have an element of control over the experience and and that was quite important for me so you know - being still able to have a birth plan and things for when you are in surgery and things like that.'

Having personal care was also very important:

'One time the midwife was quite quiet and we were all up feeding and she brought us all a cup of tea and things like that and it was really nice! And things like that made such a difference to how I felt - just made you feel a little bit cared for.'

Jo's story begins her story with a sense of shock she felt when she realised that she was unlikely to have a natural birth she had planned and hoped for and ends with an emotional picture of her feeling overwhelmed by the feeding schedule and unable to do the best for her baby:

'I just remember sitting in the chair and crying - my tears dropping onto [my baby] and me going, this probably isn't great for the baby not helping me breastfeeding and well it's not helping the oxytocin, me sitting here sobbing!'

Jo's story tells powerfully of how emotional the experience of having a baby can be and, when this isn't understood and reciprocated by staff, how unsettled and vulnerable she felt. My impression of Jo's story is that pregnancy and birth was a rollercoaster of emotions and uncertainty that, one year on, was still unresolved:

'When I try and unpick why I feel the way I do about my experiences it's hard cos there were some positives in there, but overall it's a really dark time and I don't want to go back there -and I don't know how it could be different'

*because I don't know what I could change or, you know, I don't even know
what I could expect from professionals...'*

Monika's story

Synopsis

Monika is only planning to have one child and wants what's best for her baby. During pregnancy she has to decide the best way to have her baby by balancing her knowledge, hopes and fears with her wish to be fit and healthy to care for her daughter and her desire to recover quickly and return to a normal life. Monika chooses to have a planned Caesarean, is very happy with her experience and the decisions she has made. She is confident that this was the right choice for her while acknowledging that every woman is different and should be able to choose for themselves.

Monika's story highlights the conflicts she feels as she tries to decide how to do the best for her baby that will also have the least physical and mental disruption for herself. Monika's mother experienced complications after childbirth and Monika is fearful that she could too.

Monika's metaphor poem gives a clear indication of the dilemma Monika is facing as she decides how she should have her baby:

Fingers crossed,
power of my mind,
peace of mind,
on your toes,
thoughts make you crazy,
keeping my faith,
one princess,
outside life

The language Monika uses tells how she hopes for a good experience *'fingers crossed'* and that not knowing what kind of labour she could anticipate, yields a level of uncertainty (*'on your toes'*) that is very stressful (*'make you crazy'*). She clearly indicates what is at stake if she makes the wrong decisions (*'one princess'* and *'outside life'*), and how she hopes that she has made the right decision (*'keeping my faith'*) when she insists that this is what she wants (*'power of my mind'*).

These values show how Monika is feeling about herself and her experience and how she makes sense of her experience, as well as highlighting the dilemmas she is facing and key events and experiences in the story. We are given an indication of the interplay of these themes and values when Monika talks of finding that she had a cyst in her uterus during pregnancy. This occurs early in her story and is a key event in Monika's decisions about birth.

'With the first scan they find cyst in my womb, next to the baby ... yeah so I was worried about that ...the doctors keep saying to me that this is fine, this is OK but I... I... was so conscious and I was so worried that I called my doctor back home and and he said that it is not so good. And um If cyst stays the same size it's not going to cause any harm to baby, I I stayed calm but I wanted to have c section because of that because I wanted to know about everything the baby, the cyst and um I was so afraid of pain because I, I – like my mum, and er with the first baby my mum er couldn't walk for a month.'

This gives us an early insight into the dilemma Monika is facing of balancing professional knowledge from both her obstetrician in the UK and her obstetrician at home (Northern Europe), her anxieties about pain and her knowledge of the complications her mother faced after her first birth.

I did not immediately appreciate the anxiety that Monika was expressing about her fears for childbirth during the interview and I think I was swayed by Monika's belief that her story was a straight forward account of her choices and as such was *'not very exciting'*. However, when I listened for the I-poems and reviewed the word cloud of Monika's emotions, I became more aware of the knowledge that Monika was seeking and the anxieties, fear, and hopes that she was facing:

I was worried
It was so conscious
I was worried
I called my doctor back home
It stayed calm
I wanted to have c section
I wanted to know about everything the baby, the cyst
I was so afraid of pain
I was so afraid that I couldn't take care of my baby
I really insist
I just stick to... to my[guns]
I was keeping all those thoughts away from me
I was hoping



During pregnancy Monika continued to weigh the knowledge and experience she received from clinicians and women with her own values, beliefs and anxieties:

I don't want to
I'm so afraid of the pain
It has doubts during the pregnancy
I knew from the beginning
I want c section
I read lots of information on the internet
I talked to lots of women who had c sections
I talked with a woman who had a normal delivery
I compared all the you know afterwards – bad things
I decided that c section – is is is [sic] less harming

The deciding moment in Monika's story came when she asks her friends about their experience. One friend who planned to have vaginal births has two emergency Caesareans. Monika reveals that this friend had a much longer recovery time and long term consequences (back pain). Monika therefore feels it is much better to have a planned CS if there is the possibility that you could go through labour and then need an emergency CS:

'I thought it's much better to have a planned C section than be in pain for a very long time - twenty four hours or forty eight hours and you know afterwards finally you have c section and then you know you are tired, you're exhausted and it takes much longer you know to to to recover and take care of your baby and probably it will you know affects your your breastfeeding. So, I I compared this and my other friend and she had all three you know c sections planned and she she was very happy, was very happy. And she said yah it's it's much better and you recover much quicker and you can go home you know mm very happy...so it's... it's... it's... it's much better.'

Monika decided to insist on having a planned Caesarean and found the experience to be better than expected:

'It worked even better than I was expecting. I was expecting more pain – more blood; you know, much longer recovery – time, but it worked really, really good.'

'I have just, you know, you know scar, it doesn't show at all –nothing. And it heal properly, no problems at all – no no infections – nothing. And right now I'm carrying my baby and no problems at all.'

She is confident that her choice was the right one for her:

'I'm very happy, very happy and I if anyone, you know, ask me what to choose I will always say c section.'

A particular turning point in Monika story came when she met with her own doctor at home. She indicates the importance of knowing her doctor and the confidence this gave her:

I talked to my doctor back home

I used to go every time I'm at home

I feel confident

I feel good

Crucially her doctor at home also supported her decision:

'So he know us and er he said you know – this is my choice – if I feel confident and I feel good – this is, this is for me and you know normal delivery – it's not good – and I I don't want to – I'm so afraid of pain and you know, so so it's better – it's better for my my peace of mind to have a c section.'

Once Monika knew that she would have a Caesarean, being able to prepare and get rid of some of the 'unknown' elements of her birth experience, appeared to alleviate some of her fears and anxieties, which made Monika more confident about how events will unfold:

'And with a normal delivery you're just, you know, like, on your, on your toes all the time and it happens and if you are ready, all the things are packed and I will be able to go to the hospital when something is wrong and all those thoughts - they make you crazy (laugh) and with a c section you already know – that's it! This is the date, this is the time - that's it! I'm going, I'm having my baby and it's you know it's much calmer.'

Monika's story starts with her surprise at becoming pregnant so quickly and concludes with her construction of life after motherhood. During the story, Monika tells of her fear and anxieties around birth but also of her confidence about her own health and her body which has helped her to balance the risks of surgery:

'And and I know myself I'm totally healthy person – I don't have any, you know medical issues. So I thought, you know everything's going to be, you know, fine. All the, you know, all the wounds going to heal very quickly because I'm young, I'm healthy and I'm ,I'm not obese, I don't have extra weight, so I thought you know, it's... it's... it should be fine.'

At the end of her story, Monika talks powerfully of the need for an 'outside' life and of a life beyond motherhood. I felt that Monika's story tells of how she sought to limit the disruption that

becoming a mother had to her identity as an independent woman. This independence is something she wants to role-model for her daughter:

'You have to have something – outside, to keep you interesting (pause) and, keep you going!'

'And I don't want to sit at home you know and show my daughter that you know you have to sit at home (upward inflection) and just you know depend on... on... on the man.'

Monika is confident with her choice for a Caesarean birth but she does not portray her experience as authoritative or something that other women should emulate:

'I'm not gonna, you know tell them to have a c section – to have you know scar and everything – no! It's their choice.'

Sarah's story

Synopsis

Sarah always wanted to have a planned Caesarean birth, believing that it was the best option for her and her baby. Sarah uses her personal experiences and values to deliver a compelling speech which challenges the dominant ideologies of childbirth and maternity care inherent in the National Health Service (NHS) and in social media. Sarah resists the constraints of the state system by opting for private healthcare. Ultimately her ability to pay for private care enabled her to obtain the experience she wanted. Sarah is happy with her experience of birth, she recognises that this experience is not what everyone wants but she believes that she should have been entitled to it without having to pay for it.

There are powerful values threaded throughout Sarah's story and the tensions are between: emotions and logic, knowledge and experience; empowerment and oppression; Ideology and rhetoric. Sarah spoke powerfully about her personal experiences and her story challenges the current provision of maternity services in the NHS and wider ideologies of pregnancy, birth and motherhood.

Sarah starts her story by stating that this pregnancy *'wasn't planned'* and revealing the impact a previous experience has had on her:

'I'd been pregnant before...and had a miscarriage um and things had been quite traumatic and I got a little, probably depressed - although I refuse to take the label.'

This was the first thing that Sarah said to me and I was instantly drawn to how she was able to talk about a very intimate experience and about much broader social concepts at the same time. The psychological and social impact of this experience on Sarah is clear, and she goes on to say:

'[I] made some fairly dramatic changes after that, which included quitting my job.'

My interpretation of this opening information was that Sarah's goal in this pregnancy was to avoid a similar 'trauma'. I felt that this meant avoiding both emotional trauma and social stereotyping. Sarah told me that she'd *'wanted a Caesarean delivery'* since seeing a natural birth video at school:

'I was about fourteen – fifteen when I saw a particularly hideous, probably not a particularly hideous, but to my mind a particularly hideous natural birth video at school erm it didn't put me off sex but it did remind me that contraception was probably quite a good idea (laugh).'

She rationalised her response by linking this formative experience with her perspective of the possible consequences of vaginal birth gained through her professional knowledge:

'And then when I was on the ward and a Gynae nurse erm (pause) looking after women with really damaged pelvic floors following deliveries, and not just in the immediate postnatal periods, but women who had spent twenty – thirty – forty years living with this problem, both urinary and faecal incontinence and just thinking I, you know, just not not for me!'

She added weight to her viewpoint by stating that a Caesarean may be needed for medical reasons as her height might preclude her from a vaginal birth, a perspective that was shared by her colleagues:

'Also having worked with gynaecologists and obstetricians who took one look at my size and would say yeah of course if you wanted a section, we'd do it for

you – no, no questions asked really – apart from you know sensible questions about just doing surgery and everything.'

Sarah showed that she was aware that there was a balance of risks and benefits between vaginal and surgical birth.

During pregnancy, Sarah's '*only concern*' was that she '*wanted a referral to an obstetrician to discuss and book an elective Caesarean*'. Instead Sarah was given an appointment to meet with a consultant midwife. Sarah's dilemma became whether or not she could get the birth she wanted within the NHS by challenging the system or whether she would have to opt out and pay privately for her maternity care.

Sarah rationally weighed the risks and one of her '*big concerns*' was that she would always end up with a surgical birth '*based on [her] size*'. What she was hoping to avoid was having an emergency Caesarean:

'Of course an emergency c- section is riskier - any emergency surgery is ... if I was going to end up with a surgical delivery, I would far rather it was planned...with less risks to me, less risks to the baby than it being you know a rush when things are already starting to go wrong.'

Sarah also used her knowledge of her mother and her sister's births to compound her perspective:

'My sister had two fairly awful vaginal deliveries... um my mum's had two sections and two vaginal deliveries, and was an obstetric nightmare giving birth – so didn't really feel as though genetically (laugh) I was in the best place!'

She believed that if she needed an emergency Caesarean she would lose the ability to be active in making decisions: '*it's not really the time for a big debate, and decisions and choices.*' And she clearly identified what was at stake and how her viewpoint and a rational response to her need for personal autonomy:

'I'm thirty nine, I couldn't afford for things to go wrong with my baby, because I'm not young enough to do it again, and whilst accepting that things can go wrong even with an elective section, they would be my choices of potential

consequences, rather than the consequences that somebody else thought that I should be willing to accept.'

The description of Sarah's meeting with the consultant midwife is the most highly charged scene. Sarah believes that one of the reasons she was sent to see a consultant midwife was that there is a perception that it is empowering for women; but Sarah felt disempowered, ignored, not listened to and her wishes vetoed:

'For all this, oh we know women feel empowered when they see a consultant midwife – it was a complete waste of my time – it was that there was a better chance of hell freezing over than me having a Caesarean section, no ifs, no buts – no discussion, no, no discussion about why I even wanted one.'

Sarah left the appointment *'in floods of tears'* and considered whether or not she *'should be thinking about an eighteen week termination.'* Sarah also felt angry because she felt that she had been sent to see the wrong person:

'I should have seen an obstetrician not a consultant midwife... if midwifery is expertise in the normal, well she's just a super expert in the normal, and I was actively choosing to deviate from the natural and so I didn't need to see a midwife, I needed to see the person who could actually do the surgery.'

This comment made me think about how Sarah and the consultant midwife might have viewed the purpose of this meeting and I wondered what might have worked better.

Sarah was told by the midwife that she would *'either have to go to another hospital or you'll have to pay privately'*. Sarah's response to this was to ring the Primary Care Trust (PCT) and challenge their stance on patient choice.

A lot of Sarah's anxiety appeared to stem from uncertainty and feeling that her views weren't listened to:

'Not knowing that I could have my delivery option made me miserable, I was sleepless – I was just so worried about it, and I had visions of being forced down a vaginal delivery pathway and things going horribly wrong and not being listened to when things started in my view to go wrong.'

Sarah made an appointment with a private obstetrician who agreed to do a planned Caesarean and Sarah felt *'relaxed for the first time'* since finding out she was pregnant.

Throughout her story, Sarah talked articulately about her personal power to act in ways which supported her own values and knowledge, and how she came up against challenges from policies and ideologies within the NHS maternity services. She actively challenged some of the dominant ideologies of childbirth:

'I find the use of the word empowerment really interesting because I didn't want to be empowered to have a vaginal delivery, I felt very comfortable with my choice - I didn't need somebody else saying, yes but this one's so much better!'

Sarah's story presents very rational arguments to back up her perspective but she also eloquently reveals the emotional factors that contribute to how she feels. Sarah experiences the birth she wants by paying for it. She is pleased with her experience but resents paying for it, but she acknowledges that by going private she also had some other things which she wanted and valued, including having her husband to stay the night.

She sums up what birth meant for her:

'It was just a really (pause) positive experience. But to me the delivery was never important in a sort of rite of passage sense. It was much more about how do I – what can I do to ensure that we both of us come of out this with the minimal risk to ourselves.'

Sarah's story starts with the emotional experience that has led her to this point and her story unfolds as a strong defence of an alternative viewpoint to the current, dominant cultural scripts of childbirth. This story is not just about birth and birth experience. Sarah uses her personal experience of birth to challenge some of the image of National Health Service as benevolent and caring and presents a view of a National Health Service as a social structure that responds to political ideology. Sarah does not feel that her views should be adopted by everyone, just that she should be listened to and her views respected:

'In terms of the actual decision, it was - it was great, for me. I'm not advocating it for anybody else but for me it was the right thing to do.'

Abby's story

Synopsis

Abby had a straightforward pregnancy until 31 weeks when her GP told her she was having a big baby. A scan later showed the opposite to be true - her baby was small and in a breech position. Believing her baby's birth to one of the biggest days of her life, Abby sought knowledge from wide range of sources to make choices and prepare for her Caesarean birth. Abby had a good experience of Caesarean but felt that when it came to sifting information she often had to work it out for herself and try to take the good stuff with her and leave the not so helpful stuff behind. She learnt that it was important not to fixate on having a particular experience but to control what she could.

The conflicts in Abby's story were between: not knowing and knowing; being prepared and being unprepared; having an analytical approach and having an emotional response; your own experience and someone else's; feeling that resources were available and feeling that something is missing.

The event that challenged Abby was, when 31 weeks pregnant, she was told by her GP that she was going to have a big baby. Abby didn't disbelieve her GP but she realised that she didn't have all the facts and she wanted to find out more:

'You're going to have quite a big baby and I was like, oh OK, that's good (laugh) and I – I don't know if it was the thought of having a big baby but I just thought I'd quite like to (pause), as the pregnancy progressed further, to find out a bit more.'

The dilemma Abby faced was wanting to know the facts but not wanting to hear bad things. The tension between these two factors was heightened by the significance Abby gave to this event in her life:

'I'm a bit of a control freak and I can't imagine – this is going to be the biggest thing that I ever did you know in my life – that's what it felt like and I felt like I wanted to know what the facts were and not that I didn't believe her but I just - I wanted the peace of mind to know.'

As Abby got nearer to having her baby the tensions grew and Abby found that she was being more influenced by other women's stories:

'As I got towards the end of my pregnancy, actually, how big is big? And um, you know, I was turning forty and I was like you know I want to know how the placenta's doing and how much amniotic fluid I've got – I suppose I'd just had lots of girlfriends who have had children and I've heard lots of stories and I wanted to make sure that I had all the facts.'

Abby felt herself to be someone who was able to rationally sift information but she found it more difficult to weigh the theoretical information with what people were telling her of their experiences. So at 38 weeks Abby chose to have a scan privately:

'I wanted to make sure that I had all the facts so that when I went in to have my natural hypnobirthing erm baby (laugh) erm that it was going to be possible and um so ... in the interim I decided to go and have a private scan.'

It was during the scan that 'everything was turned on its head':

'And everything that we had been told was... was the opposite (laugh), so she was breech and she was quite small and ...there wasn't a lot of fluid.'

The obstetrician told Abby that he didn't think the baby could be turned and so Abby was booked in for a Caesarean. Abby found that her disappointment at not having a natural birth was mitigated by knowing what was going to happen:

'I just said you know what's your professional view and he's just like – he rang the hospital and booked us in and that was really nice – you know I just came out of that, although disappointed slightly disappointed that – not disappointed actually, just everything had changed but I felt quite euphoric that I just knew – I knew what was going to happen.'

Abby's Caesarean experience was 'OK', she enjoyed it but found it physically tough':

'I actually quite enjoyed it in a weird sort of way, um I didn't enjoy the aftermath. I felt quite prepared for the actual operation but I was quite shocked at how painful it was afterwards...I couldn't predict it was going to

come and when it did I was just like oh my goodness that's really...quite significant abdominal surgery.'

Abby found the information she got from her pre-assessment appointment was useful but that information from friends more useful at helping her personalise her experience:

'What's useful actually - it was more the insight I got from people who had had Caesareans themselves...it was it was the softer support that I got from my girlfriends ... again I suppose it just comes down to wanting to have an experience that I could control so all of the stuff that I had jurisdiction over.'

Abby found that the relationship she formed with the theatre team and with a maternity care assistant on the postnatal ward, were highlights in her experience:

'We've got video footage in the theatre and um I suppose it's the – what I imagined the bond that you would create with a midwife if you had a normal delivery.'

'And actually I wanted somebody to (pause) yeah to show me and to look after me I suppose and she really did and she just that.'

This relationship with the care assistant emphasised for Abby where some care was missing:

'I worked out that with a really painful stomach that actually I could control the bed so that in the middle of the night when she was crying that I could sit myself up, I mean real, you know, real der of course, but nobody had shown me, and so I had to work it out for myself.'

Whereas, in theatre, Abby felt that staff were there for her and that it was well resourced, postnatally, Abby felt that she was bothering staff:

'In the middle of the night you feel a bit guilty for buzzing the buzzer and you know, thinking that are there actually other women who have got bigger demands.'

Abby's story is about navigating a path of information and trying to control what you can. Abby's story was a very different story to the one she thought she would have and in which she felt that she had to work it out for herself. Her story starts with her having a straight forward pregnancy and then learning that everything she had believed to be true was in fact the opposite. Abby

wanted 'all the facts' but found that it wasn't easy to sift all the information that was available to her because you become much more emotional when it's you and your baby. Although acknowledging that it is not always possible, Abby believes that she had to learn not to fixate on a particular experience and instead to control what she could. Ultimately, she felt it was about filtering out the not so helpful stuff and taking the good stuff with you.

Sally's story

Synopsis

Sally felt a sense of disbelief when she found she was having a baby as she didn't think she could get pregnant. Sally has diabetes and other medical conditions which she is expert in managing for herself. Sally felt the preparation staff gave her for her Caesarean focussed on the process of the birth rather than emotional or practical preparation. Sally felt quite vulnerable in theatre and was angry and disappointed that she didn't get the skin to skin experience with her baby she wanted in theatre. Sally's baby went to SCBU initially and she had to battle with staff not to give formula milk to her baby. Birth was something to 'get through' and her focus was on developing a relationship with her baby. She felt that staff did not always respect her wishes of how she wanted to care for her baby.

The conflicts in Sally's story were between: uncertainty and preparedness; vulnerability and active decision-making; independence and dependence; intimacy and separation.

Sally portrayed herself as someone who was used to making decisions about her healthcare and she had developed adaptive strategies to cope with her medical conditions. She shows us that she is prepared to be flexible and relinquish control of her healthcare up to a point. Sally had lots of planning meetings with her team and was comfortable about the possible prospect of a vaginal birth. However, as this extract from her I poem shows, her initial confidence was knocked when she was admitted to hospital during her pregnancy at which point she began to question whether or not the medical team could care for her needs:

I was actually quite impressed

I mean we'd had lots of meetings

I went in early on in pregnancy and it was a *complete* disaster

Sally reveals her uncertainty about her feelings about how to birth:

'I'd sort of like hummed and harred all the way through the pregnancy, did I want a Caesarean? Did I not want a Caesarean?'

The initial dilemma in Sally's story is whether or not she would have a planned Caesarean or a vaginal birth. This dilemma speaks about not only Sally's anxieties about birth but also her medical team's ability to manage her medical conditions in the safest way. As her story builds it is clear that Sally's story is about how far she is prepared to relinquish her personal autonomy to manage both her own health during pregnancy and birth and her wishes for her relationship with her baby. Sally initially planned to have a vaginal birth but as her pregnancy progressed she developed additional medical complications (raised blood pressure) and the prospect of vaginal birth became *'too difficult'*:

'I turn up and they go, no actually we've all met together, and we've decided that no the risk is too high.'

I didn't know a *hundred* per cent whether they would go for a Caesarean

I think in their heart of hearts *they* did

I was oh my God (laugh) don't do this to me

I like

I felt

I think a relief really

Although Sally was relieved at the final decision for planned Caesarean, she wished she had been spared all the uncertainty so that she would not have had to worry about how she was going to get her baby out.

Afterwards, Sally felt pleased to have had a Caesarean:

I think it was quite – it was a positive experience

I don't know that I would have wanted to have gone through labour

I would have gone along with whatever
I was quite pleased
I thought
I could go through
I don't know 24 – 48 hours of induction and still have a Caesarean
I think that [it] was, you know, *better*

But she didn't feel that she had much preparation for the birth, and the preparation there was focussed on processes rather than social or emotional preparation:

'They don't really tell you that much about it on the ward beforehand...they don't tell you a great deal about what's going to happen they just say oh you'll have this tablet and you'll have that tablet beforehand... there wasn't that much about how to kind of hold her... I thought...how am I going to kind of manage?'

The most highly charged scene in Sally's story relates to when she is prevented from having skin to skin contact with her baby in theatre and the midwife suggests giving her baby some formula feed. Sally shows that she knows what she wants and what is right for her and she challenged the midwife:

'I said NO, oh my God NO!

Sally reflected on the reasons why she wasn't allowed to have skin to skin and she reveals the impact this had on her in her I poem:

I know she needed to feed
I think she might
I I don't know
I wasn't
I know
I know that I'm diabetic
I was aware of that

I could have done it

I was sat up

I think that was the only kind of negative thing

I have

I was denied to be able to do that

Although Sally doesn't have skin to skin contact with her baby immediately after birth, she is able to exert some control by being adamant about not bottle feeding her baby:

'I was like well you've got to do it by syringe cos I'm going to breastfeed.'

During her story, Sally reveals that the decisions she made about mothering her baby and her desire to breastfeed her baby and for skin to skin contact, were more important to her than decisions about how she had her baby:

'One thing that I do carry with me is that they didn't respect what I wanted and they should have let me kind of have her and I know they said she was cold but we could have like put loads of blankets on her or whatever and I felt that they didn't you know and that's something I probably will take with me. I made it quite clear that I wanted to breastfeed and I feel that I struggled with it because I didn't get skin to skin and it's probably nothing to do with it but you sort of attach because it didn't go quite kind of how I wanted it.'

Sally reflects that she would make sure it happens next time: *'it didn't happen last time and you know it has to happen this time unless there is some sort of emergency.'*

There were a number of turning points in Sally's story. Sally experienced accessibility issues during an admission in pregnancy and this prompted Sally to take control:

'I'm not coming in to have my baby until you've sorted this out'

This led to meetings and joint planning, and eventually, Sally felt that she and her medical team were working well together: *'We got ourselves organised.'*

Sally felt vulnerable in theatre and was surprised by the number of people present and realised how routine this was for the staff. She also felt separated from her baby:

I think that was

I found it quite overwhelming how many people were in theatre

I went in there

I think when you feel a bit vulnerable

I know they see it day in, day out

'In theatre - you see this baby pop over the top and then they disappear and like where have they gone? And you know they they did, I mean at the time they did say right, well, she'll come over the screen and then she'll go over to see like the doctors to check her over...but you still think where...will she come back?'

Sally also felt vulnerable immediately post-surgery: *'I was worried about going back to the ward and being in a single room and like there not being anyone around'* and she had concerns about being able to be independent: *'I use all my stomach muscles to kind of sit up and everything like that.'*

Sally's baby went to the Special Care Baby Unit and she found this very hard:

'I need my baby...well actually she wasn't there...it is very difficult if you've had a Caesarean and you can't go and see your baby on special care.'

Sally found that the separation from her baby knocked her confidence about how to care for her:

'It's hard initially having a baby...it was very very hard cos you don't know what they want.' [you] come home and you've almost got a new-born baby that you don't know what to do with...because where you've had two or three weeks on special care, they're not yours.'

When Sally got home she was able to take charge again and breastfeeding was successful once left hospital:

'Until I got home and then I was just able to relax...and there wasn't that that pressure really...it was nice to just let her develop the pattern she wanted rather than...kind of being on a four hourly, three hourly, four hourly kind of cycle (to the baby) it was quite nice for you to do what you wanted.'

Sally's story starts with her disbelief at being able to become pregnant and concludes with her relief that she and her partner had got through the birth. Her story shows that *how* she had her baby was less important than being able to have a close relationship with her baby, and the emotional elements of experience of birth that come from the mother–baby relationship. Sally regrets that she did not have skin to skin contact with her baby immediately after birth and she rehearsed how she would act differently '*next time*'. Sally is able to regain her own personal autonomy once she goes home.

Kirsten's story

Synopsis

Kirsten conceived her baby through IVF which she paid for herself. She was pleased when the NICE guideline was revised as she hoped this would mean that she could choose to have a planned Caesarean birth which she believed would be the safest option for her baby. Kirsten feels that there is a stigma against planned Caesarean births that are performed when there are no medical indications. She experienced negative comments from other pregnant women about her choice and she was anxious that staff might treat her differently because of her choices. She was pleased with her experience of Caesarean birth. Kirsten believes that having a good experience is closely related to having the birth you want rather than whether or not it goes smoothly.

The conflicts Kirsten's describes in her story were between risk and safety, prejudice and open-mindedness, and evidence and experience.

Kirsten tells how she conceived her baby through IVF and it took some time for her to adjust to being pregnant and believing that everything would go well:

'But I was quite er worried all the way through the pregnancy that something would be wrong or with the baby and erm and it took me quite a long time to sort of accept that yes it's here - it's going to come.'

Accepting that having a baby would be a reality for Kirsten also seemed to impact on her fears for the baby:

'I was very worried that something would go wrong during birth in terms of oxygen starvation.'

Although Kirsten says that she has always been anxious about vaginal birth, she states that her fears were for her baby's health rather than her own health, as an excerpt from her I poem shows:

I was quite er worried all the way through the pregnancy

I was always very anxious about giving birth naturally

I wasn't so much worried about myself

I was very worried that something would go wrong during birth

The critical point for Kirsten came when her friend had a baby who was damaged at birth.

'I had a friend who um whose birth went very wrong and she now has got a very severely disabled child, so that kind of like ooh - it hit home.'

I felt that when Kirsten said that this 'hit home' she implied that until this point the risks she had worried about were distant and theoretical but at this point they became personal and therefore more real. This confirmed to her that the consequences of risks do exist.

Kirsten decided that she wanted to have a Caesarean birth and she was prepared to accept risks to her own health for the safety of her baby:

'I think the main concern for everything is when the the the er the sort of health of the child really and perhaps the mother as well I mean you don't want to be bleeding to death (laugh) or die in childbirth, which you know is also – I know it's a risk with er a c C section but I think it was one worth taking.'

She is pleased that there is new national guidance relating to requests for a planned Caesarean:

'I was always very anxious about giving birth naturally so when they changed the NICE guidelines in October I was very pleased.'

Despite this, she was worried that the guideline may not be in place or that her request may not be granted:

'I thought at first that it wasn't possible, I had heard that you can get a C-section and I was like Oh but I'm not sure if they've changed it everywhere – have they been implemented yet because sometimes these recommendations go out but don't get implemented until another year or so don't they?'

Kirsten was adamant that she wanted a Caesarean and she met with a range of clinical staff, some of whom were supportive and understanding of Kirsten's viewpoint and request and some who are not:

'The midwife said yeah you know if you want a Caesarean you can have a Caesarean, which was quite honest of her.'

'[The] consultant we spoke to who's who's really quite friendly, um he said he's not going to put me off but he wanted me to over-think you know things again – come back in. I think it was two or three weeks to find out more – how I felt and see another see and and I think they wanted me to go to a birth choice clinic.'

Kirsten began to feel that there was a stigma to her wish to have a Caesarean birth and she became anxious about prejudice:

'I was worried about how the personnel in the hospital would react towards me having a sort of like an elective Caesarean through ch through personal choice rather than medical reasons.'

'I mean she obviously realised that I hadn't done it for any medical reasons maybe that was a little bit of attitude but you know I rise above that you know it's not my concern as such.'

This prejudice wasn't confined to staff, Kirsten also feels that other women were judging her:

'When and the erm NICE guidelines changed there were a lot of discussions related to newspaper articles and comments on them and a lot of those comments were quite like you know from sort of like women who just thought that it was completely wrong.'

Kirsten was anxious to point out that she wanted a Caesarean for reasons rather than 'cosmetic' reasons:

'My main concern why I wanted a Caesarean [was] not because I was worried about not wanting to push.'

Kirsten points to there being other areas where prejudice plays a part in decisions women have to make and she uses breastfeeding as an example of what she feels the consequences of this prejudice are:

'If you're not a very strong person and the breastfeeding isn't working out for you for whatever reason, then you could really fall into a very deep hole because everybody's saying oh you must it, it's the best for the baby and you mustn't bottle feed and you mustn't give it formula and you know it's not good so if you're not a confident person I think this will – there is a lot of pushing on the breastfeeding on like that I think could push a woman into some sort of depression you know quite easily or feeling not that of... of... of lesser worth you know when... when... when perhaps a woman does and I think it's the same with Caesarean,'

In the end Kirsten feels that there is such pressure against having a baby by Caesarean when there are no medical indications, that she invents a reason for needing a Caesarean, which she believed will legitimise her Caesarean and stop people making judgements:

'If you say I'll have a Caesarean because you know cos – a couple of people said oh is that because you are too posh to push um that sort of thing so I changed my story slightly, in the end I just said I had a low lying placenta and nobody argued with me.'

The pivotal moment in Kirsten's story came, when, after seeing the first consultant, Kirsten was referred to a birth choices clinic for a second opinion. This second consultant told her of the risks:

'He started off giving me all these 'ooh and this could happen, and this could happen ' um I mean because I had researched it so much I was completely

aware of what could go wrong doing the Caesarean what were the plus and the negative sides.'

Kirsten shows that she is knowledgeable about the evidence and she challenges his information:

'umr so I was kind of like a little bit like mm but you're quoting me statistics which I don't necessarily believe are solely based on elective er Caesarean they are very much based on what when cos a lot of these emergency Caesareans are done at the last minute.'

She demonstrates that she is able to articulate and assert her views but I was also interested that she finished by saying:

'I said it wasn't um you know some... some... some people just prefer that choice.'

I wondered if, by reverting to an argument about 'choice' and wanting a particular experience, rather than *evidence* of the risks, she was resolving some of the conflict within the interaction by switching to a debate that was about *preference* - where she and the obstetrician could *agree to disagree* without any loss of face. In this situation, the preference for a type of experience wins out over the evidence of the risks.

As a result of this consultation, the obstetrician agrees to Kirsten having a Caesarean:

'In the end he just booked me in for... for a date, er so that was kind of a relief for me.'

From then on Kirsten felt less anxious and she began to find out more about what having a Caesarean would entail:

'Once that was done I was quite relaxed actually - it was finally like I knew what was going to happen I could prepare for it. I had I had a look at both Caesareans on YouTube so I knew what sort of - how gory it was and how long it would potentially take and what it was like.'

A particular turning point in Kirsten's story was when she revealed that she felt compelled to invent a reason for her Caesarean in order to fit in with other members of her antenatal group:

'Obviously you know, Caesarean was the evil of all evil. So yeah it was more sort of that that I changed my story with a few people.'

But she also wanted to be clear to distinguish herself from women who she believed opt for Caesarean for cosmetic reasons, when her reasons were concerns for her baby's health.

Other key points are when Kirsten felt that she was supported by her NCT teacher:

'I got a bit nervous towards it thinking are they going to treat me differently...but the er lady who did my antenatal class said they wouldn't discriminate in general because they just do it all day long and they just like a really good team.'

Her community midwife also supported her:

'When I spoke to my midwife she put a little note in my notes to say that I had researched this and I had thought I had given it a lot of thought it wasn't just one of those spur of the moment decisions and erm that I would like support with that into my maternity notes.'

Kirsten's story reveals the hoops she had to jump through to become a mother, both in becoming pregnant and in realising the type of birth she felt was safest for her baby. Kirsten's story starts with her telling of the physical and financial lengths she went to, to become pregnant and how it took her some time to accept that nothing would go wrong with the baby. Even when the pregnancy was going well, Kirsten was very anxious about giving birth naturally.

Despite there being a change in the policy which supports women requesting a Caesarean birth, Kirsten feels that there is a pressure to choose to birth naturally and a stigma and prejudice attached to those who don't. She felt forced to invent a (legitimate) reason for needing a Caesarean to feel accepted in her antenatal group but she felt supported by her midwife who appreciated the amount of thought Kirsten had put in to making her decision. Kirsten's finishes her story by making the point that a positive birth outcome is in the eye of the beholder, rather than an empirical fact:

'I think you can have a good experience having a C section, um and I guess you can have a bad one as well - if you don't really want it but you have to have it, which I think is also the same if you were to give it er naturally er birth naturally - if you didn't want to give it naturally I think you could have a very bad experience, even if everything actually would go quite smoothly...if your

*attitude towards giving birth naturally is... or you are very anxious... you know
I think that it goes both ways, doesn't it?*

Lisa's story

Synopsis

Lisa never intended to have a Caesarean, as she planned to have a home birth. Lisa sees natural birth as exciting and primal and an experience that connects her to millions of women across centuries. She believed that having a home birth would give her baby the best start in life. Her story tells of her quest to hold on to this wish and her commitment to making this happen. Ultimately she had to prepare for a planned Caesarean birth, face her fears of hospitals and revisit a previous traumatic experience.

With encouragement and support from a hypnotist, a midwife, an anaesthetist and her partner Lisa refocused her aim towards making her birth *special*. She reflects that she had a very different journey to the one she expected but that her experience was positive. She feels that she hasn't missed out on the experience of birth as much as she thought she would. Lisa hopes that she will be able to have a vaginal birth if she has another baby.

The conflict and tensions in Lisa's story are between: her desire for a natural birth versus her fear of intervention and hospitals, her commitment to positively influence her experience versus her inability to change the circumstances; and, her knowledge of natural birth versus her lack of knowledge about surgical (Caesarean) birth.

Lisa voices her hopes for home birth and the meaning this has for her:

'I was really excited about home birth and breathing the baby out, I was just really excited...to have the experience of a natural birth and having the same experience as millions of women throughout the centuries and I was really primal.'

We first get a sense of the tensions and conflicts Lisa is faced with when she attends an NCT class where Caesarean birth is being discussed and explored. Lisa has an unexpected and fearful response to the possibility of going into hospital:

'I had a lot of fear about going into hospital as I said. Partly (deep breath) I didn't realise I had that fear until the NCT workshop and they they talked about Caesarean and I actually burst out crying...I was just really upset I just realised how scared I was about that possibility.'

Lisa was surprised at her emotional response to this and reflected that it was due to a realisation that *'anything can happen'*. This experience made her realise that she may not be able to control what happens, that the future was uncertain and that she could end up needing intervention in order to keep herself and her baby safe. She also believed that her fears may relate back to a previous experience:

'You know but also realising that it was a real possibility and that anything can happen – the idea that with a home birth but things can... can go wrong. Well of course it's about being safe – first – and realising I um you know I had an abortion... and that it brought back in that experience I hadn't really dealt with it at the time, I was quite young um and... and just the fear of being opened up.'

As Lisa's pregnancy progresses her baby is in a breech presentation and the dilemma she faces is whether or not her baby will turn to a cephalic presentation before she goes into labour. Lisa's approach to the dilemma is to read widely and take advice about 'natural' methods for turning the baby. She seeks out and embarks on a programme of therapies and strategies to try to turn the baby. Lisa's I poem shows the lengths she went to try to control and change her situation:

*I tried ABSOLUTELY everything
I did get a bit preoccupied with it
I knew that it that I would have to have a Caesarean if I didn't
I did become
I tried everything
I think it was a bit almost sort of ludicrous
I was so focussed
I tried anything they suggested
I would
I really thought that was going to work, it didn't.
I was in the office at work you know smoking my little toe!
I had to, I did that
I just did it morning and night
I also had a course of acupuncture*

I had treatment, a course of reflexology

I was crawling from the bedroom to the bathroom

I think, you know, the only thing that I didn't try was doing a handstand at the bottom of the swimming pool

I initially thought Lisa was joking when she said that she'd considered doing a headstand in the swimming pool but she then told me that it was a documented strategy '*something to do with the pressure*' and the only reason she hadn't attempted it was that she was '*too upset to have any more disappointment*'. I was amazed at how disciplined and committed Lisa was in trying all these techniques and noted that when faced with the possibility of needing an intervention, Lisa returned to 'natural' therapies to help her take control to try to change the situation. Lisa continued with these strategies but began to get increasingly anxious when at each appointment with her midwife, the baby was still in a breech position:

'... was getting a bit anxious about that which is not particularly like me, I'm quite grounded – I'm quite level headed but I had this fear of the hospital and I don't ... you know I could never watch Casualty or anything and the only two times I've been to hospital was like was was you know when I had a bike accident quite seriously and an abortion so there was never any positive...'

The critical point for Lisa came when she attended the hospital and the doctor abandoned his attempt at turning the baby round:

'He tried only for about eight minutes maybe (upward inflexion) and I didn't realise he'd stopped and he said I'm really sorry. (quietly) And I thought he was going to continue and try again but he just left the room and came – he left the room and he came back with a diary and said I'm really sorry um you know I've booked you in for a Caesarean...'

It was then that Lisa realised that she was unlikely to realise her dream of a home birth and she was surprised by her own response and disbelief that this could be happening to her. She shows us that pregnancy and birth is a time of great uncertainty even when you have planned and prepared for it:

'And I actually just could not believe it I could not believe it. Um and then yeah there were tears and was just like why am I crying this is really not like me erm

and he said er and it was just very surreal you know because two weeks or even – two weeks before that I thought that I was going to have a home birth.'

An excerpt from Lisa's I poem shows how she felt about this, how it disrupted her plans and how she began to shift her focus onto taking control of the situation, being calm and refocussing her efforts into making the birth special:

*I realised
I was on a completely different journey
I felt really bad about the whole thing
I knew that I had to go through with it
It felt like it was a really bad start for him
I didn't feel like I had any time to prepare
I was caught up with work
I knew I just had to get on with it
I felt like
I've got to be calm
I've got to do this
I think
I just wanted it to be really special*

Lisa was able to negotiate a positive Caesarean birth experience:

'It's weird it is weird it's not you know it's not necessarily something that you enjoy but you can manage it so that it's more comfortable um and you can be proud of yourself.'

She reflects that *'nothing is ever as bad as you think.'* The birth was unique, individualised and special:

*I look back on it really fondly
I wouldn't have got that with a natural birth
I was very encouraged to hear
I could still have a natural birth if I was to have another baby
I haven't missed out as much as I thought
I've lived through it with other friends
I know*

I'm lucky

I can still have that opportunity

I feel

I feel lucky

Ultimately, she realised that she could reframe her aspirations to feeling proud about the ways she dealt with the circumstances she found herself in and in the realisation that her experience was a positive experience and unique and individual. She also reframed her concept of what it is to experience birth and she begins to think about the future:

'I...I...I actually feel that I read so much about natural birth and you know really listened intently to my other pregnant friends who've had natural births I actually feel like I've done it anyway! I actually feel like I've experienced it it's weird and I've watched so many You tube clips, I feel like I've actually had both! Because I've you know I was so fascinated by birth and read and watched so many I feel like I haven't missed out as much as I thought I might have done because I've lived through it with other friends that have had babies naturally which is quite nice and... and I know you know that I have the... the if I'm lucky enough to be pregnant again I might not but if I am I can still have that opportunity.'

Lisa's story tells of her adjustment and coming to terms with a different journey to the one she hoped and expected '*I had to completely refocus,*' and how she conquers her fear of the hospital '*I did such a lot of talking really about my fear and such a lot of crying,*'. It also tells of how she negotiated for her birth to be special: '*just little things...the music playing...this beautiful view.*'

A significant turning point for Lisa was when she took her midwife's advice and decided to visit the hospital:

'...so the midwife suggested that I just go the hospital to just face that fear just because I didn't want to be – if I did have to go to hospital I didn't want to erm undo the good work I would I know have done at home and I wanted to be familiar with the environment and I know at [hospital name] they don't allow tours you know real tours of the hospital it's only virtual tours and erm my midwife said a possible way of actually getting a tour is to go there and they

*can see how much it means to you. So I went along to the hospital um (pause)
really the initial reason to go along to the hospital was to face my fear of
hospital, to meet a doctor to ask them questions that I had and to ask for an
actual tour of the ward.'*

It struck me how important the birth environment is for women and I reflected on how changes to practice which exclude tours of the hospital could have an impact on anxiety. I was also pleased that Lisa felt she could engage with the hospital service to seek to take control of her situation even though it was an emotional experience for her:

'I went to hospital to speak to the doctor. As soon as I arrived I was in tears and he did a scan – initially he answered some questions...and he went through my fears and he was absolutely brilliant...he confirmed that, you know, baby hadn't turned and booked me in for an ECV um (long pause) and you know it was really helpful and I just thought I'll just cry and get this out you and do some probably some mourning.'

Three people appear to have had a significant impact on Lisa experience: the hypnotist, the anaesthetist and the pre-assessment midwife. Lisa was seeing a hypnotist to help turn her baby and the hypnotist showed Lisa that her preparation and effort wasn't wasted and could be applied to CS birth:

'The lady that was giving me hypnosis said you can still use relaxation for you know in the Caesarean you can still give the oxytocin you can still be calm you can still serve you know your baby - and that really helped.'

Both the Anaesthetist and the midwife made Lisa feel as though they were 'on her side':

'[The anaesthetist] was great and she said I understand that you wanted a home and she said something like if I had a baby I would give birth in a forest – I completely understand where you are coming from and she just listened to me and I found that so helpful.'

'The midwife I saw the day before was again really helpful and again just really listened and took me seriously and said you know bring along your birth plan but make sure that you get them to read it '

Deciding to make a birth plan was another turning point for Lisa and enabled her to take back some control of her experience, as revealed in her poem:

I wouldn't feel out of control in hospital
I would have a certain amount of informed choice
If I wasn't in the zone to say what I needed

Lisa's story starts with a clear indication that a planned Caesarean was not what she wished for and ends with the realisation that although she went on a very different and emotional journey to the one she planned she feels lucky to have had a positive experience:

'I feel lucky with my, with how it worked out in the end although for a time it seemed the worst thing in the world.'

I found Lisa's story to be one of realisation that it is not always possible to control what happens to you but that it is possible to negotiate to get a positive birth experience (whether this is a natural or a surgical birth). I was intrigued by her claim that she had become knowledgeable and experienced in both Caesarean and vaginal birth. I realised that this was something that resonated with me - I haven't experienced either vaginal birth or Caesarean birth and yet I would consider myself to have expertise and knowledge about the experiences of both.

Conclusion

In this chapter I have introduced the voices and stories of Charlene, Jo, Monika, Sarah, Abby, Sally, Kirsten and Lisa, using multiple analytic devices which I have used to explore their narrative identity and reveal the meaning of their experience of planned Caesarean birth.

To answer the question *what meaning do women give to their experiences of planned Caesarean birth?* I drew on a number of analytic techniques including all four readings from the *Listening Guide* and I have included excerpts from *I poems*, *emotional resonance word clouds* and *metaphor poems* to both show my analysis and to provide the reader with varied ways with which to engage with the narrative content. These tools were used to explore how each narrator ordered the flow of their experience as they made sense of events and their actions in their emotionally invested and contextualised story.

Specifically, I used the *Writing Guide* I had developed to identify and present the defining, critical moments and turning points in each story in order to represent the eight personal narratives as (what I believe to be) meaningful accounts of planned Caesarean birth. In the next chapter, I

explore how planned Caesarean birth was understood and constructed by examining the phenomena within the stories.

7. What phenomena appear in women's stories of birth by planned Caesarean?

'Human life was rarely shapely, only intermittently meaningful, its clumsiness the inevitable consequence of the victory of content over form, of what and when over how and why.'

Salman Rushdie (2012) *Joseph Anton: a memoir*, p.442. Jonathan Cape.

Introduction

In this chapter I present key phenomena of planned Caesarean birth from the eight individual narrations. Throughout my research I have attempted to illuminate the experience of women having planned Caesarean birth, through their individual stories; by keeping those stories whole and embodied and by theorising from each individual narrative rather than consistent themes across narratives (Riessman, 2008). The challenge with this approach has been in deciding what to select from the individual stories when presenting phenomena of that experience, which doesn't reduce the meaning and intention of the narrator, or yield a final account which is less than the sum of the individual parts (see Chapter 9).

My aim with this analysis was to reveal meaning and significance by exploring *how* and *why* the story was told in this way in addition to *what* was told. This means that I analysed function and tone of the narratives and what may be missing from the stories as well as thematic content.

Phenomena were derived using the four layered readings of the *Listening Guide* and by using the *capture* and *explore* phases of the *experience based design* approach (ebd) (see Chapter 5). I identified emotional 'highs' and 'lows' and the key moments and interactions (*touchpoints*) where these emotions were shaped. This enabled me to create a journey map of planned Caesarean birth. I then explored the relational significance and interdependence of the phenomena, relationships and context of these *touchpoints* (using Reading Three of the Listening Guide). Rather than presenting a prescribed pathway of care which I felt would provide a homogenous experience of planned Caesarean birth, my aim has been to provide a landscape upon which planned Caesarean birth can be viewed.

Attempts to navigate uncertainty (expressed through a delicate balance of fear, fatalism, and self-efficacy) was a feature of all eight stories as the women negotiated for a positive experience. Fear

and self-efficacy are commonly cited in the literature on vaginal birth (particularly fear of pain), but have seldom been mentioned in association with what is seen to be the increasing '*routineness, safety and ease of Caesarean*' (Mander, 2007, p.99). Fatalism, fear and self-efficacy have turned out to be important components of my findings and they are explored later in the chapter.

This chapter presents the phenomena described in the eight stories in two ways: firstly through the identification of key *touchpoints* in the unfolding journey to a planned Caesarean birth and secondly through discussion of the factors that influenced the emotional 'highs' and 'lows' and the delicate balance of fear, fatalism and self-efficacy. My findings suggest that assumptions of self-efficacy as a fixed, internalised capacity to overcome challenges are limited. Instead, I propose that self-efficacy is realised in relation to interaction with others – it is socially constructed and constantly *reforming* as part of a relational ontology.

In the following chapter I go on to situate the particular and unique experiences of planned Caesarean birth within wider dominant social constructions of childbirth and motherhood.

'Touchpoints' in planned Caesarean birth

I used the *capture* and *understand* stages of the ebd approach (NHS Institute for Innovation and Improvement 2009) (see Chapter 5) to explore the landscape of planned Caesarean described in the women's stories. I started by analysing the emotional highs and lows of each narrative and identified the *touchpoints* (the interaction/intervention/what was happening). I then mapped the emotion to the *touchpoint* and plotted them in chronological sequence, to provide a journey map. Emotions that I perceived to be positive were plotted 'above the line'; emotions I believed to be negative, below the line (see Figure 6 and Appendix 12). Using the ebd approach I was not limited solely to identifying common themes or elements of the individual stories that were *alike* and so I could reflect the differences in experience between the eight stories. However this technique still allowed me to identify where emotions (positive or negative) were clustered around an event or intervention.

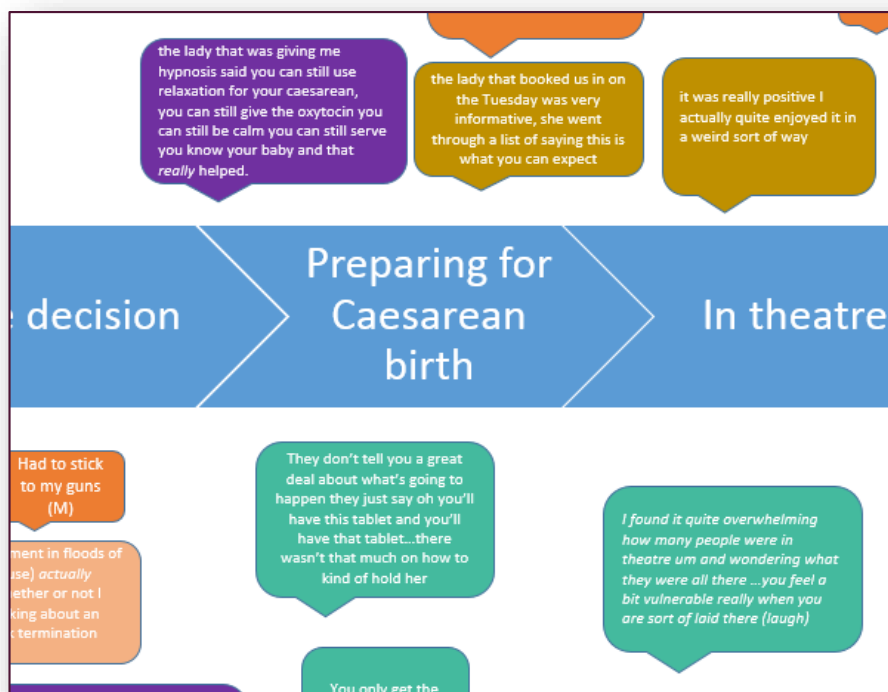


Figure 6. Magnified section of planned Caesarean journey map

The eight stories yielded very different *touchpoints* to the steps that I would have identified (from my midwife perspective) as a care pathway for planned Caesarean birth. This made me appreciate the difference between my professional experience and the experience of the women. The steps I would have identified for the care pathway for planned Caesarean were: *Booking, pregnancy care, mode of birth decision, pre-assessment, surgery, post-operative care, and discharge*. However when I plotted the touchpoints for the eight stories, the journey map revealed: *Being pregnant, seeking and sifting information, the decision, preparation for Caesarean birth, in theatre, care and recovery, being at home, the future* (see Figure 7). *Navigating uncertainty* was an underlying theme for all women throughout the planned Caesarean journey, which was mediated through a delicate balancing of fatalism, fear and self-efficacy.



Figure 7. Touchpoints in the planned Caesarean journey

The landscape of planned Caesarean birth

The following section describes how planned Caesarean experience unfolded for the eight women through the touchpoints which framed their experience. It is important to point out that the concept of making a journey map that relates specifically to planned Caesarean experience is to some extent problematic. In most circumstances, when a care pathway or journey map is charted, steps are plotted in relation to a known care/referral pathway, disease progression and treatment or surgical intervention and recovery. In the context of this study, although the planned Caesarean dominates the experience, it was only when the journey reached touchpoint three (the decision) that the pathway became to be related exclusively to planned Caesarean experience even if a planned Caesarean birth was likely or even hoped for. For most of the women this decision was made late into pregnancy, a factor which contributed to the uncertainty they experienced and underlines the fact that they did not know what path they were on.

Expressions of uncertainty was a key feature in all the stories which were revealed through a delicate balancing of fatalism (pre-determinism, hopefulness or hopelessness) fear and belief in one's ability to overcome challenges (self-efficacy). Navigating this uncertainty and negotiating for a positive outcome characterised aspects of all the stories. Specific events, interventions or interactions triggered a reordering of the inter-related concepts as each woman sought strategies to limit the uncertainty and optimise their experience.

Being pregnant and becoming a mother are important transitions in a woman's life that impact on both a biological and social self (selves) which can have the effect of producing a biographical disruption (Miller, 2005). Biographical disruption was first described in relation to patients with chronic illness (Bury, 1982) and illustrates how people are disrupted in their social relationships but also the ways in which they are able to mobilise material resources for adaption (Bury, 1982). This disruption can threaten identities (Bury, 1982) and taking a relational approach, inevitably this happens in relation to oneself (selves), to other relationships and is informed by structural and cultural factors (Lockwood, 2013).

The following section examines the touchpoints and reflects how the journey unfolded through the eight stories. A summary of the key features can be found in Appendix 13.

Being pregnant

For Monika, Sally, Kirsten and Sarah becoming pregnant was a surprise or happened earlier than they expected:

'I was shocked – I was not expecting to become pregnant, so soon ...but I was quite happy.' (Monika)

'She was a totally unexpected miracle... I think I did ten pregnancy tests before I believed it!' (Sally)

'I caught first time so I was very lucky ...it took me quite a long time to sort of accept that.' (Kirsten)

'four or five years ago [I] ...had a miscarriage... so that took us a little while to get to get our heads round what was going on.' (Sarah)

Kirsten and Sarah's comments reveal that becoming pregnant wasn't a distinct point in time (pregnant/not pregnant) instead *being* pregnant, was something that required adjustment and coming to terms with, even if it was hoped for.

Seeking and sifting information

Seeking and sifting information was a key feature of pregnancy. This was mostly revealed through contact with informal social networks, particularly social media and the internet. This seemed to offer up a wide range of possible experiences but definitive answers were out of reach. The women recognised that the information gained had the potential to increase anxiety and uncertainty but it was a way of tapping into other women's experiences:

'I joined a couple of forums ...it is just other mums... it's not the place you go for a definitive answer... it is a useful place to understand that you're not on your own.' (Jo)

'There is so much conflicting information out there it's really hard to find an answer... there seemed to be kind of extremes and nothing, nothing felt very balanced.' (Jo)

'I had a look at both Caesareans on YouTube so I knew...how gory it was and how long it would potentially take and what it was like.' (Kirsten)

'I think the internet is wonderful for sort of finding things out but it also does a lot of damage...so I tried to sort of stay away from it...[in] the last month of pregnancy, ' (Charlene)

Charlene, Sarah and Lisa *inherited* stories of birth from close family members and it was clear that these family histories were significant in influencing how they saw themselves and how they thought they might experience birth:

'My mum, every operation she's ever had she's haemorrhaged after so I was really worried ... so I'd got that into my head that I was gonna sort of have a big bleed.'(Charlene)

'My sister had two fairly awful vaginal deliveries ...my mum's had two sections and two vaginal deliveries, and was an obstetric nightmare giving birth – so didn't really feel as though genetically I was in the best place!' (Sarah)

'I was very keen to have a home birth, a natural birth ... I was really excited about home birth and breathing the baby out ... having the same experience as millions of women throughout the centuries and I was really you know primal and my mum had myself at home.' (Lisa)

For Monika, her inherited story told of her immunity to childhood disease, of being singled out and lucky:

'I didn't had [sic] in my childhood you know chicken pops... nothing...I never had, you know flu ... I thought, oh my gosh – I'm very lucky...and I really hoped for the best. ' (Monika)

Other stories were important influences too but were not always helpful in reducing anxiety:

'And one of my best friends said to me you know the spinal does hurt quite a bit and so I carried that with me and we went in and I'm thinking ...the spinal hurts a bit – the spinal didn't hurt, you know.' (Abby)

'One friend had ... c section ...an emergency... she really wanted to have a normal delivery but she couldn't...afterwards she said....her recovery time was much, much longer, yah and she already have er back problems.' (Monika)

'There was a slight fear of the um um the anaesthetist not doing their job properly ...there was just one article that I read... kind of sticks in your head.'

(Lisa)

Abby summed up the dilemma faced while sifting all this information:

'It is about stories...and I think as a woman having heard a lot of stories... I ... was trying to control ... but actually when when it's you and it's your baby you sort of walk over that threshold and you become much more emotional...[you] try to take with you the good stuff and to leave the not so helpful stuff behind and I don't always think that's possible.' (Abby)

The decision

Arriving at a decision was one of the most significant touchpoints in the journey as it signalled birth by planned Caesarean becoming a reality. This provoked a range of emotions from worry and relief to resignation and shock and upset.

'Very quickly I realised I was on a completely different journey and there was very little I could do about it and ... it was kind of like a shattering of a dream really.' (Lisa)

'It felt like a weight off our shoulders, we just, I felt relaxed for the first time.' (Sarah)

Relief was a common emotion even for some of the women who had been planning a vaginal birth because they now had a better sense of what going to happen and they could plan for it:

'Once that was done I was quite relaxed actually it was finally like I knew what was going to happen I could prepare for it.' (Kirsten)

'I was just relieved I knew, although disappointed slightly disappointed that – not disappointed actually - just everything had changed but I felt quite euphoric that I just knew – I knew what was going to happen.' (Abby)

For some of the women the decision was finalised very late in pregnancy and they wished they had known earlier so that they could have reduced the period of uncertainty and come to terms with it.

'If I'd been told a bit earlier in the pregnancy I could have had a chance to adjust ... because I spent a lot of time worrying and actually if they'd said from the beginning... I could have spared myself from worrying about how I was going to get you out.' (Sally)

Jo's story shows she had to continually reframe her attitude to vaginal or Caesarean birth and that even when she thought a decision had been made there was uncertainty:

'And I sort of came to terms with it quite slowly and in the end I was kind of thinking oh I think maybe this might be better, than natural birth! ...There was uncertainty right up until the very end because they were waiting to see if the placenta would move ... and that was quite difficult for me to deal with cos I'd come to terms with having a Caesarean...then to be told actually quite late on actually you might be giving birth naturally. Well I'd not really paid attention in the antenatal classes! I was quite complacent thinking this is nothing to do with me... at the end [I] was starting to panic that I would be having a natural birth...I was almost scared that they would say that I wasn't having a Caesarean...so it was a complete flip around from where I started.'

Preparing for Caesarean birth

Many of the women felt that they benefitted from the pre-operative assessment contact that they had at their maternity unit.

'Luckily they weren't too busy and she had time to sort of explain what the whole procedure was.' (Charlene)

The anaesthetist was mentioned as being someone who was supportive and listened to them:

(speaking with the anaesthetist) 'They came round and explained. So I was much clearer,' (Charlene)

Sometimes the information they got before surgery from the hospital staff didn't tell them all they wanted to know, especially how to personalise their experience. Again family, friends and the internet were useful sources of information:

'The lady that booked us in...was very informative, she went through a list of saying this is what you can expect ... but it was the softer support that I got

from my girlfriends who said um by the way when you are in recovery you can have as many visitors as you like - so I planned.' (Abby)

'I had to go and find and read other people's experiences of having their own birth plans to kind of get a sense of what I could and couldn't ask for.' (Jo)

Charlene would have liked information earlier than a week before surgery and felt that the period between decision and pre-op information was too long:

'I think if someone had actually sat down with me and explained everything that was going to happen, recovery period, things like that, I think I would have felt a lot more better because as soon as I had that pre-op I felt great.'
(Charlene)

For Lisa, the pre-assessment was more than information gathering, being listened to by the Anaesthetist and the midwife was key to helping with her fears about hospitals:

'... just really listened and took me seriously ... I felt at that point that there were people in the hospital that were on my side and that was that was kind of a sense of relief.' (Lisa)

Being able to make a birth plan was seen as important way to have control and limit the uncertainty. For others, the focus was on safety:

'I suppose with a Caesarean you feel like you have a lot less control over what actually happens, well you have er so I as I said before you doing sort of things like your birth plan was quite important to me.' (Jo)

'I didn't do the Caesarean birth plan and have music and all the rest of it, that just wasn't important to me, it might be important to other people but it didn't even cross my mind to ask really.' (Sarah)

'Actually what I was paying for was for the baby to be got out safely...in my view, as safely as I could. So all the frills around it was not really important.'
(Sarah)

Lisa's Hypnotherapist showed her how some of the skills she had been developing for a vaginal birth could be transferred to a surgical birth:

'The lady that was giving me hypnosis said you can still use relaxation for you know in the Caesarean you can still give the oxytocin you can still be calm you can still serve you know your baby and that really helped.' (Lisa)

Abby, Lisa, Sarah and Monika went outside the NHS to seek services that were not routinely offered in state funded maternity healthcare. Monika even returned to her home country to get an obstetric opinion.

In theatre

The experience in theatre was positive in almost all cases. The theatre team were perceived as *'reassuringly efficient'* and there were comments that suggested that the women believed that more resources were available in this part of the journey than others.

The environment was described and for some women this had an impact this had on whether or not they felt in control and what their role was:

'Very calming being in there. I never thought in a million years that I would say that it was calming being in theatre' (Charlene)

'I found it quite overwhelming how many people were in theatre um and wondering what they were all there for... and I think when you feel a bit vulnerable really when you are sort of laid there.' (Sally)

'They did say ...she'll go over to see like the doctors to check her over but you still think ... will she come back? And I think because I didn't quite know whether she would ...come straight back or not I sort of sat there.' (Sally)

Sally acknowledged that what was a new experience for her, was routine for the staff:

'I know they see it day in, day out but it's a bit sort of strange really but then I guess it's probably like that when you are in labour as well that you're in a sort of strange place.' (Sally)

Lisa opted to dissociate herself from the situation as a coping mechanism:

'I wanted to be totally present with a natural birth but with this scenario I did want dissociation really I didn't want to really think about what they were actually doing cos I knew that I would freak out a bit.' (Lisa)

Many of the women described the physical experiences of Caesarean birth:

'I didn't saw [sic] anything in the theatre – nothing...I felt you know – touches, I felt pulling I felt, I felt some things but – as far as I couldn't see anything- that's fine!' (Monika)

'... I thought I couldn't breathe where they are pushing...it feels like they're pushing everything that you've got virtually into your mouth, but it was over so quickly.' (Sally)

Most found the experience to be positive:

'I felt the whole experience was really good...I wasn't scared um I was just um yeah looking forward to it ...the whole experience I I felt was very very nice.' (Kirsten)

'It was just a really positive experience but to me the delivery was never important in a sort of rite of passage sense.' (Sarah)

'It was really positive I actually quite enjoyed it in a weird sort of way.' (Abby)

'I was actually quite impressed with you know how good the kind of system ran really, I mean we'd had lots of meetings beforehand about how the hospital was going to meet my needs.' (Sally)

'I can't fault it and I ended up as I say from being in quite a kind of upset place having actually quite a positive experience on the day and having complete confidence in the team.' (Jo)

Many attributed their positive experience to the fact that the staff worked effectively as a team and that resources were not pulled in other directions:

'Because they've got the time at the end of the day and I think that's the big issue I think they have actually got the time for you in that situation...' (Charlene)

'They haven't got to attend you know umpteen other people they are there for you.' (Charlene)

'The staff were amazing who actually um were there for the c section so and I wonder if that's because it's a procedure that requires a theatre nurse and a midwife and a surgeon so you can't scrimp on that'. (Abby)

How relationships were formed and whether staff accommodated individual plans had a key impact on experience and mitigated for a clinical environment.

'Everyone in the team introduced themselves.' (Lisa)

'I think he was born to Anthony and the Johnsons and a bit of Lily Allen and then finished up with Elvis Presley, while I was being stitched and you know I asked the baby to be skin to skin.... and they tried to pulsate the cord for as long as possible ... it was a really lovely occasion.' (Lisa)

In the main, emotional support was provided by the Anaesthetists:

'I think the anaesthetist was brilliant cos obviously they're kind of sat with you, aren't they, and talking you through what's happening and I guess it's her job to reassure you and I'm going ... obviously the doctors and the surgeons are just getting on with the job and are not interacting with you as a person at all are they? ... the anaesthetist was brilliant at sort of taking my mind off it and engaging me in conversation and telling me that it was all going fine and that was really – helpful.' (Jo)

'The anaesthetist asked if there was two students that could er stay and if that was Ok and I said that's fine but if they could only talk if they really needed to and I heard her say exactly my words (laugh) I think there were just a few a few things that they did with my birth plan and I just relaxed and it was like Ok they're not it's not just a token gesture.' (Lisa)

There was little mentioned of midwives in the theatre experience and the degree to which a midwife could provide support seemed limited:

'I was thinking if a women had to go through that on her own it would be really frightening because there was about eight or nine people in the room in the end with the students watching and there was of course the midwife seen to be there for you but she's standing up and there is no one on your level.'

(Lisa)

Care and recovery

There were few mentions of the immediate post-operative period, although entering recovery, was a significant *touchpoint* for Charlene:

'I couldn't believe once I'd got through, that I'd actually survived the operation.' (Charlene)

Sally really wanted to have skin to skin contact with her baby, immediately after birth as she knew her baby might have to go to the Special Care Baby Unit (SCBU). She didn't have skin to skin contact with her baby that she wanted and she felt that the midwife didn't respect her wishes. This seemed to be the most significant *touchpoint* in the whole of Sally's story and it marred her experience:

'I don't think that it would have made that much difference if she'd had a quick cuddle with me – I know she needed to feed ... I know that I'm diabetic it's important that she did have some sort of [feed]...I was aware of that but it was the fact that that was kind of taken away...you know it wasn't like I was haemorrhaging and about to die...I was sat up.' (Sally)

'I didn't get the skin to skin I wanted, after having her... that is probably the one thing that I do carry with me is that they didn't respect what I wanted.'
(Sally)

Physical experiences and post op pain was mentioned by a few:

'I felt quite prepared for the actual operation but I was quite shocked at how painful it was afterwards that was where I didn't feel particularly prepared.'
(Abby)

'They said that the first time that you get up it's likely that you feel like all your insides are falling out. I didn't think that was that bad –I mean yeah it hurt but I didn't think it was that bad.' (Kirsten)

'Apart from being a bit sore, I felt really well after the surgery.' (Sarah)

'I'm not sure that you can be prepared for ... quite significant abdominal surgery ... because when I came out...I was just like – I could all that all over again...but ...speak to me a week after that and I was just like, actually you

*know, that is that is that was really quite quite tough, tough experience -
tough experience, just physically quite tough.'* (Abby)

In contrast to being in theatre, post-operative care was perceived to be resource poor and busy:

*'There was lots of unanswered call buttons and it, - it er felt a bit hectic
and...at times you felt a bit on your own.'* (Jo)

*'It took them all day to get my drugs and then I left without all the right
information.'* (Abby)

Lack of time was a key element and it appeared to be intrinsically linked to whether or not women felt cared for. Lack of time was a factor that contributed to other phenomena such as not being given information or feeling lonely.

*'At the end of visiting hours at eight o'clock...he'd have to go, and...I'd see the
whole night stretching sort of in front of me and feeling completely unable to
deal with it really.'* (Jo)

*'You are just left, and you you...feel ... completely abandoned...I was in a
complete different world and to think now that I was left with my baby like
that that scares the life out of me.'* (Charlene).

*'It is just a different type of care...when you've just had surgery...they are
looking at you every five minutes and they're making sure that medically
you're not about to snuff it but when you're back on the ward...everybody
thinks you're...fine.'* (Abby)

As stated already, ironically the point at which Charlene was most alone, when her partner had gone home, instead of spending time with Charlene, the staff offered to take her baby away:

*'They kept asking me if ... I wanted them to take [my baby] for the night...
What would have been really nice is if someone just came and gave you a little
company.'* (Charlene)

Some of the women felt that they had excellent postnatal support, especially breastfeeding support. They felt reassured by this:

'I just felt more sort of cared cared for -people reassuring me, yes, this poo looks right and he's weeing enough you know he's sleeping you know that sort of thing – that was nice to have. I know a lot of women can't wait to get out and want to do all this this stuff at home but I just I just thought it was really nice to have this sort of environment and they had volunteers come round to help with the breastfeeding.' (Kirsten)

'The support from the breastfeeding nurses was incredible that you could just ring you know when if you were having difficulties and you know just to have that kind of knowledge and you know on tap... was amazing. I felt a lot more confident with breastfeeding I think as a result.' (Lisa)

Others felt that whether or not someone was caring and compassionate wasn't related to whether or not there was time to care but was down to an individual's personality and values:

(Regarding staff helping to put the baby on the breast) *'It did feel like pestering a bit.'* (Abby)

'All of those really like practical caring qualities...you know, David Cameron says you know people need to... remember why they've become a nurse... you know... it's the sort of skills that ... lots of people don't necessarily learn they just have them.' (Abby)

'I think if they had actually had the time or wanted to cos they probably did have the time –especially at night when you're lonely.' (Charlene)

'The health care assistant came round in the morning and went oh you haven't changed your baby all night – well how would I have done that because I can't sit myself up let alone ... reach over and get the baby out of the cot.' (Jo)

'I had the most incredible polish um healthcare assistant who just came in and said you've had your catheter taken out haven't you? Do you mind if I change your baby's nappy? ... You'd probably like to do it but you're probably not up to it – can I do it for you? ...And I'm like yes, yes please - yes please. She's the one I remember.' (Abby)

Being able to have time to talk with staff was described as a high point and little acts of kindness were important:

'I was in with two girls and we sort of had quite nice chats and we ended up sort of feeding in the night at the same time and one time the midwife was quite quiet and we were all up feeding and she brought us all a cup of tea.'(Jo)

'And she actually spent some time with me and she was quite happy to sit there and have a little chat, and I thought that made such a difference -, that made a big, big difference to how I felt.'(Charlene)

Some of the women felt that they were given choices without been given enough information or support for decision-making:

'I was thinking I want what's best for my baby...cos that's all any mother wants at the end of the day...but I don't know what's best.' (Charlene)

'I just accepted what people said to me and then afterwards thought ooh hang on but I was too scared to say I didn't understand what they meant.' (Jo)

Sally and Jo both experienced having their baby in SCBU, Sally from shortly after birth and Jo when her baby was admitted with jaundice. Both found this difficult to cope with. Sally found it hard to be separated from her baby and didn't feel that her baby was hers. Jo felt that there was conflict between the information she was given from the midwives on the postnatal ward and the staff on SCBU. Jo's baby was put on a 2 hour feeding schedule which left her feeling exhausted and inadequate:

'This – really quite – a- demanding plan and I couldn't help thinking you've got no idea what that actually means in practice... and then the midwife would say something different.' (Jo)

'It was very hard because she was on special care for three weeks...and I was just like, I need my baby and they were trying to kind of mediate between the two to try to negotiate for her to come up from special care and it was all a bit of a...nightmare...' (Sally)

'They're not yours – you're not looking after them, you're there and the nurses kind of deal with them.' (Sally)

Being at home

Being at home was characterised by adjustment and returning to normal: taking on the responsibilities of looking after their baby and recovering from surgery:

'I was on a high and then suddenly we were like oh my goodness ...I've got to bring this little person home.' (Abby)

'It's hard initially having a baby...cos you don't know what they want... especially having one that's been...on special care...' (Sally)

'It was just so nice to come home you know - just to have that autonomy to kind of make your own decisions ...it was nice to just let her develop the [feeding] pattern she wanted.' (Sally)

'It's just quite nice to be at home as well... actually being at home and just being nice, sort of quiet... and I think I'm less stressed.' (Abby)

Some of the women mentioned their experiences of their physical recovery:

'The first journey home form hospital... the worst experience... every single movement, every bump every turn, every acceleration – you feel it. All exactly in your scar and it just feel like you are being ripped open again.' (Charlene)

'I recovered well from it. [I] thought I was much better than I was because I ...only walked down the road and then coming back up was quite hard. I was like, oh Ok - so I'm not quite as fit!' (Kirsten)

'It's eight weeks and erm I'm almost myself. And I can, you know, wear my clothes and you know go out and enjoy myself – I can lift things, not too heavy ...I can do everything. And I'm already thinking to getting back to work.'
(Monika)

Some of the anxiety, uncertainty and information seeking that had characterised the antenatal period was also present postnatally:

'Afterwards...I guess it was a bad combination of things...with the infection and the jaundice and he didn't gain weight because of the jaundice and it didn't clear until he was like two and a half months and so the health visitor

was coming every week and weighing him and it was all a massive – he's not gaining weight - and it was all very stressful.' (Jo)

'It's really really hard, ... because I want best for my child... and you know, I'm I'm I'm reading lots of information, how to not not make her allergic or and - so all all this stuff! (Monika)

The future

As each women finished her story, I asked her how she felt about the future. Although this *touchpoint* is concerned with looking to the future it really reflects how they are looking back on their experience:

Charlene

'I don't think I could have coped with a normal delivery, as much as I would have liked to and it is the most natural thing in the world...I thought I could when I got pregnant -there is no way that I could have done'.

'I'd go through it all again tomorrow - a hundred per cent...for definite - I wouldn't question it whatsoever...it was an interesting 9 months...from the start really - so many problems but yeah once they're here...I would certainly have another section.'

Jo

'I've got all sorts of issues about birth now -I don't know why, I don't understand it or how to unpick them or what questions could I get answers to that would make me feel any differently.'

'I wouldn't necessarily want to ask for a Caesarean but deep down I think I'd really rather have one. I don't know why, maybe it's just because I know what to expect... I know how I'll be and I don't know what to expect from a natural birth, and it might end up in a Caesarean anyway and I rather it happened in a controlled way if it's going to happen.'

Monika

'This is – only one princess, no more - it's it's just too expensive, it's really expensive and it's really hard work.'

'I'm very happy, very happy and I if anyone, you know, ask me what to choose I will always say- c section.'

Sarah

'I was more than happy with my experience. Was it better or worse than a vaginal delivery? I I don't know – but then nobody knows until you try that and I didn't want to try.'

'I'm extremely happy with what we chose to do. I think it was the best option for us despite the fact that it has pretty much cleaned us out financially um, but like I say, it not only bought us the surgery, it bought us my husband being able to stay and actually...bought me piece of mind.'

Abby

'I've wanted to be a mum all my life, I suppose, so I'm just really excited, really enjoying it. Enjoying not working... Just enjoying being a family and all that brings, so yeah, it's a lovely time.'

Sally

'I don't know if I would have another child but if I did I would go for another Caesarean...having had one and got over that...I know that maybe it might be kind of painful...but once you've got over that...and I now know what it's like.'

Kirsten

'I felt it was really really good and I don't regret my decision at all,,um you know, anybody anxious about childbirth - I would certainly recommend it, but it's up to each individual, like how they mentally go into the whole process.'

'I think you can have a good experience having a C section um and I guess you can have a bad one as well, if you don't really want it but you have to have it ...I think [it] is also the same if you were to give...birth naturally- if you didn't want to give [birth] naturally I think you could have a very bad experience even if everything...[goes] quite smoothly.'

Lisa

'It's weird...it's not necessarily something that you enjoy but you can manage it so that it's more comfortable.'

'[I] feel that I read so much about natural birth, and you know, really listened intently to my other pregnant friends who've had natural births - I actually feel like I've done it anyway! I actually feel like I've experienced it -it's weird. And I've watched so many You tube clips, I feel like I've actually had both!'

'I look back on it really fondly...and I was very encouraged to hear that I could still have a natural birth if I was to have another baby.'

Navigating uncertainty – fatalism, fear and self–efficacy

When I first started exploring the degrees of uncertainty that were evident in my analysis of the stories I was anxious about using the terms fear, fatalism and self-efficacy as they felt like blunt instruments to describe what were delicate and shifting ways of knowing and experiencing pregnancy, birth and motherhood by the women, through their engagement with and responses to their experiences. My anxiety was that there would be a tendency to over simplify my findings and suggest that fear and low self-efficacy were an intrinsic feature of planned Caesarean birth experience. However, I could not think of better constructs to describe my findings and the features I found were reflective of these constructs. And I believe that this research contributes to the discourses of fear, fatalism and self-efficacy which are more commonly described in research about vaginal birth.

The diagram below (see Figure 8) shows how I have interpreted the inter-relatedness of the three concepts. The funnel should be imagined to contain free moving spheres (much like a lottery ball machine). At a given point in time, and in response to a trigger, one of the spheres assumes the

leading position and shapes how uncertainty is managed. Unlike the lottery machines, this reordering of the concepts is not random but a cognitive response to the trigger.

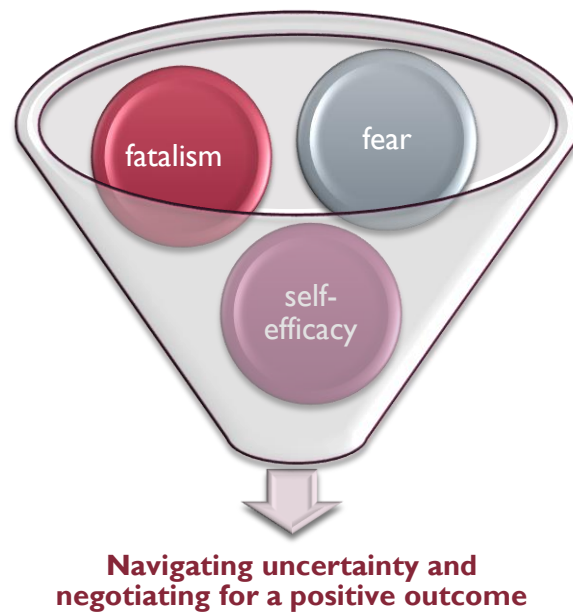


Figure 8. The inter-related concepts of fatalism, fear and self-efficacy

In the next section I present the theoretical constructs of fatalism, fear and self-efficacy. I also provide examples from my findings to illustrate how fatalism, fear and self-efficacy were inter-related and interdependent and how specific triggers caused a re-ordering of which feature was dominant.

Fatalism

There is a well-documented connection between health beliefs, health behaviour and health outcomes (Drew and Schoenburg, 2001). Fatalism can be defined as:

‘A philosophical doctrine holding that all events are predetermined in advance for all time and human being are powerless to change them.’

(Webster’s Dictionary, 2010 in Drew and Schoenburg, 2001).

Constructs of fatalism include control, optimism, hopelessness and expectancy for the future (Drew and Schoenburg, 2011). Fatalism and fear are inter-related and both Charlene and Jo spoke of their belief that they might die:

'This is going to sound ridiculous now, but I actually thought that I might die (laugh)... I was quite worried. I remember having a conversation with my mum... what will happen... if he's on his own with the baby... I don't know where I got that idea from in my head but obviously that was how I felt at the time.' (Jo)

Other experiences of fatalism were expressed as being pre-determined:

'I'd always imagined being in that theatre situation; it's really really odd...I thought the story was complete - that's the way it was supposed to go which is yeah - strange...' (Charlene)

Fatalism was also expressed in terms of hopefulness/hopelessness:

'Meanwhile someone else in the NCT group had been booked in for an elective Caesarean because her baby hadn't turned and her baby turned at the last minute, you know, half an hour before she was due to have it - so that gave me a lot of false hope actually.' (Lisa)

Growing research in fatalism has challenged constructs which portray fatalism as a purely cognitive concept (Drew and Schoenburg, 2011). Authors argue that fatalism has often been used to describe the behaviours of marginalised or minority groups whose health behaviours are viewed as ignorant or problematic (Chamberlain, 1976; Drew and Schoenburg, 2011). Research in this area has focussed on understanding the reasons why people do not follow presumably rational recommendations, for example, in planning family size (Chamberlain, 1976) and forgoing cancer screenings (Drew and Schoenburg, 2011). These authors highlight the importance of considering the context rather than viewing fatalism as an isolated psychological construct.

Audrey Chamberlain's study (1976) looked at attitudes towards planning versus fatalistic approaches to pregnancy and childbirth in 100 women living in Leeds who had six or more live babies. She found that *planning* was a desirable approach to life but certain conditions were necessary before planning could be enjoyed. She proposed that perception of the choices open to an individual were founded on their appreciation of their expectations and the resources they felt

were available to them. The women in her study felt they had obstacles which affected their ability to plan. These included not enough money to plan and the threat of sickness and falling out of work. She argued that given the circumstances of limited resources, their responses reflect a highly rational adaptation of aspirations and achievement potential (Chamberlain, 1976).

Drew and Schoenburg (2011) studies of health decisions around cancer treatments illustrate the complexities and contestability of constructions of fatalism. In particular they challenge the notion that fatalism constitutes a major barrier to participation in positive health behaviours and outcomes. They argue that delays in treatment are often explained in terms of a fatalistic subculture in which women postpone or delay treatment because they believe that the fate of their bodies is predetermined and beyond their personal control. Instead, their study found that complex factors such as inadequate access to health services, competing priorities and inadequate knowledge were major contributors to fatalistic behaviours. These behaviours are also aligned to perceptions of personal risk within a risk balancing framework that takes account of other pathogenic or salutogenic influences (Hunt et al, 2000) including real life circumstances and constraints, perceptions of risk because of power and agency, and family history - which may include personal experiences in health care settings (Angus et al, 2005).

They also proposed that while women may express fatalistic attitudes, these attitudes may not necessarily signify powerlessness or hopelessness, rather such expressions are a culturally acceptable way of expressing oneself in times of great challenge and when facing constrained choices (Drew and Schoenburg, 2011).

The balance between fear and self-efficacy

Fear of childbirth is widely reported (Mander, 2007), with severe fear reported to affect 6-10% of pregnant women (Salomonsson et al, 2013). The focus of fear in childbirth is often unstated (Mander, 2007) but may include pain, *'loss of control, dread of hospitals, fear of self-exposure'* (Mander, 2007, p.97), and even fear of death (Bayes, 2010). A previous traumatic experience, particularly of childbirth, is also a factor (Brodrick, 2014). Offering a planned Caesarean is often cited as the solution to fear of pain of labour (Mander, 2007). However, constructions of fear in childbirth are clearly complex (Brodrick 2014) as evidence suggests that women predominantly expect that birth will be spontaneous, vaginal and a positive experience (Bayes, 2010) and that requests for a Caesarean birth are low (Gamble and Creedy, 2001).

Fear was a feature of elements of the women's stories at different phases in their care:

'I'd always been petrified of falling pregnant because I'd always been petrified of the end result of having to, you know, actually deliver.' (Charlene)

'Not knowing that I could have my delivery option made me miserable I was sleepless – I was I was just so worried about it.' (Sarah)

But fear wasn't only in relation to vaginal birth. Lisa was surprised to find out that she had a fear of hospitals which was revealed during an antenatal education class and Kirsten's fear was for her baby health and that she might be discriminated against because she had requested a Caesarean:

'I don't necessarily think I have a fear of childbirth – that it hurts or anything like this but something that could happen to the health of the child for me it's not about pain.' (Kirsten)

'I got a bit nervous towards it thinking are they going to treat me differently because they know I've elected it for no medical reasons [but]...through personal choice.' (Kirsten)

Pregnancy carries particular stresses because the path and outcome of childbirth are unknown in advance. Studies of self-efficacy have been used to shed light how stressful situations are appraised. Self-efficacy is:

'concerned with people's beliefs in their capabilities to exercise control over their own functioning and over events that affect their lives.'

(Bandura, 1994, p.80).

The degree to which someone is able to exercise self-efficacy is determined by their belief in what outcome a given behaviour will have in a given situation (outcome expectancy) and their belief in their ability to perform that behaviour in the actual situation (self-efficacy expectancy) (Bandura, 1994). A person may be aware of a helpful behaviour but lack confidence in her capability to perform it. In contrast, the person may have confidence in her capability to perform but doubts whether the expected outcome will occur (Bandura, 1994). People who believe they cannot manage potentially adverse situations experience a high level of stress and anxiety (Bandura, 1994). Bandura argued that self-efficacy has four main sources of influence: prior experience of mastering obstacles, experiencing someone similar to oneself manage tasks and demands

successfully, encouragement from others that one has the capabilities to succeed in given activities, and inferences from physical symptoms and emotional states (e.g. stamina and stress) that indicate personal strengths and vulnerabilities (Bandura, 1994).

Studies of self-efficacy and the development of a self-efficacy inventory by Lowe (1993) were attempts to understand and measure maternal confidence in labour and birth. Women were asked what behaviours they had used when coping with labour. These were drawn into a matrix of behavioural domains: concentration, thinking, support, motor/relaxation, self-encouragement, control and breathing (Lowe, 1993). Lowe's original scale was based on interviews with women who had just given birth vaginally. In Salomonsson et al's study women who were between 32 and 38 week pregnant with severe fear of childbirth were asked about their expectations for the approaching birth.

They identified eleven domains and supporting components, six correlated to Lowe's findings and seven domains were newly identified (see Appendix 14). They also found indications that in adverse situations increased levels of fear of childbirth decreased positive traits for self-efficacy (Salomonsson et al, 2013). They note that pain was only mentioned in passing which they concluded indicates that severe fear of labour and birth is a more complex problem than just coping with pain. Four overall aspects of childbirth self-efficacy were found by the authors: *own capacity to perform activities; need for others to be able to manage; capacity of the female body; fatalism*.

Own capacity to perform activities without support from others was the predominant aspect (nine of the thirteen components). The women in the Salomonsson et al's study were unsure how helpful the expected behaviours (see Appendix 14) would be and had doubts as to whether they would be able to carry them out (Salomonsson et al, 2013). The authors propose that this is because women in their first pregnancy lack the most powerful source of self-efficacy – experience of mastering labour and birth (Salomonsson et al, 2013, Bandura, 1994).

The need for others to be able to manage was characterised by believing that skilled professionals as well as the partner were crucial in helping a woman cope with labour. Guidance on what to do and handing over control and responsibility were aspects of this component.

Capacity of the female body was expressed as confidence that the body is designed for managing labour and birth. This was seen as a prerequisite for being able to cope with childbirth and manage control (Salomonsson et al, 2013). In this context, the birth became feasible to manage

through a process of control being handed over to the body along with responsibility for what to do.

Fatalism in the context of this work had two elements: resignation that because nature was in control, labour and birth were beyond the woman's own control; and confidence in the fact that women have always been able to give birth.

Own capacity to perform activities without support from others

The women in my study all used concepts of fatalism, fear and self-efficacy (to a greater or lesser degree) in their stories of birth by planned Caesarean. The characteristics underpinning this domain described by Salomonsson et al (e.g. use of distraction, being present, focus on the future etc.) all focus on coping with a current *known* situation (i.e. labour), even if the possible outcome of that situation is uncertain. For all of the women in the study, knowing that they would have a planned Caesarean birth was not something that was confirmed until the latter stages of pregnancy. For Jo, Sally and Lisa the decision was still uncertain until a few days before birth. This meant that pregnancy was characterised by uncertainty and constant reasoning as to how they should birth.

Characteristics of fatalism, fear and self-efficacy were not only attributed to vaginal birth but were also expressed as they sought or reconciled the need for a Caesarean birth. While severe fear of childbirth wasn't a specific feature of the women's stories many of the women talked of fears in relation to childbirth (this was not exclusively related to vaginal birth). This is unsurprising, as first time mothers they did not have the benefit of prior experience, which is reported to be most significant source of self-efficacy (Bandura, 1994).

The need for others to be able to manage

Seeking *guidance on what to do*, a feature in this domain of handing over responsibility to professionals (Salomonsson et al, 2013), was a strong characteristic in all the stories, either through information seeking or in interactions with staff. Jo, Sally and Abby's stories also reveal that experiences in pregnancy, of inconsistency in information or encounters with staff that give conflicting information may heighten the desire to limit the possible variations in what might be experienced. Salomonsson et al (2013) state that doubts of *own capacity to perform activities*

without the support for others may explain why some women with severe fear of childbirth request a Caesarean birth to avoid giving birth vaginally. But the findings from my study, for instance Sarah's anxiety that a surgeon performing an emergency procedure may have been up all night, suggest that resource constraints and access to resources (emotional, physical, time, skilled decision making) may also be a significant factor. In this context the onus on self-belief and self-efficacy may be replaced by a desire to be confident about access to the right resources (including staff) that can support you to get you through labour and make the right decisions at the right time.

Capacity of the female body

Jo and Lisa both had specific clinical reasons why a Caesarean birth was indicated. For Jo, hearing that she had a low lying placenta made her feel that her *'body wasn't doing what it was supposed to do'* and that she had *'failed already'*. It is also evident from the women in my study that when attempting to *'tell myself that women have always managed to give birth'* that they would carry with them stories from friends and family who told them of experiences where this has not been so. As Abby said, it's not always easy to *leave the not so helpful stuff behind*. In situations of stress and anxiety it is likely that these stories are likely to come to the fore.

Fatalism

For Jo, Lisa and Sally, who developed obstetric or medical conditions that necessitated them having a planned Caesarean, the notion that *'nature was in command'* might not have been helpful. However, fatalism is not only synonymous with risk and catastrophe and positive fatalistic feelings such as beating the odds are also described in the literature (Hoffman-Goetz, 1999). Monika's claim of being immune to childhood diseases and being *lucky* with her health points to this. In this context, though, rather than smoothing the way for a vaginal birth, Monika believed this might help her get through a surgical birth safely and avoid excessive bleeding.

In addition, using Bandura's concepts of the features influencing self-efficacy (*prior experience of mastering obstacles, experiencing someone similar to oneself manage tasks and demands successfully, encouragement from others that one has the capabilities to succeed, and inferences from physical symptoms and emotional states*), and relating them to Jo's experience it is not surprising that she had a difficult experience:

As a first time mother she had no prior experience to fall back on: *'it's something you've never done before, having a baby was all completely new...I didn't know anything about it, I didn't really have any close friends who'd had babies, so it's very scary new journey to me and feeling ...that your body wasn't doing what it was supposed to do.'* She found that she was unable to find information she wanted: *'You're worried about the risks and ...I just couldn't find that information.'* She didn't feel supported by staff and felt that they were disengaged and unemotional: *'I don't think anyone's thinking about how this might feel – to me – you know someone's come over and not even introduced themselves and they're going to make a really important decision that will completely determine what my birth is like and I don't even know who they are!'* When she heard that she might need a Caesarean she was surprised and shocked by the strength of her emotional reaction to the news: *'as I say, completely irrational - over the top reaction'*.

The particular and often conflicting experiences of self-efficacy revealed in the women's stories suggest to me that the demands of self-efficacy are complex and not fully explained by current theories of prior learning and the mastery of skills. Instead I propose that self-efficacy should be reconceptualised as a relational ontology.

Self-efficacy as a relational ontology

Bandura's model of self-efficacy provides a helpful framework for exploring the complexities of how people *'feel, think, motivate themselves and behave'* (Bandura, 1994, p.71). However, the theoretical position I have taken which views subjectivities as multiple, fluid and part of a relational ontology, mean that I believe that some elements of Bandura's model are limited.

Bandura's concepts of self-efficacy are founded on his social learning theory (Bandura, 1971, 1986). Social learning theory provides a model of *reciprocal causality* (Bandura, 1989, Ahmad, Ellins et al, 2014) where the individual plays an active role in their own development by learning from the social environment, particularly through observation or instruction. In this model, cognition, behaviour and environmental events all influence each other (Ahmad, Ellins et al, 2014). In turn, responses or the motivation to act (or refrain from action) are influenced by anticipated consequences and outcome expectations (Bandura, 1986).

While Bandura's model moves beyond a purely behavioural stance by taking account of the cognitive factors that mediate between stimuli and responses, it tends towards a deterministic

view of behaviour (Sammons, 2015) where subjectivities are self-sufficient, stable and the predictable result of prior learning. Bandura's notion of reciprocal causation does conceive of an agentic self, where '*people partly determine the nature of their environment and are influenced by it*'...and '*can generate novel ideas and innovative actions that transcend their past experience*', (Bandura, 1989, p.1182) but this is conceptualised as a self that is independent rather than interdependent.

Challenges to Bandura's model can be seen in Judith Butler's work on *performativity* which describes an active self who is 'manufactured' in performance (Butler, 1990, Aranda et al, 2012). Butler's model of performativity arose from studies of gender identity. She theorises of a self who is not just an external expression of an internal self but is a fluid and fluctuating *performance* in response to normative ideals (Butler, 1988). In this model, performativity is inherently relational as the 'act' is performed by a reflexive self, who is always in the act of becoming, played out against and in response to social relationships and norms.

The women's stories in my study revealed multiple, evolving subjectivities that were influenced by dynamic social relationships and events. Bandura proposes that mastery of experiences is the principal means of personality change (Bandura, 1994). In this model, structured techniques ('*creating an environment where someone can perform successfully despite themselves*', (Bandura, 1994, p.75)), attempt to build coping skills and exercise control over potential threats. Techniques to promote self-efficacy in women who are approaching childbirth, which concentrate on the development of coping mechanism are becoming more common (Brodrick, 2014). However, if these are viewed purely as a process of self-regulation and adaption, they may be limited. If, however, subjectivities are viewed as relational, '*interdependent rather than dependent ...embedded in a web of intimate and larger social relations*' (Mauthner and Doucet, 2003, p.422), the significance of these relationships can be understood as more than a simple process of learning.

Exposure to other women's stories, the uncharted course of pregnancy and late decisions to have a planned Caesarean birth increased the uncertainty for the women in my study. When I reviewed the touchpoints of the stories – the key moments when emotions were formed, I also began to discern the *relational* elements of these interactions. Throughout the stories that women told me, the significant touchpoints that shaped their experience were influenced not only by acts or decisions performed (particularly by maternity staff) but by *how* that person acted, and in particular, whether or not they listened and responded to the woman. I realised that the

triggers or interventions that caused a re-ordering of women's perception of fear, fatalism and self-efficacy were not just material happenings but spaces in which identities were reformed.

If the contact with the professional also held the opportunity for mutual understanding and meaning to be created in the moment, the intervention was perceived positively even if the act or decision was not one that was preferred:

'He was really... really lovely...he had a bit of a joke...I felt completely confident with him cos before that I didn't have clue who was doing the op and you are worried about who it is and but with him I felt completely at ease...he was lovely and I think that made a hell of a difference - had he have been a bit brash or you know...hadn't taken the time for me then I would have been a lot more anxious in there.' (Charlene)

'I had to see the anaesthetist. She was great and she said I understand that you wanted a home [birth] and she said something like, 'if I if I had a baby I would give birth in a forest – I completely understand where you are coming from,' and she just listened to me and I found that so helpful.' (Lisa)

'The lady was putting my catheter in erm I felt really nervous –but I actually felt okay with her doing it and I presume that's because things were so calm in there.' (Charlene)

And conversely if there was no shared understanding, the intervention was viewed negatively:

'She...put the fear of God into me - she was quite brash, like she didn't understand...she was like oh I understand you're worried, she said we're really busy today so if you want an examination we need to do it now, if you don't, you need to go... That's exactly how she said it to me. She said if you want to find out if everything's OK we need to do it right now. So there was no time...I just felt pressured that I had to for the sake of my baby. [Afterwards] they didn't ask if I OK, nothing at all, they just let me sit there and sob.'(Charlene)

This intervention led Charlene to request a planned Caesarean having originally planned to have a vaginal birth. And for Sarah:

'I then had got sent an appointment to see the consultant midwife at our local hospital and she was a bitch, it was a complete waste of my time... there was a

better chance of hell freezing over than me having a Caesarean section.'

(Sarah)

Following this interaction, Sarah stopped going to midwifery appointments and opted out of NHS care.

One of the factors that appeared to threaten whether an intervention (as social interaction) could be meaningful was if birth was perceived as 'routine'. The nature of working in maternity services is that clinicians may witness on a daily basis, an event which for the woman experiencing it happens once or twice in her life. Sarah Bayes' study of Australian women's experiences of medically necessary elective Caesarean (Bayes et al, 2012b) found that women spoke of the day of their Caesarean as 'special' and of having expected the staff would recognise it as such. However on arrival at the hospital they felt unimportant, passive recipients of a routine procedure. Some reported being referred to as a number i.e. second on the list etc. (Bayes et al, 2012b). In my study, the way Jo learned that she had a placenta praevia and may need a planned Caesarean provoked a huge emotional reaction and made her feel very isolated:

'It was all very kinda you know off hand – just passing comment almost - oh you might have to have a Caesarean – it's kinda like that! You know it's no big deal just, cos you know they see it every day, and it was very much like that. It wasn't a big deal to them. And it was a huge deal to me and I remember getting out of the room having the scan and just bursting into tears and me feeling like I was acting really irrationally because there was no kind of acknowledgment of that in the process I was going through ... But it did leave you feeling a bit um on your own with it really – I've got all these emotions I don't know what to do with, and no one's kind of acknowledged that I might be feeling like that.' (Jo)

She felt that her emotional response was compounded by the lack of emotion expressed by staff who found it all very routine:

'People I was coming into contact with, the midwives and the consultants...are so matter of fact about everything and there was no room for emotion...'

'You know it's no big deal just cos you know they see it every day, and it was very much like that. It wasn't a big deal to them and it was a huge deal to me and I remember getting out of the room having the scan and just bursting into tears (smiling) and me feeling like I was acting really irrationally because there

was no (quieter) kind of acknowledgment of that in the process I was going through.'

In contrast, when Charlene told me her story, she spoke of staff that had been memorable for her during the birth. She mentioned two midwives who had also been excited about the approaching birth:

'The two midwives when I first went in both of them were lovely and both of them were sort of excited that I was having a girl and that I knew and it settled my nerves.' (Charlene)

Conventional descriptions of interventions in healthcare usually relate to strategies to improve health or alter the course of disease. But In childbirth practices *interventions* are also described in discourses about the increased use of technology, in what is perceived to be a medicalisation of a physiological event (i.e. birth) (Davis-Floyd, 2003; Mander, 2007) (see Chapter 8). However, I believe that the concept of and use of interventions in childbirth now also needs to focus on relational aspects - the personal and social interaction that occurs concurrently with the event, act or decision. From my analysis, descriptions of self-efficacy as a characteristic of a separate, self-sufficient, independent and rational self are limited. I believe that self-efficacy is evolving; reproduced by a fluid, interdependent and relational self that is inextricably embedded in relationships with others and the cultures we live in. I believe that if an *intervention* has the capacity to modify and potentially improve health and influence self-efficacy, and is conceived of as a relational, social interaction, then what constitutes *support* and the way in which this can be realised needs to be defined.

Concepts of support in childbirth

Trends in healthcare policy in recent years have reflected a greater awareness of patient centred and humanistic approaches to healthcare. In particular a nursing (and midwifery) strategy have called for a particular focus on compassion in healthcare (NHS Commissioning Board, 2012). In my study, emotional 'highs', in Charlene's experience were being listened to and, for Abby, having her needs anticipated by the Polish healthcare assistant. Being able to anticipate needs suggests empathy and a capacity for imagining what the experience is like from the perspective of the person experiencing it and then seeking to address these needs. Additionally, it suggests a willingness to engage in a relationship.

Humanistic and holistic strategies within maternity care that have focussed on providing positive supportive care for labouring women propose the concept of one-to-one care. This denotes that a midwife is able to focus all her efforts on one labouring woman, and that having no responsibilities elsewhere, is able to provide continuous support. Continuous support in labour is argued to impact positively on clinical outcomes including type of birth, analgesia used, length of labour, Apgar scores and women's feelings about their birth experience (Ross-Davie et al, 2013). Although, in reality, even if staffing levels are adequate, the unpredictable nature of labour and birth produces fluctuating activity on delivery suite which means that this is sometimes difficult to achieve.

Until recently, much of the attention on the need for continuous support through one-to-one care was focussed on trying to balance resources to achieve the relevant ratios of midwives to women rather than attempts to articulate what that care should encompass. However a recent study by Ross-Davie et al (2013) used a new computerised systematic observation tool to identify the quality and quantity of support behaviours needed. This instrument, '*the supportive midwifery in labour instrument*' or SMILI assessed behaviours chosen from theoretical definitions of high quality intrapartum support and the large body of research undertaken with women as to what they experienced as being supportive and unsupportive (Ross-Davie et al, 2013).

Ross Davie takes as her definition of support in labour from Simkin (2002), where intrapartum support has been defined as:

'Non-medical care that is intended to ease a woman's anxiety, discomfort, loneliness and exhaustion, to help her draw on her own strengths and to ensure that her needs and wishes are known and respected. It includes physical comfort measures, information and instruction and support for the partner.'

(Simkin 2002, p.721).

Ross-Davie et al state that '*Quality in healthcare is defined as person centred, safe, effective, efficient, equitable and timely*' (Ross-Davie et al 2013, p.176). However I believe that the definition of support needs to include provision for the forming of meaningful (reciprocal) relationships. And, for there to be equality in maternity care I would suggest that we need to broaden the scope of this definition and find ways to realise these aims for all women, at all stages of care and in all locations: in pregnancy, in theatre and postnatally.

Broadening the scope of support should also focus on *who* provides that support. In my study, many of the women mentioned that the anaesthetist provided them with emotional support in theatre. This was also a feature of Bayes et al's study (2012b) but I could find no acknowledgement of this facet of an anaesthetist's role in any of the practice guidance for anaesthetists in obstetrics (National Collaborating Centre for Women's and Children's Health, 2011; Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association, 2013; The Royal College of Anaesthetists, 2014; NHS Choices, 2014). This raises questions as to how the support role should be adopted and developed. With a few exceptions, the midwife was largely absent from the narratives of *in theatre* experience in my study. This is a direct challenge to foundational concepts of midwifery support to childbearing women and that nature of the midwife-mother relationship which has been seen as fundamental to the role of the midwife:

'The relationship between the women and the midwife is at the core of human caring and may provide the basis of the professional body of knowledge that encapsulates midwifery.' (Siddiqui, 1999, p.111).

This may in part relate to the nature of the midwifery role when caring for women for whom they are not the lead carer or changes to the role of the midwife that necessitate taking on additional roles such as 'scrubbing' or 'taking the baby' rather than the primary role of emotional support to the mother. I feel that it is important not to demonise midwives but to take account of the increasingly evolving midwifery role, and there is a body of work exploring the discourses of the midwife-mother relationship and the social context in which midwives carry out their *emotion work* (Deery, 2003; Deery and Hunter, 2010) (see Leap, 1997; Kirkham, 1999; Kirkham, 2000; Kirkham et al, 2002; Deery, 2003; Deery and Hunter, 2010; Guilliland and Pairman, 1995; Pairman, 2010; Walsh, 2006, 2007). Returning to my personal experience of working as a midwife in New Zealand and being influenced by the Partnership model (Guilliland and Pairman, 1995) (see Chapter 1), the key component that underpins this model is *reciprocity* (Guilliland and Pairman, 1995) which makes provision for relationships based on different expertise but which come together as mutual understanding (see also Deery and Hunter, 2010). From my research, how and in what ways emotional support can be provided in theatre and postnatally still needs to be determined (see Chapter 9, Recommendations for policy, practice, research and education).

Emerging narratives of planned Caesarean birth

The emerging narratives reveal planned Caesarean birth as a journey of navigating uncertainty and attempting to negotiate towards a positive experience. The decision for a surgical birth was often made late in the pregnancy. Prior to the decision, information was actively sought on different modes of birth, and pregnancy was characterised by the dilemma of *how to (give) birth?* (See Appendix 13 for a summary of the landscape of planned Caesarean birth).

The stories in my study indicate that women not only consider their self-efficacy for a possible labour and birth but also other eventualities including induction of labour, planned Caesarean and emergency Caesarean birth. Simplistic notions of how women navigate a pathway, where they seek to limit and optimise their birth experience, have characterised women who seek a planned Caesarean as making poor health decisions or being '*too push to push*' (Moorhead, 1999) (see chapter 8 for further exploration of this concept). In the current context of childbearing, where one in four births is by Caesarean, perceptions of the likelihood of not achieving vaginal birth but instead having an emergency Caesarean birth are not just cognitive constructs or irrational worry but are borne out by empirical evidence. In this context, if the focus is avoiding an *emergency* Caesarean rather than avoidance of vaginal birth, we can begin to imagine that opting not to *rely on one's own body to birth* or believing that *nature is in command* may be a pragmatic response to the knowledge of the increasing incidence of emergency Caesarean birth and a concern to militate against the told stories of emergency Caesarean birth experience.

The narratives reflect that concepts of fatalism (and self-efficacy) are often simplistic and we need to consider social, political and economic context in which health is experienced and healthcare is '*imagined, sought and utilised*' (Drew and Schoenburg, 2011, p.116). When fatalism and self-efficacy are viewed as social, political and economic constructs further complexities emerge. In a context where Caesarean birth accounts for 40% of the maternity birth budget in England, despite being only 25% of all births (NHS Institute for Innovation and Improvement, 2006), it is not difficult to imagine that the resources necessary to provide positive support for labour and birth are constrained. In contrast to this, women in my study saw their experience in theatre as resource-rich, in terms of the number of dedicated staff allocated to care for them and, judging from Monika's comment on having a surgical birth that '*no one's gonna let you die*', in the expertise they offered. This was contrasted by their experience of postnatal care which was perceived as resource poor in terms of the available time trained staff could spend with them and the degree of emotional support they experienced. This confirms other studies that reflect

dissatisfaction with postnatal care, particularly lack of information and not being treated with kindness and understanding (Healthcare Commission, 2007).

It is also possible that in the context of great uncertainty and competing and conflicting information about birth experience and outcome, that expressions of fatalism may not necessarily reflect a notion of one's own self-efficacy but may be one of the culturally acceptable scripts available to childbearing women in which to express distress in times of greatest challenge when faced with constrained choices, as described by Drew and Schoenburg (2001). An in-depth consideration of the cultural scripts available to childbearing women will be discussed in Chapter 8.

Salomonsson et al's study focused on self-efficacy in preparation for vaginal birth. It is likely that notions of self-efficacy when approaching planned Caesarean will be different and will require unique strategies. Some of the participants in my study described the positive effect of writing a birth plan (Lisa, Abby and Jo) which can be seen to be a self-efficacy strategy that fits within the domain of *control*. Although documenting wishes maybe a way of exerting control, the important element described by Lisa's story appears to be that the staff listened to her and were prepared to adapt to and support her individual wishes. *I think there were just a...few things that they did with my birth plan and I just relaxed and it was like, Ok...it's not just a token gesture... they did look at it and they took it on board (Lisa).*

Importantly, before assessing a person's health beliefs and behaviours, the context in which fatalism, fear and self-efficacy is expressed should be explored (Drew and Schoenburg 2001). Self-efficacy will be affected by obstacles which affect the ability to plan (such as uncertain care pathway) and perceptions of limited access to resources (such as how staff are deployed within a care pathway). These emerging narratives suggest that self-efficacy strategies should not focus solely on preparation for labour and birth, strategies also need to be developed and applied to Caesarean birth.

Conclusion

In this chapter I have explored the eight stories to reveal the phenomena of planned Caesarean birth and how it was experienced, understood and constructed. I used an improvement

methodology technique – experience-based design (NHS Institute of Innovation and Improvement, 2009) to present a landscape of planned Caesarean birth by identifying the emotional highs and lows and the key touchpoints in the unfolding journey, where these emotions were shaped. Despite having a planned surgical birth all women experienced a great deal of uncertainty regarding possible mode of birth.

My research has not been aimed at exploring why some women seek a planned Caesarean birth but the findings from my study offer alternative narratives to the *'too posh to push'* narrative which contains preconceptions and stereotypes and has fuelled debates about planned Caesarean birth. Further research is required to explore self-efficacy in women approaching pregnancy and birth that also takes note of the social, political and economic contexts that frame maternity care and motherhood.

This research contributes to the discourses of fear, fatalism and self-efficacy which are commonly described in research about vaginal birth. My findings suggest that assumptions of self-efficacy as a fixed, internalised capacity to overcome challenges are limited. Instead the emerging narratives here demonstrate that self-efficacy is socially constructed and constantly *reforming* as part of a relational ontology.

These explorations have led me to appreciate the complex and socially situated nature of childbirth and childbirth practices. The following chapter will focus on how these eight women's personal accounts of planned Caesarean birth relate to dominant ideologies of birth and motherhood.

8. How does a woman's personal story of birth (of planned Caesarean) relate to dominant narratives and ideologies of pregnancy, birth and motherhood?

'Stories matter; they do things.'

Andrews M (2007) *Shaping History: Narratives of Political Change*, p.12, Cambridge Press.

Introduction

In this chapter I focus on what the eight participant stories told of the dominant narratives and ideologies of childbirth and motherhood and the social, political and economic contexts that frame maternity care in England. In particular I focus on the dominant narratives of *vaginal birth*, *the medicalisation of childbirth*, *choice*, and the moral framework of motherhood characterised by *the good mother* narrative.

Personal narratives are always told in relation to grand narratives, structures and practices. Narrative researchers are interested in the ways in which people accept or resist dominant narratives and how counter narratives are produced as strategies for social change. I examine how the narrators drew on and positioned themselves against cultural resources in telling their stories and the extent to which they accepted or resisted ideologies of pregnancy, birth and motherhood. I discuss stories as modes of resistance and propose that rather than (binary) distinctions of stories as either accepting of or resisting dominant narratives (through the production of counter-narratives), stories are produced by a reflexive self whose political identity is fluid, varied and relational.

Dominant narratives tend to presume a universality, which can override individual experience and fail to accommodate and value the diversity that exists in experiences of birth and mothering. One strategy for challenging dominant narratives is to increase the repertoire of narratives that women may draw on to tell of their experience. The women in my study did not experience pregnancy, birth and motherhood uniformly and this research extends the possible storylines that are available to women.

Identifying dominant narratives of childbirth

My aim in exploring the dominant narratives and ideologies of pregnancy, birth and motherhood was to be able to examine how these personal stories were contextualised and situated and what they revealed about the positioning and intentionality of the narrator in the construction of their narrative identity.

I am aware that there are apparent contradictions in my desire to look at how the participants have positioned themselves and yet I have not drawn on biographical data to situate their experiences (this is discussed more fully in chapter nine). However, my justification for this is that I believe that it is not possible for me to know the participant in any authentic sense, as the stories are constructions of experience. But I can attempt to understand the meaning inherent in their stories and the context in which they were told, by examining how the participants presented themselves in particular and strategic ways (Miller, 2005). As my action has been on analysis of the story as it was told to me, I have responded to storied biographical details if they were included as an expression of narrative identity within the story.

As stated previously, it was hard to fix on what could be counted as a dominant narratives and achieve a balance between my prior knowledge and experience and *listening* for the multiple and contradictory voices in each personal narrative and my responses to them (see Chapter 5 – Addressing my research questions). My analysis has inevitably been guided by my own personal and socio-culturally situated experience and my experience as a midwife (see Chapter 1). This knowledge and experience was also built on through my readings of the literature of Caesarean birth (in Chapter 2) and feminist writings of motherhood. To address this research question, I turned predominantly to the analysis I had undertaken using readings four and three of the Listening Guide (which themselves were premised on readings one and two of the Listening Guide) (see Chapter 5 and Appendix 8).

I focused on reading four from the Listening Guide: *Listening for broader, social, political, cultural and structural contexts*, to listen for structured power relations and dominant ideologies that frame narratives, and the extent to which the individual narratives were culturally, socially and politically patterned and shaped. I listened for places where their thoughts, feelings, decisions and choices seemed constrained by those contexts. I looked for instances where the women's stories reflected expectations of childbirth and motherhood or resisted cultural norms. I also listened for the woman's use of language, what they felt they 'should' or 'ought' to do and what

was taken-for-granted, in order to indicate the moral language and cultural imperatives and expectations of women as mothers.

I then used my analysis from Reading Three of the Listening Guide: *Listening for relationships*, to explore how the participants spoke about their interpersonal relationships, with for instance, their partners, friends and relatives and staff. This drew my attention to the characteristics of positive relationships and where there were relationship difficulties experienced during their planned Caesarean birth.

In putting this chapter together I am aware that this is a partial exploration of dominant narratives and ideologies of pregnancy, birth and motherhood as I perceive them. This exploration does not comprehensively address all dominant narratives relating to childbirth, rather I have examined the relationships, connections and autonomy of the narrators in relation to the cultural contexts and social structures they revealed in their stories. Specifically, this analysis does not critically challenge normative assumptions of, for example, heterosexuality, and able-bodiedness that may underpin healthcare relations, structures and practices and shape and construct healthcare subjects in particular ways (Zeeman et al, 2014). Instead, I have invited the reader to be aware of assumptions they may make about the participants' race, sexuality and able-bodiedness as they read my *retelling* of their stories.

Dominant narratives and ideologies of pregnancy, birth and motherhood.

Becoming a mother has a major influence on an individual's life story and yet the expectations and experiences for that individual will be shaped by the social and cultural contexts in which they live their lives (Miller, 2005). Dominant narratives are cultural scripts (Miller, 2005) which individuals will draw on to tell about their experience. As Rice states (in Andrews, 2007) '*The story of an individual life and the coherence of that identity depends for its very intelligibility on the stories of collective identity that constitute a culture* (p.12). These scripts provide individuals with a way of identifying what is assumed to be a normative experience, and in reinforcing what is normative, other experiences are excluded or only partially rendered (Andrews, 2004).

Cultural scripts are premised on forms of authoritative knowledge. The forms of authoritative knowledge that 'count' in relation to pregnancy and childbearing will shape individual expectations and experiences and ultimately what sense is made of them (Kent, 2000, McAra-Couper et al, 2012). Feminist research questions the social processes that frame childbirth and

motherhood in particular ways and contests essentialist, biological constructions of maternal bodies and motherhood (Miller 2005). In particular, feminist researchers attend to what can and cannot be voiced in relation to experiences of becoming a mother (Miller, 2005) and which experiences are marginalised or untold.

Within narrative theory, social change can occur through the telling of stories that initially resist and then provide alternative or counter narratives. Increasing the repertoire of narratives that women may draw on to tell of their experience is another strategy for challenging the dominant narratives. In writing this chapter I have attempted to show the range and variety of stories that women tell about planned Caesarean birth. The primary dominant narratives that were revealed in the eight stories were *vaginal birth*, the *medicalisation of childbirth*, *choice* and the *good mother*. These dominant narratives did not appear as discrete categories and they should be considered as overlapping, complementary, contradictory and inter-dependant.

Vaginal birth

Approximately three quarters of babies are born vaginally in England each year (The Information Centre 2014), vaginal birth is proposed to be the optimal way for women with healthy pregnancies to birth (Enkin et al, 2000; Royal College of Midwives, 2004; NICE, 2007; NHS Institute for Innovation and Improvement, 2011), and evidence suggests that most women expect to birth vaginally (Bayes, 2010).

The terms *normal* and *natural* are used interchangeably when describing vaginal birth and these terms suggest that vaginal birth is the anticipated and accepted mode of birth for the majority of women and perceived to be a physiological and biological event. However, birth is more than a biological event and is a fundamental and transformative experience (Miller, 2005; Bayes, 2010). Birth is inextricably linked to the transformation from woman to mother as a *rite of passage* (Bergum, 1989) which is metaphorically and perhaps literally linked to the act of *giving* birth.

Since the late 1990s, women who have challenged vaginal birth as the only legitimate way to birth, particularly those who have requested a planned Caesarean have been vilified as '*too posh to push*' (Moorhead, 1999). This term first appeared in the popular press in 1999 (Moorhead, 1999) for women choosing a planned Caesarean in the absence of clinical indications and has become well established in the UK media (Weaver and Magill-Cuerden, 2013) despite limited evidence that women request Caesarean births or have an aversion to vaginal birth (Gamble et al, 2007; McCourt et al, 2007; Weaver and Magill-Cuerden, 2013). The derivation of the phrase

appears to have come from a belief that highly educated or more wealthy women were seeking birth by Caesarean (Weaver and Magill-Cuerden, 2013) often by paying to have the operation privately. The original article in the Daily Mail highlighted the advantages of being able to organise work and social life around the birth (Moorhead, 1999).

While evidence suggests that fear for the mother or baby's health, or a previous traumatic experience underpins many requests for a planned Caesarean (Lavender et al, 2006; Fenwick et al, 2010; Brodrick, 2014), the image of requesting Caesarean as a lifestyle choice continues (Weaver and Magill-Cuerden, 2013). A planned Caesarean birth seems to attract negative attention irrespective of the reasons behind why it was performed. The number of maternal request Caesarean births performed has been over reported as has their possible link to rising Caesarean rates (Gamble et al, 2007).

Medicalisation of childbirth

Despite the dominant narrative for normal, vaginal birth, childbirth practices have been increasingly influenced by medical technology and medical intervention has become the norm (Johanson, Newburn et al, 2002). The implications of the medicalisation of childbearing for women has been to shift the focus of birth from the social and emotional to the physiological and medical. Pregnancy and birth are regarded as an illness in need of intervention (Kent, 200; Mc Ara-Couper, 2012) in the form of expert management and supervision (Miller, 2005).

Women's expectations and experiences in pregnancy and birth are relational - produced through interactions with others (Miller, 2005). Changes in family make up and different ways of living mean that informal sources of knowledge and support may no longer be available and therefore expectations and experiences are shaped in reference to expert (authoritative) knowledge. Authoritative knowledge negates other potentially relevant sources, such as women's prior experience and the knowledge she has about her body (Miller, 2005), and does not recognise or accommodate the diversity of women's lived experiences. As a result there is little space for alternative ways of thinking or knowing about pregnancy and birth and women may feel it is unsafe to disclose experiences which do not resonate with expectations (Miller, 2005).

Through medicalisation of childbirth, pregnancy and birth are increasingly believed to be inherently risky and with the potential to threaten the health of the mother and baby. Pregnancy is characterised by regular monitoring and routine visits with medical experts (National Institute for Clinical Excellence [2008], 2010), and hospital is seen as the 'natural' place to give birth

(Miller, 2005) in an environment which is managed by professionals. These monitoring practices reinforce and legitimise the dominant narrative that pregnancy and birth are risky and they have become accepted as the 'normal' or 'natural' way to do things (Miller, 2005). Many women feel that they are obliged to embrace all the available technology to ensure the safe arrival of their baby (Lavender and Kingdon, 2006; Mc Ara-Couper, 2012) and as they become increasingly at ease with and reassured by technology, less value is placed on the ability of a woman to birth naturally (Lavender and Kingdon, 2006). Coupled with knowledge that the Caesarean birth rate is rising, expectations of normal or uncomplicated childbearing are likely to be lower (Mander, 2007).

The medicalisation of childbirth also affects midwifery practice, as what constitutes 'normal' has changed, reducing the likelihood of physiological birth and limiting the role and scope of the midwife (Mander, 2007). Increasingly the practices of midwives are redefined to include activities defined by medical personnel (Mander, 2007). This is particularly evident in Caesarean birth where midwives may have a number of roles beyond supporting the mother, including assisting or 'scrubbing' for the operation and providing neonatal resuscitation and support. There is a dichotomy for midwives as to how to respond to this. Mander argues that a midwife's steadfast position that she is a '*guardian of normality*' (Downe, 2004, p.173) may mean that '*she has effectively shot herself in the foot*' (Mander, 2007, p.150). However, midwives may have developed strategies to cope with their changing role - Green (2005) found that midwives coping mechanisms for dealing with uncertainty meant that they were ambivalent towards Caesarean (Green 2005) (see chapter 7). Ultimately, the increasing incidence of Caesarean birth suggests that it may be becoming '*just another kind of birth*' and '*even regarded as a 'normal' procedure*' (Mander, 2007, p.13).

Choice

Since the 1990s, the right for women to exercise choices in order to take control of their birth experiences has been a central feature of maternity policy (House of Commons Health Committee, 1992, Department of Health 1993, 2007). Childbirth is an increasingly planned event (Miller 2005, Mander, 2007) and women are faced with an array of choices: when to get pregnant, whether or not to know the sex of their baby before birth, where and how to birth (McAra-Couper et al, 2011). However, choice in childbirth is a highly disputed issue (Crossley 2007, Mander and Melender, 2009, McAra-Couper et al, 2011), as choice is '*socially constructed and politically constrained*' (McAra-Couper et al, 2011, p.82). Real choice for women is believed to

be a myth (Crossley, 2007; Mander and Melender, 2009) as choices are usually limited by and shaped by the interests of particular groups who are able to exercise authoritative knowledge, in this case medical institutions and healthcare professionals (McAra-Couper et al, 2011).

Notions of choice are also criticised for being a feature of neoliberal ideologies which insist on freedom of choice, while also promoting freedom of consumption, competition and a trend towards privatisation of health care services (Zeeman et al, 2014). These ideals may actually increase health inequalities by fragmenting systems and disrupting the development of equitable healthcare (Lister 2013). High rates of planned Caesarean births in private healthcare organisations (which act independently of state funded health care policy) have led to associations between the choice for planned Caesarean birth by women who are wealthy (Mander, 2007).

Offering choice can become problematic if there is conflict between a woman's right to make her own decisions and the clinician's right to practise according to professional standards (Amu et al 1998). Some authors argue that traditional views of decision-making resting with the experts are now changing to a position where decision-making sits with the pregnant woman with the expert '*simply presenting one opinion among many*' (McAra-Couper et al, 2011, p.87). The implication is that women are demanding surgery and that health professional's role is purely to make sure that the woman is fully *informed* of all the risks. However, the fact that women perceive Caesarean birth to be a '*safe and reasonable*' alternative to vaginal birth is not surprising given the support for it in medical discourses (Fenwick et al, 2008, p.394). Ultimately, choice is always situated and powerfully influenced by the context in which women birth (McAra-Couper et al, 2011), with the discourse of risks in childbirth constraining choice and the normalisation of surgery extending it. Unfortunately, the culture in which women are expected to make decisions about their childbearing is '*peopled with disciplines whose occupational assumptions are diametrically opposed,*' (Mander, 2007 p.83) and so choices in relation to intervention in childbirth are always '*situated*' even if the notion of informed choice obscures this fact (McAra-Couper et al, 2011, p.94).

As mentioned in chapter seven, recent policy initiatives produced in response to healthcare failings (Francis, 2013) are beginning to shift the emphasis away from choice towards providing *care, compassion, competence, communication, courage and commitment* (NHS Commissioning Board 2012), in a context of *shared* decision-making where there is '*no decision about me without me*' (Department of Health, 2010, p.13).

The moral framework of motherhood and the *good mother*

The transition to motherhood is a personal experience and a public event. Mothers are scrutinised, fathers are not (Goodwin and Huppatz, 2010). Motherhood occurs within a moral framework (Miller 2005) that places *'pressure on women to conform to particular standards against which they are judged and judge themselves'* (Goodwin and Huppatz, 2010, p.1). Although feminist critique has challenged imperatives that all women wish to be mothers, the embodied physical act of birth, inextricably links a women to her biological role in reproduction (Oakley, 1980).

Mothering identities are complex, changing and at times fragile embodied constructs (Miller, 2005), which even when resisted, are perceived within the dominant moral contexts of motherhood (Miller, 2005). What constitutes 'good' mothering changes with time but ideals are produced through multiple social structures including public policy, the media and popular culture (Goodwin and Huppatz, 2010) which exert pressure on women to present themselves in ways in particular ways (Miller 2005) that are culturally recognisable (Goodwin and Huppatz, 2010). Good mothering is premised on ideas of being with children, fulfilling the demands of intensive nurturing whilst at the same time taking up paid work and providing financially for a child (Hays, 1996). The dominant narratives of *good* motherhood may make it hard to voice narratives that we do not think are 'normal' (Mauthner, 2002).

Mothering is intensive and mothers are primarily responsible for nurturing the child (Hays 1996) in a process which is *'child-centred, expert guided, emotionally absorbing and labour intensive'* (Hays, 1996, p.8). There are culturally acceptable ways of preparing for childbirth and motherhood that are predominantly determined by authoritative ways of knowing (Miller, 2005). However, the dominant narratives which reinforce the *good mother* ideals are inherently contradictory and create dichotomies: pregnant women are expected to be instinctive mothers and yet attend preparation for parenting courses and they have to balance sacrificing their interests over the interests of their baby:

'The mother has been criticised for being selfish for wanting a Caesarean on the grounds of being 'too posh to push'. Paradoxically, she has also been criticised for not wanting a Caesarean on the grounds that she is selfishly prioritising her own wishes over her baby's health and welfare.' (Mander, 2007, p.13).

Close monitoring continues after birth, but becomes almost entirely about the baby - the mother's independent status is lost as she is only seen in relation to the baby and experts continue to provide advice on what is best for the child (Miller, 2005).

Motherhood is romanticised and women who fall short of the ideals are heavily criticised (Mauthner, 2002). Women who strive for perfection are likely to experience a disparity between the ideals and the realities of their experience (Mauthner, 2002). The dominant narrative for the *good mother* both shapes the identities of mothers and the meaning it holds for them (Goodwin and Huppatz 2010). This often involves comparing oneself to others '*in a confusing context where 'normal' mothering is not defined but powerfully reinforces expectations*' (Miller 2005, p.59).

There have been tensions within feminist writing over the uniqueness of women's embodied experience. Some feminist work assumes that social structures and cultural discourses affect women in uniform (and usually negative) ways (Miller 2005). Mauthner (2002) criticises moves which advocate a return to paid work through stressing the importance of autonomy and independence to women's psychological health as she believes that it devalues women's caregiving and homemaking roles by advocating a return to the pre-mother identity (Mauthner 2002). She suggests that there is still a need to explore the different ways in which individual women deal with the ideologies, meanings, practices and social conditions of childbirth and motherhood (Mauthner 2002). However, feminist research is increasingly moving towards a situation where reproduction is not seen as oppressive (Miller, 2005) and the diversity in women's experiences of pregnancy, birth, child rearing, and familial roles and responsibilities is valued (Goodwin and Huppatz 2010).

These four complementary and contradictory dominant narratives provide context with which to situate my reading and analysis of the eight stories. They can be traced through each of the personal narratives although they are not necessarily expressed or defined according to the discrete terms I have used. Importantly, they are not experienced uniformly and the extent to which they are accepted or rejected is realised in individual and fluid ways:

Charlene

Charlene tells how rather than motherhood being instinctive and normative, she felt *'young and naïve'* and in need of direction and support: *'I would have loved to have been able to be put at ease more in there.'*

She felt pressurised by other people views: *'most people were saying that you know childbirth is the most natural thing in the world and you know you're a woman that's what you should go through.'* This made her feel that she was inadequate and a *'failure'*:

'To be told constantly all the way through that I'm a women I should be able to you know just give birth naturally that was, you know, caused a lot of issues in my head and a lot of upset,'

'You feel like you're not a woman if you can't go through that so I think that's tough ...so erm you should be able to discuss things with people and not have their opinion forced upon you.'

Charlene was *'really embarrassed about telling people'* that she was having a Caesarean and she was surprised by the strength of other people's opposition to it: *'even ...my sister [was]... against it'*. Having a bone fide reason for it seemed to be important in gaining support and acceptance and because she *'couldn't tell them why'* she was having it, she felt particularly under pressure.

'[They were] just very opinionated and just ...had their say. And then you walk away from that situation and you feel like you're a complete failure.'

She also felt that staff were not able to appreciate that having a vaginal birth was too much of a hurdle for her to get over:

'They think [you] should be able to cope if have a good partner...a lot of them were in the mind set of think you've got a good partner you know you'll be able to get through it.'

Charlene felt that she knew the limits of what she could cope with and advocated the importance of 'listening' to her body when gauging what was possible for her. Even though Charlene was happy with her Caesarean birth she did reflect that:

'I do feel part of me has missed out on the experience of birth.'

Charlene portrayed herself as young and inexperienced: 'I didn't have a clue' and she believes that this contributed to her being passive in some situations. She felt forced and pushed into things by the staff's perceptions of risks to her baby:

'She said if you want to find out if everything's OK we need to do it right now...I knew that it was best for her sake (looking to baby) if I had it but I desperately didn't want it -I just felt pressured that I had to for the sake of my baby.'

Rather than making her feel more empowered, being given choices in her care without support for decision-making made Charlene feel more vulnerable and she felt staff were unable or not prepared to be part of the decision making:

*'And I kept saying to them... should I be carrying on - does she need formula?
And they were looking at me like I was stupid like, I should know.'*

*'They kept saying it's your choice...we're not here to push you either way...they weren't pressurising breast or anything which I thought would be the case...
...but it wasn't that at all, it was more the point that you need to make up your mind... you've got to stick one way of the other. And I didn't know, I didn't know what to do I didn't know what was best. I wanted whatever was best...
and I felt really stupid because...you know I've got to make a decision...how do you make that sort of decision?'*

Charlene's story, in particular, shows how she sees herself in contrast to the ideologies of motherhood as instinctive and in terms of what she was or was not able to cope with for the sake of her baby. Choice is portrayed as clinical staff handing over the decision-making (whilst withholding providing professional knowledge or perspective) rather than a shared endeavour.

Jo

Jo's story clearly demonstrates the dominant ideology of vaginal birth as the optimum and expected way to birth. She tells of her shock of realising that she might need a Caesarean because she'd *'had all these ideas about having a nice natural birth you know er and that wasn't going to be the case.'* Jo shows that vaginal birth is idealised as homely: *'Obviously when you're having a Caesarean you don't have the luxury of bean bags and low lighting'*; and needing a Caesarean made Jo feel that she'd *'failed'* as a mother *'before I'd even had my baby'*. She describes her feelings of inadequacy that she isn't able to birth vaginally:

'Your body wasn't doing what it was supposed to do - the only thing it's supposed to do and it wasn't doing it right.'

During her pregnancy Jo sought information to help her make decisions but she felt she was never able to have all the information in one point in time and that she was *'having to make decisions in the dark.'* She became less confident about her ability to mother, less sure of her decision making; more guilty and emotional:

'I just felt guilty about everything – I didn't expect that.'

The impact of this was significant. She was surprised at her emotional reaction which in turn affected her self-image:

'I turned out not to be a very strong person in those circumstances – I was just very, very emotional, lots of tears.'

Jo sought to gain some control by writing a birth plan. She didn't feel that staff encouraged this:

'The hospital they don't go oh and you can write a birth plan and you can ask for this and we can... they kind of responded cos I'd done it - they didn't encourage it.'

Jo resists the ideology of motherhood as instinctive *'having a baby was all completely new'* and is able to voice her insecurities: *'I've got this baby, I've never I've never held a baby that small'*. She felt that staff expected her *'to be able to just feed my baby'*, and they were *'quite judgemental'* when she struggled to establish breastfeeding. Not knowing what was expected by the staff in terms of frequency of feeds during the night, meant that Jo to let her baby sleep for longer than staff felt appropriate and Jo then *'felt awful that she'd neglected her baby.'*

Jo felt that she wasn't able to get the birth 'right' and that 'this carried over through to other experiences' particularly breastfeeding and Jo went out of her way to try to comply with an unrealistic feeding schedule. Jo was adamant that she would continue to breastfeed and resisted the option of bottle feeding her baby even when staff advised her to:

'Are you telling me that I don't have enough milk? Because no one said that I'm not producing milk. I don't really understand why – why can I not just breastfeed him more regularly for a day and see what happens...I felt like I had to ask questions all the time and I don't feel that it was very welcome...I think people just expected you to accept what they were telling you.'

Jo continued to put considerable investment into breast feeding successfully but found that this was also fraught with ideologies of how it should be done. When she came home she attended a breastfeeding support group but she was criticised for leaving her baby to wake naturally for feeds. This came at a time when Jo was beginning to feel that things were 'starting to move in the right direction' and it gave her the confidence to withdraw from the group:

'I'm thinking, I got up this morning and felt brilliant and I've come here now and I feel like the worst mother in the world - so I didn't go any more...I don't need to be around people who are going to make me feel bad about things.'

Jo's story tells of the expectations for a vaginal birth, instinctive motherhood and the *good mother*. She is able to voice that these notions are idealised and tells powerfully of the emotional experience of finding a dissonance between what she anticipated and what she experienced, particularly in regard to her shifting sense of self and how she thought she would cope. So strong were the normative practices that Jo tried to comply even when she knew that there were unrealistic. Ultimately, it was only when Jo's experience and expertise increased during the first few weeks of becoming a mother that she was able to resist some of the idealised frameworks of motherhood.

Monika

In Monika's story she includes some of the narratives associated with good motherhood and sacrifice, particular around avoiding pain killers while breastfeeding:

'Because I did breastfeeding , so I thought, you know, I you know – as soon as possible I – as soon as possible I can walk and I I able to you know live with the pain I I I [sic] don't want any tablets , nothing.'

But she also constructs good mothering as wishing to care for her baby straight away and views recovery to be slow with vaginal birth or emergency Caesarean. Monika resist the dominant ideology for vaginal birth: *'I really insist'* [for a planned Caesarean]. Monika sees motherhood as responsibility to do what is best for her daughter, which for Monika also necessitates having only one child:

'And I can't understand the people with the three, four, five babies, you know...how they could manage to, you know, to prepare these children for life, because I want best for my child, I want you know best school, best nursery, best college, everything what is best for her.'

For Monika, wanting what's' best for her daughter also means showing her that there is a life outside and beyond motherhood, a life of self-determination and independence:

'And I don't want to sit at home you know and show my daughter that you know you have to sit at home and just you know depend on on on the man. You have to do your own thing, you have to discover yourself...'

As Monika did not grow up in England originally it is possible that she was influenced by a different set of cultural scripts to those shaping maternity care in England. Having visited and got the support of her doctor at home she felt able to insist on having a Caesarean birth. Interestingly, there is no mention of midwifery support or antenatal information or education from the maternity service anywhere in Monika's story.

Her focus was on wanting what she believed was best for her baby. This was in the context that becoming a mother was one facet of her life and how she saw herself. During the story Monika voices her confidence to make the decision for a planned Caesarean birth for herself against the dominant ideology of vaginal birth and as such her story provides an alternative viewpoint of both childbirth and motherhood.

'All children gonna grow up, it doesn't matter how many you you will have, no one's gonna stick with you and stay with you all the time and its going to be

very selfish to ask your child to stay with you and to stick with you all the time. You have to let them go. And er with the family you have to have something – outside, to keep you interesting - and, keep you going!

Sarah

Sarah's story provides an alternative viewpoint and challenge to the dominant narratives. In particular Sarah shows an awareness of the ideologies and policies that direct maternity service provision within the NHS and she seeks to show the flaws in them. Sarah's whole story tells of her inner strength to battle with the social structures and ideologies that are seeking to repress her.

Sarah starts her story with telling of an emotionally traumatic experience of a miscarriage. She talks of being vulnerable '*I got a little...depressed*' but is also defiant '*although I refuse to take the label*'. Sarah wants to make her own decisions, she shows the maternity service systems to be patriarchal and she resents having care options dictated to her:

'It does worry me somewhat that there's this perception that adult women can't make informed choices without somebody helping them.'

'And whilst accepting that things can go wrong even with an elective section, they would be my choices of potential consequences rather than the consequences that somebody else thought that I should be willing to accept.'

She actively criticises maternity service policy within the NHS:

'I didn't need counselling – I wasn't bothered by my decision... it still worries me somewhat with the NICE guidance that the whole idea of counselling is to counsel you to the correct choice.'

'I'm not entirely sure that they are best placed to be dictating policy which at the end of the day is based on an ideology.'

Sarah's story resists dominant narratives that portray women as not wanting interventions and deferring to professional knowledge:

'I should have seen an obstetrician not a consultant midwife... she's just a super expert in the normal and I was actively choosing to deviate from the natural.'

She shows where there are conflicting messages and alludes to there being a conspiracy of silence particularly against information which doesn't support current maternity policy to promote normal birth:

'Given that everyone bangs on about how it is major abdominal surgery but hey we want you walking, we want you carrying trays, we want you carrying your baby – but it's major abdominal surgery and I think this dissonance in the message.'

'Perhaps there is a role for surgical nurses on postnatal wards that nobody wants to you know acknowledge.'

'If you don't get a normal, straight forward vaginal delivery, actually your outcomes can be far worse um and it's those outcomes which are never talked about.'

'Nobody talks about the risks of a vaginal delivery... you almost felt that you were being difficult for raising risks that nobody wanted to talk about.'

'I sometimes wonder if the risks of [surgery] are played up.'

Her challenge is not only confined to the health service and its policies, she also challenges discourses that advocate normal birth and highlights that gender issues influence childbirth discourses:

'Because it's pregnancy... I don't know whether it's because people feel that they've fought against medicalisation in the 60s and 70s that people like me who want medicalisation are some sort of betrayal of the sisterhood or something bizarre like that.'

'Signing up to a misogynistic agenda and this assumption that you only want a Caesarean section because you don't want to damage your vagina because you want to be as tight as you were when you were 16 is like, actually, I'm far more concerned about whether I can still hold my bladder up when I'm 65.'

Sarah described herself as being in a minority and 'deviant'. She challenges constructs surrounding choice in maternity care:

'All this rhetoric about choice - where's my choice? ...basically you can have any delivery you like as long as it's vaginal but we'll allow you to choose the venue!'

'I felt very comfortable with my choice, I didn't need somebody else saying, yes but this one's so much better!'

'I just don't understand what motivates other people who wouldn't chose it for themselves to decide because they wouldn't chose it for themselves it shouldn't be a choice available to anybody either and that was very much the tone of the of the discourse... and as surgery gets safer then why should people be denied it?'

Sarah was at ease with and reassured by technology but she also had a political awareness of the ideologies that were driving maternity policy:

'It's very much a natural delivery area around here, very much the whole ethos and which is great if that's what you want but at the end of the day it's not an evidence based commissioning policy, it's an ideological based commissioning policy.'

Eventually, she realises that she can't work within the system and she opts out by '*going private*'.

Sarah's birth choice is focussed on outcome and having a positive outcome rather than a desire for wish for a particular experience:

'Was for the baby to be got out safely...as safely as I could. So all the frills around it was not really important.'

'It was just a really positive experience but to me the delivery was never important in a sort of rite of passage sense it was much more about how do I – what can I do to ensure that we both of us come of out this with the minimal risk to ourselves.'

Throughout her story Sarah challenges the dominant narratives and ideologies, authoritative knowledge and normative practices. However she is only able to exercise her resistance by opting

out of the state system and opting for private healthcare. Ultimately, her ability to pay for private care enables her to obtain the experience she wants.

Abby

When Abby is told by her GP that she is going to have a large baby she opts to have a scan privately. She was keen to point out that she didn't disbelieve her GP but that she wanted to have more information:

'I felt like I wanted to know what the facts were...not that I didn't believe her.'

Abby shows that in addition to authoritative knowledge from professionals within maternity services, women have access to information about pregnancy and birth through the media and from listening to other women's experiences. In particular, she talks of the television programme *One Born Every Minute*, a programme which presents edited sequences of women's birth experiences within a maternity service. She initially reflects that it is possible to disassociate from this experience:

'A lot of people in my NCT [antenatal group] watched it – probably in a different way in a much more – oh my god this is going to happen to me whereas I just watch it and think...yes this might happen to me but I probably won't deal with it like that.'

When faced with the experiences of women she knows, this is more difficult. She reflects that although other women 'try and be *really* helpful' by sharing their birth experiences it is difficult to be detached and logical about the portrayed risks of childbirth and the need for medicalisation. There is also the implication that most of the stories other women share of negative experiences:

'When it's you and it's your baby you sort of walk over that threshold and you become much more emotional...[you] try to take with you the good stuff and to leave the not so helpful stuff behind and I don't always think that's possible.'

When Abby knows that she will have a planned Caesarean she takes control by planning how she will personalise her experience:

'So I planned. So all of that stuff – oh take your ipod in – Neil Diamond...'

Abby was very aware of the staff resources available to her which she felt contributed to her positive experience in theatre:

'I wonder if that's because it's a procedure that requires a theatre nurse and a midwife and a surgeon so you can't scrimp on that, you have to have all those numbers – and you can't not have those people there.'

She confounds the view that technological birth is unemotional compared to normal birth and relationships are different formed:

'[I] felt like we'd made friends... I suppose it's the – what I imagined the bond that you would create with a midwife if you had a normal delivery that's what I imagine you know people say you remember these women for the rest of your life because they were there.'

She tells of the impact of becoming a mother for her: *'it was probably one of the biggest days of my life'* and how becoming a mother fits within her life:

'I've wanted to be a mum all my life I suppose so I'm just really excited really enjoying it... Enjoying not working...Just enjoying being a family and all that brings...I'm just actually really enjoying doing something different and actually being challenged in different ways.'

She reflects that there is a loss of compassion in healthcare (despite it being driven at policy level) and believes that this is something that cannot be taught:

'You know David Cameron says, you know, people need to you know remember why they've become a nurse'... you know, it's the sort of skills that I don't – that lots of people don't necessarily learn they just have them.'

Abby shows that she believes that while she is in hospital that she is expected to play a particular role. She opts to resist this and cites her customer/consumer status:

'I suppose that might just be my character that I felt like I was bothering them and that maybe I should just roll over and go to sleep but I didn't because I was like actually, no, I pay my taxes!'

Abby describes how she handed over responsibility for her autonomy: *'[during] the operation you are so looked after that you hand over all that responsibility'* but that when she becomes a

mother she is expected to be responsible for her child as well as herself: *'you are then taking responsibility for this new life'* which *'is a bit more daunting'*.

Abby doesn't resist authoritative knowledge but she shows that she is able to seek to increase her own knowledge in order to actively engage in decisions about her care. In terms of Ideologies of motherhood, Abby shows how her sense of self has changed and that now that she is a mother her priorities are different, and that when she resists these feelings, she feels guilty:

'I just feel like where I need to be right now with her is at home...and just being nice sort of quiet time getting to know her just feels like the right thing to do'

'When I'm out and about I think why am I out? Am I out for her or am I out for me? Cos I want to catch up with...people and then I - it is that sort of slight guilty feeling when you think you know what I'm not out for you (baby's name) am I out because I want to go out for a coffee.'

Sally

Sally starts by telling us of her interaction with her GP who tries to persuade her not to continue with the pregnancy because she has medical conditions. From this we learn that she had *'always wanted to be a mother'* even if she *'didn't even know she was pregnant'* and that she is prepared to act against medical advice to fulfil this wish. It also suggests that there are ideals of who should and who shouldn't chose to become mothers and that Sally resists this:

'I went to my GP and he was like ooh no, this is really high risk, I don't advise you to go forward and I decided that actually I was going to go forward and cos that was something you know that I'd always wanted so yes I had a pregnancy where I was very closely monitored.'

Sally's narrative challenges the portrayal of vaginal birth as an important physical act necessary to her emotional experience of becoming a mother: *for me [it was] a relief really...to know that...we were just going to go and get it over and done with.'*

Sally was separated from her baby who was on the Special Care baby Unit (SCBU). Through Sally's narrative of this we learn how important developing a relationship with her baby was to her and how being separated from her baby disrupted this:

'You don't actually feel that they're yours... well actually, she wasn't there.'

Sally reflects the extent of the desire for a mother to care for her baby when she describes women the *'next day looking half dead being wheeled down in wheel chairs'* to SCBU. But she challenges the belief of staff that women don't feel post-operative pain because they are absorbed in caring for their baby *'and everyone was like oh it won't hurt and you'll have a baby afterwards and I was like how does the baby make any difference.'*

She demonstrates that vaginal birth is the dominant ideology and that staff pay less attention to Caesarean birth and don't invest it with the level of emotion attached to vaginal birth:

'They don't really talk about it [Caesarean] that much. Having been on the ward and heard the whole discussion that people have...with you about having a Caesarean it's well you just go in there – you have it – it will be fine, and then we'll get you up the next day.'

When Sally was seeking information about what she might expect she found it difficult to get the information she wanted. She was given procedural and practical information: when *'you have a catheter put in – you can have it in theatre or you can have it on the ward... and 'My midwife said to me about having like big pants'* but information from staff about more emotional elements was missing: *'there wasn't that much about how to kind of hold her.'*

Sally resists the ideology that vaginal birth is a necessary pre-requisite for bonding with your baby, rather she sees it as a physical process to get through/get over before building a relationship with her baby. Her focus is on close physical contact with her baby immediately after birth and she believes that skin to skin contact is a pre-requisite for successful breastfeeding. Sally portrays herself as an expert in her own health and knowledge of her body's strengths and limitations but she depicts childbirth as a time of vulnerability despite involvement in discussions with the medical team. Sally wishes that she had acted differently in her acceptance of not having skin to skin contact and her key message is that women should be listened to and their views and wishes respected as these experiences are held as memories.

Kirsten

Kirsten starts her story by saying that her pregnancy was realised through in vitro fertilization (IVF) and it is possible that this also had an impact on Kirsten's desire to seek a surgical birth. The increased numbers of women who seek and or conceive pregnancies through IVF challenges dominant narratives that present pregnancy as inevitable rather than individually sought or arrived at through reproductive technologies.

Kirsten's story tells us that women are more able to request Caesarean birth than before but that there is a process of selection and hurdles to overcome to have access to this (*'jumping through hoops'*). She indicates that these hoops are tacit but known to people using and working in maternity services. She demonstrates that if you are more articulate in discussion with health care professionals and you research the topic you are more likely to be able to get what you want. She implies that current data on risks to mother and baby are being used by clinicians to effect a certain outcome i.e. avoidance of planned Caesarean birth. She shows that she is prepared to challenge the knowledge of these professionals and that she is knowledgeable about both the evidence base and the policy that directs maternity care within the NHS.

Kirsten does demonstrate some of the *good mother* ideals of sacrifice. She sees Caesarean birth as a necessary sacrifice for having a birth that she perceives poses less risk to her baby, even though it might pose some risks for her:

'I think the main concern for everything is ... the sort of health of the child really and perhaps the mother as well I mean you don't want to be bleeding to death.'

She wanted to emphasise to me that she was breastfeeding (there was a bottle of milk on the table during her interview) but that she is expressing breast milk so that her partner could also be involved in feeding their baby. She described how she didn't look after herself and skipping meals or having a snickers bar because she is busy feeding and caring for her baby:

'When I did come home I found that I didn't have time to eat cos I was like too busy looking after the little one.'

She reflects that despite having surgery she doesn't like *'playing the victim'* and she copes with post-operative pain in order to care for her baby.

In particular she notes the ideal of breastfeeding but she says that there is a lack of support for this and she describes the impact this lack of support. She implies that the services provided and the expectations of those who promote breastfeeding can be damaging *'you could really fall into a deep hole'*.

Central to her story is that society (and healthcare professionals) judge whether or not you are a good mother by looking at your birth and feeding choices and she feels that there is a prejudice against Caesarean birth:

'I think there's some sort of ...stigma attached to it [Caesarean] that women think that it is more heroic to struggle for fifty hours um you know obviously then they are a much better mother than someone who elects to go for a Caesarean...There seems to be a lot of er prejudice against Caesarean that it's terrible to have - out there... '

'So I was more anxious that you know er there was something um going to happen during the birth which might erm lead to some sort of disability or whatever so er that was my main concern why I wanted a Caesarean not because I was worried about not wanting to push or that sort of thing.'

She was anxious that she might be treated differently because of her beliefs and choices about birth. In the end Kirsten resorts to fabricating a reason why she is having a Caesarean:

'I have to admit it I was probably not that honest with people about the Caesarean and my reasons for it ... in the end I just said I had a low lying placenta and nobody argued with me.'

The message here is that having a Caesarean is morally acceptable as long as it is for medical reasons.

Kirsten resists natural birth as a construction of good mothering (in reference to women coping with pain of labour) and instead offers Caesarean as the heroic option:

'The main thing was that he was OK ...I was willing to take that risk and also the sort of mm the sacrifice...to go through that.'

'I know it's a risk with er a c C section but I think it was one worth taking...I mean people donate kidneys for their children don't they? And nobody questions that sort of thing.'

In terms of the *good mother* ideal, Kirsten spoke of how she was still able to bond with her baby despite having a surgical birth:

'I didn't feel like I was restricted and couldn't really bond with the child and I felt all that was a lot of rubbish you know I didn't feel that I you know the delay during the birth when he was being checked out following the c section I mean that was maybe 5 minutes (upward inflexion) until he was on me – I didn't really feel that was stopping the bonding process at all so it all depends I think how you're attitude is towards the whole experience.'

Lisa

Lisa starts her story by declaring that it was not her intention to '*go anywhere near a Caesarean*' as she planned to have a home birth. Lisa hopes to have a positive birth experience and to feel that she is proud of herself and that she has given her baby the best start in life. She feels that this will be achieved by having a home birth and she puts considerable investment (education and preparation) to ensure that this will happen:

'I'd read, um you know Ina May Gaskin; Sarah Buckley and you know birth without violence – I went to home birth NCT groups and I was really excited about home birth.'

Lisa also realises that she is different from her friends but that she wants to be part of something that is a shared (and historical) experience with women:

'I was just really excited er you know (quieter) despite my friends thinking I was a bit crazy for wanting to have the experience of a natural birth you know and er having the same experience as millions of women throughout the centuries.'

Lisa clearly described her wishes for her birth experience and her motivations for why she wanted that experience (good start for her baby, personal growth for her, wanting to feel proud of herself). She also showed what is at stake if she didn't get this by describing the extent of her

fears by connecting these fears to a previous experience. She shows how far she was prepared to go to try to get the right experience by trying lots of therapies and strategies and spending money on specialist services:

'I tried everything! (laugh) you know. So I had two session of hypnosis, where the hypnotist talked to my baby (laugh) to turn it – and I paid them lots of money for that! (laugh)'

Lisa's story tells of the conflict and a disconnection between her expectations of birth and how she would cope with it and the situation she found herself in. Lisa wanted to feel proud of herself and she initially believes that this is solely achieved through vaginal birth. She tells of how she came to the realisation she could reframe her aspirations to feeling proud about the ways she dealt with the circumstances she found herself in:

'And you can be proud of yourself which I did and so you know it's it's all turned out for the best (laugh) and I had that two and a half weeks over Easter that I wouldn't have had a with a natural homebirth.'

She described her experience as positive, individual and unique, characteristics that are usually aspirations (and outcomes) of vaginal birth. In contrast to opinion papers which suggest that women are actively choosing Caesarean birth, Lisa describes the lengths she went to in order to avoid a Caesarean birth and the fears she had to overcome. Lisa is restricted in her options by nature of her having a breech presentation. The default response to this from the obstetricians is that this necessitates a Caesarean birth. A midwife does talk through the option of a vaginal breech birth but Lisa considers that she is not prepared to take the risk of complications. She bases this decision on her knowledge of a friend's birth where the baby died and the '*midwife's face*'.

Lisa is able to explore some alternatives by purchasing specialist support (hypnotherapy, moxibustion, etc.). She also takes an active role in trying to affect a different outcome. She does this through seeking and acquiring more knowledge about practices that could help the baby to turn. Lisa is able to negotiate elements of her Caesarean birth. She visits the hospital to familiarise herself with the environment and engages staff in following her birth plan. Her parents are able to visit her in recovery.

Several dominant narratives are embedded in Lisa's story. Lisa's story demonstrates aspects of ideologies of good mothering through the sacrifices she makes for the benefit of her baby. She plans a natural home birth to *'give her baby the best start'* and when vaginal birth appears unlikely she goes to extraordinary lengths to try to make it happen. Ultimately, she has to face her fears of hospitals and surgery for the safety of her baby. Initially, birth is portrayed as being the most important part of the mothering experience (rather than time after the birth). This changes when her circumstances change. She also demonstrates that financial power provides access to additional options even though ultimately she is unable to affect the experience Lisa wants and she feels that she wasted this money:

'I spent all that money on all those treatments, you know. Maybe I wish I'd not spent too much money on that and actually...I could do something else with the baby that's special, like doing the little dippers and teaching him to swim or something.'

She also comments that the literature available to women reinforces dominant ideologies of vaginal birth and notions of choice in childbirth:

'I think I read too much - a lot of negative things about Caesareans and how you are not doing the best for your baby but actually sometimes there is no choice and because I had all the kind of legacy of the books that were downplaying Caesareans... it made me feel really bad that I wasn't doing the best for him.'

A relatively small number of women currently choose a home birth so Lisa was already resisting dominant ideologies of childbirth which have until recently portrayed home birth in a first pregnancy as risky (Birthplace in England Group 2011). Lisa resisted the suggestion that she would need a Caesarean and she actively tried alternative strategies to help her baby turn. For some of these therapies Lisa opted to purchase the services privately rather than accept what was being offered in the NHS. Ultimately Lisa accepted the need for a Caesarean birth rather than opting for a vaginal breech birth.

Counter-narratives, stories of resistance and the reflexive self

There is growing interest in narrative research in stories of childbirth and motherhood because childbearing is uniquely positioned at the interface between the biological and the social self and because motherhood reflects a self in transition - a time of biographical disruption (Miller, 2005). Throughout this chapter I have presented elements of the individual stories told to me and used these stories to extract meaning in the light of ideologies of pregnancy and birth, motherhood and maternity practices. Now I turn to explore *how and why individuals select certain experiences to be included in the stories they tell about themselves... and on what basis are other experiences excluded or only partially rendered?* (Andrews, 2004, p.24).

Arthur Frank's (1997) powerful writing on illness narratives and how '*those truly living in chaos cannot tell in words*' (p. 98) and Kim Etherington's (2003) stories of physical (bodily) expressions of childhood trauma and subsequent transformation, reflect the interest of narrative theorists of *what can and cannot be (re)told in stories*. In Chapter 7, I offered a possible interpretation of expressions of fatalism as a narrative of distress – a culturally acceptable script available to childbearing women in which to express distress in times of greatest challenge when faced with constrained choices (Drew and Schoenburg, 2011). Tina Miller (2005) argues that powerful ideologies both shape expectations and render experiences which do not conform to some idealised notion of motherhood difficult to make sense of, to confront and to voice. Women strategically construct and voice their narratives drawing on cultural and social knowledge that constitute master narratives. These master narratives offer individuals a way of identifying what is assumed to be a normative experience (Andrews, 2004) and women are likely to present a particular version of themselves in ways which are culturally patterned (Miller, 2005). However, when an individual finds that their experiences do not fit with existing narratives she may produce a counter narrative - as a crucial strategy when her identity is not expressed in the dominant ones (Somers, 1994).

My position is that whether or not a narrative should be considered to be a counter narrative is ultimately a consideration of multiple layers of positioning, as my narrative approach reflects a relational ontology rather than a singular, fixed subjectivity. Some authors argue that exactly how one positions oneself in relation to dominant cultural narratives may vary from person to person but that all of us create our narratives from the 'toolkit' (Bruner, 1987) which is culturally available to us (Andrews, 2007). However, Riessman (2004) extends the possibility of responses to dominant ideologies:

'Despite the power of cultural plots, we do not simply follow them in re-storying our lives over time. We interpret past experiences in composing lives in the present that adapt to, resist and sometimes reach beyond the master narratives of dominant cultural institutions'

(Riessman, 2004, p.33).

Importantly, the meaning of counter narrative and their relationship to master or dominant narratives suggests positioning tensions between categories. Ultimately, though, what is dominant and what is resistant are shifting placements and relational categories (Andrews, 2004).

If story telling provides us with an identity, a sense of existing through time and of acting purposively in the world, then producing meaningful accounts for self and others will reflect the complexities, coherences and contradictions of a relational, reflexive self:

'Thus the subject is the site of competing and conflicting forms of embodied subjectivity privately experienced, but which are relationally and collectively lived.'

(Aranda, Zeeman and Scholes 2012, p.554).

Self is inextricable from relationships with others and cultures we live in and stories are *subjective* in both senses of the word. Stories tell of an individual *self* in a particular setting *and* they are constructed by that individual. Importantly, this individual self is never singular and fixed but exists and responds in relation to others. Stories, therefore, tell of an embodied self who is also worldly and relational, where subjectivities are fluid and constituted and constructed: *'The story is one's identity, a story created, told, revised and retold throughout life'* (Lieblich et al, 1998 p.7).

Exploring subjectivity and the meanings attributed by individuals to their actions through narrative research can help us understand social life and practices. Personal narratives can provide a rich basis from which to explore social and political identities as:

'Critically what an individual or a community choose to tell about themselves is intrinsically tied to how they construct their political identities.'

(Andrews, 2007, p.11).

While listening to and analysing these stories I have thought about questions of positioning both in terms of the narrator's relational ontology and mine: *Why do people tell? Are we more sensitised to some stories than others? What are our responsibilities when listening to and retelling stories?*

There is an assumption built into many data analysis methods that the researcher, the method and the data are separate entities rather than reflexively interdependent and interconnected (Mauthner and Docuet, 2003). However in line with the Listening Guide methodology I am aware that I am also an embodied, situated and subjective self (selves) in relation to these stories and how I interpret them. The reader response elements of the Listening Guide method require me to listen to how I am responding emotionally and intellectually to this person (Mauthner and Doucet, 2003).

Andrews argues that as researchers '*we privilege our own ability to know the meaning of someone else's life and rarely question the harmful effects our work may inadvertently cause*' (Andrews, 2007 p.42). I have attempted to act ethically throughout my research, by making plain the decisions I have made and by considering alternatives to my interpretations. I have repeatedly reflected on whether these eight women would reject or accept the interpretive framework that I have offered to make sense of their experiences. However, my position is that narratives are inherently meaningful precisely because '*a dialogic approach between speaker and listener/investigator depends upon a recognition of the inevitable tension between different locations and perspectives*' (Andrews, 2014, p.10).

Narrative researchers see their role as assisting others to articulate their narrative identities (Andrews 2007): '*We listen to the stories they tell and from this try to make sense of them and the world they inhabit*' (Andrews, 2007 p.42). Narrative methodologies have often been chosen to research those others who are disenfranchised and/or socially marginalised as '*many believe that their work 'gives a voice to'*' (Andrews, 2007 p.40) those who views or experiences are usually excluded. But as Riessman (1993) argues, *we cannot give voice, but we can hear voices that we record and interpret* (Riessman 1993, p.8).

There is increasing interest in how narrative researchers present their data and findings. The use of first person data is a strategy that is commonly used, but Andrews argues that this technique may mask inequalities rather than address them as research participants may appear to be speaking for themselves rather than as people in response to specific questions (Andrews, 2007). In addition she argues that the '*questions which guide our research originate from deep within*

ourselves- are personally invested despite appearance of professional detachment' (Andrews, 2007, p.27).

My interest has been to see how the women in my study view struggles to get what they want, how they attempted to resolve these struggles and how they located themselves within this process. The stories here are derived from a frozen moment at a critical time of change in the lives of women who are becoming mothers through a planned Caesarean birth. My study is not a longitudinal study of the transition to motherhood. With the exception of Jo, whose baby was almost a year old when I met with her, the stories were told to me in the first eight weeks after birth. Therefore, I am not able to examine how experiences evolved over time. But returning to the concept of storytelling as *a propositional* (intentional) act (Ricoeur, 1990), I can consider why each woman might want to tell her story to me, in the way she did, even though I recognise the inevitable tension between our locations.

I believe that for all of the women there was a level of altruism that led them to accept me into their homes and give up their time to speak to me. In addition, Jo, Sarah, Abby and Kirsten voiced that they had been involved in undertaking research themselves and they were likely to be aware of the anxiety and stress that researchers feel when trying to identify and recruit willing participants. However, I do not feel that altruism was the only factor but that each woman wanted to share some element of their experience and convey something of that experience that I might previously have not been aware.

When I listened to each of the stories I experienced an emotional and intellectual response to what they were saying, the impact of which was meaningful to me. From Charlene and Jo I felt I became more aware of the depth of the emotional impact of key interventions and practices within maternity services. From Jo I began to appreciate the impact (and disruption) that a childbirth experience could have on how you see yourself. I heard how the situations she found herself in were unanticipated and that she was shocked at how she was or wasn't able to respond in a way that was familiar to her sense of who she was in other areas of her life. I felt that Sarah, Monika and Kirsten's stories were more politicised than the others. Sarah's story felt like a speech, through which she convincingly challenged and drew attention to the dominant cultural scripts by providing a coherent alternative viewpoint. Monika spoke of her choice to have one child so that she could give her the best in life and of a life beyond being a mother. Kirsten told of the politicised nature of childbirth and a prejudice against planned Caesarean birth. She highlighted the conflict between ideologies and policies which advocate an ability for women to take part in decisions about their care and choose particular options but only if it is the 'right' choice. She

described how clinicians were aware of and worked within this context and how she was able to challenge and use authoritative knowledge to her advantage. Sally had a strong desire to have skin to skin with her baby immediately after birth and was not able to achieve this, I felt that in telling her story she was able to rehearse what she would do 'next time' as a way of redressing what she didn't get first time around. Abby spoke of the huge amounts of often conflicting information and knowledge she was exposed to and the challenge of sifting the information to keep a *presence of mind* to process and deal with it. Lisa told how she had a different journey to the one that she planned but how, with the right support, she was able to personalise and have a positive experience.

In answering this research question, I have not so much captured women's experiences as used them to produce an account of planned Caesarean birth in relation to dominant narratives of childbirth and motherhood. While I have made attempts to reflect my positioning I am not attempting to distance myself from the part I have played in this *retelling*. I believe that, inevitably, our accounts are relationally experienced, interdependent, partial and perspectival. I also believe that this account of the eight stories also challenges some of the essentialist notions of interview encounter and the privileged position of the researcher. In the interview with Charlene I noted in my journal that she wished to 'take charge' and direct the interview, she clearly knew what she wanted to tell me and how she planned to do it- '*I'll tell you about that later*'. I felt that she, for the most part, led the interview. Sally asked me more questions than I posed to her - about what other women had said and about what I wanted to find out. Sarah told me that she had 'googled' me and Abby also audio recorded our interview to have a record of our encounter. All of the women knew I was a midwife, none of them asked if I was a mother which I took to mean that it was not of particular significance to them.

I am aware that I swept into these women's lives, briefly; I listened to their story and left them with the promise of a summary of my research in due course. This was our contractual arrangement, endorsed by a research ethics committee, designed to be manageable for the student researcher and not burdensome to the participant. However I am also aware that, with the growth of social media, my whole thesis is likely to be available to those with the technical skills to access it and that it may be possible for individuals to contact me in the future, to agree with or challenge my account.

Ultimately, these eight stories and my account of them are a cultural product as:

'We understand, live and recount our lives to others in ways which are culturally accessible not only to others but to ourselves. Even while we resist certain frameworks of meaning as we spin the tales we tell, we cannot help but weave our stories in relation to those very frameworks.'

(Andrews, 2007, p.53).

Dominant cultural scripts in relation to pregnancy and childbearing were discernible in the stories told to me as were some elements of resistance against dominant ideologies. The women in my study told of circumstances in which they accepted or resisted dominant ideologies and they were differently and unequally realised. Normative practices which were in conflict with ways of knowing grounded in subjective, embodied experiences contributed to difficulties in making sense of a shifting sense of self. In particular Jo and Sally were given breastfeeding regimes for their babies which were demanding and impractical. However there was also some evidence of challenge to authoritative knowledge particularly in how additional information or expertise was obtained. For Lisa seeking out 'expert' assistance led her to a specialist in alternative therapies. And many of the women relied on social networking or friends experience for their sources of knowledge about childbirth and mothering even when they recognised that this was not always helpful and that the information, while readily available, might be skewed. Expectations that women will continue to have babies affected attitudes to risk. Kirsten didn't plan to have another child and felt that the risks were not adjusted accordingly. Lisa noted that the most literature focussed on preparing for birth rather than preparing for parenthood and said that she had been swayed by all the negative things that were written about Caesarean birth and pointed out that *'sometimes there is no choice'* whether or not to have a Caesarean.

All of the women in my study voiced or alluded to the moral context of motherhood, in particular Charlene, Jo, Sarah and Kirsten spoke of issues of stigma and prejudice. Many of the women expressed surprise at the amount of opinion they received from other people either directly or on social networking sites. This was usually directed at the choices women were prepared to make. Both Charlene and Kirsten were unhappy telling people why they were going to have a Caesarean and Kirsten resorted to fabricating a reason to reduce the prejudice.

The danger of the single story

Master narratives tend to presume a universality which can override individual experience and fail to accommodate the diversity that exists in experiences of mothering (Coombes and Morgan, 2004; Miller, 2005). Dominant narratives have the ability not just to tell the story of another person but to make it the definitive story of that person (Adichie, 2009). When I returned to the literature on experience of Caesarean birth, I found it hard to find narratives that expressed women's experiences beyond feeling *forgotten, redundant, fearful, rescued* or being indicative of them making poor health decisions. I was keen to reflect the varied responses the women in my study had to their planned Caesarean birth, as I did not want there to be a *single* (uniform) story of planned Caesarean birth. A powerful talk by the writer Chimamanda Ngozi Adichie, when talking of her Nigerian heritage, warns of the danger of the *single* story:

'All these stories make me who I am but to insist on only the negative stories is to flatten my experience and overlook the many other stories that formed me. The single story creates stereotypes. The problem with stereotypes is not that they are untrue but that they are incomplete. They make one story become the only story.'

Adichie (2009).

From my readings of eight stories I found that women do not experience pregnancy, birth and motherhood uniformly and this research extends the possible storylines that are available to women. Just as birth and motherhood are uniquely experienced, dominant ideologies will shift over time (Bamberg and Andrews 2004) and have dimensions to them that may fit with or contradict individual experience (Miller 2005). Extending the limited repertoire of personal narratives may provide an opportunity to build more collaborative and inclusive models of (authoritative) knowledge that take into account embodied, experiential ways of knowing.

Conclusion

The ways in which narratives are constructed and contextualised and their apparent omissions, incoherencies or chaotic dimensions enable us to understand the meanings individuals give to actions and identities. The mothers in my study did not simply either reject or embrace cultural ideals of pregnancy, birth and motherhood. At the start of the pregnancy, individual women

accepted vaginal birth as natural and something all women should experience (Charlene, Jo, Lisa) while others rejected this in favour of the technology of surgical birth (Monika, Sarah, Kirsten). Women's experiences were unique, varied and often conflicting. Women spoke of feeling vulnerable in the hospital environment (Charlene, Jo, Sally) but also challenged authoritative forms of knowledge by getting second opinions (Sarah, Abby) and seeking complementary therapies (Lisa). Sometimes this was achieved by exercising their material (financial) resources to opt out of the NHS system (Sarah, Kirsten, Abby, Lisa). In particular the women showed an awareness of the ideologies directing pregnancy and birth policy and, in some cases that this drove how resources were allocated. Motherhood was portrayed variously as requiring hard work and sacrifice and as rewarding. Abby voiced that she felt fulfilled and was enjoying staying at home to take on the new responsibilities of motherhood, whereas Monika was keen to return to paid work. Most of the women's stories articulated ideologies of good mothering, for instance breastfeeding, but in some cases they highlighted a lack of support for these ideals.

Becoming a mother is a biological and a social event. There are different and sometimes competing cultural scripts that shape ways of knowing about reproduction and childbirth in cultures. The contexts in which women live their lives as mothers are socially constructed, historically specific and culturally varied. Attending to the stories presented here has helped me to better understand the times in which I live and practise as a midwife and at the same time gain a deeper appreciation of individual's lives by exploring the broader social and political frameworks which lend them meaning.

9. What can we learn from women who have their first baby by a planned Caesarean?

'We all know, with reference to our own lives, the curious ways in which truth can be not so much distorted as multi-faceted. Give the kaleidoscope a shake and a different picture forms. Each of us sees through a glass darkly, impeded not just by the frailties of memory but by our own convictions. We see what we persuade ourselves that we have seen.'

Penelope Lively (1984) *According to Mark*, p. 206, Penguin Modern Classics.

Introduction

In this chapter, I pull together the narrative and conceptual thread of my thesis to provide evidence of the contribution this research will have to new knowledge about planned Caesarean birth. My contributions to the production of knowledge can be located within three broad areas: Caesarean birth experience, narratives of childbirth and motherhood (including discourses of fear and self-efficacy), and narrative methodology and methods.

In the following sections I provide an overview of the study and critically and reflexively analyse my contribution to what we can learn from women's stories of planned Caesarean birth in their first pregnancy, both in terms of the emerging narratives and in the context of the possibilities of narrative research. I also suggest areas for further research. Finally, I share my learning and the impact this research has had on me and my thoughts for the future.

Overview of the study

Context (see Chapters 1 and 2)

This research was carried out in England between June 2011 and May 2012, against a background of rising Caesarean section rates. At the time, this rise was perceived as problematic by women, clinicians and policy makers, and the literature revealed discourses about what an acceptable rate should be, why rates were rising and what should be done about it. This debate was evident in professional and research literature as well as social media but there was little empirical evidence of women's experience of Caesarean birth to contribute to this discussion.

My research interest stemmed from my realisation that, in the absence of evidence of women's experience of planned Caesarean birth, opinion papers dominated the debate, and women's experiences were either absent or perceived as universally realised. Despite evidence that maternal request Caesarean births had little impact on rising rates, they have continued to dominate the discourses.

Research purpose (see Chapters 2 and 3)

My aim was to reveal how planned Caesarean birth was experienced, understood and constructed by women having their first baby. My growing interest in feminist narrative research into pregnancy, birth and motherhood also made me appreciate how the lack of empirical research of women's experience of planned Caesarean birth limits the repertoire of narratives available for women to draw on and perpetuates the dominant narratives of pregnancy and birth. This gap means that stories of women's experience do not inform professional knowledge or maternity service improvement programmes and policy initiatives.

I focussed specifically on three research questions:

1. What meaning do women give to their experiences of planned Caesarean birth? (see chapter 6).
2. What phenomena appear in women's stories of birth by planned Caesarean? (see chapter 7).
3. How does a woman's personal story of birth by planned Caesarean (in her first pregnancy) relate to dominant narratives of pregnancy, birth and motherhood? (see chapter 8).

I believe that these questions were well suited to my research purpose and that they have yielded rich, individual narratives of personal experience. The questions I posed cannot be divorced from the narrative approach that I took, and the degree to which I could answer these questions satisfactorily using a narrative approach will be explored later (see section - Research design).

I also included a fourth question: *what can we learn from women who have their first baby by planned Caesarean?* as praxis (reflection and action) (Friere [1968] 1996, Lutz et al 1997) . In this context, praxis is '*the synchronous conjoining of thinking and doing, it is the moral imperative to move beyond thinking or theorising to an energised achieving or attaining,*' (Lutz et al 1996, p. 24). My objective with this question was informed by my desire to act ethically in my research - for it to 'do' something. This was compounded by my background in working in healthcare improvement and made me hope that I could write my analysis as a narrative *call to action* that

could translate into practice (or policy). I think this aim was ambitious and it is difficult for me to ascertain at this stage whether or not it could be successful. However, I believe that it is reasonable for me to think that some of what I have written here has the potential for revision and redistribution in future stories (see section later in chapter– Dissemination techniques – moving from personal to public narrative).

Research boundaries (Chapter 4)

This research related to women who were first time mothers, who had their baby by a planned Caesarean operation. Women who had an emergency Caesarean or women who were booked to have a planned Caesarean but who went into labour were not part of the study. Both women who hoped for a planned Caesarean birth and women who hoped for a vaginal birth, but who had a planned Caesarean, were included in the study. The experiences of partners or staff were not part of the study. My study focussed on personal narratives (first-hand accounts) which excluded women who were not comfortable in telling their story in English. Excluding non-English speaking participants inevitably reduced the range of possible narrative responses in my study and additional research in this area is warranted. The study looked at single narratives within a year of the planned Caesarean birth, therefore I was not able to explore how experience of planned Caesarean changed over time. I do not think that this is a particular weakness in my study and I see one of the strengths of my study is that I have been clear that my analysis has been on the story *told* rather than an analysis of someone's direct experience or an accurate account of their unfolding life story.

Findings and contribution to knowledge (see Chapters 6, 7 and 8)

This work provides new insight into how women experience, understand and construct planned Caesarean birth in their first pregnancy. It also confirms other theoretical and empirical studies. This research can provide a resource for professional knowledge and also has the potential to contribute to maternity service improvement strategies, by providing a better understanding of how women negotiated to improve their experience and by having a greater depth of knowledge with which to provide women with information to prepare for a planned Caesarean. The findings can be located within three broad areas: *Caesarean birth experience, narratives of childbirth and motherhood* and *narrative methodology and methods*:

Caesarean birth experience

One of my critiques of the current literature was that it was not possible to build a picture of planned Caesarean birth from the existing accounts of experience (see Chapter 2) and that having a planned Caesarean birth was perceived to be a binary concept of either wished for/medically indicated.

The emerging narratives from my study offer an insight into the complexity and range of women's experiences of planned Caesarean birth. The eight individual stories provide evidence that the current accounts of planned Caesarean birth experience are limiting. They offer alternative perspectives and extend the limited repertoire of narratives available to mothers experiencing a planned Caesarean birth. They offer a richer and deeper knowledge base from which to both prepare women for this experience and to plan services to provide women with a positive experience.

I locate my findings against previously published research and theory: Weaver et al's study (2007) found that no women requested Caesarean section in the absence of, what she herself considered to be clinical or psychological indications (see chapter 2). The reasons behind Monika, Sarah and Kirsten's requests for a Caesarean appeared to be either a concern for themselves or their baby, coupled with the belief that Caesarean section was safest for their baby. Unlike Porter, van Teijlingen et al's study (2007) where anaesthesia was the single factor that caused women most distress, the women in my study described their experience with the anaesthetist as positive, particularly in respect of emotional support. This was also found to be the case in Sara Bayes' study of Western Australian women who had an elective Caesarean for medical reasons. However, unlike Sara's study, women in my study did not necessarily expect that birth would be '*spontaneous, vaginal and a positive life experience.*' (Bayes, 2010, p.157). Sara's study described how women faced a core problem of *being made redundant* (Bayes, 2010). This was not a particular feature of the stories from my study but Sally reported that she '*just sat there*' while waiting for her baby to be checked by the Paediatrician and Jo stated that she '*just lay down in a room and then they handed me a baby.*' Though the fact that she adds '*it couldn't have been easier*' implies that this was not a difficult experience. However, Lisa did describe how during the Caesarean she actively disassociated herself with what was happening, which was a dominant feature of Sara's findings. Being *written off* as not *real* women or *real* mothers by midwives,

doctors, theatre staff, partners, friends and family (Bayes, personal correspondence, July 2008) did appear to be a factor for Charlene, Jo and Kirsten.

The discrepancy between staff perceptions of birth as 'routine' compared to the women's experiences of it as a deeply personal and unique event were also described in Sara's study as '*Caesarean section is hospital not women's business*,' however for all the women in my study, except Sally, the experience in theatre was the most positive part of their experience and it was the relationships with staff in pregnancy or postnatally which lacked emotional sensitivity and compassion.

My research sits alongside Sara Bayes' grounded theory exploration of Western Australian women's experiences of medically-necessary, elective Caesarean. Both studies explored how women responded to and integrated the experience of a planned Caesarean birth; with my research focussing specifically on first time mothers. My study complements and extends the range of possible narratives of planned Caesarean birth and situates them within a National Health Service (NHS) in England.

Narratives of childbirth and motherhood

Although designed to focus specifically on women's experience of planned Caesarean birth in their first pregnancy, the participant's stories in my study were also examined in relation to dominant narratives and ideologies of pregnancy, birth and motherhood. The mothers in my study did not simply either reject or embrace cultural ideals of pregnancy, birth and motherhood - their experiences were unique, varied and often conflicting. Each of the women alluded to the dominant ideology of the *good mother*.

Women spoke of feeling vulnerable in the hospital environment (Charlene, Jo, Sally) but also challenged authoritative forms of knowledge by getting second opinions (Sarah, Abby) and by seeking complementary therapies (Lisa). Sometimes this was achieved by exercising their material (financial) resources to access services outside of the NHS system (Sarah, Kirsten, Abby, Lisa). In particular, the women showed an awareness of the ideologies directing pregnancy and birth policy and, in some cases that this drove how resources were allocated.

Uncertainty and the delicate balance of fatalism, fear and self-efficacy was a feature of all stories. My proposal that self-efficacy is realised within a relational ontology that is positively or negatively affected by the relationship with others (particularly staff and other women) transfers

to broader childbirth and motherhood narratives. In addition, I believe that this research demonstrates that women's experience of (child)birth and becoming a mother (by whatever mode) is particular, varied, and evolving.

Narrative methodology and methods

My research *shows the workings* of how a particular narrative was operationalised in order to satisfy my endeavours for researcher reflexivity. And I have attempted to demystify the process for other researchers as a contribution to debates on possibilities of narrative research and how operationalised.

In particular my research problematises issues of participant, researcher and reader subjectivities; narrative meaning and the possibilities of a personal narrative. I have been surprised by how much of the focus of my research and my learning about planned Caesarean birth has also involved a desire to explore the narrative method. I believe that this is in part due to my personal love of stories and their power to transform, my previous expertise as a midwife (for example, in providing a Listening Service – see chapter 1) and my experience in undertaking this study. A dilemma I faced throughout my research was whether or not I could find an analytic framework that could enable me to keep the participant stories whole and emplotted, whilst I attempted to produce a *meta*-story of those individual experiences. This was both a theoretical and conceptual imperative for me as one of my primary aims was to attempt to capture experiences that were about difference as much as they were about the similarity between participants. However, in my readings of narrative research I found few examples (see Mauthner, 2002) that satisfied what I was trying to achieve.

The Listening Guide (see chapter 5)

Finding the *Listening Guide* analytic framework was a major turning point in my research. With an underpinning theory of relational ontology (see Chapter 5), the Listening Guide is more than an analytic method and it provides a theoretical framework, which along with dialogic narrative approaches, has supported the approach I have taken to writing this thesis and has guided the (modest) extent of my claims in knowledge production.

The Listening Guide has been fundamental in my research and I have made a conscious decision to show the workings of how I used the Guide. Few researchers describe their methods in detail

and as a novice researcher it is difficult to appreciate the intricacies of different techniques. The Listening Guide was able to fulfil my aim to consider both structure and content of a story, in the form of emplotment; but it is not perfect. I found it incredibly time consuming and I felt that I have to develop alternative approaches with which to manage such large amounts of data. Its particular strength is in findings ways into the data and in supporting the researcher in attend to the narratives, by consciously listening in different ways. To operationalise the Listening Guide analytic method to support my research successfully, I have designed additional methods: emotional resonance' word clouds', Metaphor poems and the Writing Guide, which I believe complement and enhance the technique. The benefits and inherent contradictions of narrative research theories and how they impacted on my research will now be reflected upon.

Research design (Chapters 3, 4 & 5)

I used Narrative inquiry methodology to explore the individual, unique and situated accounts against broader political, cultural, and structural contexts of pregnancy, birth and motherhood. These personal narratives were analysed using the *Listening Guide* method.

Narrative approaches are particularly useful in researching life events at times of biographical disruption and they are important tools for exploring meaning, identity and culture. I do not feel that a narrative approach is the only way to provide answers to my research questions and inevitably other researchers would answer the questions differently and potentially more rigorously. But the narrative approach I have used has been invaluable in reflecting the intensity of the unique and shifting ways that individual women have made sense of their experience - and the narratives I have produced are plausible and coherent within the framework of trustworthiness that underpins narrative research. I feel that a narrative approach also fulfils the feminist narrative imperative to get stories 'out there' (as resources for woman to draw on to challenge dominant narratives) better than techniques which rely on coding schemes to reduce narratives to themes.

Throughout this research I have been aware of the tensions within narrative research particularly in how they relate to a desire to get at and understand accounts of experience. Most distinctions originate from the historical development of narrative research and the disciplines (humanist or humanities) which informed this development (see Chapter 3 - historical developments of narrative research). The divergences relate to whether stories are '*representing internal individual states or external social circumstances*' and the degree to which they are '*reinterpreted and*

reinterpretable', (Squire et al, 2008, p. 5). Despite these tensions, Squire et al argue that it is preferable to '*work across the contradictions*' (Squire et al, 2008, p.4) rather than try to resolve the inherent conflicts.

The approach I have taken is to see these women's stories, not as captured observations of their lives outside the interview, but as acts of engagements with me as researcher (Mishler, 1986). Thus self and identity are not seen as essential (or authentic) properties of the person but are contextually shaped and constituted in talk and social practice (Bamberg et al, 2007), although this does not preclude the possibility of a knowing, experiencing subject outside of their narrative (Doucet and Mauthner, 2008).

Aspects of the theoretical approaches to narrative that originated from phenomenological perspectives, such the need to demystifying text through interpretation (hermeneutic suspicion) (Ricoeur, 1984) and the critique of approaches which can separate out one's preconception ahead of analysis (Gadamer, [1960] 2012) have continued to influence my approach to analysing narrative text. But I have been increasingly influenced by the dialogic approaches adopted by Bakhtin (see Chapter 3). In particular, I have taken a pluralist approach to subjectivities and a multilevel and dialogic/relational approach to narrative potential which have influenced my approach to data analysis, the write up of my research, my research claims and issues of validity within my research.

Narrative findings are not generalisable in the conventional research sense, and my responsibility has been to demonstrate that my interpretations are reasonable (verisimilitude) and that I have been transparent about my knowledge production. As Koch says: '*If the research product is well sign-posted, the readers will be able to travel easily through the worlds of the participants and makers of the story and decide for themselves whether the story is a legitimate research endeavour*' (Koch, 1998, p.1189). Throughout this thesis I have tried to be transparent in my interpretations and acknowledge that they are partial, perspectival and historically contingent. I also appreciate that there are limits to what I can understand and that a researcher's understanding of a participant's words is '*always contingent upon our ability to imagine the worlds they are trying to convey*, (Squire et al, 2008, p.14).

Early in my research, I made a decision not to seek demographic details from participants and I have therefore not been able to provide the reader with details of their social location. I appreciate that this is an area of my research (and other narrative research) that is inherently contradictory as narratives are believed to be meaningful *because* they are situated and

contextualised accounts of experience. However, I was influenced by Somers' writing on identity and troubled by what I perceived to be a tendency for identity to be seen as fixed, essentialist, singular and categorical, rather than an overlapping network of relations that shift over time (Somers 1994). This is similar to Ricoeur's stance that the dynamics of identity emerges inter-subjectively always being mediated by other people (Ricoeur, 1981). He adds that '*we are literally entangled in stories*' (Ricoeur, 1996, p.6) and we '*receive a narrative identity from the stories that are told to us and those we tell ourselves, and this identity is mingled with that of others*' (Shankar et al, 2001, p.445).

However, issues of difference are important and the concepts exploring them are becoming more sophisticated with a growing interest in *intersectionality*: '*the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power*' (Davis, 2008, p.68). In future studies I would like to invite participants to write their own biographies but the approach I have taken in this research is to invite the reader to engage with how they may be reading them.

Recommendations for policy, practice, research and education

The findings from my study reflect the range and intensity of women's experiences of planned Caesarean birth. Key events and interventions in their journey that have the potential to positively or negatively impact on their experience have been highlighted. My study reveals a number of areas where improvements could be made that would transform women's experience of planned Caesarean birth:

Policy

- Women's individual narratives of childbirth could contribute to shifting ways of knowing. Women can be actively involved in debates about what constitutes effective and desirable maternity care and in co-designing maternity services.
- There needs to be a shift in focus from how women birth (mode of birth) to an understanding of the impact of the whole experience (from pregnancy to motherhood).

- Uncertainty has a negative effect on self-efficacy. Strategies for sifting the large amounts of data that are available to women can be developed that take account of what is meaningful and particular for individual women. This could be achieved using techniques that have been used previously in the development of decisions aids (e.g. see birth options after Caesarean decision aid at <http://sdm.rightcare.nhs.uk/pda/birth-options-after-previous-Caesarean/>)
- Explore opportunities for partners to be resident during hospital stays so that they can provide emotional and practical support. Many units now offer initiatives for partners to stay overnight. Benefits include: equal opportunity for partners to be present immediately after birth of their baby regardless of day or night, extended opportunity for partners to bond with their baby and a reduction in anxiety for women and their partners in the early phase of labour (see <http://www.westernsussexhospitals.nhs.uk/services-and-treatments/maternity/st-richards/involving-dads/>)

Practice

- Self-efficacy is positively or negatively affected by relationships with others (particularly staff and other women). At every contact, opportunities can be sought to listen to and support women.
- Recognise that pregnancy and birth are deeply personal and unique events in parent's lives. Provide opportunities for personalising the birth (e.g. writing birth plans that are co-designed with staff). The use of birth plans was recommended by previous research (Bayes 2010). However, I believe that the plans need to be jointly written by each woman and her clinician so that they become a tool where individual expertise and understanding can be meaningfully brought together.
- Develop birth plans which recognise the uncertainty of the planned Caesarean pathway by covering more than one scenario whilst capturing what the woman believes is important to her and any key decision points.

- Implement techniques which have been shown to mitigate against anxiety in childbirth preparation, for example mindfulness techniques (see Fisher et al 2012).

Research

Research is now needed to explore:

- Self-efficacy in women approaching pregnancy and birth, that also takes note of the social, political and economic contexts that frame maternity care and motherhood.
- Self-efficacy as a relational ontology within the mother-midwife relationship.
- Effective strategies for emotional support in theatre and postnatally for women having planned Caesarean birth.
- The experience of partners of women having planned Caesarean birth.
- Staff experience of planned Caesarean birth (as professional practice).
- The ways in which maternity staff balance their own concepts of fatalism, fear and self-efficacy in relation to how they carry out their professional practice.
- The effectiveness of service improvement strategies and techniques that may be used in the implementation of findings from this study (e.g. co-design improvement methodology or action research techniques).

Education

- Women's personal experience of planned Caesarean birth could underpin clinical education on planned Caesarean birth.
- Innovative techniques that include the use of personal narratives can be used for staff training and service improvement/redesign (see dissemination techniques).

- Anaesthetists in training need to be aware of the important role they have in providing emotional support to women and preparation for this aspect of their role could be part of their educational curriculum.

My learning and the impact of the research on me

I had ambitious personal objectives for this research which I feel were partially realised. I wanted to be able to analyse the structure and content of personal, relational, unfinalised stories of experience and then deliver them *whole* to the reader in a way that was meaningful and more than the sum of any individual part. With the help of the Listening Guide method I believe that I went some way towards being able to distinguish and analyse the many voices within each story but the method was hugely time consuming and I initially struggled to find ways to condense huge amounts of data into something that I could present to a reader without losing the narrative intention of the story. Although I struggled with issues of pulling together the meta-story, whilst attempting to resist presenting a master narrative of planned Caesarean birth, I don't believe that it was a pointless endeavour - just that it was difficult to achieve. I do believe that I have managed to achieve an analysis that goes beyond a thematic analysis but I had to design two tools (metaphor poems and the Writing Guide) and use an improvement technique (touchpoints) in order to condense the narrative to elements which balanced plot with content.

Sharon, Debs and Sarah, who acted as advisors to my study, were invaluable in supporting me in my research endeavour. However I feel that I did not fully engage them and collaborate with them fully. If I were to repeat this or undertake similar research I would aim to have a more participatory approach, where research participants or advisory group members could also participate in the research activity. I also feel that the experience based design (ebd) approach has a lot to offer researchers. Since completing this research I have been involved in an improvement programme that used the ebd approach with patients and staff in a non-maternity setting. Narratives in the form of filmed discovery interviews were used to bring about shared understanding between patients and staff, who then worked together to co-design their services. The technique would be ideally suited for action research.

This research has had a significant impact on the way I practise as a midwife. Fundamentally, becoming a mother is always more than a biological event and a Caesarean is more than an operation. Birth experience is a deeply embedded (emplotted) in the stories of others and the

dominant narratives of the culture. The Listening Guide analytic method has helped me to appreciate deep layers of narrative meaning in stories and the importance of relationships to an evolving, reflexive self. I have been a midwife for 23 years and I have often been involved in specific interventions which require advanced listening skills. Arthur Frank describes caregivers as *'people who are willing to listen...and to respond to their individual experiences... it shows the person that her life is valued because it recognizes what makes her experience particular'* (Frank, 1991, p.48). As a result of this research I now feel that I listen in a different way and (hopefully) with greater understanding.

Dissemination techniques – moving from personal to public narrative

At the beginning of Chapter 8, I used Molly Andrews' quote *'stories matter, they do things,'* (Andrews, 2007 p.12) to indicate the ability of narratives to transform. In my review of the literature (in Chapter 2), I heard Sarah Clement say of women who experienced a Caesarean *'we are a growing and forgotten band of child bearers'* (Clements 1995 p. xv). This struck a chord with me and now makes me question how I can harness the power of these eight stories and make them 'count'.

When I was carrying out the analysis of the stories I found the devices I used (I poems, metaphor poems, emotional word clouds) to be particularly helpful in creating different ways of seeing and experiencing the text. Examples of innovative ways of using and disseminating research are growing. A play called the *Tuesday Group* was performed in 2013 by medical students at Brighton and Sussex Medical school as part of their ethics curriculum. The dialogue for this play was derived from ten years of notes taken from support meetings held for dying patients. Its aim within the curriculum was to explore the potential benefits of openness around diagnosis and prognosis for cancer patients with life limiting disease (University of Brighton Community Partnership Programme, 2013). This example shows how research, knowledge and practice can come together. My hope is that I can continue to develop new and interesting ways of presenting the research findings to engage readers and disseminate the findings as a dialogic endeavour.

Koch asks: *'How can we secure readers and engage them in stories we tell? How can these projects move beyond the story into a better understanding and if appropriate, action.'* (Koch, 1998, p.1183.) In the context of my research I believe that dissemination is also retelling the research story. Stories teach, make a point, evoke a response – they are not simply examples and illustrations (Ganz, 2010) and, as such they are moral endeavours (Grant et al, 2012). When

stories are told well, we can experience the point of them and that experience can move us to action (Ganz, 2010). This *call to action* has been a recognised feature in many social movements (e.g. civil rights movement, fair trade) (Ganz, 2008), and developing personal narratives into public narratives of social change is now becoming more popular in social, political, and public arenas including health (e.g. Dementia Action Alliance).

A call to action asks us to tell a story of 'self', a story of 'us' and a story of 'now' (Ganz, 2008; Ganz, 2010). The story of 'self' communicates the values that motivates us to take action; the story of 'us' communicates values that can inspire others to take action together; the story of 'now' communicates the urgent challenge to act (Ganz, 2010). As I plan my dissemination strategy, I want to create a call to action for planned Caesarean birth and tailor my public narratives for specific audiences: women, clinicians, commissioners and policy makers.

The stories told to me by Charlene, Jo, Monika, Sarah, Abby, Sally, Kirsten and Lisa have each had an impact on me personally and how I approach my clinical practise as a midwife. Some of the features they described were not new to me but the intensity with which they were revealed has made me appreciate the significance and impact of my role supporting women as they prepare for pregnancy, birth and motherhood.

From Charlene I learned the importance of being listened to, of not being made to feel young and naive and of the benefits of talking to others in a similar situation. From Jo, I learned how important it was to have all the information in one place at one time and to have room to explore the emotions of an experience with staff. From Monika I learned that motherhood is important and something to invest in heavily, but it is also balanced with other relationships and versions of *ourselves*. From Sarah I learned that 'maternal choice' operates in a context where the making the right choice is determined by others. From Abby, I learned that sifting information was about taking the good stuff with you and leaving the not so helpful stuff behind; that it was not to fixate on a particular experience but to focus on having a positive experience by taking part and making plans. From Sally I learned that having an immediate close relationship with your baby is more important than how you have your baby. From Kirsten I learned that dominant cultural narratives about how women should birth or feed their babies can make women feel bad. And that having a good experience is about having the birth you want. From Lisa I learned that not having the birth you planned doesn't mean that you have missed out and that what is important is making birth *special*. Lisa's message was that with the right focus and attention to detail, birth can be special regardless of the way in which that baby is born. And that it is more important to focus energies and effort on making birth feel special irrespective of how it is achieved.

These stories richly add to my knowledge. The stories both complement and contradict each other. This has opened my eyes to the value of exploring the many and varied personal accounts of childbirth experience and the cost of excluding or limiting narratives to a single story of planned Caesarean birth. When I started this research, I believed that, for my research to be ethical, it should *do something* (Mander, 2007). My hope, is that with this research, I have extended the range of available narratives of planned Caesarean birth and raised awareness that there are many more to be discovered.

Concluding (and opening) remarks

Throughout this thesis I have tried to write reflexively about how and what I have come to know through my research and how I have constructed this knowledge through the writing up of my research. This activity has been relational, in the form of three sets of critical relationships: with the research participants, with the readers of this research and with my (reflexive) self. I have tried to maintain a difficult balance of handling the participant stories with integrity and being transparent with a potential reader about how I have approached the intricacies of *doing* research, whilst appreciating that my own personal background influences my research interest (Doucet, 2008).

Like other researchers, I have worried about whether participants would '*see themselves in the accounts that I told*' (Doucet, 2008, p.79) and imagined that I was sitting beside my participants '*as they read what is written about them*' (Andrews, 1991, p.49). I have also not always found it easy to balance these relationships and pin down a neat and tidy research *output*, while adopting a theoretical position where narratives are unique, unfinalised, incomplete, and whose meaning is perpetually open and orientated to the future. However, I believe this research narrative and the interpretations of the narratives it contains, contributes to new ways of knowing about planned Caesarean birth.

Narratives speak of who we are. As Chimamanda Ngozi Adichie says, '*Stories matter. Many stories matter.*' (Adichie, 2009). I believe that there cannot be only one story of planned Caesarean birth, particularly if that one story focusses solely on women who request a Caesarean birth and then perversely portrays her as both too weak and too strong; too weak if she won't contemplate vaginal birth and too strong if she challenges childbirth ideologies. There needs to be many stories of planned Caesarean birth. The women who took part in this study had rich and varied

approaches to and experiences of birth. My research extends the (limited) repertoire of available narratives of planned Caesarean birth.

Many voices are woven into this narrative; those of the research participants, the advisory group, The *Listening Guide* study group, my supervisors and my (researcher) voice. Each will also be infused with the narrative meaning of the reader.

Rather than an *ending*, I believe that stories have a beginning, and middle and a *future*. Stories (including this one) are told to be *retold*.

*

'But of course this isn't the end of the story, the stories. An ending is an artificial device; we like endings – they are satisfying, convenient – and a point has been made. But time does not end, and stories march in step with time. Equally, chaos theory does not assume an ending; the ripple effect goes on and on. These stories do not end, but they spin away from one another, each on its own course.'

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Appendix 1. Consent Form

*
University of Brighton



Centre for Nursing and Midwifery
Faculty of Health & Social Science
Mayfield House, room 266
Falmer, Brighton BN1 9PH
Tel: 01273 644029
Fax: 01273 644541

Consent Form

Women's Stories of Planned Caesarean Birth

I agree to take part in this research which is to explore the experience of women who have their first baby by a planned Caesarean.

The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.

I have had the procedure explained to me and I have read the information contained in this website/leaflet. I understand the procedures fully.

I am aware that I will be required to tell the story of my baby's birth and that this will be voice recorded.

Either:

I understand that any confidential information will be seen only by the researcher and will not be revealed to anyone else.

Or I wish my contribution to this study to be attributable to me and for my real name to be used.

I am aware that detailed passages and direct quotes will be used in this study thesis and in presentations and publications about this study

I would like a summary of the findings from this research to be sent to me

I understand that the research data collected during the study may be looked at by individuals from the research team, sponsor, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

I understand that I am free to withdraw from this research at any time without needing to give a reason.

Name:

Phone number:

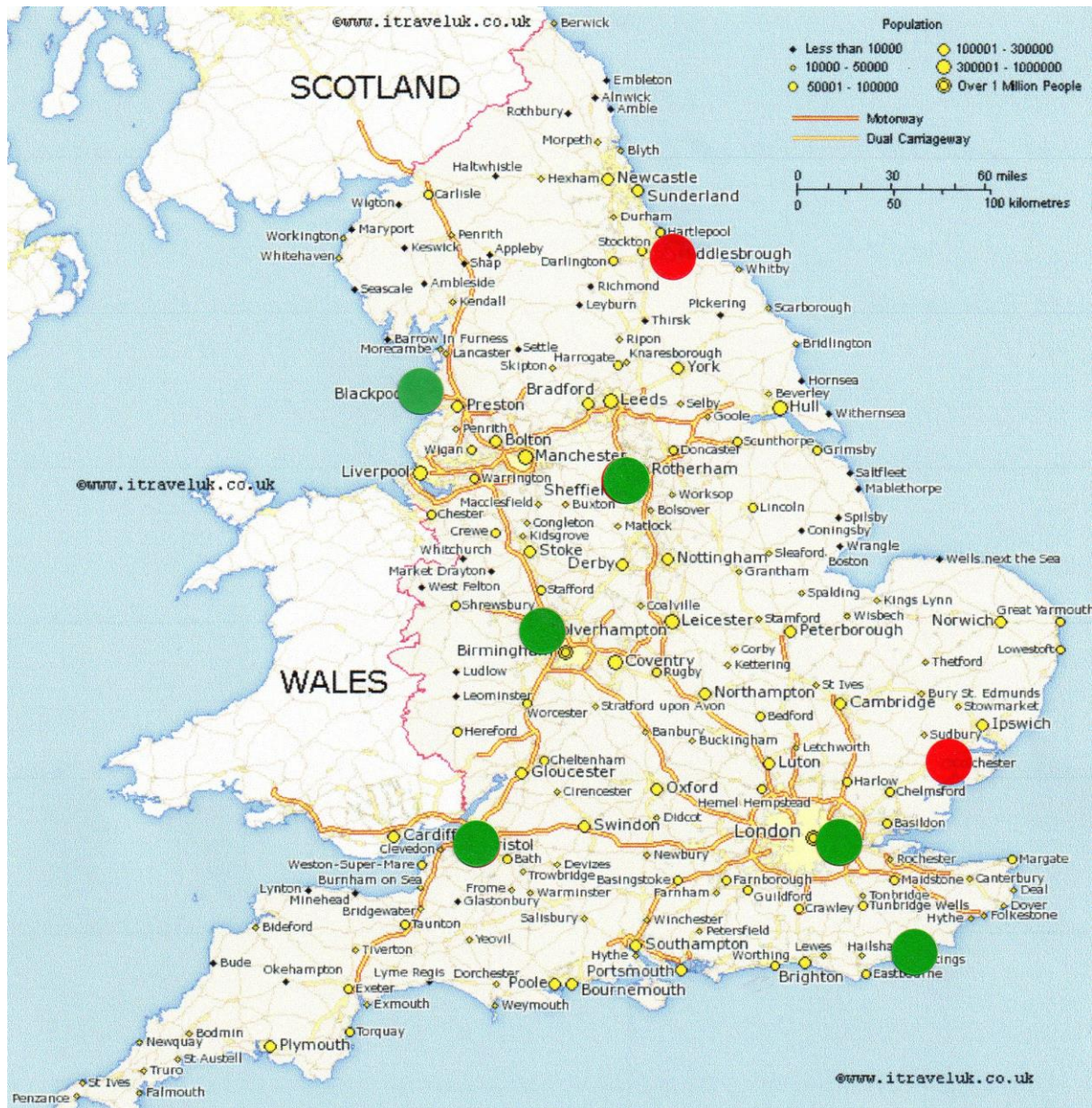
email address:

Address

Signature

date:

Appendix 2. Recruitment localities in England



Key

- Active recruitment sites
- Sites approached but not involved in recruitment

Appendix 3. Agreed amendments to the research protocol to include a partner, family member or friend at the interview

In circumstances where a research participant requests that a partner, family member or friend is present during the interview:

- the partner, family member or friend may be present regardless of whether or not they consent to have their contribution analysed
- the partner, family member or friend will be asked to read the participant information sheet for partners, family members or friends and sign a consent form if they wish to take part
- their contribution to the discussion will only be included in the analysis should they consent
- as the research pertains to women's stories of planned Caesarean birth, data from partners, family members or friends will only be used where it is intrinsic to the woman's story and will not be commented on in any other context
- the partner, family member or friend has the right to decline to be part of the research at any time at which point their data would not be included in the transcription or analysed as part of the research.

Appendix 4. Website screen shots.

Examples of screen shots from my website www.birthstories-csection.co.uk (This website is no longer active).

Home - Microsoft Internet Explorer provided by The NHS Institute

http://www.birthstories-csection.co.uk/

File Edit View Favorites Tools Help

Share Browser WebEx

Home

Women's stories of planned Caesarean birth

Researcher

Advisory Group

What is the research about?

Has this research been reviewed?

Why is the research important?



This website contains information about a research project looking at the experiences of women who have their first baby by a planned Caesarean.

Done

start

Inbox - Microsoft Out... transfer document fin... Bluetooth Settings Home - Microsoft Inte...

Researcher - Microsoft Internet Explorer provided by The NHS Institute

http://www.birthstories-csection.co.uk/researcher.html

File Edit View Favorites Tools Help

Share Browser WebEx

Researcher


Researcher

Advisory Group

What is the research about?

Has this research been reviewed?

Why is the research important?



What does it involve?

My name is Nicky Mason and I am a midwife. I live in a village in Sussex with my husband and two dogs. In my spare time I enjoy reading, art and music, walking my dogs and holidays in Cornwall.

Done

start

Inbox - Microsoft Out... transfer document fin... Bluetooth Settings Researcher - Microso...

What is the research about? - Microsoft Internet Explorer provided by The NHS Institute

http://www.birthstories-csection.co.uk/what%20is%20the%20research%20about.html

File Edit View Favorites Tools Help

EPSON Web-To-Page Print Print Preview

Share Browser WebEx

Favorites Google Suggested Sites Free Hotmail Web Slice Gallery Customize Links Windows Marketplace Windows Media Windows

What is the research about?

Home **What is this research about?**

Researcher The aim of this research is to discover information about women's experience of having a planned Caesarean birth in their first pregnancy by listening to stories of their experience. I am not setting out to prove a particular point but to understand how women feel about their Caesarean birth and what it means to them.

Advisory Group

What is the research about? In total I would like to explore 12 women's experience of planned Caesarean birth. You can take part in the research if:

- This is your first baby
- You have had your baby by a planned Caesarean (also known as an elective or scheduled Caesarean)
- You did not have any signs or symptoms of labour before having your Caesarean (e.g. regular contractions or waters breaking)
- You and your baby are healthy now

Has this research been reviewed?

Why is the research

start

Inbox - Microsoft Out... transfer document fin... Bluetooth Settings What is the research ... Internet 100% 12:38

Has this research been reviewed? - Microsoft Internet Explorer provided by The NHS Institute

http://www.birthstories-csection.co.uk/has%20the%20research%20been%20reviewed.html

File Edit View Favorites Tools Help

EPSON Web-To-Page Print Print Preview

Share Browser WebEx

Favorites Google Suggested Sites Free Hotmail Web Slice Gallery Customize Links Windows Marketplace Windows Media Windows

Has this research been reviewed?

Researcher This study has been looked at by a research ethics committee. A research ethics committee has a responsibility to safeguard the rights, safety, dignity and well-being of people taking part in research. They have given an opinion that this research is ethical and may go ahead. It has also been reviewed by the University research and ethics proposal committee (Faculty of Health and Social Science Research Ethics and Governance Committee) and they have approved this project.


Advisory Group

What is the research about? If you have any complaints about this piece of research or content of this website you can send your comments to Val Hall at v.hall@brighton.ac.uk

Has this research been reviewed?

Why is the research important?

What does it involve?



start

Inbox - Microsoft Out... transfer document fin... Bluetooth Settings Has this research bee... Internet 100% 12:40

Appendix 5. Methodological dilemma – oral or written narrations? Audit trail excerpt

As an example of how the advisory group have impacted on my research I describe here how they helped me to resolve a methodological dilemma. This dilemma related to whether the primary narrations (which were to be the focus of analysis) should be oral or written (textual).

A fellow research student tested my assumptions that oral narrations were the best or only approach to answer my research questions and together we discussed the possible benefits and impact of written narrations as the primary narration. We were interested in both the practical and theoretical considerations. Practically speaking, there would be no need to transcribe narrations, no inconvenient meeting times for mother or researcher, the potential for broader recruitment (as there were no travel restrictions) and women could take as long as they liked to construct and submit their narration.

From a theoretical perspective I had a number of questions: *Would data collection via written narrations bias the sample to women familiar with web or social networking? Would a narration constructed over time rather than 'live' narration impact on the ability to resolve the research questions? What impact would the researcher being absent (virtual) have on the narration? Would the narrative be purer at the point it is presented to the reader?*

My first instinct was to meet with my advisory group to explore this. I did this and I recorded our discussion which I then transcribed:

I asked the group members how they would feel about writing an account of their birth experience rather than telling it.

'I'd want to contact you and speak to you I wouldn't want to write something..'

'I think it is easier to talk to somebody and probably throw questions back'

'I couldn't be bothered - I know that sounds awful but, absolutely, I wouldn't be bothered. I just think oh it's just one more thing to do, especially if you've got a baby or a child which obviously if you've had the Caesarean – I just wouldn't do it.'

NICKY: What would make you think this is something you wanted to do?

'I think people like talking about themselves'

NICKY: Right. But the talking is important is it? - rather than writing, or do you think some people like to write?’

‘I think you lose something in the writing – I think people sit down and think about it a bit more or maybe take things [out] or [find] they can’t take out things but they might try to perfect it, whereas when you talking you might get more emotion

NICKY: Me, being a midwife in the room – would it affect what you said?

‘I don’t think so – I think it would be women like us who are interested in what happens in maternity services that will carry it on whereas some people have had their baby and they think – that’s it – it was a routine [operation] – they’ve had their baby and they don’t want to talk about it some people will say I really want to do that – some people will not.’

‘I think you would cut down the mixture of people you would have – it would only be people that were confident enough to write – an assertive sort of person – I’m not that confident writing and they may think with you being a midwife someone less educated than me might be completely put off the whole idea because they haven’t got the confidence to do it.’

‘If people don’t have a computer it cuts out that group of people’

As you can see from the transcription, the group members had a strong preference for oral personal narratives, giving practical and personal reasons for why they felt this was the best method. In their comments they addressed the areas of interest that I had posed when considering written narratives, namely sample bias (linked to method preference) and loss of content if narration was not spontaneous. Having the researcher in the room was perceived to be either of no consequence or a bonus as questions could be asked of the researcher.

Having met with my advisory group I was reminded of the perceived benefits to the approach we had already laid out in the research design – that of listening to oral narrations in a face to face interview. I then reviewed theoretical assumptions with this method and explored them in the light of midwifery theories and my research questions.

When I explored the theoretical constructs within narrative theory I found little (apart from practical considerations) to support changing my primary intention to collect personal oral narratives to personal written narratives. It is possible that any of these theoretical concepts that focus on oral narrations could be applied equally to written text but they tend not to be. More arguments for the benefits narrative analysis of written narrative could probably be found within literary theories but

given the response from my advisory group it appeared that written narrations would not enhance my research methodology and methods.

Appendix 6. Methods for eliciting stories

I'm curious to understand what it was like for you to become a mother and to have your baby.

I have no set questions to ask you...I just want you to tell me about your experience as if it were a story with a beginning, a middle and how things will look in the future.

There is no right or wrong way to tell your story...just tell me in any way that is most comfortable for you.'

If you were writing a book or a film of your story, how/ where does your story start?

I also prepared some interrogate prompts:

What memories do you have from this time?

Who were the significant people for you during this stage and why?

If you were writing your book for other women, what chapters would you include? What are the topics of these chapters?

What has surprised you?

Is anything different for you now?

How do you see yourself in the future? What's next?

Is there anything you want to say to me?

Appendix 7. Holistic content, holistic form and categorical form analysis – Charlene’s story: audit trail excerpt

Holistic Content:

Following the guidance from Lieblich et al (1998) model of holistic content analysis I read the story (empathically and with an open mind) several times until I believed a pattern emerged as a focus of the entire story. I then made notes about my initial and global impressions of the story. I noted exceptions to the general rule and unusual features or contradictions or unfinished descriptions. Having done this I decided on special content or themes that I wanted to focus on by using the space devoted to the theme in the text, or omissions within the story to guide my selection. Using coloured pens I marked the various themes in the story which I read separately and repeatedly. I noted my conclusions as I followed the theme through each story, specifically where the theme appeared for the first and last times, the transitions between themes and the context for each one and their relative prominence in the text. I paid special attention to episodes that seem to contradict them in terms of content, mood or evaluation in the narrator. I then met with my advisory group to explore and discuss the themes and their meaning.

Holistic Form:

I also looked at plot and characterisation within the story using Lieblich et al’s model of holistic form analysis (1998). Initially this involved considering the narrative typology. Most stories share one of four forms; romance, comedy, tragedy or satire. The terms should not be confused with conventional meanings of the words but with the narrative arc (structure) associated with dominant story types and the progressions or regression of the narrative. For example, a *romance* does not convey contemporary notions of ‘love’, in this context a romance describes a narrative where a hero faces a series of challenges en route to his or her goal and eventual victory, where the essence of the journey is the struggle itself (Lieblich et al, 1998). The goal of *comedy* is the restoration of social order and the hero must have the requisite social skills to overcome the hazards that threaten that order. In *tragedy* the hero is defeated by the forces of evil and ostracized by society. The *satire* provides a cynical perspective on social hegemony (Lieblich et al, 1998).

Using this model I looked at the progression of the narrative – development of plot over time by exploring whether the narrative was progressive (where the story advances steadily), regressive (where there was a course of deterioration or decline) or stable. I then reviewed narrative

cohesiveness of the story, how it was constructed; specifically looking at the ongoing plot to determine if there was a clearly defined objective or series of events that progress towards that objective. The relations of sequence and causality among those events were then explored using the thematic focus to explore the development of the plot and particular forms of speech to explore the dynamics of the plot. My global impression of Charlene's story was that it was a story of struggle and getting through. Charlene faced a series of challenges that she got through with the support of her partner. In narrative typology it most closely resembled *Romance*. Like my earlier concerns about finalising identities, the concept of exploring typologies could be perceived to be reductionist or diminutive and I think I would need to be cautious about how these typologies are portrayed.

I found the *Holistic Form* technique was more suited to analysis of a complete life story than through event/experience as it was difficult to measure whether there is progression or regression of the narrative over time.

Categorical Form:

I then moved to look at analysis using *categorical form* and started by analysing the whole of Charlene's story in reference to the linguistic aspects described in the model:

Process for categorical form analysis

(from Tamar Zilber in Lieblich A, Tuval-Mashiach R and Zilber T (1998) Narrative Research: reading, analysis and interpretation).

1. Select difficult episodes (or emotionally charged narratives) in the whole story for analysis
2. Attended to the accounts of the of the actual occurrence rather than speaker's evaluation
3. Attempt to remove dialogic influences

Review the following formal linguistic aspects:

- Adverbials such as suddenly – may be indicative of how expected or unexpected an event may be
- Mental verbs such as I thought, I understood and I noticed may be indicative of the extent to which an experience is in consciousness and is undergoing mental processing.
- Denotations of time and place may be indicative of attempts to distance an event or bring it closer to the narrator

- Past, present or future forms of verbs and the transitions between them, may be indicative of a speaker's sense of identification with the events being described.
- Transitions between first person, second person and third person speakers may be indicative of a split between the speaking self and the experiencing self due to difficulty of reencountering a difficult experience
- Passive and active forms of verbs may be indicative of a speaker's perception of agency
- Intensifiers such as really or very or de-intensifiers such as maybe or like raise questions about whether intensifiers consistently appear in connection with markers of the magnitude of an experience and whether de-intensifiers always appear in conjunction with expressions of helplessness and inability to cope.
- Breaking the chronological or causal progression of events by way of regressions, digressions, leaps in time or silences may be indicative of attempts to avoid discussing a difficult experience.
- Repetitions of parts of the discourse (syllables, words sentences, ideas) may indicate that the subject of discussion elicits an emotional charge in the speaker's narrative
- Detailed descriptions of events may be indicative of reluctance to describe difficult emotions.

During this process I did find that I was able to detect a layer of complexity of meaning and significance in the experience described which reflected my memories of what I had 'felt' whilst listening to the story during the interview. However, interpreting what the presence of these linguistic features revealed was time consuming and complex so I chose to focus on a short section of her story in which Charlene tells of her wish to have communicated with women who had also experienced Caesarean births during her stay on the postnatal ward (see Figure 9 below).

Each of these approaches had merit but none suited my objectives fully; the Holistic Content method yielded depth in the textual content but separated the content from the narrative arc of the story, the *Holistic Form* was more suited to a life story than a life event; the *Categorical Form* method was too detailed to extend across a whole story and then seven other stories. Ultimately, I was left with unanswered questions and reflections that left me searching for an alternative technique.

Figure 9. Analysis of a section of Charlene’s story using categorical form analysis

In the following section, Charlene is telling of her wish to communicate with women who had also experienced Caesarean birth. The setting is the postnatal ward. I have interpreted the linguistic features she used to do this to convey additional meaning in the text. I have placed the text and the interpretation side by side in a table to make it easier for the reader to assess my interpretation in reference to the original text.

Section from Charlene’s story	My interpretation of the linguistic features
<p>CHARLENE: when you’re in there you feel like you want to talk to the – cos I was in a bay with, you know, other people that had sections and I would have loved to have been able to sort of talk to them</p> <p>NICKY: right and that didn’t happen?</p>	<p>Charlene starts this scene by describing herself in the second- person ‘you’ before moving to the first person ‘I’, this connects Charlene with her <i>experiencing self</i> before her <i>speaking self</i> takes over to tell of that experience. She is highlighting that direct experience is important. It also has the effect of drawing the listener into sharing or imagining that experience. She describes the place where this experience happens using the adverb ‘there’. The actual location is the postnatal ward which she frequently refers to as ‘there’ in other sections of her story. The postnatal ward and postnatal phase of experience are previously portrayed as difficult episodes. Denoting the place where the experience takes place as ‘there’ (as distinct from here) may be an attempt to distance herself from the location which suggests that this experience of being ‘there’ was painful or difficult. The use of ‘when’, to open the scene, implies that the topic of the scene (feeling like you want to talk) is conditional on the situation of being ‘there’ suggesting that there is something missing in that environment that makes this necessary. The wish ‘to have been <i>able</i>’ and the use of the de-intensifier ‘sort of’ imply a lack of agency to action that wish.</p>
<p>CHARLENE: and they would have liked it too but it was only sort of the thing you found out on the last day that you’d sort of maybe start talking but I think that would have <i>really</i> helped a lot, you know, if people actually spoke to each other in there and um you know you could actually sit and talk and sort of discuss how you are feeling and</p>	<p>Charlene ignores my question and asserts the other’s women’s views: ‘they would have liked it too’ but her use of ‘but’ and ‘only’ modify this assertion and denote that this was contingent on finding out, something that did not happened until the last day. The use of ‘last day’ describes a <i>leap in time</i> which acts as a signpost, perhaps to a missed opportunity which the second- person ‘you’ locates this as direct experience. The use of de-intensifiers ‘sort of’ (used twice) and ‘maybe’ suggest helplessness in the experience at which point Charlene changes to a first-person telling of the experience using the mental verb ‘I think’ which indicates the level of consciousness now applied to this experience and the mental processing of that experience. The intensifier ‘really’ (really helped)</p>

<p>you know have you got this and have you done that and I think that would have been...</p> <p>HUSBAND: they kept themselves to themselves didn't they?</p> <p>CHARLENE: yeah well it was very much all the curtains were just closed round everyone and erm</p> <p>NICKY: right and was that something the women did or was it something</p> <p>CHARLENE: I don't think so</p> <p>NICKY: the staff did?</p> <p>CHARLENE: that's more just how it was</p>	<p>implies that her conclusion from this mental processing of the experience was that talking (to other women) had the capacity to positively change the experience of being 'there'. The use of the adverb 'actually' before 'spoke to each other' indicates that a positive action is required to make it happen and by repeating 'actually' before 'sit and talk' Charlene implies that one action will lead to another. This repetition also denotes an increase in the level of emotion attributed to this action. The description of what be experienced – discussion of 'how you are feeling, have you got this? Have you done that?' is located in the second-person 'you' which identifies it with the experiencing self but the application of 'I think' at the end of the phase implies a conscious (cognitive) evaluation of that experience.</p> <p>Charlene's husband shifts the focus onto the behaviour of the other women. This could purely be an observation from his experience but may indicate that he is attributing responsibility for who could or should have acted.</p> <p>Charlene uses the intensifier 'very' to emphasis her point which is that the situation was caused by the environment not the people in the situation. That the curtains were 'just' closed implies an inability to change things and describes <i>the way things are</i> 'here'.</p> <p>Charlene's response to my question indicates that she has consciously processed the experience and causal elements and does not attribute this to the other women.</p>
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<p>NICKY: right, okay</p> <p>CHARLENE: um in there and I think people are frightened to sort of - everyone is frightened of sort of approaching people – what to say um but I thought if perhaps the midwife had suggested you know something</p> <p>NICKY: or introduced you to other women</p> <p>CHARLENE: yes. Just an introduction. Cos the lady in the bay opposite was having exactly the same with feeding as I was and yet we had no means of talking to each other cos we didn't know each other and I sat there all night listening to the midwife giving her advice and she had a different woman that kept attending to her and her advice was completely different to the advice I'd been getting so I was sort of earwiggling trying to listen out for what she'd had whereas if we had the opportunity to speak then yeah simple introduction I think would have been would have gone a long way and I think that's the same for any birth. I think that would have been good.</p>	<p>Her response regarding staff involvement implies that they too may be powerless within this environment and the repetition of 'just' indicates that discussion of this subject elicit strong emotion.</p> <p>The repetition of 'in there' carries on the emotional element of this experience and points to belief that these people would or could act differently somewhere else. Charlene continues by suggestion a reason, the 'I think' denoting that she has consciously reflected on her experience. The emotion 'frightened' is repeated to intensify the strength of the feeling and 'sort of' implies helplessness in the experience. The change of tense from 'I think' to 'I thought' intensifies Charlene's identification with the experience and that, at the time, she thought the midwife could have acted to change the situation.</p> <p>Charlene's repetition of 'just' highlights the emotion of the situation, in this case frustration and the use of 'cos' (because) brings a causal explanation of this frustration which is amplified by the use of the intensifier 'exactly' to describe a woman with a matching experience. The precise positioning of the 'lady' (the bay opposite) brings her, and the experience, closer to the attention of the listener.</p> <p>The de-intensifiers 'yet' and 'no' (no means) imply helplessness to act in the situation and the visual description of 'I sat' emphasises this feeling of passivity. In this case the denotation of 'there' may be used by Charlene as a distancing of herself from the experience but is also has action of reconnecting the listener with the environment previously described. Repetition of 'different', 'advice' and 'introduction' again imply heightened emotions in the experience. The use of 'sort of' and 'trying' denote feelings of helplessness and 'earwiggling' implies that Charlene's actions were covert. Her repetition of 'I think', which occurs three times in the last two sentences denotes the level to which this experience has undergone conscious cognitive assessment and evaluation of how the experience could have been different (and better).</p>
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Appendix 8. The Listening Guide – guide to the readings

Reading one – Reading for plot

- Read for the overall plot, the story being told, the main events, protagonists and subplots. The goal is to get a sense of what is happening: follow the plot, the unfolding of events, listen to the drama – the who, what, when, where and why of the narrative. Ask what is happening here?
- Attend to recurring words and images, central themes, metaphors, emotional resonances, contradictions or inconsistencies, revisions and absences, the sound of the voice, the narrative position (first, second or third person narration).
- How is the narrative told, structured and organised?
- Who is the narrative being told to? Where, when and why is this narrative being told? What is the purpose of the narrative?

Reading one – Reading for reflexivity

- Consciously and actively focus on and document our own response to what is being expressed.
- Read the narrative on our own terms – how we respond emotionally & intellectually to what we are hearing. Consider why we think we respond this way and how our thoughts and feelings might affect our understanding of the person and our interpretation of the stories being told.
- Read for ourselves in the text –how our own background, history and experiences relate to the interviewee and how this might affect our understanding of the person and the stories being told.
- Examine where some of our own assumptions and views – whether personal, political or theoretical might affect our interpretation or how we later write about the person.
- Note our own social location in relation to the participant, the nature of our relationship with them.

- Reflect on ourselves as people in privileged position of interpreting life events of another.

Reading two – Listening for the voice of ‘I’

- Discover how our participants’ speak of themselves before we speak about them - listen to what this person knows of themselves and how they experience, speak and feel about themselves.
- Attempt to hear the person, agent or actor voice her sense of agency whilst recognising the social location from which she speaks. Pay attention to the respondent’s own understandings within a temporally and relationally situated narrative.
- Listen for the voice of the ‘I’ speaking. Focus on use of personal pronouns – I, me, you and identify shifts between I, we, you signalling changes in how the respondent perceives and experiences themselves.
- Identify where the participant may be struggling to say something
- Follow the use of first person pronoun and construct ‘I’ poems - I poems select ‘I’ phrases, maintain them in the sequence of the text and construct poem Sometimes these capture something not said directly but central to meaning.
- Try to identify multi- layered voices that co-exist within the narrative.
- Within this perspective narratives provide people with identities and allow them to speak about who they believe they are.

Reading three – Reading for relationships

- This reading is informed by feminist theoretical critiques of individualist concepts of agency and their replacement with relational concepts of subjects - all narrated subjects are understood as intrinsically relational and as part of networks of relations.
- Listen for when, why and how the respondents speak about their interpersonal relationships, with their partners, relative, friends and children and the broader social networks in which they live, parent and work
- Examine connections, autonomy and dependence within relationships - how does the narrator construct themselves within the relationships – are they enabling or constraining? Does it depend who they are speaking about?

- Consciously read for relationships which are particularly valuable in revealing the theoretical framework.

Reading four – Placing people within cultural contexts and social structures

- Here the narrative is explored within broader political, cultural and structural contexts – how does the narrator position themselves within larger social structures and cultural discourses?
- How do respondents draw on cultural resources in telling narratives? How do they speak about themselves in relation to cultural and material structures?
- Link micro-level narratives with macro-level processes and structures.
- Focus on structured power relations and dominant ideologies that frame narratives.

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Appendix 9. Data analysis of Monika's story

Listening One – reading for plot and themes

Main events, plots, actors and relationships.

Events	Actors	Relationship	Plot	reflexivity
Surprised at becoming pregnant so soon	Doctor (GP)	Confirms pregnancy and everything's fine	Not knowing own body (what capable of). Clinician as knowing	I didn't know where Monika was from/grew up. I had spoken to her on the phone and having heard her accent I wondered if she was from Poland. I had previously met several women from Poland who had been told by their doctors that because they were short sighted that they would need a CS. I wondered if this might be the reason that Monika had a CS.
Cyst found	English Dr Lithuanian Dr	Drs give opposing perspectives Dr 'back home' knowledge +trust 'I called my doctor back home...I stayed calm.'	Monika is worried, reveals emotional and thinking self 'I was so conscious' Cyst as problematic – reason for CS 'because of that'	I was unsurprised that Monika contacted her doctor 'back home' and trusted his advice rather than UK doctor's advice (I would probably do the same if I was in the same circumstances.) I wondered about the influence of others (friends, family, staff etc) on how Monika felt about the cyst and the implications of having a cyst. I found it hard to listen attentively to Monika's story while her baby was crying and I was hoping that she would pause to pick her baby up and comfort it.

Mother couldn't walk for a month after birth of first baby	Monika's mother	Passing on childbirth experience	Passed on birth knowledge from mother to daughter (vaginal birth as problematic)	I recalled that the two women I interviewed before Monika also told me that their mothers had told them of difficulties in childbirth
	'Everyone'	Provide dominant ideology of normal birth as better 'everyone telling me that this is better for me to have a normal birth.'	Reveals story as counter narrative	
'Insists' on c section	Alluding to UK medical +/- midwifery staff	Mode of birth decisions and power struggles	Monika's autonomy challenged by the childbirth conventions but Monika 'sticks to her [guns]' Monika's personal feeling and experience (mother's) is stronger than the dominant discourse. Choices/beliefs as battle	I wondered if Monika's knowledge of her mother's first birth 'couldn't walk for a month' was a stronger influence on her wish for a c section than the presence of the cyst.
Not thinking about potential problems with c section	Ignoring 'everyone's' thoughts/experiences	Separate from others	Role of hope in decision making	
C section experience as 'perfect'	Other people's experience	Monika separates her experience from other peoples – is different	Other people's experience may be different from yours	I was glad that Monika's experience was positive. Monika said that she had expected more pain – I asked her if she meant this in relation to the spinal or the wound – from previous experience I am interested in how women think through what they are hoping to

				achieve/ what they are hoping to avoid when planning mode of birth
Sick during operation	Surgeon	Kind and funny 'cheer me up'	Experience wasn't perfect	I wondered why Monika needed cheering up and how she might have 'looked' (anxious/upset etc) if I had been observing her at the time.
Able to walk earlier than allowed	Staff 'they	Hold her	Better than expected Staff constrained her when she was able.	
Stopped pain relief early to breastfeed	Monika Staff in hospital	Altruistic towards baby supportive	Motherhood as role of sacrifice	
Horror stories	Rest of the women in hospital	Other birth experiences/modes	Vaginal birth as traumatic	Thoughts on how women share birth experiences and representations of experience – narrative realities.
Friend's experience and viewpoint	Friend who had x 3 planned c section	Reinforcing advancements in technology and modern surgical birth as safe	Hospital as place of safety and rescue 'no one's gonna let you die' Reassurance counter knowledge/experience/narrative Mind over matter	I recognised theme of fatalism/fear of dying present in other participant interviews.
Stopped breastfeeding after 3 weeks Monika reveals that she 'had very little milk' but	Monika Me	I perceived that Monika might assume that I was pro breastfeeding.	Stopping breastfeeding is reframed as being best for baby as baby was hungry.	From my midwifery experience I was aware of the associations between CS birth and breastfeeding success and I wondered about the level of support Monika might have had from staff and if there were any cultural influences around breastfeeding.

then that her baby 'was hungry all the time.'				
Monika ended her story				I was worried that Monika had ended her story too soon and that I had failed to grasp the meaning and I wanted more so I asked her a question about her relationship and the involvement of her doctor back home. Monika talked about her doctor in Lithuania and this was the first time that I knew that this was where she was from.
Contacts with doctor back home	Doctor 'back home'	Good Private (a service that is paid for)	Importance of the status of the doctor and that he has known Monika for many years.	From my previous experience of private obstetrics I wondered if this altered the relationship between Doctor –'patient' relationship as 'patient' becomes 'customer'. Wondered if this affected the doctor's autonomy to put across his viewpoint or to challenge. I admired the continuity of carer that Monika was able to achieve
Monika's mother had twins	Monika's mother	Birth as not straight forward in Monika's family.	Monika's mother's obstetric history revealed as complex	
Monika's choice for CS supported	Doctor 'back home'	Know Monika and family history	Knowledge and prior knowledge give confidence (i.e. known carer). Choice. Planned CS reduces anxiety 'it's better for my peace of mind.'	I expected that doctors in different countries would have different views on childbirth practices. I wondered if anyone had dealt with Monika's anxieties re pain/blood loss. <i>Have we helped?</i>

				I was worried that the CS is a sticking plaster and that we haven't dealt with underlying issues (fears/worries)
Doubts in pregnancy			Pregnancy as time of doubts (about your body, about decision making)	I wished I had explored this
Gaining information from the internet/talking to women	Internet CS women Normal birth women	Sources of knowledge	Fact finding focussed on looking at bad things Choices as personal and individual 'it works for me.'	
Thinking through all the things that can happen can make you crazy			Too many variable to cope with Planned CS enables you to prepare for experience	I can appreciate this as I tend to mentate on things too!
Weighed up risks	Monika	Body and health	Sees herself as healthy	
Experience as better than expected			Preparation important to experience 'what you're expecting is what you're getting.'	
Thinking about going back to work	Other women who have had normal birth		Almost back to normal – see herself as 'working' mother. This isn't possible with normal birth	I was surprised how Monika was framing this as women who have a straight forward vaginal birth recover faster than women having a CS (lifting, driving etc). I wondered if the women. Monika was referring to were having vaginal birth with complications.
'Every woman is different'...'thinks different			Viewpoints are different not just experience	

'if it works for you, fine.'	Monika	Women having normal birth	Wouldn't belittle other women's choices or experience	
Not liking blood but opting for an operation			Experience of cs operation <u>not seeing</u> but feeling. Not seeing makes it OK	I saw the contradiction here and wanted to understand how she thought about it. I also wondered what information she had received antenatally.
Other women bleeding	Other women	Bleeding /other experience	Fatalism- concerned might die but hospital place of safety	
Postnatal bleeding			Experience better than expected. Trust in hospital as place of safety 'no one's going let you die.' stakes are high in childbirth and childbirth decisions.	
Concepts of health	Monika and other women	Monika is healthier than other women	Enables her to balance health and possible risks of surgery.	I wondered why she didn't feel that she had a good chance of a normal birth and positive experience.
Childhood diseases	Monika	Different from other children. 'immune'	Lucky/healthy previously. Role of past experience and hope in decision making	
Friends experience of emergency CS	Friend who had x2 emergency CS	Wanting normal birth don't necessarily get it.	Emergency CS= different or longer recovery – worse than planned CS Emergency CS as inevitable/likely from labour	'than be in pain for a very long time' I was disappointed that there was no clear message about what support there is available – I noticed that there was no mention of a midwife /role of midwife for support in labour.

	Friend x 3 planned CS	Happy with experience and recovery	Planned CS preferable to Emergency CS. ? risks of em cs preclude attempts at vaginal birth.	
			Going home =Wellness Concepts of recovery linked to scar healing	
	Pregnant women	Happy to share own experience of planned CS		
Family now complete/no plans for more children	Husband Monika's mother	Portrayed as person who works away from home + works hard –unable to help with childcare Now age 65	Having babies is expensive and hard work and special (princess) Women's role as 'mothers' is age/time dependent Selfish to ask for help	
			Motherhood is role of preparing children for life. Aspirations for child – wanting the best	
Reading information			Doing it right is hard work/time consuming	

	Monika and baby	Role model for women	Aspirations for university – passed on knowledge and role model	Bonus to hear this. Fascinating and refreshing – independence and strength. I usually here stories of ‘good mothering’
	Husband	To be an equal must contribute	Staying at home doing childcare not enough for personal fulfilment Children grow up and leave home Something outside of being a mother is important/necessary	Found it moving and felt close to Monika (a connection) felt emotional that she shared this with me. I wondered how this would be viewed in Lithuania.

Plot

- Balancing forms of knowledge (Doctors in UK and ‘back home’, passed on from mother and friends) with experience and hopes (caring for baby, recovery/return to normal) and fears (pain. Blood, death) and what she can control. Cognitive process. Wish to avoid emergency i.e. labour and then cs = risky and longer recovery and complications (breastfeeding, back pain).
- Choice is right – reflected in other women’s stories (blood etc) Motive is wanting to take care of baby quickly.
- Childbirth, motherhood and recovery – getting it right
- Motherhood is contextualised within life story – motherhood as transient.

Recurring words & images

worried, fear, anxiety, totally perfect, nothing, hope, wanting to take care of baby, as soon as possible, no one going to let you die, knows me, it’s not me, best (for child) , selfish, sit at home.

Central themes

- Happy with herself and her choices
- Staying true to her thoughts and wishes (and knowledge at home in Lithuania) against popular thought.
- Birth as risky/problematic

- Wanting to care for baby
- Recovery/return to 'normal'

Metaphors/phrases (in sequence)

Fingers crossed

Power of my mind

Peace of mind

On your toes

Make you crazy

Keeping my faith

One princess

Outside life.

Emotional resonances (in sequence)

Surprise shocked perfect worried conscious worried calm wanted wanted afraid afraid hoping perfect happy confident really~really~good calming
 confident good afraid doubts better better really~really~good afraid afraid surprised healthy healthy healthy lucky hoped hoped very~happy very~happy
 selfish really~really~hard



Contradictions/inconsistencies

- Pregnancy as totally ‘perfect’ but has complication of cyst (+ fears and anxieties)
- Knew from the beginning that she wanted a C section – doubts in pregnancy
- Concepts of self as healthy but this fears that vaginal birth would not be straight forward (doubts ability to birth vaginally)
- Blood phobia but chooses surgical birth
- Theatre experience as ‘totally perfect’ but describes being ‘sick’
- No problems in hospital but surrounded by horror stories
- Feels she is fit but possibility she could die
- Portrays long labour as cause of breast feeding problems – stopped breastfeeding after three weeks.

Revisions/absences

- No mention of midwife
- Partners views/involvement in decision-making

What moral language is being used?

- Pregnancy was totally perfect. CS as perfect birth.
- Childbirth as dangerous where bad things occur.
- Concepts of 'the good mother' –sacrifice and wanting what's best for baby (re stopping painkillers - able to 'live with the pain')

How is the narrative told, structured and organised?

- Complete, straight forward tale.
- Made own decisions with good reason – different from other women
- Good outcome – good choice
- Would repeat experience and choice for planned CS
- Same story – different perspective
- Counter narrative – 'to be of any value a counter narrative must be close to the truth than the dominant narrative' (Martin)

The sound of the voice

- Authoritative
- Simple story

Who is the narrative being told to?

- Other women
- Midwives, Obstetricians

What is the purpose of the narrative?

- Alternative viewpoint - counter narrative of childbirth and motherhood

Reading two – Listening for the voice of ‘I’

How does Monika speak of herself? What does she know, experience and feel?

- Monika speaks of herself as healthy (lots of detail about physical health – confidence in her health)
- Happy with experience and choices
- Decisions driven by wish to take care of baby (repeated theme)
- Doesn’t mention risks in relation to the baby
- Responsive to needs of baby stopped breastfeeding – she was very hungry
- ‘I’m very lucky’ – health and luck – re childhood diseases has history of being different/special

Sense of agency

- Hospital staff – supportive
- ‘I compared all the you know bad things’ – autonomy to seek information on outcomes
- ‘I decided that C section is less harming’ –active in selecting chosen path
- Medical staff – ‘I insist’ ‘stick to my [guns] (does her culture increase her ability to ‘insist’?)
- Sacrifice for baby – I stopped pain killers early
- Relationship with other women – able to be different
- ‘no one’s gonna let you die’ – childbirth as time when give up body autonomy - Hospital as place of rescue –
- Lithuanian doctor gives her permission to choose mode of birth
- Talks of other women’s right to choose vaginal birth ‘I’m not going , you know tell them to have a c section – to have you know scar and everything – no! It’s their choice.’ Counter narrative but not authoritative.
- ?trusting/belief in own body
- Strong willed – power of my mind
- Right decision in hindsight but experienced doubts in pregnancy
- Birth choices – strength to insist on CS rather than confidence in ability to birth naturally

I-poems how she constructs herself (see appendix 2 for Monika's I-poems)

- Stanza 1 – own knowledge – body as surprise, seeks Dr's knowledge
- Stanza 2 – worried about future events, seeks support in own culture for guidance re health decisions. Dilemmas and quest for knowledge to balance fears with possible outcomes
- Stanza 3 – inner thoughts as approach to choosing CS
- Stanza 4 – physical experience of cs operation
- Stanza 5 – CS operation better than expected; concepts and motivations re motherhood; importance of other's experience and own; inner thoughts re ability to feed (previously described as baby very hungry)
- Stanza 6 – sources of knowledge; when thinking of CS; when thinking of vaginal birth; researched choices; focussed on risks to influence her choice
- Stanza 7 – preparation – saw herself as healthy ? risks challenged.- but experience better than expected
- Stanza 8 – recovery
- Stanza 9 – weighing up of choices and other women's choices; experiences in theatre – felt but not seen ? related to acknowledging or facing fears; role of hope/faith/fatalism and experience; better than expected had hoped for the best but knew could be different
- Stanza 10 – signing of papers for blood transfusion – tacit knowledge of risks – uses knowledge of own health to balance possible outcomes; have been lucky/charmed as a child
- Stanza 11- cognitive assessment of risks balanced with fears/phobia – used knowledge of own health to mitigate about bad outcomes from CS – didn't relate to possible positive outcomes from vaginal birth
- Stanza 12 mothering and the future different from other mothers – role as woman/partner

Where may be struggling to say something:

- I'll have doubts
- I'll want C section
- Is is is it's I decided is less harming – it works for me.
- I'll really didn't want it (blood transfusion) [part of signing for c section]
- I'll don't know [childhood diseases]
- I don't I don't I don't know

- Ill can't be selfish and ask her to come
- I'm I'm I'm reading lots of information

Narrative position

- First person – telling of experience (only one 2nd person telling (describing wound) no 3rd person telling)

Multilayered voices

- Counter narrative of childbirth – defiant/persistent
- Knowledge – hope and belief
- Monika's identity – healthy woman – birth as stage in her life – not absolute in defining who she is.

Reading three – Reading for relationships

- Dr confirms pregnancy and that body is working well - 'everything's fine'
- Cyst- 'and all the movements and kicking was in the right side' – body telling her something is wrong
- 'I was keeping all those thoughts away from me' – tension between fears, hopes and knowledge
- Monika's mother's first baby – no named/gendered in the story ? significance
- 'I was so afraid I couldn't take care of my baby' – good mother relationship
- 'everyone is explaining to me' (risks of cs birth) – autonomy is challenged, constraining - CS as bad choice. Monika resists this.
- Relationship between potential risks and choices – weighing up of risks.
- 'other women my age have lots of problems' – she's herself as better/healthier than other women therefore low risk for complications with surgery
- 'I had doubts during the pregnancy' body and mind relationship
- 'All these thoughts make you crazy'- body as strong – mind as weak (later talks of peace of mind)
- 'keeping my faith' – frightening time and hoping to be lucky
- Relationship with Dr 'back home' is 'known' and trusted – visited repeatedly during pregnancy
- 'this is my choice if I feel confident and I feel good this is for me' – authority to choose and know own self

- 'I was very happy with the surgeon that did it' – expecting a service Monika's mother – reflects complexities of childbirth – couldn't walk after first baby plus twin pregnancy
- Friend who has emergency CS – not prepared to try labour in case has emergency CS- consequences of trying vaginal birth and not succeeding
- 'they kept me in bed' –constraining when able
- You have quite a big wound – experiencing self
- 'I could walk' 'and was that a surprise to you?' 'No' – knew body better than others (knew best)best
- Other mothers tell horror stories – justification of CS over vaginal birth
- 'its' their choice' – agency of other women – counter narrative but not authoritative
- 'every woman is different' – not *them and me* but all women are different
- When everything went well – 'probably it's just the power of my mind' balance of cognitive and emotional processes
- Hospital as somewhere you go when something goes wrong + place of safety and rescue ' I will be able to go to the hospital when something is wrong' - 'not gonna let you die.'
- Quick recovery – body as healthy 'I can do everything'
- 'and it works for me' (C section birth) – relationship between decisions and experience is good
- Recovery tied into getting back to work – different to other women 'other women, they can't do this.'
- 'almost myself' – role as mother and return to normal (?changed by experience)
- Husband = worker unable to help with baby
- Monika's Mother is too old and has already raised four children – motherhood as sacrifice
- Relationship with baby – role model – keen to work – aspirations for good education
- Motherhood
 - bringing up children is hard work
 - only one 'princess' want best for child – sacrifice (more babies = stay at home)
 - need for outside life
 - role model for daughter re independence and motherhood as transient/not enough
 - concepts of motherhood – children don't stay with you 'no one's gonna stick with you' – relationship not reciprocal
- independent thinker – not tied to other women or men
- 'I think it's much better' – aware not everyone will agree

Reading four – Placing people within cultural contexts and social structures

- Monika sees her narrative as counter narrative? Role of 'other'
- Hospital as material structure and place of rescue – blood transfusion signs away her authority – didn't want it but hospital's role allows it.
- What purpose does a counter narrative serve for narrator?
- Ask how the narrator marks the beginning and the end of the narrative and how it is constructed.
- Shock at becoming pregnant → life beyond children and motherhood.
- What change bought about? Monika presents an alternative viewpoints – childbirth in context of whole life story. Matter of fact. Counter narrative
- Good motherhood – sacrifice/doing the best for the child
- These societal narratives are being resisted – 'i really insist'
- Motherhood constructed as wishing to care for baby
- Dominant ideologies birth as risk and bad things happen, women horror stories of vaginal birth/em cs recovery is slow.
- Relationship with Dr in Lithuania 'he said this is my choice' – concepts of choice and decision making and the role of the professional
- When asked to think of the future – talks of return to normal and childless state (child leave you) concepts of self not tied to motherhood relationship

Beginning: It was a surprise when I get pregnant, first of all and er I was shocked – I was not expecting to become pregnant, so soon and um yeah but I was quite happy. Er I went to see my doctor and he confirmed that I'm pregnant and everything's fine. My pregnancy was totally perfect except one thing that er with the first scan they find cyst in my womb, next to the baby.

and that the baby was in the right side (pointing to her abdomen/uterus) and the cyst was in the left side. And all the time baby was in the right side. Yeah and er all the movements and kicking was all the time in the right side

yeah so i was worried about that because they they just, you know – they- doctors keep saying to me that this is fine, this is OK but I I was so conscious and i was so worried that I called my doctor back home and (baby screaming) and he said that it is not so good. And um If cyst stays the same size it's not going to cause any harm to baby, I I stayed calm but I wanted to have c section (upward inflexion) because of that (baby screaming) because I wanted to know about everything the baby, the cyst and um I was so afraid of pain because I, I – like my mum, and er with the first baby my mum er couldn't walk for a month

End: all children gonna grow up – it doesn't matter how many you you will have -no one's gonna stick with you and stay with you all the time and its going to be very selfish to ask – your child to stay with you and to stick with you all the time - you have to let them go and er with the family you have to have *something* – outside, to keep you interesting - and, keep you *going!*

- How does the narrator seek to affect the listener in the story, what change does the narrator seek to bring about in the listener?
- How does the story represent a world view that is typical of some people in particular social situations e.g. oppressed peoples?
- What larger societal narratives are embedded in the specific narratives told by the speaker?
- How are the social narratives being accepted or resisted?

Reading five

What is the premise of the story?

Monika is only planning to have one child and wants what's best for her baby. During pregnancy she has to decide the best way to have her baby by balancing her knowledge, hopes and fears with her wish to be fit and healthy to care for her daughter and to recover and return to a normal life after childbirth. Monika chooses to have a planned Caesarean, is very happy with her experience and the decisions she has made. She is confident that this was the right choice for her while acknowledging that every woman is different and should be able to choose for themselves.

What values are you dealing with? They are usually universal and in opposition e.g. love/hate, physiological birth/surgical birth

'Values':

- Knowledge – experience
- Physiological birth – surgical birth
- Motherhood (role as carer) – personal autonomy (without dependents)
- Uncertainty - control

How does this develop over time?

- Knowledge and experience of friends is privileged over UK medical professionals and determines choice to have planned CS

What is the inciting incident? Inciting incident is an event that displaces and challenges the central character/suggests a goal/highlights a need/that is either revelation or action/engages the reader/suggests an ending)

- Introduction of the cyst – tells of her anxieties for her baby to come to harm, her fear of pain and not being able to care for her baby (and moral language of *the good mother*) plus insight that she wanted a Caesarean section despite medical advice that it is not necessary.
- How do her thoughts re birth and her health relate to this? Revelation used to say that she wanted a c section. Shows fears and intentions and wishes.

Is there a crisis? (the dilemma) what is in the balance/going to happen?

- Risks of slow recovery plus bleeding or even death and how could affect ability to care for her daughter.
- Weighing up knowledge and information from professionals and experience from women with her own values, beliefs and anxieties.

Climax –the most highly charged scene/deciding moment – what is being shown and why? How does the character act?

Monika asks friends about their experience, one friend who planned to have vaginal births has two emergency Caesareans - Monika reveals that this friend has a much longer recovery time and long term consequences (back pain) and that therefore it is much better to have a planned CS if there is the possibility that you could go through labour and then need an emergency CS.

‘ I thought it’s much better to have a planned C section than be in pain for a very long time - twenty four hours or forty eight hours and you know afterwards finally you have c section and then you know you are tired, you’re exhausted and it takes much longer you know to to to recover and take care of your baby and probably it will you know affects your your breastfeeding. So, I I compared this and my other friend and she had all three you know c sections planned and she she was very happy, was very happy. and she said yah it’s it’s much better and you recover much quicker and you can go home you know mm very happy of course it it’s going to be painful at least you know you already prepared and you have pain killers – so it’s it’s it’s it’s much better.’

Resolution – what is the outcome and how does the character respond to it?

- Has a planned Caesarean, finds the experience to be better than expected – ‘will always say c section’ confident in her choice.

Narrative arc -Looking at the beginning and end – what has changed and why?

- Monika voices the confidence to make decision for planned Caesarean birth for herself against dominant ideology of vaginal birth.

Characters should have something to lose and something to gain – what is it?

- Health (physical and mental) short and long term. Ability to care for daughter and recover (return to normal life)

Where are the turning points and shifts ? (usually of value changes – can be subtle)

- Turning points – Dr ‘back home’ supports her autonomy to choose mode of birth (knows her ? how affects perceptions of authoritative knowledge)
- Knowledge – experience
 - Dr UK – pregnancy Ok no need for CS, Dr In Lithuania – it’s up to her talk to women, mother friend (NB) friend planned CS, friend em cs.
Power of mind
- Physiological birth – surgical birth
 - Horror stories ‘how they suffer, how painful, mother couldn’t walk, twins, pain, cuts everything
 - Scar, blood transfusion, blood loss, lifting, pain, walking
 - Turning point emergency cs as worse case scenario= pain and postnatal complications
- *Motherhood (role as carer) – personal autonomy (without dependents)*
 - Sacrifice and wanting what is best for her daughter compared to independence and sense of self (and role model of independence)
 - ‘and I don’t want to sit at home you know and show my daughter that you know you have to sit at home (upward inflection) and just you know depend on on on the man. You have to do your own thing, you have to discover yourself and you know sitting, sitting at home – you can’t do that.’
 - Shift – dependence of daughter; right foods, right school etc →role model for life
- Uncertainty – control
 - ‘On your toes – makes you crazy’ vs prepared, date time, when to go in definitely having baby, know hospital and drs too.
 - ‘with a planned Caesarean you already know the date, you already know the hospital and the doctors.’ Turning point seeking control
 - Hospital ‘won’t let you die’
 - Ability to prepare and know what to expect ‘what you are expecting [is] what you’re getting.’
 - ? control includes return to normal

Appendix 11. Metaphor poems

Charlene's Metaphor poem

History of abuse
A hundred per cent I would back you
Didn't have a clue
First point of call
Umpteen questions
In such a panic
Such a rush
Whole chunk was missing
Stressed out
a lot of them were in the mind-set
Would have been in a much worse place now
Part of me has missed out
Sort of try to dig information out of you
In floods of tears
Down there, you know, *invaded*
Fear of God into me
Fell to bits
In absolute pieces
They were stretched
I was in a right state
Pushed into doing things
Playing out what the fears might be
Being able to let it out?
Vent at each other
Throw things at each other and sort of compare notes
Issues in my head
everyone's got a different story at the end of the day
Good energy in the room

Go into yourself
Get through it yourself
The story was complete
Never in a million years
Vent my whole story at him
Finally – break through
Had no clue
Squeeze me in
Chase things up
Scaring you to death
Steer clear
It is all heightened.
Skin to skin
Right frame of mind
Just a mixture of nerves
Whipped it out
Completely zonked
Scares the life out of me
Done it off their own backs
In an ideal world
Have batted an eyelid
Umpteen other people
Gave you a little company
Get her to latch on
Like *this* or *this*
Best for my baby
Earwiggling trying to listen
With closed ears

Completely at ease

Popped his head round to see if I was okay

Hell of a difference

Like pins and needles

Plonked in the middle

Standing up for yourself a bit

Listen to your own instincts

Jo's Metaphor poem

A huge deal for me

Off hand

No big deal

See it everyday

Huge deal for me

Over the top reaction

Throw away comment

Gutted like a fish

Complete flip around

In the air

Running backwards and forward

A complete stranger

All very clinical and knives

Beat myself up

Hormones kicking in

A fidgety feeder

Whole night stretching in front of me
Whisked him up
Dropped out of the human race
Don't have the luxury of bean bags
Knew their jobs
Jumping on your ribs
Lay down in a room and they handed me a baby
Such a *dark* time
Dead on my feet
Takes its toll
Move in the right direction
Decisions in the dark
My head was spinning
Wouldn't have said boo to a goose
Hard to unpick
Tiny baby birds

Monika's metaphor poem

Fingers crossed
Power of my mind
Peace of mind
On your toes
Thoughts make you crazy
Keeping my faith
One princess
Outside life.

Sarah's metaphor poem

Refuse to take the label
Emotionally bruised
Get our heads round what was going on
No questions asked
Risks of that played up
Get our heads round it
Better chance of hell freezing over
No ifs, no buts
I'm a complete control freak
End of the day
Run around shooting about in a blaze of glory
Super expert in the normal
Burning off a lot of steam
Just rubbish
Visions of being forced down a vaginal delivery
Kick up a fuss
Weight off our shoulders
Ran like a dream
Out my face
Another pair of hands getting in the way
Nip in
All the frills
Knocked back
Rite of passage
Come out of this
One time shot
Cleaned us out
Bought me piece of mind
Making it to the other side
Five pennyworth
Sort of trade off
Betrayal of the sisterhood

Abby' metaphor poem

A control freak
Peace of mind
Everything was turned on its head
Lot of faff
Aftermath
One born every minute
You can't scrimp on that
Pester them for pain relief
Bond that you would create
Stayed with me
You're not about to snuff it
Just a bit wobbly
Buzzing my buzzer
Roll over and go to sleep
I was on a high
Bring this little person home
Being a spare part
Controlling visitors
Horror stories about induction
Labour kicks in
Great scheme of things
Keep presence of mind
That's other people's stuff
Walk over the threshold
Leave the not so helpful stuff behind

Sally's metaphor poem

Unexpected miracle
Hummed and harred all the way through
A complete disaster
Everybody on hand
Behind the scenes
Out she popped
A close eye afterwards
A bit of a nightmare
Running round at the last minute
Rally round
A little conveyor belt that happens to you
Laid there
They see it day in day out
You're in a sort of strange place
It's not left me
We haven't been too scarred
Move on with that
They're not yours
Come over the screen
Into your mouth
I didn't know a hundred per cent
In their heart of hearts they did
Worried about having to kind of weather the labour

Kirsten's metaphor poem

In London at Harley Street
I caught first time
It hit home
you have to jump through a couple of hoops
Ooh and this could happen, and this could happen
You never know
Too posh to push
Like nature intended
Caesarean was evil of all evil
I changed my story
They just do it all day long
Treat people the same
I was sort of third in line
You feel like all your insides are falling out
Wasn't like a no-no
Looking after the little one
I wasn't sort of like playing the victim for six weeks
Quite a few voices said that should be the woman's choice
You could really fall in a deep hole
It wasn't just one of those spur of the moment decisions
I rise above that
I can't give you the green light
But it is up to each individual like how they mentally go into the whole process
It goes both ways doesn't it?

Lisa's metaphor poem

Go anywhere near a Caesarean
Be another way
Breathing the baby out
burst out crying
Anything can happen
hadn't really dealt with it
Fear of being opened up
Bypass the experience of birth
Sticks in your head
Going back to that place
Blood on the walls
Hear the skin being cut
Smoking my little toe
Downward dog
Face that fear
Undo the good work
Face my fear
in tears
Pumped full of drugs against my will
I'll cry and just get this out
If I wasn't in the zone to say
I'd have that as backup
False hope
Different journey
Booked in
Story that I had with me

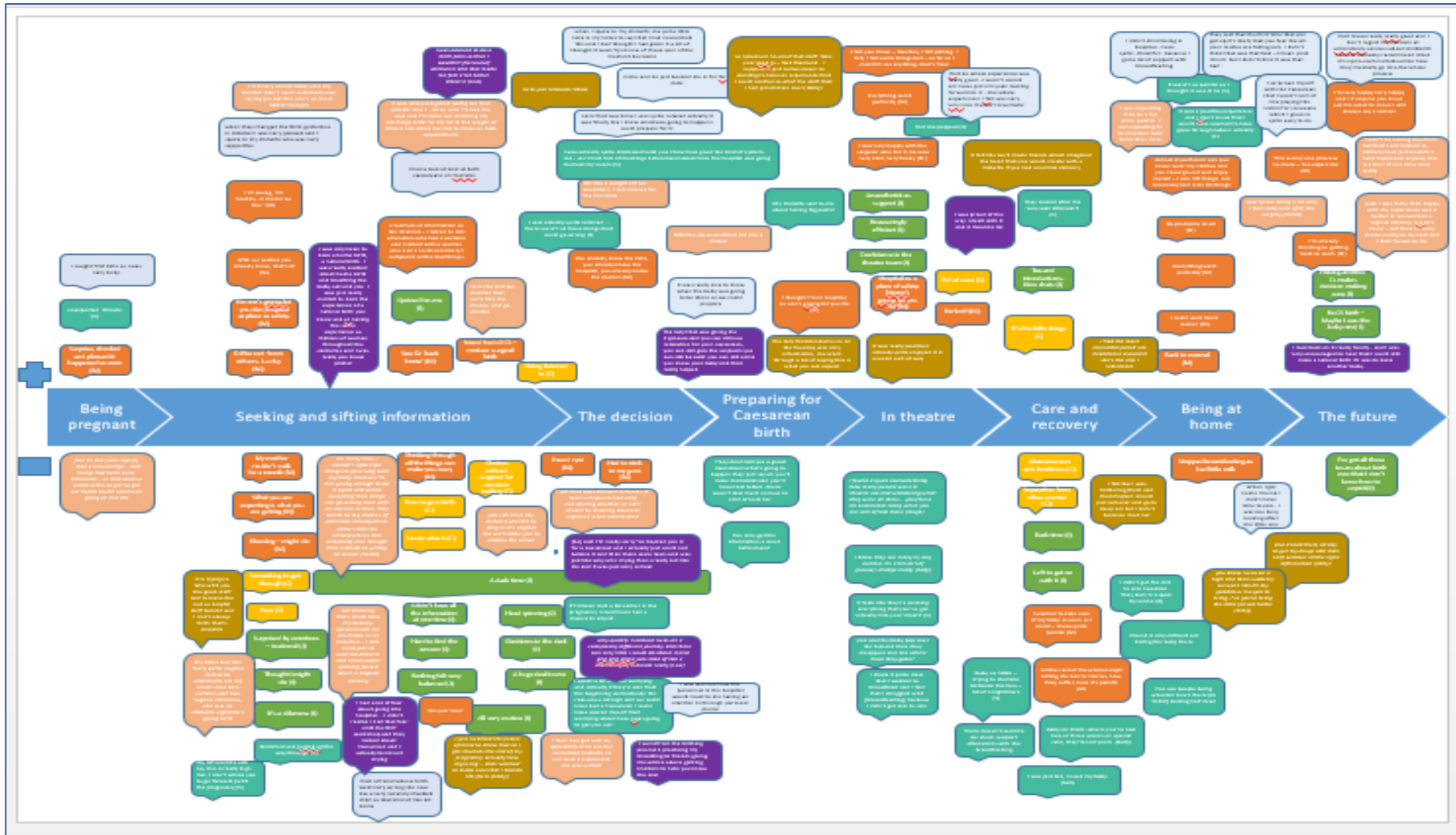
Time the other side
Missed out on that chapter
Looked down on
Cosy and indulging in my sorrow
Give myself a really good talking to
Tie up work
Got into a bubble
Talked rubbish at each other
Build up
Give birth in a forest
On my side
Laugh about it one day
Not just a token gesture
Sound of knives on the metal tray
Spun out a bit
midwife seen to be there for you
no one there for you
wanted to be totally present
freak out a bit
feeling that someone's inside you
put that thought out my head
surreal
a bit trippy
on tap
cocooned
built up in my head
all these issues
legacy of the books

a horror film in my head

swayed by this

I haven't missed out as much as I thought

Appendix 12. Emotional mapping – touchpoints



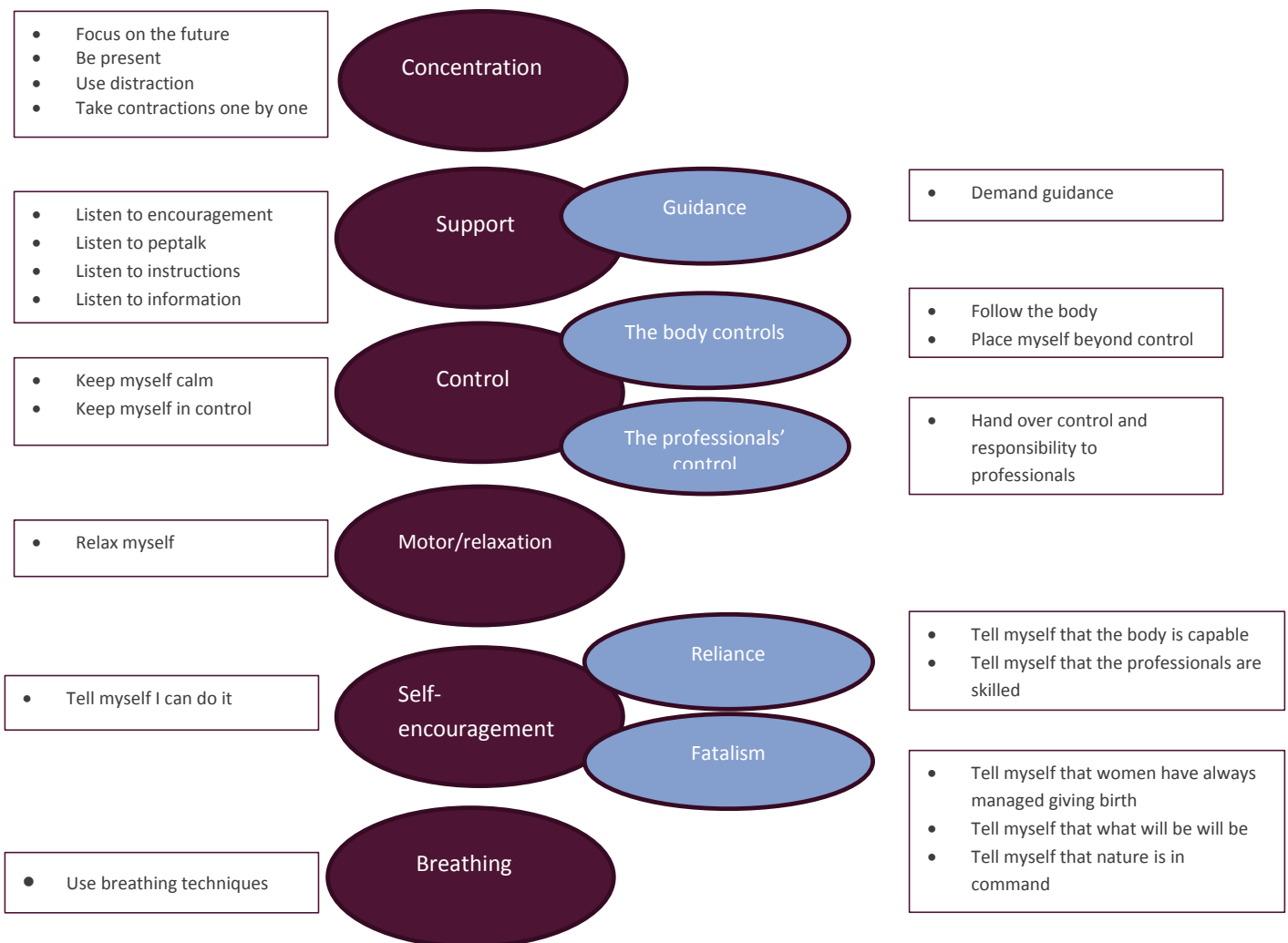
Appendix 13. Summary of the landscape of planned Caesarean birth

- Planned Caesarean birth emerged as a journey of navigating uncertainty and attempting to negotiate towards a positive experience.
- Expressions of uncertainty were mainly revealed through a complex balancing of fatalism, fear and self-efficacy. A delicate balance of these concepts was threaded through all stories. Specific events or interventions often triggered a reordering of these interrelated concepts as each woman sought strategies to limit and optimise their experience.
- The decision for a surgical birth was often made late into the pregnancy.
- Prior to the decision information was actively sought on different modes of birth, and pregnancy was characterised by the dilemma *how to (give) birth?*
- Seeking information was achieved through informal networks, particularly social media and the internet which offered up a wide range of possible experiences, but definitive answers were out of reach. In the main, NHS (maternity) professional expertise was not specifically sought outside of scheduled contacts. Information gained had the potential to increase anxiety and uncertainty but was a way of tapping into other women's experiences. Large amounts of often conflicting information was perceived as problematic and the challenge was to sift out the unhelpful to keep what was helpful.
- Arriving at a decision was highly significant as it signalled birth by planned Caesarean becoming a reality. This provoked a range of emotions.
- The experience in theatre was positive in almost all experiences. The theatre team were perceived as reassuringly efficient. Women believed that more resources were available in this part of the care journey. How relationships were formed and whether staff accommodated individual plans had a key impact on experience and mitigated for a clinical environment.
- Emotional support in theatre was mainly provided by anaesthetists.

- All of the women were pleased to have avoided an emergency Caesarean which appeared to hold a greater preoccupation than avoidance of vaginal birth.
- Post-operative care was perceived to be resource poor and busy. Lack of time was linked to whether or not women felt cared for and contributed to other phenomena such as not being given information or feeling lonely.
- Some of the anxiety, uncertainty and information seeking that had characterised the antenatal period was also present postnatally.
- Having a baby on SCBU significantly impacted on experience and it was difficult to feel that 'your baby was yours'. Information from midwives and staff on SCBU was conflicting. Feeding regimens on SCBU were perceived to be unrealistic.
- Being at home was characterised by adjustment and returning to normal and taking on the responsibilities of looking after their baby.
- Being listened to and simple acts of kindness made a difference to whether or not an experience or event was perceived as positive.
- There was a discrepancy between staff behaviours of practices that had become routine and the personal (and emotional) experience of the events felt by the women. Staff were unaware of the impact of some of their decisions and actions which increased women's feelings of isolation.
- The ability to be caring and compassionate was perceived to be down to an individual's personality and values rather than related to the amount of time to care.
- Having time to talk with staff was a high point and little acts of kindness were important.

- Most of the women spoke positively of their birth experience and would repeat or recommend planned Caesarean birth. In some cases this was because it was preferable to repeat a known experience than to encounter further uncertainty.

Appendix 14. Identified and defined childbirth self-efficacy in the context of severe fear of childbirth.



Salomonsson B, Bertero C and Alchagen (2013) Self-Efficacy in Pregnant Women with Severe Fear of Childbirth, *JOGNN*, 42 191-202.